



AMA House of Delegates Handbook

**2024 Annual Meeting
Hyatt Regency Chicago
June 7-12**

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

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MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

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



UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

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 Numbers are deleted and not reused when policies are rescinded.

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

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

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

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

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

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

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

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

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

LIST OF MATERIALS INCLUDED IN THIS HANDBOOK (A-24)

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

The informational reports contain no recommendations and will be filed on Saturday, June 8, unless a request is received for referral and consideration by a Reference Committee (similar to the use of a consent calendar).

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

FOLLOWING COLLATED BY REFERRAL

12. Report(s) of the Board of Trustees - Willie Underwood, III, MD, MSc, MPH, Chair

01	Annual Report	F
02	New Specialty Organizations Representation in the House of Delegates	Amendments to C&B
03	2023 Grants and Donations	Info. Report
04	AMA 2025 Dues	F
05	Update on Corporate Relationships	Info. Report
06	Redefining AMA's Position on ACA and Health Care Reform	Info. Report
07	AMA Performance, Activities, and Status in 2023	Info. Report

08	Annual Update on Activities and Progress in Tobacco Control: March 2023 through February 2024	Info. Report
09	Council on Legislation Sunset Review of 2014 House P	B
10	American Medical Association Health Equity Annual Report	Info. Report
11	Safe and Effective Overdose Reversal Medications in Educational Settings	B
12	AMA Efforts on Medicare Payment Reform	Info. Report
13	Prohibiting Covenants Not-to-Compete	B
14	Physician Assistant and Nurse Practitioner Movement Between Specialties	B
15	Augmented Intelligence Development, Deployment, and Use in Health Care	B
16	Support for Mental Health Courts	B
17	Drug Policy Reform	B
18	Supporting Harm Reduction	B
19	Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication	B
20	Criminalization of Providing Medical Care	Info. Report
21	American Medical Association Meeting Venues and Accessibility	F
22	AMA Public Health Strategy: Update	Info. Report
23	United States Professional Association for Transgender Health Observer Status in the House of Delegates	F
24	Report on the Preservation of Independent Medical Practice	Info. Report
25	Environmental Sustainability of AMA National Meetings. Supporting Carbon Offset Programs for Travel for AMA Conferences	F
26	Equity and Justice Initiatives for International Medical Graduates	F
27	AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates	Info. Report
28	Encouraging Collaboration Between Physicians and Industry in AI Development	F
29	Transparency and Accountability of Hospitals and Hospital Systems	G
30	Proper Use of Overseas Virtual Assistants in Medical Practice	G
31	The Morrill Act and Its Impact on the Diversity of the Physician Workforce	C
32	Independent Medical Evaluation	Info. Report
33	Employed Physicians	F
34	Demographic Report of the House of Delegates and AMA Membership	Info. Report

13. Report(s) of the Council on Constitution and Bylaws- Mark Bair, MD, Chair

01	AMA Bylaws—Nomination of Officers and Council Members	Amendments to C&B
02	AMA Bylaws—Run-Off and Tie Ballots	Amendments to C&B
03	AMA Bylaws—Removal of Officers, Council Members, Committee Members and Section Governing Council Members (D-610.997)	Amendments to C&B
04	AMA Bylaw Amendments Pursuant to AIPSC (2nd ed.)	Amendments to C&B

14. Report(s) of the Council on Constitution and Bylaws and the Council on Long Range Planning and Development - Mark Bair, MD, Chair and Gary Thal, MD, Chair

01	Joint Council Sunset Review of 2014 House Policies	F
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15. Report(s) of the Council on Ethical and Judicial Affairs - David A. Fleming, MD, Chair

01	Short-Term Global Health Clinical Encounters	Amendments to C&B
02	Research Handling of De-Identified Patient Data (D-315.969)	Amendments to C&B

03	Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices	Amendments to C&B
04	Physicians' Use of Social Media for Product Promotion and Compensation	Amendments to C&B
05	CEJA's Sunset Review of 2014 House Policies	Amendments to C&B
06	Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report	Info. Report

16. Report(s) of the Council on Long Range Planning and Development - Gary Thal, MD, Chair

01	Establishment of a LGBTQ+ Section	F
02	Scenarios on Collective Action and Physician Unions	Info. Report

17. Report(s) of the Council on Medical Education - Cynthia Jumper, MD, MPH, Chair

01	Council on Medical Education Sunset Review of 2014 House of Delegates' Policies	C
02	The Current Match Process and Alternatives	C

17. Report(s) of the Council on Medical Service - Sheila Rege, MD, Chair

01	Council on Medical Service Sunset Review of 2014 House Policies	G
02	Improving Affordability of Employment-Based Health Coverage	A
03	Review of Payment Options for Traditional Healing Services	A
04	Health System Consolidation	Info. Report
05	Patient Medical Debt	G
06	Economics of Prescription Medication Prior Authorization	G
07	Ensuring Privacy in Retail Health Care Settings	A
08	Sustainable Payment for Community Practices	A

18. Report(s) of the Council on Science and Public Health - David J. Welsh, MD, MBA, Chair

01	Council on Science and Public Health Sunset Review of 2014 House Policies	E
02	Comparative Effectiveness Research	E
03	Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders	D
04	Sex and Gender Differences in Medical Research	E
05	Biosimilar/Interchangeable Terminology	E
06	Greenhouse Gas Emissions from Metered Dose Inhalers and Anesthetic Gases	D
07	Androgen Deprivation in Incarceration	E
08	Decreasing Regulatory Barriers to Appropriate Testosterone Prescribing	E
09	Prescribing Guided Physical Activity for Depression and Anxiety	D
10	Teens and Social Media	D
11	Stand Your Ground Laws	D
12	Universal Screening for Substance Use and Substance Use Disorders during Pregnancy	E
13	Decreasing Youth Access to E-Cigarettes	D

19. Report of the House of Delegates Committee on the Compensation of the Officers - Claudette Dalton, MD, Chair

01	Compensation Committee Report	F
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20. Report(s) of the Speakers - Lisa Bohman Egbert, MD, Speaker; John H. Armstrong, MD, Vice Speaker

01	Report of the Resolution Modernization Task Force Update	F
02	Report of the Election Task Force 2	Info. Report
03	Updated Parliamentary Authority	Info. Report

**21. Joint Report(s)
CCB/CLRPD**

01	Joint Council Sunset Review of 2014 House Policies	F
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22. Resolutions

001	Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout	CB
002	Removal of the Interim Meeting Resolution Committee	CB
003	Amendments to AMA Bylaws to Enable Medical Student Leadership Continuity	CB
004	The Rights of Newborns that Survive Abortion	CB
005	AMA Executive Vice President	CB
006	Treatment of Family Members	CB
007	AMA Supports a Strategy for Eliminating Nuclear Weapons	CB
008	Consolidated Health Care Market	CB
009	Updating Language Regarding Families and Pregnant Persons	CB
012	Ethical Pricing Procedures that Protect Insured Patients	CB
013	Ethical Impetus for Research in Pregnant and Lactating Individuals	CB
014	The Preservation of the Primary Care Relationship	CB
015	Health and Racial Equity in Medical Education to Combat Workforce Disparities	CB
016	Guiding Principles for the Healthcare of Migrants	CB
017	Addressing the Historical Injustices of Anatomical Specimen Use	CB
018	Opposing Violence, Terrorism, Discrimination, and Hate Speech	CB
019	Supporting the Health of Our Democracy	CB
020	Voter Protections During and After Incarceration	CB
021	Opposition to Capital Punishment	CB
022	Health and Racial Equity in Medical Education to Combat Workforce Disparities	CB
101	Infertility Coverage	A
102	Medicaid & CHIP Benefit Improvements	A
103	Medicare Advantage Plans	A
104	Medicaid Estate Recovery Reform	A
105	Medigap Patient Protections	A
106	Incorporating Surveillance Colonoscopy into the Colorectal Cancer Screening Continuum	A
107	Requiring Government Agencies to Contract Only with Not-For-Profit Insurance Companies	A
108	Requiring Payments for Physician Signatures	A
109	Coverage for Dental Services Medically Necessary for Cancer Care	A

110	Coverage for Shoes and Shoe Modifications for Pediatrics Patients Who Require Lower Extremity Orthoses	A
111	Protections for “Guarantee Issue” of Medigap Insurance and Traditional Medicare	A
112	Private and Public Insurance Coverage for Adaptive Sports Equipment including Prostheses and Orthoses	A
113	Support Prescription Medication Price Negotiation	A
114	Breast Cancer Screening/Clinical Breast Exam Coverage	A
115	Payments by Medicare Secondary or Supplemental plans	A
201	Research Correcting Political Misinformation and Disinformation on Scope of Practice	B
202	Use of Artificial Intelligence and Advanced Technology by Third Party Payors to Deny Health Insurance Claims	B
203	Medicaid Patient Accountability	B
204	Staffing Ratios in the Emergency Department	B
205	Medical-Legal Partnerships & Legal Aid Services	B
206	Indian Health Service Youth Regional Treatment Centers	B
207	Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse	B
208	Improving Supplemental Nutrition Programs	B
209	Native American Voting Rights	B
210	Support for Physicians Pursuing Collective Bargaining and Unionization	B
211	Deceptive Hospital Badging 2.0	B
212	Advocacy Education Towards a Sustainable Medical Care System	B
213	Access to Covered Benefits with an Out of Network Ordering Physician	B
214	Support for Paid Sick Leave	B
215	American Indian and Alaska Native Language Revitalization and Elder Care	B
216	The AMA Supports H.R. 7225, the Bipartisan “Administrative Law Judges Competitive Service Restoration Act”	B
217	Protecting Access to IVF Treatment	B
218	Designation of Descendants of Enslaved Africans in America	B
219	Bundling for Maternity Care Services	B
220	Restorative Justice for the Treatment of Substance Use Disorders	B
221	Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability	B
222	Studying Avenues for Parity in Mental Health & Substance Use Coverage	B
223	Increase in Children’s Hospital Graduate Medical Education Funding	B
224	Antidiscrimination Protections for LGBTQ+ Youth in Foster Care	B
225	Humanitarian Efforts to Resettle Refugees	B
226	Protecting Access to IVF Treatment	B
227	Medicare Reimbursement for Telemedicine	B
228	Waiver of Due Process Clauses	B
229	Opposition to Legalization of Psilocybin	B
230	Protecting Patients from Inappropriate Dentist and Dental Hygienist Scope of Practice Expansion	B
231	Supporting the Establishment of Rare Disease Advisory Councils	B

232	Medicare Advantage Part B Drug Coverage	B
233	Prohibiting Mandatory White Bagging	B
234	State Prescription Drug Affordability Boards - Study	B
235	Establish a Cyber-Security Relief Fund	B
236	Support of Physicians Pursuing Collective Bargaining and Unionization	B
237	Encouraging the Passage of the Preventive Health Savings Act (S.114)	B
238	AMA Supports Efforts to Fund Overdose Prevention Sites	B
239	Requiring stores that sell tobacco products to display NYS Quitline information	B
240	Expanding Visa Requirement Waivers for NY IMGs Working in Underserved Areas	B
241	Healthcare Cybersecurity Breaches	B
242	Cancer Care in Indian Health Services Facilities	B
243	Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes	B
244	Graduate Medical Education Opportunities for American Indian and Alaska Native Communities	B
301	Fairness for International Medical Students	C
302	The Role of Maintenance of Certification	C
303	Amend Policy D-275.948 Title “Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training”. Creation of an AMA Task Force to Address Conflicts of Interest on Physician Boards.	C
304	Spirituality in Medical Education and Practice	C
305	Public Service Loan Forgiveness Reform	C
306	Unmatched Graduating Physicians	C
307	Access to Reproductive Health Services When Completing Physician Certification Exams	C
308	Transforming the USMLE Step 3 Examination to Alleviate Housestaff Financial Burden, Facilitate High-Quality Patient Care, and Promote Housestaff Well-Being	C
309	Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine	C
310	Accountability & Transparency in GME funding with Annual Report	C
311	Physician Participation in Healthcare Organizations	C
312	AMA Collaboration with FSMB to Assist in Licensing Reentrant Physicians	C
313	CME for Rural Preceptorship	C
314	Reducing the Lifetime Earnings Gap in the U.S. with Similar Educational Attainment by Employing the Gainful Employment Rule	C
315	Cease Reporting of Total Attempts of USMLE STEP1 and COMLEX-USA Level 1 Examinations	C
316	Reassessment of Continuing Board Certification Process	C
317	Physician Participation in the Planning and Development of Accredited Continuing Education for Physicians	C
318	Variation in Board Certification and Licensure Requirements for Internationally-Trained Physicians and Access to Care	C
319	AMA Support of U.S. Pathway Programs	C

401	Addressing Social Determinants of Health Through Closed Loop Referral Systems	D
402	Guardianship and Conservatorship Reform	D
403	Occupational Screenings for Lung Disease	D
404	Protections Against Surgical Smoke Exposure	D
405	Default Proceed Firearm Sales and Safe Storage Laws	D
406	Opposition to Pay-to-Stay Incarceration Fees	D
407	Racial Misclassification	D
408	Indian Water Rights	D
409	Toxic Heavy Metals	D
410	Access to Public Restrooms	D
411	Missing and Murdered Indigenous Persons	D
412	Lithium Battery Safety	D
413	Sexuality and Reproductive Health Education	D
414	Addressing the Health Sector's Contributions to the Climate Crisis	D
415	Building Environmental Resiliency in Health Systems and Physician Practices	D
416	Furthering Environmental Justice and Equity	D
417	Reducing Job-Related Climate Risk Factors	D
418	Early and Periodic Eye Exams for Adults	D
419	Addressing the Health Risks of Extreme Heat	D
420	Equity in Dialysis Care	D
421	Annual Conference on the State of Obesity and its Impact on Disease in America (SODA)	D
422	Immunization Registry	D
423	HPV Vaccination to Protect Healthcare Workers over Age 45	D
424	LGBTQ+ Senior Health	D
425	Perinatal Mental Health Disorders among Medical Students and Physicians	D
426	Maternal Morbidity and Mortality: The Urgent Need to Help Raise Professional and Public Awareness and Optimize Maternal Health – A Call to Action	D
427	Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals	D
428	Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals	D
429	Assessing and Protecting Local Communities from the Health Risks of Decommissioning Nuclear Power Plants	D
430	Supporting the Inclusion of Information about Lung Cancer Screening within Cigarette Packages	D
431	Combatting the Public Health Crisis of Gun Violence	D
432	Resolution to Decrease Lead Exposure in Urban Areas	D
433	Improving Healthcare of Rural Minority Populations	D
501	Fragrance Regulation	E
502	Tribally-Directed Precision Medicine Research	E
503	Unregulated Hemp-Derived Intoxicating Cannabinoids, and Derived Psychoactive Cannabis Products (DPCPs)	E

504	FDA Regulation of Biosimilars	E
505	Mitigating the Harms of Colorism and Skin Bleaching Agents	E
506	Screening for Image Manipulation in Research Publications	E
507	Ban on Dual Ownership, Investment, Marketing or Distribution of Recreational Cannabis by Medical Cannabis Companies	E
508	AMA to support regulations to decrease overdoses in children due to ingestion of edible cannabis	E
509	Addressing Sarcopenia and its Impact on Quality of Life	E
510	Study to investigate the validity of claims made by the manufacturers of OTC Vitamins, Supplements and “Natural Cures”	E
511	National Penicillin Allergy Day and Penicillin Allergy Evaluation & Appropriate Delabeling	E
512	Opioid Overdose Reversal Agents Where AED’s Are Located	E
513	Biotin Supplement Packaging Disclaimer	E
601	Annual Holocaust Remembrance Event	F
602	Ranked Choice Voting	F
603	End Attacks on Health and Human Rights in Israel and Palestine	F
604	Confronting Ageism in Medicine	F
605	Walking the Walk of Climate Change	F
606	Creation of an AMA Council with a Focus on Digital Health Technologies and AI	F
607	Appealing to our AMA to add clarity to its mission statement to better meet the need of physicians, the practice of medicine and the public health	F
608	The American Medical Association Diversity Mentorship Program	F
701	Opposition to the Hospital Readmissions Reduction Program	G
702	The Corporate Practice of Medicine, Revisited	G
703	Upholding Physician Autonomy in Evidence-Based Off-Label Prescribing and Condemning Pharmaceutical Price Manipulation	G
704	Pediatric Readiness in Emergency Departments	G
705	20 Minute Primary Care Visits	G
706	Automatic Pharmacy-Generated Prescription Requests	G
707	Alternative Funding Programs	G
708	Medicolegal Death Investigations	G
709	Improvements to Patient Flow in the U.S. Healthcare System	G
710	The Regulation of Private Equity in the Healthcare Sector	G
711	Insurer Accountability When Prior Authorization Harms Patients	G
712	Full transparency - Explanation of Benefits	G
713	Transparency – non-payment for services to patients with ACA exchange plans with unpaid premiums	G

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

Preamble

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

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

Declaration

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

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

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

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

Delegate/Alternate Delegate Job Description, Roles and Responsibilities

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

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

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

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

A. Qualifications

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

B. Responsibilities

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

SEATING ALLOCATION – 2024 ANNUAL MEETING

ADDICTION MEDICINE – 3

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

AMDA – 1

AMDA – The Society for Post-Acute and Long-Term Care
Medicine (AMDA) – 1

AMGA - 1

American Medical Group Association (AMGA) - 1

ANESTHESIOLOGY - 10

American Society of Anesthesiologists (ASA) - 8
American Society of Regional Anesthesia and Pain Medicine
(ASRAPM) - 2

ARS – 1

American Rhinologic Society (ARS) - 1

CARDIOLOGY - 15

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

CHEST PHYSICIANS - 4

American College of Chest Physicians (CHEST)
(ACCP) – 4
Delegates – 3
Resident and Fellow Section Delegate – 1

CRITICAL CARE MEDICINE- 2

Society of Critical Care Medicine (SCCM) - 2

DERMATOLOGY - 13

American Academy of Dermatology Assoc. (AAD) – 5
American College of Mohs Surgery (ACMS) – 1
American Contact Dermatitis Society (ACDS) - 1
American Society for Dermatologic Surgery Assoc
(ASDSA) - 3
American Society of Dermatopathology (ASD) - 1
Society for Investigative Dermatology (SID) - 1
Society for Pediatric Dermatology (SPD) – 1

EMERGENCY MEDICINE - 11

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

ENDOCRINOLOGY - 3

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

FAMILY PHYSICIANS - 26

American Academy of Family Physicians (AAFP) - 26
Former Board Chair (Langston) - 1
Delegates - 25

GASTROENTEROLOGY - 6

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

GERIATRIC MEDICINE - 2

American Geriatrics Society (AGS) – 2

GREAT LAKES - 66

Illinois - 19
Trustee (Siddiqui) – 1
Delegates - 12
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
American College of Legal Medicine (ACLM) - 1
American Med Women’s Association (AMWA) - 1
Obesity Medicine Association (OMA) - 1
Society of Nuclear Medicine and Molecular Imaging
(SNMMI) - 1
Indiana - 6
Delegates – 5
Medical Student Regional Delegate- 1
Michigan – 17
Trustee (Mukkamala) - 1
Delegates - 14
Medical Student Regional Delegate – 1
Resident and Fellow Section Delegate - 1
Ohio - 14
Delegates (minus Speaker) - 11
Medical Student Regional Delegate – 1
Resident and Fellow Section Delegate – 1
Amer Assn of Neuromuscular & Electordiagnostic Med
(AANEM) - 1
Wisconsin - 10
Former Board Chair (Flaherty) – 1
Delegates - 5
Medical Student Regional Delegate – 1
Resident and Fellow Section Delegate - 1
Undersea & Hyperbaric Medical Society (UHMS) – 2
Delegate -1
Resident and Fellow Section Delegate – 1

HEART OF AMERICA - 12

Kansas – 4
Delegates - 3
Medical Student Regional Delegate- 1
Missouri – 8
Former President (Barbe) - 1
Delegates - 5
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate – 1

HEMATOLOGY - 2

American Society of Hematology (ASH) - 2

HOSPITAL MEDICINE - 3

Society of Hospital Medicine (SHM) – 3

INFECTIOUS DISEASE – 2

Infectious Diseases Society of America (IDSA) - 2

INTERNAL MEDICINE - 37

American College of Lifestyle Medicine (ACLSM) – 1
American College of Physicians (ACP) – 35
Trustee (Fryhofer) – 1
Delegates – 34
Former President (Wilson)
Renal Physicians Association (RPA) - 1

MOBILITY CAUCUS - 13

American Acad of Orthopaedic Surgeons (AAOS) – 5
Former President (Gurman) - 1
Delegates – 4
American Association for Hand Surgery (AAHS) - 1
American Orthopaedic Association (AOra) - 1
American Orthopaedic Foot and Ankle Society
(AOFAS) - 1
American Society for Surgery of the Hand (ASSH) - 1
American Society of Interventional Pain Physicians (ASIPP) -
1
International Society for the Advancement of Spine Surgery
(ISASS) – 1
North American Spine Society (NASS) - 2

NEUROSCIENCES – 32

Academy of Consultation-Liaison Psychiatry (ACLP) – 1
American Academy of Addiction Psychiatry (AAAP) - 1
American Academy of Child and Adolescent Psychiatry
(AACAP) - 2
American Academy of Hospice and Palliative Medicine
(AAHPM) - 2
American Academy of Neurology (AAN) – 5
Delegates – 3
Resident and Fellow Section Delegate - 2
American Academy of Pain Medicine (AAPM) - 1
American Acad of Psychiatry and the Law (AAPL) - 1
American Assoc for Geriatric Psychiatry (AAGP) - 1
American Association of Neurological Surgeons
(AANS) - 2
Former President (Carmel) - 1
Delegate – 1
American Psychiatric Association (APA) - 10
Former President (Harris) – 1
Delegates - 8
Resident and Fellow Section Delegate – 1
American Society of Neuroimaging (ASNI) - 1
Congress of Neurological Surgeons (CNS) - 2
GLMA : Health Professionals Advancing LGBTQ
Equality – 1
North American Neuromodulation Society (NANS) - 1
International Pain and Spine Intervention Society
(IPSIS) - 1

NEW ENGLAND - 31

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

NEW YORK - 29

Former President (Nielsen) – 1
Trustee (Madsjski) – 1
Delegates - 23
Medical Student Regional Delegate - 1
American College of Nuclear Medicine (ACNM) - 1
American Society of Neuroradiology (ASN) - 2

NORTH CENTRAL - 17

Iowa – 5
Delegates – 4
Outpatient Endovascular and Interventional Society
(OES) - 1
Minnesota – 6
Delegates - 5
Americas Hernia Society (AHS) - 1
Nebraska – 2
North Dakota - 2
South Dakota - 2

OBSTETRICIANS AND GYNECOLOGISTS - 19

American Association of Gynecologic Laparoscopists
(AAGL) - 2
American College of Medical Genetics and Genomics
(ACMGG) - 1
American College of Obstetricians and Gynecologists
(ACOG) – 15
Trustee (Koirala) - 1
Delegates – 14
Former President (Wah)
American Soc for Reproductive Medicine (ASRM) - 1

ONCOLOGY - 7

Association for Clinical Oncology (ACO) – 7
Delegates – 5
Former President (McAneny)
Resident and Fellow Section Delegates – 2

PACWEST CONFERENCE – 86

Alaska - 1
Arizona - 8
Delegates – 5
American Coll of Radiation Oncology (ACRO) - 1
American Institute of Ultrasound in Medicine
(AIUM) – 2
California - 44
Former Presidents (Corlin, Plested) – 2
Trustee (Ding, Ajayi) - 2
Delegates - 32
Medical Student Regional Delegates - 2
Resident and Fellow Section Delegates - 2
American Clinical Neurophysiology Soc (ACNS) – 1
American Soc for Radiation Oncology (ASRO) – 2
North American Neuro-Ophthalmology Society
(NANOS) – 1
Colorado - 7
Delegates - 6
Medical Student Regional Delegate - 1
Hawaii - 2
Idaho - 1
Montana - 1
Nevada – 3
Delegates - 2
Resident and Fellow Section Delegate – 1

PACWEST CONFERENCE (cont’d)

New Mexico – 4
Delegates – 2
Resident and Fellow Section Delegate - 1
American Academy of Allergy, Asthma & Immunology
(AAAAI) – 1
Oregon – 5
Delegates - 4
Medical Student Regional Delegate- 1
Utah – 3
Washington – 6
Wyoming – 1

PATHOLOGY - 9

American Society for Clinical Pathology (ASCP) – 3
American Society of Cytopathology (ASC) - 1
College of American Pathologists (CAP) – 4
National Association of Medical Examiners (NAME) - 1

PEDIATRICS - 8

American Academy of Pediatrics (AAP) – 8
Delegates - 5
Resident and Fellow Section Delegates - 3

PENNSYLVANIA - 18

Trustee (Heine) - 1
Delegates - 14
Resident and Fellow Section Delegate – 1
American Association of Physicians of Indian Origin
(AAPIO) – 1
National Medical Association (NMA) - 1

PHYSICAL MEDICINE AND REHABILITATION - 5

American Academy of Physical Med & Rehabilitation
(AAPMR) – 4
Delegates - 3
Resident and Fellow Section Delegate - 1
Association of Academic Physiatrists (AAPHY) - 1

PREVENTIVE MEDICINE - 6

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

RADIOLOGY - 17

American College of Radiology (ACR) – 9
Delegates – 8
Former President (Johnson)
Resident and Fellow Section Delegate - 1
American Roentgen Ray Society (ARRS) – 3
Association of Academic Radiology (AAR) - 1
Radiological Society of North America (RSNA) – 3
Society of Interventional Radiology (SIR) - 1

RHEUMATOLOGY - 2

American College of Rheumatology (ACRr) - 2

SECTIONS - 11

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

SERVICES - 6

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

SLEEP MEDICINE – 2

American Academy of Sleep Medicine (AASM) - 2

SOUTHEASTERN - 118

Alabama – 4
Arkansas – 4
Trustee (Ferguson) – 1
Delegates – 2
Medical Student Regional Delegate- 1
Delaware - 2
Former Board Chair (Permut) – 1
Delegate - 1
District of Columbia - 3
Former Board Chair (Scalettar) - 1
Delegates - 2
Florida – 20
Trustee (Butler) - 1
Delegates – 17
Medical Student Regional Delegate- 1
The Triological Society (TS) - 1
Georgia – 6
Kentucky - 5
Louisiana - 7
Maryland - 9
Trustee (Edwards) - 1
Delegates – 6
Medical Student Regional Delegate - 1
Acad of Physicians in Clinical Research (APCR) - 1
Mississippi – 4
Delegates – 3
Resident and Fellow Section Delegate - 1
New Jersey - 10
Delegates - 8
Medical Student Regional Delegate- 1
American Osteopathic Association (AOA) – 1
North Carolina – 7
Delegates - 6
Medical Student Regional Delegate- 1
Oklahoma – 7
Delegates - 4
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegates - 2
Puerto Rico - 2

SOUTHEASTERN (cont’d)

South Carolina – 8
Former Presidents (Harmon, Smoak) – 2
Trustee (Pastides) - 1
Delegates – 4
Medical Student Regional Delegate- 1
Tennessee – 8
Delegates – 6
Medical Student Regional Delegate- 1
American Vein and Lymphatic Society (AVLS) - 1
Virginia – 10
Delegates - 8
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
West Virginia – 2

SURGEONS - 44

American Academy of Cosmetic Surgery (AACS) - 1
American Acad of Facial Plastic and Reconstructive Surgery
(AAFPRS) – 1
American Academy of Ophthalmology (AAO) – 5
Delegates - 4
Resident and Fellow Section Delegate - 1
American Academy of Otolaryngic Allergy (AAOA) - 1
Amer Acad of Otolaryngology - Head & Neck Surgery
(AAOHNS) - 3
American Association for Thoracic Surgery (AATS) - 1
American Association of Plastic Surgeons (AAPS) - 1
American College of Surgeons (ACS) - 8
Delegates (minus Vice Speaker) – 7
Resident and Fellow Section Delegate - 1
American Society for Aesthetic Plastic Surgery
(ASAPS) – 1
American Society for Metabolic and Bariatric Surgery
(ASMBS) - 1
American Society for Reconstructive Microsurgery
(ASRMS) - 1
American Society of Breast Surgeons (ASBS) - 1
American Society of Cataract and Refractive Surgery
(ASCTRS) - 2
American Society of Colon and Rectal Surgeons
(ASCRS) - 1
American Soc of Maxillofacial Surgeons (ASMS) - 1
Amer Soc of Ophthalmic Plastic & Reconstructive Surg
(ASOPRS) - 1
American Society of Plastic Surgeons (ASPS) – 3
American Society of Retina Specialists (ASRS) - 1
American Society of Transplant Surgeons (ASTS) - 1
American Venous Forum (AVF) – 1
International Coll of Surgeons-US Section (ICS-US) - 1
Society for Vascular Surgery (SVS) - 1
Society of Amer Gastrointestinal Endoscopic Surgeons
(SAGES) - 2
Society of Laparoscopic and Robotic Surgeons (SLRS) - 2
Society of Thoracic Surgeons (STS) - 2

TERRITORIES - 2

Guam - 1
Virgin Islands - 1

TEXAS - 28

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

THORACIC MEDICINE - 2

American Thoracic Society (ATS) - 2

UROLOGY - 4

American Assoc of Clinical Urologists (AACU) - 2
American Urological Association (AUA) – 2

OFFICIAL OBSERVERS - 28

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

TELLERS - 5

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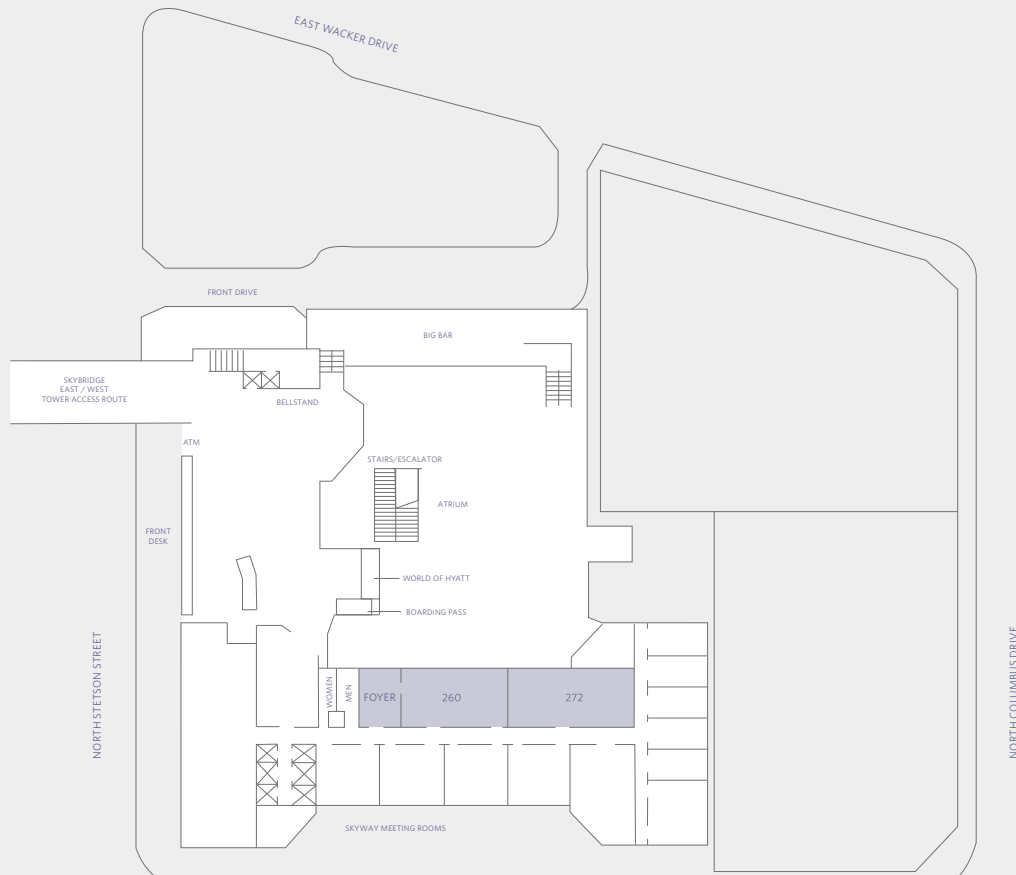


CAPACITY CHART



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

FLOOR PLAN



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

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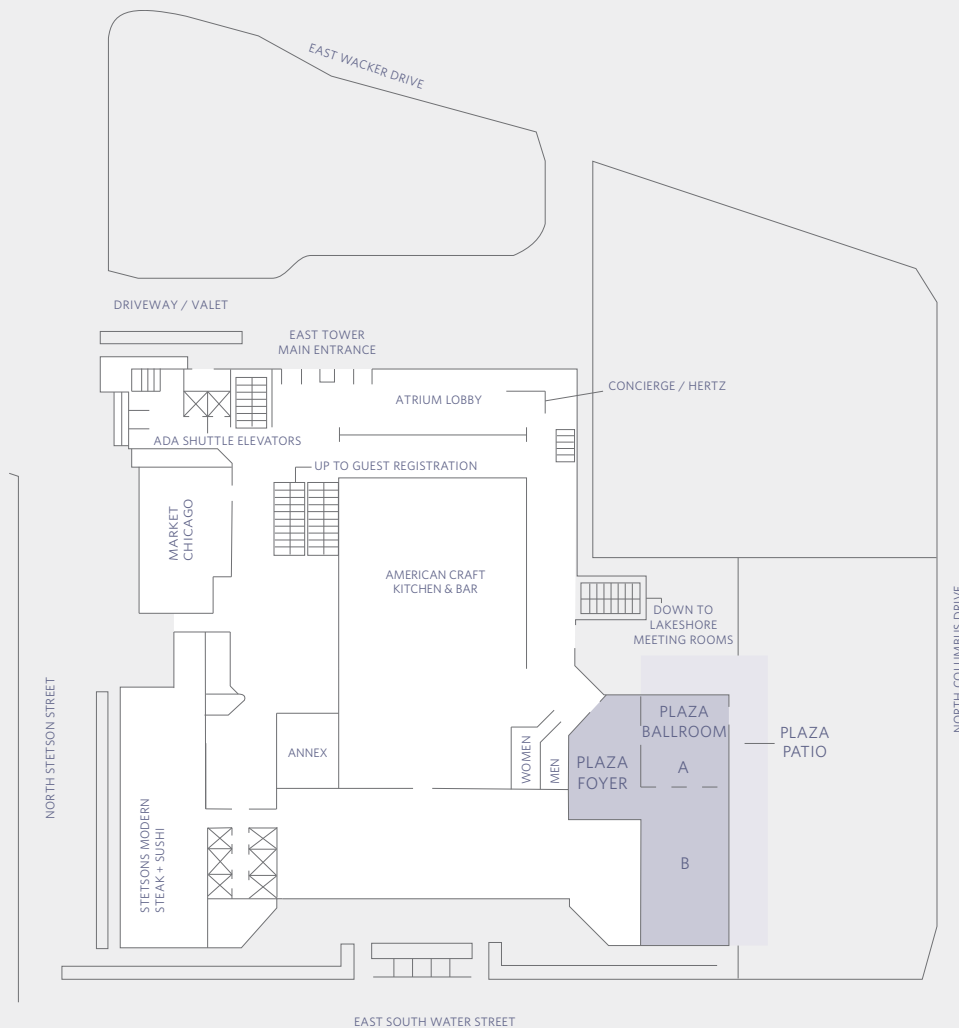


CAPACITY CHART



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

FLOOR PLAN



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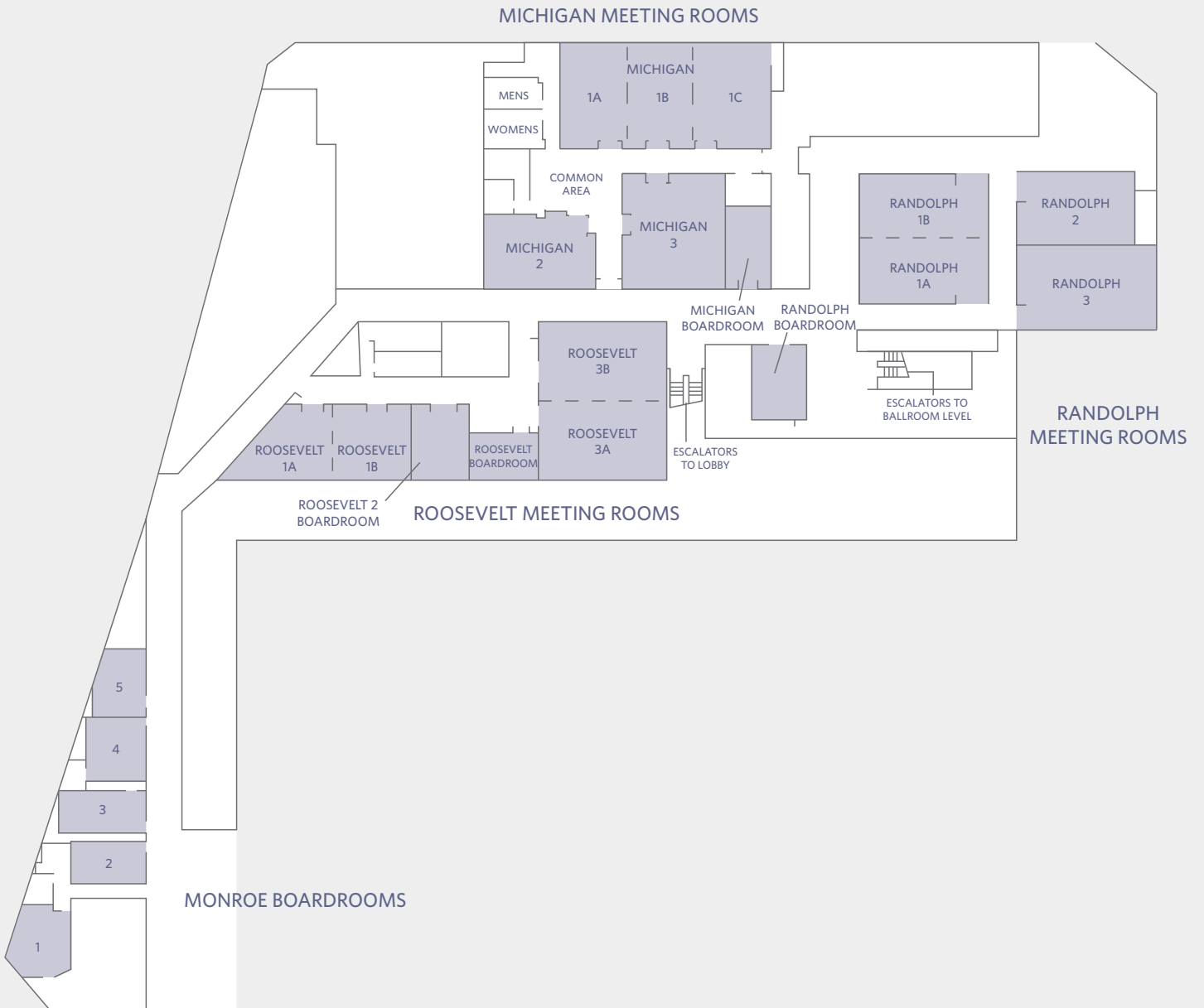
Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Concourse Level (East Tower)										
LAKESHORE MEETING ROOMS										
Michigan 1A, 1B, 1C	33'4" x 74'5" x 8'6"	2,475	140	250	270	135	40/50*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

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FLOOR PLAN
Concourse Level (East Tower)



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CAPACITY CHART



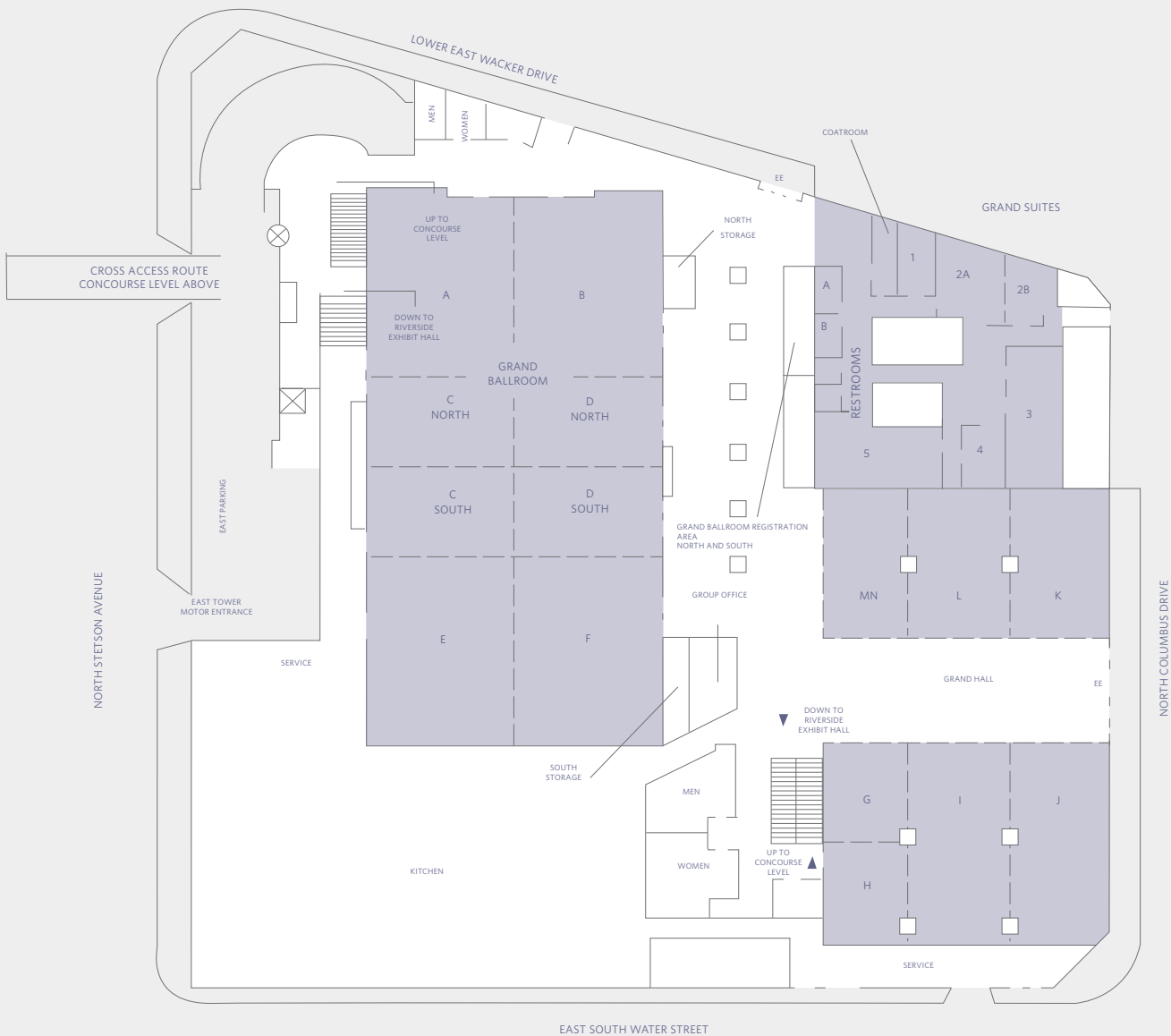
Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Ballroom Level (East Tower)										
GRAND BALLROOM	213' x 114' x 17'	24,282	1,800	3,000	2,400	1,250	—	—	—	137
Grand A or B	71' x 57' x 17'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

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FLOOR PLAN
 Ballroom Level (East Tower)



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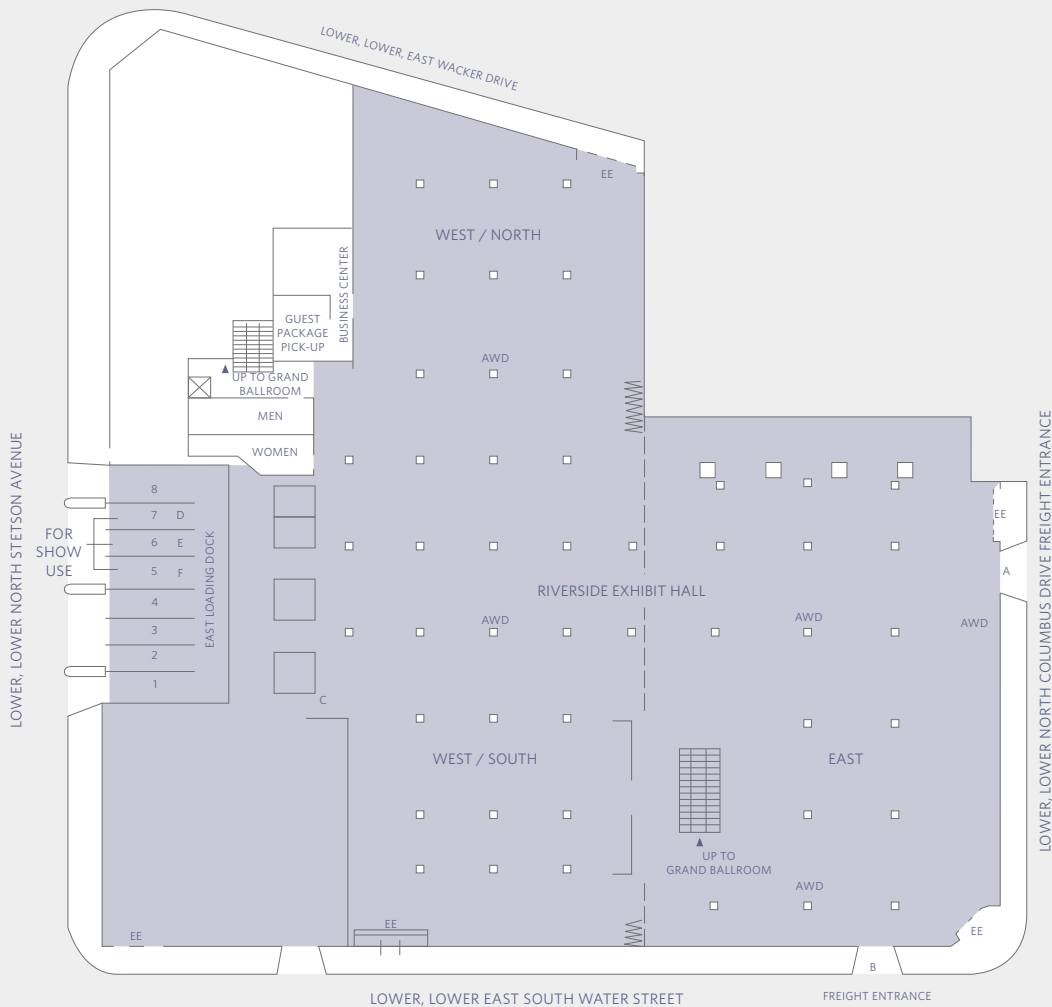


CAPACITY CHART



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Exhibit Level (East Tower)										
RIVERSIDE EXHIBIT HALL										
HALL	CEILING HEIGHT 12'	70,000	2,330	7,000	—	—	—	—	—	355
EAST	—	30,000	870	2,500	2,400	—	—	—	—	151
WEST	—	40,000	1,330	4,500	3,300	—	—	—	—	204
EAST DOCK (D, E, F)	—	3 Bays	—	—	—	—	—	—	—	—

FLOOR PLAN



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

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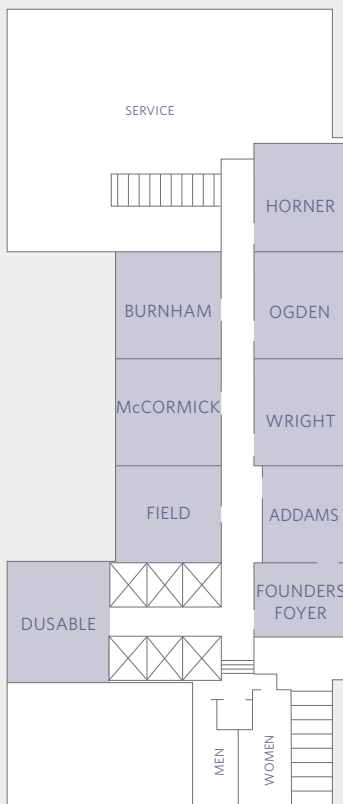


CAPACITY CHART



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

FLOOR PLAN



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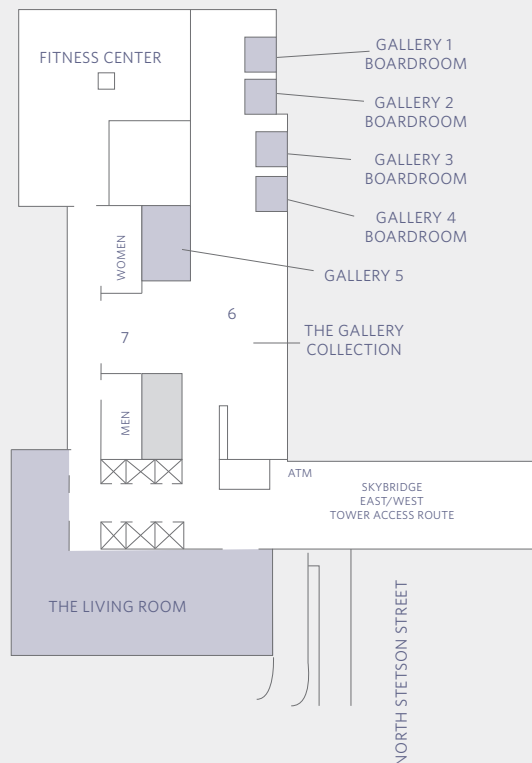


CAPACITY CHART



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

FLOOR PLAN



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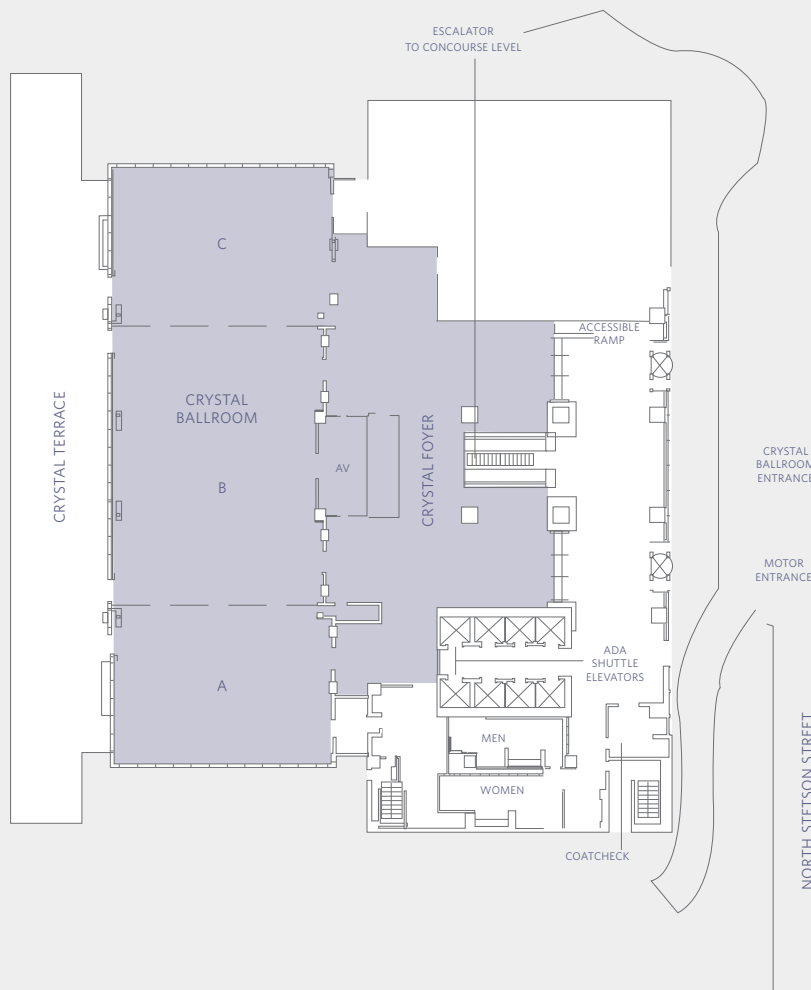


CAPACITY CHART



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

FLOOR PLAN



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CAPACITY CHART

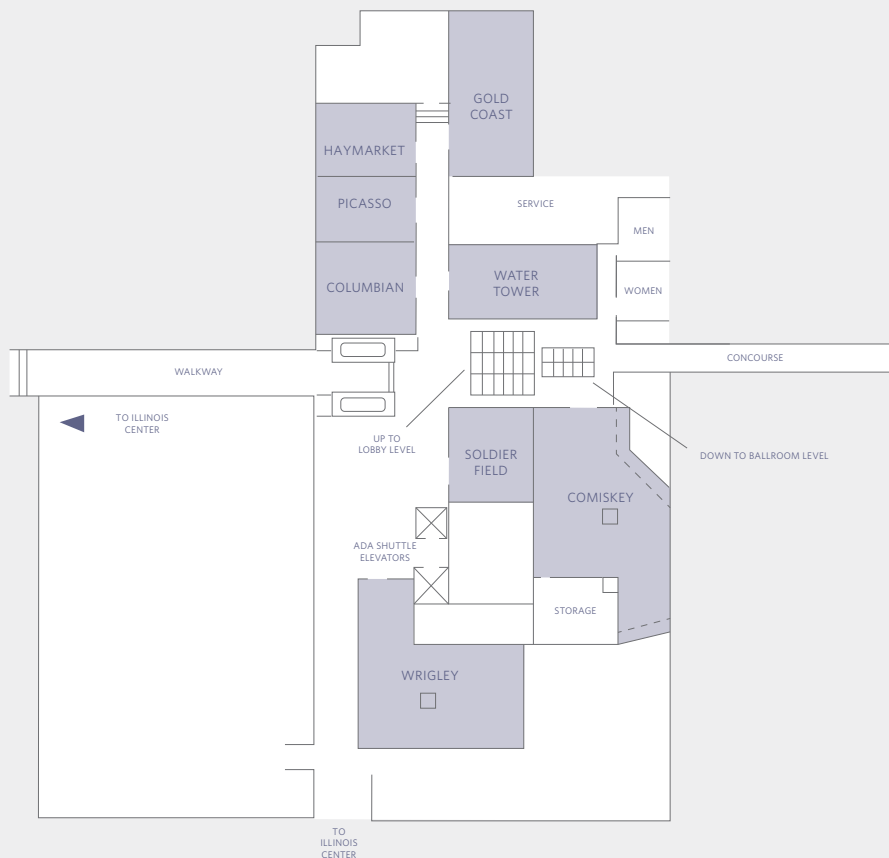


Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
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Concourse Level (West Tower)

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

FLOOR PLAN



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CAPACITY CHART



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

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FLOOR PLAN
Ballroom Level (West Tower)



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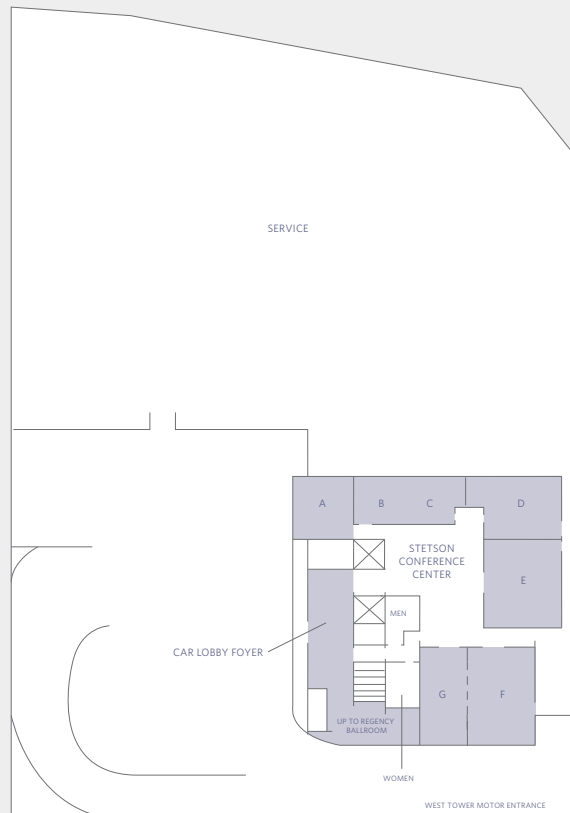


CAPACITY CHART



Room Name	Room Dimensions L x W x H	Room Size Sq. Ft.	Banquet 6' Rnds of 10 (No AV)	Reception	Theater (AV)	Classroom (AV)	Boardroom	U-Shape	Hollow Square	Exhibit
Exhibit Level (West Tower)										
STETSON CONFERENCE CENTER										
Stetson Suite A	9' x 19' x 8'	378	10	25	24	15	12	—	—	—
Stetson Suite BC	30' x 17' x 8'	510	30	40	45	18	24	27	30	—
Stetson Suite D	18' x 24' x 8'	432	10	25	30	18	20	10	12	—
Stetson Suite E	30' x 27' x 8'	810	40	55	50	21	26	14	16	—
Stetson Suite F	36' x 25' x 8'	900	50	60	70	45	34	18	20	—
Stetson Suite G	36' x 14' x 8'	504	30	40	48	27	14	14	14	—
Stetson Suite F-G	36' x 39' x 8'	1,404	80	90	—	—	—	—	—	—

FLOOR PLAN



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2024 ANNUAL MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Official Call to the Officers and Members of the American Medical Association to attend the June 2024 Annual Meeting of the House of Delegates in Chicago, Illinois, June 7 – 12, 2024.

The House of Delegates will convene at 6:00 p.m., on June 7 at the Hyatt Regency Chicago.

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

Alabama 4	Guam 1	Massachusetts 13	New York 23	Tennessee 6
Alaska 1	Hawaii 2	Michigan 14	North Carolina 6	Texas 20
Arizona 5	Idaho 1	Minnesota 5	North Dakota 2	Utah 3
Arkansas 2	Illinois 12	Mississippi 3	Ohio 12	Vermont 1
California 32	Indiana 5	Missouri 5	Oklahoma 4	Virgin Islands 1
Colorado 6	Iowa 4	Montana 1	Oregon 4	Virginia 8
Connecticut 4	Kansas 3	Nebraska 2	Pennsylvania 14	Washington 6
Delaware 1	Kentucky 5	Nevada 2	Puerto Rico 2	West Virginia 2
District of Columbia 2	Louisiana 7	New Hampshire 1	Rhode Island 2	Wisconsin 5
Florida 17	Maine 2	New Jersey 8	South Carolina 4	Wyoming 1
Georgia 6	Maryland 6	New Mexico 2	South Dakota 2	

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

American Academy of Child and Adolescent Psychiatry 2	American Society for Clinical Pathology 3
American Academy of Dermatology 5	American Society for Dermatologic Surgery 3
American Academy of Family Physicians 25	American Society for Gastrointestinal Endoscopy 2
American Academy of Hospice and Palliative Medicine 2	American Society for Radiation Oncology 2
American Academy of Neurology 3	American Society of Addiction Medicine 2
American Academy of Ophthalmology 4	American Society of Anesthesiologists 8
American Academy of Orthopaedic Surgeons 4	American Society of Cataract and Refractive Surgery 2
American Academy of Otolaryngology-Head and Neck Surgery 3	American Society of Echocardiography 2
American Academy of Pediatrics 5	American Society of Hematology 2
American Academy of Physical Medicine and Rehabilitation 3	American Society of Neuroradiology 2
American Academy of Sleep Medicine 2	American Society of Plastic Surgeons 3
American Association of Clinical Urology, Inc. 2	American Society of Regional Anesthesia and Pain Medicine 2
American Association of Gynecologic Laparoscopists 3	American Thoracic Society 2
American College of Cardiology 7	American Urological Association 2
American College of Chest Physicians (CHEST) 3	Association for Clinical Oncology 5
American College of Emergency Physicians 8	College of American Pathologists 4
American College of Gastroenterology 2	Congress of Neurological Surgeons 2
American College of Obstetricians and Gynecologists 14	Infectious Diseases Society of America 2
American College of Physicians 34	North American Spine Society 2
American College of Radiology 8	Radiological Society of North America 3
American College of Rheumatology 2	Society for Cardiovascular Angiography and Interventions 2
American College of Surgeons 8	Society of American Gastrointestinal Endoscopic Surgeons 2
American Gastroenterological Association 2	Society of Critical Care Medicine 2
American Geriatrics Society 2	Society of Hospital Medicine 3
American Institute of Ultrasound in Medicine 2	Society of Laparoscopic and Robotic Surgeons 2
American Psychiatric Association 8	Society of Thoracic Surgeons 2
American Roentgen Ray Society 3	The Endocrine Society 2

Remaining eligible national medical specialty societies (78) are entitled to one delegate each.

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

State Medical Associations	312
National Medical Specialty Societies	312
Professional Interest Medical Associations	3
Other National Societies (AMWA, AOA, NMA)	3
Medical Student Regional Delegates	26
Resident and Fellow Delegate Representatives	35
Sections	11
Services	5
Total Delegates	707

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

Jesse M. Ehrenfeld, MD, MPH
President

Lisa Bohman Egbert, MD
Speaker, House of Delegates

David H. Aizuss, MD
Secretary

2023 - 2024

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Madelyn E. Butler (2025).....	Tampa, Florida
Alexander Ding (2026).....	Louisville, Kentucky
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Scott Ferguson (2026).....	West Memphis, Arkansas
Sandra Adamson Fryhofer (2026).....	Atlanta, Georgia
Marilyn J. Heine (2026).....	Dresher, Pennsylvania
Pratistha Koirala (2024).....	Danbury, Connecticut
Ilse R. Levin (2024).....	Silver Spring, Maryland
Thomas J. Madejski (2024).....	Medina, New York
Bobby Mukkamala (2025).....	Flint, Michigan
Harris Pastides (2024).....	Columbia, South Carolina
Aliya Siddiqui (2024).....	Milwaukee, Wisconsin
Michael Suk (2024), <i>Chair-Elect</i>	Danville, Pennsylvania
Willie Underwood, III (2024), <i>Chair</i>	Buffalo, New York

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Secretary: Amber Comer, Chicago, Illinois.

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Secretary: Andrea Garcia, Chicago, Illinois.

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Executive Director and Treasurer: Rob Jordan, Washington, District of Columbia.

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

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Susan R. Bailey	2020-2021	Patrice A. Harris	2019-2020	William G. Plested, III	2006-2007
David O. Barbe	2017-2018	J. Edward Hill	2005-2006	Jack Resneck	2022-2023
Lonnie R. Bristow	1995-1996	Ardis D. Hoven	2013-2014	J. James Rohack	2009-2010
Peter W. Carmel	2011-2012	Daniel H. Johnson, Jr.	1996-1997	Randolph D. Smoak, Jr.	2000-2001
Yank D. Coble, Jr.	2002-2003	Jeremy A. Lazarus	2012-2013	Steven J. Stack	2015-2016
Richard F. Corlin	2001-2002	Barbara L. McAneny	2018-2019	Robert M. Wah	2014-2015
Nancy W. Dickey	1998-1999	Alan R. Nelson	1989-1990	Cecil B. Wilson	2010-2011
Andrew W. Gurman	2016-2017	John C. Nelson	2004-2005	Percy Wootton	1997-1998
Gerald E. Harmon	2021-2022	Nancy H. Nielsen	2008-2009		

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Joseph P. Annis	2006-2014	J. Edward Hill	1996-2004	William G. Plested, III	1998-2005
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John H. Armstrong	2002-2006	William E. Jacott	1989-1998	Liana Puscas	1999-2001
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Susan R. Bailey	2011-2018	Matthew D. Kagan	1999-2000	Ryan J. Ribeira	2013-2014
Timothy E. Baldwin	1987-1989	Christopher K. Kay	2008-2012	J. James Rohack	2001-2008
David O. Barbe	2009-2016	William E. Kobler	2012-2020	David A. Rosman	2002-2004
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Lonnie R. Bristow	1985-1994	W. J. Lewis	1979-1984	Sarah Mae Smith	2019-2020
Peter Carmel	2002-2010	Audrey J. Ludwig	1990-1991	Randolph D. Smoak, Jr.	1992-1999
Alice A. Chenault	1984-1985	Justin B. Mahida	2009-2010	Steven J. Stack	2006-2014
Yank D. Coble	1994-2001	Omar Z. Maniya	2016-2017	Michael Suk	1994-1995
David S. Cockrum	1993-1994	Barbara L. McAneny	2010-2017	Andrew M. Thomas	1997-1999
MaryAnn Contogiannis	1989-1993	William A. McDade	2016-2020	Jeffrey A. Towson	1998-1999
Malini Daniel	2012-2013	Mary Anne McCaffree	2008-2016	Georgia A. Tuttle	2011-2019
Christopher M. DeRienzo	2006-2008	Joe T. McDonald	2005-2006	Jordan M. VanLare	2011-2012
Nancy W. Dickey	1989-1997	Samuel J. Mackenzie	2014-2015	Robert M. Wah	2005-2013
Alexander Ding	2011-2013	Sandeep "Sunny" Mistry	2000-2001	Peter Y. Watson	2001-2003
William A. Dolan	2007-2011	Mario Motta	2018-2022	Monica C. Wehby	2011-2013
Timothy T. Flaherty	1994-2003	Elizabeth Blake Murphy	2020-2021	Kevin W. Williams	2016-2020
Melissa J. Garretson	1992-1993	Alan R. Nelson	1980-1988	Meredith C. Williams	2010-2011
Michael S. Goldrich	1993-1997	John C. Nelson	1994-2003	Cecil B. Wilson	2002-2009
Julie K. Goonewardene	2012-2016	Nancy H. Nielsen	2005-2007	Percy Wootton	1991-1996
Andrew W. Gurman	2007-2015	Albert J. Osbahr, III	2011-2019		
Patrice A. Harris	2011-2018	Rebecca J. Patchin	1988-1989		

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2024 Annual Meeting of the AMA House of Delegates

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

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American Association of Endocrine Surgeons	Dina Elaraj, MD
American Association of Hip and Knee Surgeons	Beau Kildow, MD
American College of Correctional Physicians	Charles Lee, MD
American Dermatological Association	Murad Alam, MD
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American Urogynecologic Society	Jennifer Wu, MD
Association of Professors of Dermatology	Christopher R. Shea, MD
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Korean American Medical Association	John Yun, MD, Jennifer Inhae Lee, MD
United States and Canadian Academy of Pathology	Nicole Riddle, MD; Daniel Zedek

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David D. Odell, Ann Arbor MI

The Society of Laparoscopic and Robotic Surgeons

Delegate(s)

Camran Nezhat, Redwood City CA

Ceana Nezhat, Atlanta GA

Undersea and Hyperbaric Medical Society

Delegate(s)

Laurie Gesell, Brookfield WI

Alternate Delegate(s)

Helen Gelly, Marietta GA

Resident and Fellow Sectional Delegate(s)

Emma Rogers, Philadelphia PA

US Public Health Service

Delegate(s)

Kristie Clarke, Mililani HI

Alternate Delegate(s)

Lily Balasuriya, New Haven CT

Academic Physicians Section

Delegate(s)

Alma B. Littles, Tallahassee FL

Alternate Delegate(s)

Gary Gaddis, St. Louis MO

Integrated Physician Practice Section

Delegate(s)

Steven Wang, Bakersfield CA

Alternate Delegate(s)

Russell C. Libby, Fairfax VA

International Medical Graduates Section

Delegate(s)

Afifa Adiba, Wallingford CT

Alternate Delegate(s)

Deepu Sudhakaran, Chesterfield MO

Medical Student Section

Delegate(s)

Rajadhar Reddy, Houston TX

Alternate Delegate(s)

Laurie Lapp, Madison WI

Minority Affairs Section

Delegate(s)

Luis Seija, New York NY

Alternate Delegate(s)

Shannon Zullo, San Francisco CA

Private Practice Physician Section

Delegate(s)

Timothy G. Mc Avoy, Waukesha WI

Alternate Delegate(s)

Daniel Eunsuk Choi, Garden City Park NY

Resident and Fellow Section

Delegate(s)

Anna Heffron, New York NY

Alternate Delegate(s)

Joey Whelihan, Philadelphia PA

Senior Physicians Section

Delegate(s)

Virginia E. Hall, Hummelstown PA

Alternate Delegate(s)

Douglas M. DeLong, Cherry Valley NY

Women Physicians Section

Delegate(s)

Nicole L. Plenty, Marietta GA

Alternate Delegate(s)

Anna Brown, Howard WI

Young Physicians Section

Delegate(s)

Alisha Reiss, Greenville OH

Alternate Delegate(s)

Sean Figy, Omaha NE

**Reference Committee Hearing Room Assignments
Saturday, June 8**

1:30pm

Room

Amendments to Constitution & Bylaws	Grand Hall I/J
B Legislative advocacy	Regency A/B
E Science and Technology	Regency C
F AMA governance and finance	Grand Ballroom
G Medical Practice	Regency D

**Reference Committee Hearing Room Assignments
Sunday, June 9**

8:00am

Room

A Medical Service	Regency A/B
C Advocacy on medical education	Regency C
D Public Health	Regency D

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

2024 Annual Meeting Notes on Orders of Business Grand Ballroom, Hyatt Regency Chicago

FIRST SESSION, Friday, June 7, 6:00 – 8:00 pm

SECOND SESSION, Saturday, June 8, 12:30 – 1:00 pm

THIRD SESSION, Monday, June 10, 1:00 – 6:00 pm

FOURTH SESSION, Tuesday, June 11, 9 am (or 10 minutes after Election Session) – 3:00 pm

Note: The Inauguration of Bruce A. Scott, MD, as the 179th President of the American Medical Association, will be held at 5:00 pm in the Crystal Ballroom of the Hyatt Regency Chicago.

FIFTH SESSION, Wednesday, June 12, 8:30 am – completion of business

SUMMARY OF FISCAL NOTES (A-24)

Report(s) of the Board of Trustees

01	Annual Report	None
02	New Specialty Organizations Representation in the House of Delegates	Minimal
03	2023 Grants and Donations	Informational Report
04	AMA 2025 Dues	Minimal
05	Update on Corporate Relationships	Informational Report
06	Redefining AMA's Position on ACA and Health Care Reform	Informational Report
07	AMA Performance, Activities, and Status in 2023	Informational Report
08	Annual Update on Activities and Progress in Tobacco Control: March 2023 through February 2024	Informational Report
09	Council on Legislation Sunset Review of 2014 House P	Minimal
10	American Medical Association Health Equity Annual Report	Informational Report
11	Safe and Effective Overdose Reversal Medications in Educational Settings	Minimal
12	AMA Efforts on Medicare Payment Reform	Informational Report
13	Prohibiting Covenants Not-to-Compete	Minimal
14	Physician Assistant and Nurse Practitioner Movement Between Specialties	Minimal
15	Augmented Intelligence Development, Deployment, and Use in Health Care	Minimal
16	Support for Mental Health Courts	Minimal
17	Drug Policy Reform	Minimal
18	Supporting Harm Reduction	Minimal
19	Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication	TBD
20	Criminalization of Providing Medical Care	Informational Report
21	American Medical Association Meeting Venues and Accessibility	Minimal
22	AMA Public Health Strategy: Update	Informational Report
23	United States Professional Association for Transgender Health Observer Status in the House of Delegates	Minimal
24	Report on the Preservation of Independent Medical Practice	Informational Report
25	Environmental Sustainability of AMA National Meetings. Supporting Carbon Offset Programs for Travel for AMA Conferences	\$20,000
26	Equity and Justice Initiatives for International Medical Graduates	Minimal
27	AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates	Informational Report
28	Encouraging Collaboration Between Physicians and Industry in AI Development	Minimal
29	Transparency and Accountability of Hospitals and Hospital Systems	Minimal

SUMMARY OF FISCAL NOTES (A-24)

30	Proper Use of Overseas Virtual Assistants in Medical Practice	Moderate
31	The Morrill Act and Its Impact on the Diversity of the Physician Workforce	Minimal
32	Independent Medical Evaluation	Informational Report
33	Employed Physicians	Minimal
34	Demographic Report of the House of Delegates and AMA Membership	Informational Report

Report(s) of the Council on Constitution and Bylaws

01	AMA Bylaws—Nomination of Officers and Council Members	Minimal
02	AMA Bylaws—Run-Off and Tie Ballots	Minimal
03	AMA Bylaws—Removal of Officers, Council Members, Committee Members and Section Governing Council Members (D-610.997)	Minimal
04	AMA Bylaw Amendments Pursuant to AIPSC (2nd ed.)	Minimal

Report(s) of the Council on Ethical and Judicial Affairs

01	Short-Term Global Health Clinical Encounters	Minimal
02	Research Handling of De-Identified Patient Data (D-315.969)	Minimal
03	Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices	Minimal
04	Physicians’ Use of Social Media for Product Promotion and Compensation	Minimal
05	CEJA’s Sunset Review of 2014 House Policies	Minimal
06	Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report	Informational Report

Reports(s) of the Council on Long Range Planning and Development

01	Establishment of a LGBTQ+ Section	\$16,000 per annum
02	Scenarios on Collective Action and Physician Unions	Informational Report

Report(s) of the Council on Medical Education

01	Council on Medical Education Sunset Review of 2014 House of Delegates’ Policies	Minimal
02	The Current Match Process and Alternatives	Minimal

Report(s) of the Council on Medical Service

01	Council on Medical Service Sunset Review of 2014 House Policies	Minimal
02	Improving Affordability of Employment-Based Health Coverage	Minimal
03	Review of Payment Options for Traditional Healing Services	Minimal
04	Health System Consolidation	Informational Report
05	Patient Medical Debt	Minimal

SUMMARY OF FISCAL NOTES (A-24)

06	Economics of Prescription Medication Prior Authorization	Minimal
07	Ensuring Privacy in Retail Health Care Settings	Minimal
08	Sustainable Payment for Community Practices	Minimal

Report(s) of the Council on Science and Public Health

01	Council on Science and Public Health Sunset Review of 2014 House Policies	Minimal
02	Comparative Effectiveness Research	Minimal
03	Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders	Minimal
04	Sex and Gender Differences in Medical Research	Minimal
05	Biosimilar/Interchangeable Terminology	Minimal
06	Greenhouse Gas Emissions from Metered Dose Inhalers and Anesthetic Gases	Modest
07	Androgen Deprivation in Incarceration	Minimal
08	Decreasing Regulatory Barriers to Appropriate Testosterone Prescribing	Minimal
09	Prescribing Guided Physical Activity for Depression and Anxiety	Minimal
10	Teens and Social Media	Moderate
11	Stand Your Ground Laws	Minimal
12	Universal Screening for Substance Use and Substance Use Disorders during Pregnancy	Modest
13	Decreasing Youth Access to E-Cigarettes	Minimal

Joint Report(s) of the Council on Constitution and Bylaws and the Council on Long Range Planning and Development

01	Joint Council Sunset Review of 2014 House Policies	Minimal
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Report(s) of the HOD Committee on Compensation of the Officers

01	Compensation Committee Report	\$4,500 if all non-leadership board members were reimbursed to the secretarial reimbursement maximum
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Report(s) of the Speakers

01	Report of the Resolution Modernization Task Force Update	Modest
02	Report of the Election Task Force 2	Informational Report
03	Updated Parliamentary Authority	Informational Report

SUMMARY OF FISCAL NOTES (A-24)

Resolutions

001	Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout	Modest
002	Removal of the Interim Meeting Resolution Committee	Minimal
003	Amendments to AMA Bylaws to Enable Medical Student Leadership Continuity	Minimal
004	The Rights of Newborns that Survive Abortion	Minimal
005	AMA Executive Vice President	Minimal
006	Treatment of Family Members	Modest
007	AMA Supports a Strategy for Eliminating Nuclear Weapons	Minimal
008	Consolidated Health Care Market	Moderate
009	Updating Language Regarding Families and Pregnant Persons	Minimal
012	Ethical Pricing Procedures that Protect Insured Patients	Modest
013	Ethical Impetus for Research in Pregnant and Lactating Individuals	Modest
014	The Preservation of the Primary Care Relationship	Moderate
015	Health and Racial Equity in Medical Education to Combat Workforce Disparities	Moderate
016	Guiding Principles for the Healthcare of Migrants	Moderate
017	Addressing the Historical Injustices of Anatomical Specimen Use	Possible High FN
018	Opposing Violence, Terrorism, Discrimination, and Hate Speech	Modest
019	Supporting the Health of Our Democracy	Moderate
020	Voter Protections During and After Incarceration	Moderate
021	Opposition to Capital Punishment	Minimal
022	Health and Racial Equity in Medical Education to Combat Workforce Disparities	Moderate
101	Infertility Coverage	Modest
102	Medicaid & CHIP Benefit Improvements	Modest
103	Medicare Advantage Plans	Modest
104	Medicaid Estate Recovery Reform	Minimal
105	Medigap Patient Protections	Minimal
106	Incorporating Surveillance Colonoscopy into the Colorectal Cancer Screening Continuum	Modest

SUMMARY OF FISCAL NOTES (A-24)

107	Requiring Government Agencies to Contract Only with Not-For-Profit Insurance Companies	Minimal
108	Requiring Payments for Physician Signatures	Minimal
109	Coverage for Dental Services Medically Necessary for Cancer Care	Modest
110	Coverage for Shoes and Shoe Modifications for Pediatrics Patients Who Require Lower Extremity Orthoses	Minimal
111	Protections for “Guarantee Issue” of Medigap Insurance and Traditional Medicare	Moderate
112	Private and Public Insurance Coverage for Adaptive Sports Equipment including Prostheses and Orthoses	Moderate
113	Support Prescription Medication Price Negotiation	Modest
114	Breast Cancer Screening/Clinical Breast Exam Coverage	Modest
115	Payments by Medicare Secondary or Supplemental plans	Moderate
201	Research Correcting Political Misinformation and Disinformation on Scope of Practice	\$330,526: Comprehensive literature review; Field research through focus groups and surveys.
202	Use of Artificial Intelligence and Advanced Technology by Third Party Payors to Deny Health Insurance Claims	Minimal
203	Medicaid Patient Accountability	Modest
204	Staffing Ratios in the Emergency Department	Modest
205	Medical-Legal Partnerships & Legal Aid Services	Minimal
206	Indian Health Service Youth Regional Treatment Centers	Minimal
207	Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse	Modest
208	Improving Supplemental Nutrition Programs	Minimal
209	Native American Voting Rights	Minimal
210	Support for Physicians Pursuing Collective Bargaining and Unionization	\$43,308; Consult experts and coordinate with medical societies to identify and communicate ways to aid physicians in collective bargaining efforts
211	Deceptive Hospital Badging 2.0	Modest
212	Advocacy Education Towards a Sustainable Medical Care System	Modest

SUMMARY OF FISCAL NOTES (A-24)

213	Access to Covered Benefits with an Out of Network Ordering Physician	Resolved 1: Modest Resolved 2: \$22,980. Develop a comprehensive portfolio of education, experts, and toolkits.
214	Support for Paid Sick Leave	Minimal
215	American Indian and Alaska Native Language Revitalization and Elder Care	Moderate
216	The AMA Supports H.R. 7225, the Bipartisan “Administrative Law Judges Competitive Service Restoration Act”	Minimal
217	Protecting Access to IVF Treatment	Modest
218	Designation of Descendants of Enslaved Africans in America	Moderate
219	Bundling for Maternity Care Services	Modest
220	Restorative Justice for the Treatment of Substance Use Disorders	Modest
221	Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability	Minimal
222	Studying Avenues for Parity in Mental Health & Substance Use Coverage	Modest
223	Increase in Children’s Hospital Graduate Medical Education Funding	Modest
224	Antidiscrimination Protections for LGBTQ+ Youth in Foster Care	Minimal
225	Humanitarian Efforts to Resettle Refugees	Minimal
226	Protecting Access to IVF Treatment	Modest
227	Medicare Reimbursement for Telemedicine	Minimal
228	Waiver of Due Process Clauses	Modest
229	Opposition to Legalization of Psilocybin	Minimal
230	Protecting Patients from Inappropriate Dentist and Dental Hygienist Scope of Practice Expansion	Modest
231	Supporting the Establishment of Rare Disease Advisory Councils	Minimal
232	Medicare Advantage Part B Drug Coverage	Moderate
233	Prohibiting Mandatory White Bagging	Modest
234	State Prescription Drug Affordability Boards - Study	Modest
235	Establish a Cyber-Security Relief Fund	Moderate
236	Support of Physicians Pursuing Collective Bargaining and Unionization	\$43,308; Consult experts and coordinate with medical societies to identify and communicate ways to aid physicians in collective bargaining efforts

SUMMARY OF FISCAL NOTES (A-24)

237	Encouraging the Passage of the Preventive Health Savings Act (S.114)	Modest
238	AMA Supports Efforts to Fund Overdose Prevention Sites	Minimal
239	Requiring stores that sell tobacco products to display NYS Quitline information	Modest
240	Expanding Visa Requirement Waivers for NY IMGs Working in Underserved Areas	Minimal
241	Healthcare Cybersecurity Breaches	Moderate
242	Cancer Care in Indian Health Services Facilities	Moderate
243	Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes	
244	Graduate Medical Education Opportunities for American Indian and Alaska Native Communities	Minimal
301	Fairness for International Medical Students	Minimal
302	The Role of Maintenance of Certification	Minimal
303	Amend Policy D-275.948 Title “Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training”. Creation of an AMA Task Force to Address Conflicts of Interest on Physician Boards.	\$14,354: Creation of an AMA Task Force
304	Spirituality in Medical Education and Practice	Minimal
305	Public Service Loan Forgiveness Reform	Modest
306	Unmatched Graduating Physicians	Minimal
307	Access to Reproductive Health Services When Completing Physician Certification Exams	Minimal
308	Transforming the USMLE Step 3 Examination to Alleviate Housestaff Financial Burden, Facilitate High-Quality Patient Care, and Promote Housestaff Well-Being	Minimal
309	Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine	Minimal
310	Accountability & Transparency in GME funding with Annual Report	Minimal
311	Physician Participation in Healthcare Organizations	Minimal
312	AMA Collaboration with FSMB to Assist in Licensing Reentrant Physicians	Modest
313	CME for Rural Preceptorship	Modest
314	Reducing the Lifetime Earnings Gap in the U.S. with Similar Educational Attainment by Employing the Gainful Employment Rule	Modest
315	Cease Reporting of Total Attempts of USMLE STEP1 and COMLEX-USA Level 1 Examinations	Minimal
316	Reassessment of Continuing Board Certification Process	Minimal

SUMMARY OF FISCAL NOTES (A-24)

317	Physician Participation in the Planning and Development of Accredited Continuing Education for Physicians	Minimal
318	Variation in Board Certification and Licensure Requirements for Internationally-Trained Physicians and Access to Care	Modest
319	AMA Support of U.S. Pathway Programs	over \$10K
401	Addressing Social Determinants of Health Through Closed Loop Referral Systems	Modest
402	Guardianship and Conservatorship Reform	Modest
403	Occupational Screenings for Lung Disease	Minimal
404	Protections Against Surgical Smoke Exposure	Minimal
405	Default Proceed Firearm Sales and Safe Storage Laws	Minimal
406	Opposition to Pay-to-Stay Incarceration Fees	Modest
407	Racial Misclassification	Minimal
408	Indian Water Rights	Modest
409	Toxic Heavy Metals	Modest
410	Access to Public Restrooms	Minimal
411	Missing and Murdered Indigenous Persons	Minimal
412	Lithium Battery Safety	Modest
413	Sexuality and Reproductive Health Education	Minimal
414	Addressing the Health Sector's Contributions to the Climate Crisis	Minimal
415	Building Environmental Resiliency in Health Systems and Physician Practices	Minimal
416	Furthering Environmental Justice and Equity	Minimal
417	Reducing Job-Related Climate Risk Factors	Minimal
418	Early and Periodic Eye Exams for Adults	Minimal
419	Addressing the Health Risks of Extreme Heat	Minimal
420	Equity in Dialysis Care	Modest
421	Annual Conference on the State of Obesity and its Impact on Disease in America (SODA)	\$252,347 Annually to convene an annual meeting of Federation partners on obesity
422	Immunization Registry	Modest
423	HPV Vaccination to Protect Healthcare Workers over Age 45	Modest
424	LGBTQ+ Senior Health	\$122,712 Contract with third-parties to develop educational content and training for physicians

SUMMARY OF FISCAL NOTES (A-24)

425	Perinatal Mental Health Disorders among Medical Students and Physicians	Modest
426	Maternal Morbidity and Mortality: The Urgent Need to Help Raise Professional and Public Awareness and Optimize Maternal Health – A Call to Action	Modest
427	Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals	Moderate
428	Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals	\$51,420 Development of continuing medical education module to be hosted on AMA EdHub
429	Assessing and Protecting Local Communities from the Health Risks of Decommissioning Nuclear Power Plants	Modest
430	Supporting the Inclusion of Information about Lung Cancer Screening within Cigarette Packages	Modest
431	Combatting the Public Health Crisis of Gun Violence	Modest
432	Resolution to Decrease Lead Exposure in Urban Areas	Moderate
433	Improving Healthcare of Rural Minority Populations	
501	Fragrance Regulation	Moderate
502	Tribally-Directed Precision Medicine Research	Minimal
503	Unregulated Hemp-Derived Intoxicating Cannabinoids, and Derived Psychoactive Cannabis Products (DPCPs)	Modest
504	FDA Regulation of Biosimilars	Minimal
505	Mitigating the Harms of Colorism and Skin Bleaching Agents	Minimal
506	Screening for Image Manipulation in Research Publications	Minimal
507	Ban on Dual Ownership, Investment, Marketing or Distribution of Recreational Cannabis by Medical Cannabis Companies	Minimal
508	AMA to support regulations to decrease overdoses in children due to ingestion of edible cannabis	Modest
509	Addressing Sarcopenia and its Impact on Quality of Life	\$101,420: Contract with third-parties to develop educational content; advertise beyond standard AMA channels
510	Study to investigate the validity of claims made by the manufacturers of OTC Vitamins, Supplements and “Natural Cures”	Minimal
511	National Penicillin Allergy Day and Penicillin Allergy Evaluation & Appropriate Delabeling	Minimal
512	Opioid Overdose Reversal Agents Where AED’s Are Located	Minimal

SUMMARY OF FISCAL NOTES (A-24)

513	Biotin Supplement Packaging Disclaimer	Minimal
601	Annual Holocaust Remembrance Event	Moderate
602	Ranked Choice Voting	Modest
603	End Attacks on Health and Human Rights in Israel and Palestine	Minimal
604	Confronting Ageism in Medicine	\$47,934 Initial cost to review and report back on existing policy and develop educational session for CME, plus annual costs for continued advocacy and education
605	Walking the Walk of Climate Change	Moderate
606	Creation of an AMA Council with a Focus on Digital Health Technologies and AI	
607	Appealing to our AMA to add clarity to its mission statement to better meet the need of physicians, the practice of medicine and the public health	Minimal
608	The American Medical Association Diversity Mentorship Program	Moderate
701	Opposition to the Hospital Readmissions Reduction Program	Minimal
702	The Corporate Practice of Medicine, Revisited	Modest
703	Upholding Physician Autonomy in Evidence-Based Off-Label Prescribing and Condemning Pharmaceutical Price Manipulation	Minimal
704	Pediatric Readiness in Emergency Departments	Modest
705	20 Minute Primary Care Visits	Modest
706	Automatic Pharmacy-Generated Prescription Requests	Minimal
707	Alternative Funding Programs	Moderate
708	Medicolegal Death Investigations	Modest
709	Improvements to Patient Flow in the U.S. Healthcare System	Moderate
710	The Regulation of Private Equity in the Healthcare Sector	Modest
711	Insurer Accountability When Prior Authorization Harms Patients	Modest
712	Full transparency - Explanation of Benefits	Moderate
713	Transparency – non-payment for services to patients with ACA exchange plans with unpaid premiums	Moderate

Minimal - less than \$1,000

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

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

RESOLUTIONS – BY SPONSOR (A-24)

SPONSOR	Reso #	TITLE
Academic Physicians Section	304	Spirituality in Medical Education and Practice
American Academy of Dermatology	230	Protecting Patients from Inappropriate Dentist and Dental Hygienist Scope of Practice Expansion
American Academy of Ophthalmology	201	Research Correcting Political Misinformation and Disinformation on Scope of Practice
American Academy of Pediatrics	223	Increase in Children’s Hospital Graduate Medical Education Funding
	704	Pediatric Readiness in Emergency Departments
American Academy of Physical Medicine and Rehabilitation	110	Coverage for Shoes and Shoe Modifications for Pediatrics Patients Who Require Lower Extremity Orthoses
	112	Private and Public Insurance Coverage for Adaptive Sports Equipment including Prostheses and Orthoses
American Association of Clinical Urologists	202	Use of Artificial Intelligence and Advanced Technology by Third Party Payors to Deny Health Insurance Claims
American Association of Public Health Physicians	007	AMA Supports a Strategy for Eliminating Nuclear Weapons
American College of Emergency Physicians	709	Improvements to Patient Flow in the U.S. Healthcare System
	710	The Regulation of Private Equity in the Healthcare Sector
American College of Legal Medicine	216	The AMA Supports H.R. 7225, the Bipartisan “Administrative Law Judges Competitive Service Restoration Act”
American College of Medical Genetics and Genomics	231	Supporting the Establishment of Rare Disease Advisory Councils
American College of Obstetricians and Gynecologists	013	Ethical Impetus for Research in Pregnant and Lactating Individuals
	219	Bundling for Maternity Care Services
American College of Preventive Medicine	237	Encouraging the Passage of the Preventive Health Savings Act (S.114)
	432	Resolution to Decrease Lead Exposure in Urban Areas
American Society for Gastrointestinal Endoscopy	106	Incorporating Surveillance Colonoscopy into the Colorectal Cancer Screening Continuum
American Society for Metabolic and Bariatric Surgery	421	Annual Conference on the State of Obesity and its Impact on Disease in America (SODA)
American Society for Reproductive Medicine	217	Protecting Access to IVF Treatment
American Urological Association	318	Variation in Board Certification and Licensure Requirements for Internationally-Trained Physicians and Access to Care

SPONSOR	Reso #	TITLE
Association for Clinical Oncology	109	Coverage for Dental Services Medically Necessary for Cancer Care
	232	Medicare Advantage Part B Drug Coverage
	233	Prohibiting Mandatory White Bagging
	234	State Prescription Drug Affordability Boards - Study
	706	Automatic Pharmacy-Generated Prescription Requests
	707	Alternative Funding Programs
California	220	Restorative Justice for the Treatment of Substance Use Disorders
	221	Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability
	307	Access to Reproductive Health Services When Completing Physician Certification Exams
	414	Addressing the Health Sector's Contributions to the Climate Crisis
	415	Building Environmental Resiliency in Health Systems and Physician Practices
	416	Furthering Environmental Justice and Equity
	417	Reducing Job-Related Climate Risk Factors
	504	FDA Regulation of Biosimilars
Delaware	236	Support of Physicians Pursuing Collective Bargaining and Unionization
Edmond Cabbabe, MD	306	Unmatched Graduating Physicians
Epps, Thomas W. MD	004	The Rights of Newborns that Survive Abortion
Florida	203	Medicaid Patient Accountability
	204	Staffing Ratios in the Emergency Department
Georgia	312	AMA Collaboration with FSMB to Assist in Licensing Reentrant Physicians
Hsu, Albert L. MD	503	Unregulated Hemp-Derived Intoxicating Cannabinoids, and Derived Psychoactive Cannabis Products (DPCPs)
Illinois	229	Opposition to Legalization of Psilocybin
	507	Ban on Dual Ownership, Investment, Marketing or Distribution of Recreational Cannabis by Medical Cannabis Companies
	705	20 Minute Primary Care Visits
Indiana	412	Lithium Battery Safety
Integrated Physician Practice Section	001	Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
	401	Addressing Social Determinants of Health Through Closed Loop Referral Systems
Maryland	315	Cease Reporting of Total Attempts of USMLE STEP1 and COMLEX-USA Level 1 Examinations
Massachusetts	431	Combatting the Public Health Crisis of Gun Violence
McAneny, Barbara L. MD,	008	Consolidated Health Care Market

SPONSOR	Reso #	TITLE
Medical Student Section	002	Removal of the Interim Meeting Resolution Committee
	003	Amendments to AMA Bylaws to Enable Medical Student Leadership Continuity
	101	Infertility Coverage
	102	Medicaid & CHIP Benefit Improvements
	104	Medicaid Estate Recovery Reform
	105	Medigap Patient Protections
	205	Medical-Legal Partnerships & Legal Aid Services
	206	Indian Health Service Youth Regional Treatment Centers
	207	Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse
	208	Improving Supplemental Nutrition Programs
	209	Native American Voting Rights
	214	Support for Paid Sick Leave
	215	American Indian and Alaska Native Language Revitalization and Elder Care
	224	Antidiscrimination Protections for LGBTQ+ Youth in Foster Care
	225	Humanitarian Efforts to Resettle Refugees
	301	Fairness for International Medical Students
	402	Guardianship and Conservatorship Reform
	403	Occupational Screenings for Lung Disease
	404	Protections Against Surgical Smoke Exposure
	405	Default Proceed Firearm Sales and Safe Storage Laws
	406	Opposition to Pay-to-Stay Incarceration Fees
	407	Racial Misclassification
	408	Indian Water Rights
	409	Toxic Heavy Metals
	410	Access to Public Restrooms
	419	Addressing the Health Risks of Extreme Heat
	501	Fragrance Regulation
	502	Tribally-Directed Precision Medicine Research
	505	Mitigating the Harms of Colorism and Skin Bleaching Agents
	506	Screening for Image Manipulation in Research Publications
	601	Annual Holocaust Remembrance Event
701	Opposition to the Hospital Readmissions Reduction Program	
Michigan	218	Designation of Descendants of Enslaved Africans in America
	413	Sexuality and Reproductive Health Education

SPONSOR	Reso #	TITLE
Minority Affairs Section	019	Supporting the Health of Our Democracy
	020	Voter Protections During and After Incarceration
	021	Opposition to Capital Punishment
	022	Health and Racial Equity in Medical Education to Combat Workforce Disparities
	242	Cancer Care in Indian Health Services Facilities
	243	Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes
	244	Graduate Medical Education Opportunities for American Indian and Alaska Native Communities
	319	AMA Support of U.S. Pathway Programs
	433	Improving Healthcare of Rural Minority Populations
608	The American Medical Association Diversity Mentorship Program	
Mississippi	005	AMA Executive Vice President
	012	Ethical Pricing Procedures that Protect Insured Patients
	107	Requiring Government Agencies to Contract Only with Not-For-Profit Insurance Companies
	108	Requiring Payments for Physician Signatures
	508	AMA to support regulations to decrease overdoses in children due to ingestion of edible cannabis
Missouri	006	Treatment of Family Members
	226	Protecting Access to IVF Treatment
	227	Medicare Reimbursement for Telemedicine
	228	Waiver of Due Process Clauses
National Association of Medical Examiners	708	Medicolegal Death Investigations
New England	014	The Preservation of the Primary Care Relationship
	015	Health and Racial Equity in Medical Education to Combat Workforce Disparities
	113	Support Prescription Medication Price Negotiation
	316	Reassessment of Continuing Board Certification Process
	427	Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals
	428	Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals
	429	Assessing and Protecting Local Communities from the Health Risks of Decommissioning Nuclear Power Plants
	430	Supporting the Inclusion of Information about Lung Cancer Screening within Cigarette Packages
	511	National Penicillin Allergy Day and Penicillin Allergy Evaluation & Appropriate Delabeling
	606	Creation of an AMA Council with a Focus on Digital Health Technologies and AI

SPONSOR	Reso #	TITLE
New Jersey	235	Establish a Cyber-Security Relief Fund
	426	Maternal Morbidity and Mortality: The Urgent Need to Help Raise Professional and Public Awareness and Optimize Maternal Health – A Call to Action
	510	Study to investigate the validity of claims made by the manufacturers of OTC Vitamins, Supplements and “Natural Cures”
	607	Appealing to our AMA to add clarity to its mission statement to better meet the need of physicians, the practice of medicine and the public health
New York	016	Guiding Principles for the Healthcare of Migrants
	017	Addressing the Historical Injustices of Anatomical Specimen Use
	018	Opposing Violence, Terrorism, Discrimination, and Hate Speech
	114	Breast Cancer Screening/Clinical Breast Exam Coverage
	115	Payments by Medicare Secondary or Supplemental plans
	238	AMA Supports Efforts to Fund Overdose Prevention Sites
	239	Requiring stores that sell tobacco products to display NYS Quitline information
	240	Expanding Visa Requirement Waivers for NY IMGs Working in Underserved Areas
	241	Healthcare Cybersecurity Breaches
	317	Physician Participation in the Planning and Development of Accredited Continuing Education for Physicians
	512	Opioid Overdose Reversal Agents Where AED’s Are Located
	513	Biotin Supplement Packaging Disclaimer
	712	Full transparency - Explanation of Benefits
	713	Transparency – non-payment for services to patients with ACA exchange plans with unpaid premiums
Ohio	111	Protections for “Guarantee Issue” of Medigap Insurance and Traditional Medicare
	422	Immunization Registry
	711	Insurer Accountability When Prior Authorization Harms Patients
Oklahoma	103	Medicare Advantage Plans
	305	Public Service Loan Forgiveness Reform
	313	CME for Rural Preceptorship
	411	Missing and Murdered Indigenous Persons
Oregon	210	Support for Physicians Pursuing Collective Bargaining and Unionization
Organized Medical Staff Section	211	Deceptive Hospital Badging 2.0
	212	Advocacy Education Towards a Sustainable Medical Care System
	702	The Corporate Practice of Medicine, Revisited

SPONSOR	Reso #	TITLE
Pennsylvania	310	Accountability & Transparency in GME funding with Annual Report
	311	Physician Participation in Healthcare Organizations
	420	Equity in Dialysis Care
Private Practice Physicians Section	213	Access to Covered Benefits with an Out of Network Ordering Physician
	302	The Role of Maintenance of Certification
Resident and Fellow Section	009	Updating Language Regarding Families and Pregnant Persons
	222	Studying Avenues for Parity in Mental Health & Substance Use Coverage
	308	Transforming the USMLE Step 3 Examination to Alleviate Housestaff Financial Burden, Facilitate High-Quality Patient Care, and Promote Housestaff Well-Being
	309	Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine
	418	Early and Periodic Eye Exams for Adults
	603	End Attacks on Health and Human Rights in Israel and Palestine
	703	Upholding Physician Autonomy in Evidence-Based Off-Label Prescribing and Condemning Pharmaceutical Price Manipulation
Senior Physicians Section	423	HPV Vaccination to Protect Healthcare Workers over Age 45
	424	LGBTQ+ Senior Health
	509	Addressing Sarcopenia and its Impact on Quality of Life
	604	Confronting Ageism in Medicine
	605	Walking the Walk of Climate Change
Women Physicians Section	314	Reducing the Lifetime Earnings Gap in the U.S. with Similar Educational Attainment by Employing the Gainful Employment Rule
	425	Perinatal Mental Health Disorders among Medical Students and Physicians
Young Physicians Section	303	Amend Policy D-275.948 Title "Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training". Creation of an AMA Task Force to Address Conflicts of Interest on Physician Boards.
	602	Ranked Choice Voting

Reference Committee on Amendments to Constitution and Bylaws

Report(s) of the Board of Trustees

- 02 New Specialty Organizations Representation in the House of Delegates

Report(s) of the Council on Constitution and Bylaws

- 01 AMA Bylaws—Nomination of Officers and Council Members
- 02 AMA Bylaws—Run-Off and Tie Ballots
- 03 AMA Bylaws—Removal of Officers, Council Members, Committee Members and Section Governing Council Members (D-610.997)
- 04 AMA Bylaw Amendments Pursuant to AIPSC (2nd ed.)

Report(s) of the Council on Ethical and Judicial Affairs

- 01 Short-Term Global Health Clinical Encounters
- 02 Research Handling of De-Identified Patient Data (D-315.969)
- 03 Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices
- 04 Physicians' Use of Social Media for Product Promotion and Compensation
- 05 CEJA's Sunset Review of 2014 House Policies

Resolutions

- 001 Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout
- 002 Removal of the Interim Meeting Resolution Committee
- 003 Amendments to AMA Bylaws to Enable Medical Student Leadership Continuity
- 004 The Rights of Newborns that Survive Abortion
- 005 AMA Executive Vice President
- 006 Treatment of Family Members
- 007 AMA Supports a Strategy for Eliminating Nuclear Weapons
- 008 Consolidated Health Care Market
- 009 Updating Language Regarding Families and Pregnant Persons
- 012 Ethical Pricing Procedures that Protect Insured Patients
- 013 Ethical Impetus for Research in Pregnant and Lactating Individuals
- 014 The Preservation of the Primary Care Relationship
- 015 Health and Racial Equity in Medical Education to Combat Workforce Disparities
- 016 Guiding Principles for the Healthcare of Migrants
- 017 Addressing the Historical Injustices of Anatomical Specimen Use
- 018 Opposing Violence, Terrorism, Discrimination, and Hate Speech
- 019 Supporting the Health of Our Democracy
- 020 Voter Protections During and After Incarceration
- 021 Opposition to Capital Punishment
- 022 Health and Racial Equity in Medical Education to Combat Workforce Disparities

REPORT OF THE BOARD OF TRUSTEES

B of T Report 02-A-24

Subject: New Specialty Organizations Representation in the House of Delegates

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 The Board of Trustees (BOT) and the Specialty and Service Society (SSS) considered the
2 applications of the Academy of Consultation-Liaison Psychiatry, American College of Lifestyle
3 Medicine, American Venous Forum, Association of Academic Psychiatrists, and Society for
4 Pediatric Dermatology for national medical specialty organization representation in the American
5 Medical Association (AMA) House of Delegates (HOD). The applications were first reviewed by
6 the AMA SSS Rules Committee and presented to the SSS Assembly for consideration.

7
8 The applications were considered using criteria developed by the Council on Long Range Planning
9 and Development and adopted by the HOD (Policy G-600.020). (Exhibit A)

10
11 Organizations seeking admission were asked to provide appropriate membership information to the
12 AMA. That information was analyzed to determine AMA membership, as required under criterion
13 three. A summary of this information is attached to this report as Exhibit B.

14
15 In addition, organizations must submit a letter of application in a designated format. This format
16 lists the above-mentioned guidelines followed by each organization's explanation of how it meets
17 each of the criteria.

18
19 Before a society is eligible for admission to the HOD, it must participate in the SSS for three years.
20 These organizations have actively participated in the SSS for more than three years.

21
22 Review of the materials and discussion during the SSS meeting at the November 2023 Interim
23 Meeting indicated that the Academy of Consultation-Liaison Psychiatry, American College of
24 Lifestyle Medicine, American Venous Forum, Association of Academic Psychiatrists, and Society
25 for Pediatric Dermatology meet the criteria for representation in the HOD.

26
27 **RECOMMENDATION**

28
29 Therefore, the Board of Trustees recommend that the Academy of Consultation-Liaison Psychiatry,
30 American College of Lifestyle Medicine, American Venous Forum, Association of Academic
31 Psychiatrists, and Society for Pediatric Dermatology be granted representation in the AMA House of
32 Delegates and that the remainder of the report be filed. (Directive to Take Action)

Fiscal Note: Less than \$500

APPENDIX
Exhibit A

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

National Medical Specialty Societies

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

RESPONSIBILITIES OF NATIONAL MEDICAL SPECIALTY ORGANIZATIONS

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

Exhibit B - Summary Membership Information

Organization	AMA Membership of Organization's Total Eligible Membership
Academy of Consultation-Liaison Psychiatry	378 of 1,471 (26%)
American College of Lifestyle Medicine	974 of 3,937 (25%)
American Venous Forum	115 of 439 (26%)
Association of Academic Physiatrists	162 of 779 (21%)
Society for Pediatric Dermatology	154 of 564 (27%)

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 01-A-24

Subject: AMA Bylaws—Nomination of Officers and Council Members

Presented by: Mark Bair, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2023 Interim meeting, the House of Delegates adopted Recommendation 21 of Speakers
2 Report 3, Report of the Election Task Force 2 (Policy G-610.089). Policy G-610.089 directed that
3 Bylaw 6.8.1 be updated to clarify that nominations are made by the chair of the Board of Trustees
4 or by a member of the House of Delegates at the opening session of the meeting at which elections
5 take place. The Council found similar language in Bylaw 3.3. To maintain internal bylaw
6 consistency and to accurately describe the nomination process for Officers and Council members
7 the Council submits amended language for 3.3 and 6.8.1 for House action.

8 9 RECOMMENDATIONS

10
11 The Council on Constitution and Bylaws recommends that the following amendments to our AMA
12 Bylaws be adopted, that Policy G-610.989 be rescinded, and that the remainder of this report be
13 filed. Adoption requires the affirmative vote of two-thirds of the members of the House of
14 Delegates present and voting.

15 16 **3 Officers**

17 ***

18
19
20 **3.3 Nominations.** Nominations for President-Elect, Speaker and Vice Speaker, shall be
21 made ~~from the floor~~ by a member of the House of Delegates at the opening session of
22 the meeting at which elections take place. Nominations for all other officers, except for
23 Secretary, the medical student trustee, and the public trustee, shall be made ~~from the~~
24 ~~floor~~ by a member of the House of Delegates at the opening session of the meeting at
25 which elections take place ~~and may be announced by the Board of Trustees.~~

26 27 **6 Councils**

28 ***

29 30 31 **6.8 Election – Council on Constitution and Bylaws, Council on Medical Education,** 32 **Council on Medical Service, and Council on Science and Public Health**

33
34 **6.8.1 Nomination and Election.** Members of these Councils, except the medical
35 student member, shall be elected by the House of Delegates. The Chair
36 ~~Nominations shall be made by the chair~~ of the Board of Trustees will present
37 announced candidates, who shall be entered into nomination by the Speaker
38 at the Opening session of the meeting at which elections take place.

1 Nominations ~~and~~ may also be made from the floor by a member of the
2 House of Delegates at the opening session of the meeting at which elections
3 take place.

4
5 (Modify Bylaws)

Fiscal Note: No Significant Fiscal Impact

RELEVANT AMA POLICY

G-610.089, Directives on Nominations from Speakers Report 3. The language in Bylaw 6.8.1, “Nomination and Election” be updated to clarify that nominations are made by the chair of the Board of Trustees or by a member of the House of Delegates at the opening session of the meeting at which elections take place.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 02-A-24

Subject: AMA Bylaws—Run-Off and Tie Ballots
(Report of ETF 2 - Rec. #13)

Presented by: Mark Bair, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2023 Interim meeting of the American Medical Association (AMA) the House of Delegates
2 (HOD) considered Recommendation 13 from Speakers Report 3, Report of the Election Task Force
3 2, that asked that Bylaws 3.4.2.1.3, 3.4.2.2, and 6.8.1.4 be amended to change the rules for
4 elections of officers and councils with multiple nominees so that the lowest vote getter on each
5 ballot is dropped on the subsequent ballot, with the exception of a tie for lowest vote getter in
6 which case both would be dropped. While the Reference Committee recommended adoption of
7 Recommendation 13, the HOD ultimately referred the recommendation over concerns about
8 complex onsite bylaw language not being able to be considered at caucuses.

9
10 The AMA has a long-standing precedent of requiring that all office holders are elected by a
11 majority of those casting legal ballots. During Council on Constitution and Bylaws (the Council)
12 discussions of potential bylaw language, it became apparent that there are three very unlikely
13 scenarios in which a strict elimination of the nominee with the lowest vote tally as proposed in the
14 Speakers 3-I-23 would enable a nominee who had not received a majority of votes cast to be
15 elected:

- 16
17 • For example, if five nominees were running for four vacancies on the Board of Trustees (or
18 an elected Council), and only three receive a majority of votes, then, of the remaining two,
19 one would be eliminated, effectively installing a nominee who had not yet received a
20 majority of votes.
- 21 • Even more unlikely, albeit possible, is a situation whereby those two remaining candidates
22 tie, and subsequently would then both be eliminated if the Bylaws were strictly interpreted.
- 23 • A similar but even more unlikely event could occur in an election for an officer. For
24 example, if three nominees (A, B, and C) were running for Speaker in a House of 100
25 votes, then it is possible that A could receive 34 votes, and B and C could each receive 33.
26 Again, a strict interpretation of the rule would eliminate both B and C, effectively
27 installing a Speaker who had not received a majority of votes.
- 28 • The Council noted that a more common occurrence is a multi-vacancy, multi-nominee race
29 with one more nominee than there are vacancies. For such a race, a more likely outcome is
30 that two nominees do not attain a majority vote with only one vacancy remaining. and must
31 run against each other for the remaining vacancy.
- 32 • Lastly, the Council noted that were elections held at the I-23 meeting with a potential of
33 705 credentialed delegates, theoretically a contested race with three nominees could end in
34 a three-way tie (with each nominee receiving 235 votes).

1 Admittedly, these are highly unlikely scenarios, but for completeness, your Council on Constitution
2 and Bylaws felt they should be addressed to avoid controversy should they occur. Minor
3 conditional language has been added in order to prevent such scenarios.

4
5 RECOMMENDATIONS

6
7 The Council on Constitution and Bylaws recommends that the following amendments to our AMA
8 Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative
9 vote of two-thirds of the members of the House of Delegates present and voting.

10
11 **3 Officers**

12 ***

13 **3.4 Elections.**

14 ***

15 **3.4.2 Method of Election.** Where there is no contest, a majority vote without ballot shall
16 elect. All other elections shall be by ballot.

17
18 **3.4.2.1 At-Large Trustees.**

19
20 **3.4.2.1.1 First Ballot.** All nominees for the office of At-Large Trustee
21 shall be listed alphabetically on a single ballot. Each elector
22 shall have as many votes as the number of Trustees to be
23 elected, and each vote must be cast for a different nominee.
24 No ballot shall be counted if it contains fewer or more votes
25 than the number of Trustees to be elected, or if the ballot
26 contains more than one vote for any nominee. A nominee shall
27 be elected if they have received a vote on a majority of the
28 legal ballots cast and are one of the nominees receiving the
29 largest number of votes within the number of Trustees to be
30 elected.

31
32 ~~**3.4.2.1.2 Runoff Ballot.** A runoff election shall be held to fill any
33 vacancy not filled because of a tie vote.~~

34
35 ~~**3.4.2.1.2**~~ **3.4.2.1.2³ Subsequent Ballots.** If all vacancies for Trustees are not filled
36 on the first ballot, and there are more than two remaining
37 nominees, the nominee with the fewest votes shall be dropped
38 and the remaining nominees shall be placed on the subsequent
39 ballot. In the event of a tie for the fewest votes, both
40 nominees shall be dropped. If these actions would result in
41 fewer than two nominees, the nominee(s) with the fewest
42 votes shall not be dropped and all remaining nominees shall be
43 placed on the subsequent ballot. On any subsequent ballot, a
44 nominee shall be elected if they have received a vote on a
45 majority of the legal ballots cast and are one of the nominees
46 receiving the larger number of votes within the number of
47 Trustees to be elected or remaining to be elected, and 3 or
48 more Trustees are still to be elected, the number of nominees
49 on subsequent ballots shall be reduced to no more than twice

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~~the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. When 2 or fewer Trustees are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are Trustees yet to be elected, and must cast each vote for different nominees. This procedure shall be repeated until all vacancies have been filled.~~

3.4.2.2 All Other Officers, except the Medical Student Trustee and the Public Trustee. All other officers, except the medical student trustee and the public trustee, shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions would result in fewer than two nominees, the nominee(s) with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. ~~the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.~~

6 Councils

6.8 Election – Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health

6.8.1.1 Separate Election. The resident/fellow physician member of these Councils shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominee with the fewest votes shall be dropped and the remaining nominees shall be placed on the subsequent ballot. In the event of a tie for the fewest votes, both nominees shall be dropped. If these actions result in fewer than two nominees, the nominees with the fewest votes shall not be dropped and all remaining nominees shall be placed on the subsequent ballot. ~~nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure~~

1 shall be continued until one of the nominees receives a majority of the
2 legal votes cast.

3
4 **6.8.1.2 Other Council Members.** With reference to each such Council, all
5 nominees for election shall be listed alphabetically on a single ballot.
6 Each elector shall have as many votes as there are members to be
7 elected, and each vote must be cast for a different nominee. No ballot
8 shall be counted if it contains fewer votes or more votes than the
9 number of members to be elected, or if the ballot contains more than
10 one vote for any nominee. A nominee shall be elected if they have
11 received a vote on a majority of the legal ballots cast and are one of the
12 nominees receiving the largest number of votes within the number of
13 members to be elected.

14
15 **6.8.1.3 ~~Run-Off Ballot.~~** ~~A run-off election shall be held to fill any vacancy~~
16 ~~that cannot be filled because of a tie vote.~~

17
18 **6.8.1.4 Subsequent Ballots.** If all vacancies are not filled on the first ballot,
19 and there are more than two remaining nominees, the nominee with
20 the fewest votes shall be dropped and the remaining nominees shall be
21 placed on the subsequent ballot. In the event of a tie for the fewest
22 votes, both nominees shall be dropped. If these actions would result in
23 fewer than two remaining nominees, the nominee(s) with the fewest
24 votes shall not be dropped and all remaining nominees shall be placed
25 on the subsequent ballot. On any subsequent ballot, a nominee shall be
26 elected if they have received a vote on a majority of the legal ballots
27 cast and are one of the nominees receiving the largest number of votes
28 within the number of council members to be elected or remaining to be
29 elected. and 3 or more members of the Council are still to be elected,
30 the number of nominees on subsequent ballots shall be reduced to no
31 more than twice the number of remaining vacancies less one. The
32 nominees on subsequent ballots shall be determined by retaining those
33 who received the greater number of votes on the preceding ballot and
34 eliminating the nominee(s) who received the fewest number of votes
35 on the preceding ballot, except where there is a tie. When 2 or fewer
36 members of the Council are still to be elected, the number of nominees
37 on subsequent ballots shall be no more than twice the number of
38 remaining vacancies, with the nominees determined as indicated in the
39 preceding sentence. In any subsequent ballot the electors shall cast as
40 many votes as there are members of the Council yet to be elected, and
41 must cast each vote for a different nominee. This procedure shall be
42 repeated until all vacancies have been filled.

(Modify Bylaws)

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 03-A-24

Subject: AMA Bylaws—Removal of Officers, Council Members, Committee Members
and Section Governing Council Members
(D-610.997)

Presented by: Mark Bair, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2023 Interim meeting of the American Medical Association (AMA), the House of Delegates
2 adopted as amended Recommendation 26 from Speakers Report 3: Report of the Election Task
3 Force 2 (D-610.997). Policy [D-610.997](#) asked that our AMA consider developing bylaw language
4 regarding the removal of elected individuals or candidates and the criteria by which such removal
5 would be accomplished and to report back at A-24.

6
7 The Council on Constitution and Bylaws (the Council) has developed this report specifically to
8 comprehensively address the removal of officers, council members, and section governing council
9 members. The report does not address candidates as the Council strongly believes this is more
10 appropriately addressed by the Election Committee. Successfully elected candidates would be
11 considered officers or council members and would be covered under the Council’s
12 recommendations in this report.

13
14 Recommendations are presented for consideration by the House of Delegates.

15 16 BACKGROUND

17
18 As part of its fact-finding mission, the Council reviewed applicable bylaws, policies and statutes
19 that address the removal of such parties from office:

20 21 Bylaws

- 22
- 23 • AMA Bylaw [3.2.1](#) specifies that AMA membership is a condition for holding office.
24 Nonrenewal of AMA membership would make a candidate or incumbent ineligible to hold
25 office.
 - 26 • AMA Bylaws for the Resident/Fellow Trustee [[3.5.5.1](#)] and the Medical Student Trustee
27 [[3.5.6.3](#)] have provisions specifying termination of their terms should they no longer
28 qualify as a resident/fellow or medical student (there also is a grace period if this occurs
29 within 90 days of the annual meeting). Similar bylaw provisions exist for residents and
30 medical student members of AMA councils [[6.11](#)].
 - 31 • Bylaw [1.5](#) states that the Council on Ethical and Judicial Affairs (CEJA) after due notice
32 and hearing, may censure, expel, or place on probation any member of the AMA for an

1 infraction of the Constitution or these Bylaws, for violation of the Principles of Medical
2 Ethics, or for unethical or illegal conduct.

- 3 • Bylaw [3.6.4](#) states that if an officer misses six consecutive regular meetings of the Board of
4 Trustees (Board), this matter shall be reported to the House of Delegates by the Board and
5 the office shall be considered vacant.
- 6 • AMA Bylaws provide a mechanism for filling vacancies for all Officers and for the elected
7 and appointed Councils.
- 8 • AMA Bylaws do not prohibit the resignation of any Board member or Council member for
9 any reason.
- 10 • AMA's Parliamentary Authority, as specified in Bylaw [11.1](#) is the current edition of The
11 American Institute of Parliamentarians Standard Code of Parliamentary Procedure
12 (AIPSC). AIPSC (2nd ed.) acknowledges in Section 3.15 the rights of an organization to
13 discipline, suspend and/or expel members, directors and officers in accordance with its
14 bylaws, the parliamentary authority, and within the law.

15
16 Policies

- 17
18 • The [AMA Principles of Medical Ethics](#) ("Principles") were last revised in June 2001 but
19 initially adopted as the AMA's Code of Conduct when AMA was formed in 1847. The
20 Principles are standards of conduct that define the essentials of honorable behavior for
21 physicians. Principles applicable to this report include:
 - 22 ○ II. A physician shall uphold the standards of professionalism, be honest in all
23 professional interactions, and strive to report physicians deficient in character or
24 competence, or engaging in fraud or deception, to appropriate entities.
 - 25 ○ III. A physician shall respect the law and also recognize a responsibility to seek
26 changes in those requirements which are contrary to the best interests of the
27 patient.
 - 28 ○ IV. A physician shall respect the rights of patients, colleagues, and other health
29 professionals, and shall safeguard patient confidences and privacy within the
30 constraints of the law.
- 31
32 • Policy [H-140.837](#), "Policy on Conduct at AMA Meetings and Events," includes language
33 to the effect that "The CCAM (Committee on Conduct at AMA Meetings and Events) will
34 review all incident reports, perform further investigation (if needed) and recommend to the
35 Office of General Counsel any additional commensurate disciplinary and/or corrective
36 action, which may include but is not limited to the following: prohibiting the violator from
37 attending future AMA events or activities; removing the violator from leadership or other
38 roles in AMA activities; prohibiting the violator from assuming a leadership or other role
39 in future AMA activities; notifying the violator's employer and/or sponsoring organization
40 of the actions taken by AMA; referral to the CEJA for further review and action; and
41 referral to law enforcement.

42
43 Law

- 44
45 • Our AMA is incorporated in the State of Illinois under the General Not For Profit
46 Corporation Act of 1986 (the "Act"). As such, the following provisions apply:
47
48 Sec. 108.35. Removal of directors.
49 (a) One or more of the directors may be removed, with or without cause. In the case of a
50 corporation having a board of directors which is classified in accordance with

1 subsection 108.10(e) of this Act, the articles of incorporation or bylaws may provide
2 that such directors may only be removed for cause.
3 (b) In the case of a corporation with no members or with no members entitled to vote on
4 directors, a director may be removed by the affirmative vote of a majority of the
5 directors then in office present and voting at a meeting of the board of directors at
6 which a quorum is present.
7 (c) In the case of a corporation with members entitled to vote for directors, no director may
8 be removed, except as follows:
9 (1) A director may be removed by the affirmative vote of two-thirds of the votes present
10 and voted, either in person or by proxy.
11 (2) No director shall be removed at a meeting of members entitled to vote unless the
12 written notice of such meeting is delivered to all members entitled to vote on removal of
13 directors. Such notice shall state that a purpose of the meeting is to vote upon the
14 removal of one or more directors named in the notice. Only the named director or
15 directors may be removed at such meeting.
16 (3) In the case of a corporation having cumulative voting, if less than the entire board is
17 to be removed, no director may be removed, with or without cause, if the votes cast
18 against his or her removal would be sufficient to elect him or her if then cumulatively
19 voted at an election of the entire board of directors.
20 (4) If a director is elected by a class of voting members entitled to vote, directors or
21 other electors, that director may be removed only by the same class of members entitled
22 to vote, directors or electors which elected the director.
23 (d) The provisions of subsections (a), (b) and (c) shall not preclude the Circuit Court from
24 removing a director of the corporation from office in a proceeding commenced either by
25 the corporation or by members entitled to vote holding at least 10 percent of the
26 outstanding votes of any class if the court finds (1) the director is engaged in fraudulent
27 or dishonest conduct or has grossly abused his or her position to the detriment of the
28 corporation, and (2) removal is in the best interest of the corporation. If the court
29 removes a director, it may bar the director from reelection for a period prescribed by the
30 court. If such a proceeding is commenced by a member entitled to vote, such member
31 shall make the corporation a party defendant.
32 (Source: P.A. 96-649, eff. 1-1-10.)
33

- 34 • While the AMA’s Office of the General Counsel (OGC) notes that the Act does not
35 directly apply to elected or appointed Council members or appointed committee members,
36 it should be noted that the Illinois statute is broad and vague. Thus, our AMA is fully
37 empowered and has the authority to provide that “all elected and/or appointed individuals”
38 would be required to be bound by the removal language in the statute if it so desired.
39 Lastly, OGC advised that whatever is the final determination of the House of Delegates
40 (the “House”), to the extent it conflicts with Illinois law, Illinois law will govern.
41

42 DISCUSSION

43
44 As part of its fact-finding, the Council read with interest an article from the American Hospital
45 Association’s Trustee Insights, entitled “When a Board Member Crosses the Line: Removing a
46 Trustee Midterm,¹ whereby organizations are urged to define the desired behaviors of its board
47 members, clarify behaviors that are clearly unacceptable and create a standard process to

¹ Orlikoff, J, When a Board Member Crosses the Line: Removing a Trustee Midterm: Addressing problem behaviors is key to a high performing board. AHA Trustee Insights, September 2023
[\[https://trustees.aha.org/when-board-member-crosses-line-removing-trustee-midterm\]](https://trustees.aha.org/when-board-member-crosses-line-removing-trustee-midterm)

1 immediately address them if exhibited by any board member. Board members are classified into
2 four categories: superstars, solid performers, nonperforming/deadweight members, and toxic
3 members. While nonperforming members are typically managed by an organization through peer
4 pressure, not being re-elected or appointed, or resignations due to personal or health reasons, the
5 article supports removal of a toxic member for reasons such as violating the conflict-of-interest
6 policy, including failure to disclose a conflict; attempting to use information obtained as a board
7 member in such a way as to derive personal, financial or other benefit; violating the confidentiality
8 policy; verbally abusing board members, staff or patients/families; any physical assault on board
9 members, staff or patients/families at any time, in any place; actively working to subvert stated
10 board policy or decisions; accusation or conviction of felony; speaking against the organization or
11 the board or the CEO or staff in public; or racist or sexist comments or behavior, failure to attend a
12 minimum of 50% (or other specified percentage) of board meetings; failing to attend three
13 consecutive board meetings; and sleeping during board or board committee meetings (two or more
14 instances).

15

16 The Council notes that the Standing Rules of the AMA Board of Trustees provide for the removal
17 of the chair-elect or chair, positions elected internally by Board members. The Council also
18 emphasizes that existing AMA bylaws, policies and Illinois law cover most but not all, of the other
19 behaviors defined as unacceptable.

20

21 In further discussing the issue, the Council noted that only AMA Trustees have a fiduciary
22 responsibility, and those who do not complete their responsibilities (through negligence or blatant
23 recklessness) could cause the AMA to incur unnecessary liability.

24

25 The Council also found that while the Speakers Report did not address the removal of individuals
26 who serve on appointed councils, the Council believes there should be a comparable process for
27 removal similar to those who serve on elected councils, with those procedures to be adopted by the
28 House. Similarly, while Section governing council members have no fiduciary responsibilities, the
29 bylaws also should incorporate a removal provision, with those Rules to be approved by the AMA
30 Board of Trustees. Several Section Internal Operating Procedures already provide for the removal
31 of a governing council member. The Council would work collaboratively with the Council on Long
32 Range Planning and Development, CEJA, OGC, and the House of Delegates to develop the
33 procedures to be employed.

34

35 In perusing other published literature, personal one-on-one intervention is often cited as a less
36 formal solution to managing problematic board, council or committee members. For example, if an
37 individual has failed to attend a specified number of meetings in a row, has a specified number of
38 unexcused absences or has become an impediment to the group's work, the most senior member
39 often meets informally with the individual in question. Additionally, offering or granting a leave of
40 absence is another option to make it possible for individuals to take a leave of absence from a
41 board, council or committee if they have health, work or other reasons why they cannot participate
42 fully during the current term. AMA Bylaws, Council Rules and Section Internal Operating
43 Procedures all provide a mechanism for filling vacancies. Lastly, term limits are cited as ways to
44 minimize less than effective performance, and there are already term limits for AMA Trustees,
45 Council members and Section governing council members in place.

46

47 The Council learned that the bylaws or governing documents of several other organizations
48 incorporated in Illinois, such as the American Dental Association, American Bar Association,
49 Illinois Association for Behavior Analysis, include provisions that allow for the removal of elected
50 trustees, council members or committee members, with varying language and detail:

- 1 • **American Dental Association:** ADA Bylaws state that “The House of Delegates may
2 remove a trustee for cause in accordance with procedures established by the House of
3 Delegates. The procedures shall provide for notice of the charges alleged and an
4 opportunity for the accused to be heard in their defense. A two-thirds (2/3) affirmative vote
5 of the delegates present and voting is required to remove a trustee from office.” The ADA
6 Governance Manual provides further details that include: The House of Delegates may
7 remove an elective officer for cause in accordance with procedures established by the
8 House of Delegates. The procedures shall provide for notice of the charges alleged and an
9 opportunity for the accused to be heard in his or her defense. A two-thirds (2/3) affirmative
10 vote of the delegates present and voting is required to remove a trustee from office.
11
- 12 • Similarly, the ADA Governance Manual includes language to address removal of elected
13 or appointed Council members: “Removal for Cause. The Board of Trustees may remove a
14 council member for cause in accordance with procedures established by the Board of
15 Trustees. Those procedures shall provide for notice of the charges, including allegations of
16 the conduct purported to constitute each violation and a decision in writing which shall
17 specify the findings of fact which substantiate any and all of the charges. Prior to issuance
18 of the decision by the Board of Trustees, no council member shall be excused from
19 attending any meeting of a council unless there is an opportunity to be heard or compelling
20 reasons exist which are specified in writing by the Board of Trustees.” Similar language
21 also exists for the removal of Commission members, “Removal for Cause. Any of the
22 commissions of this Association shall have the sole authority to remove any of its members
23 for cause pursuant to its Rules, with notice of such removal being given to the ADA Board
24 of Trustees.”
25
- 26 • **Illinois Association for Behavior Analysis -- Removal of Board Member.** An elected
27 Board Member may be removed from their positions on the Board without cause if such
28 removal is approved by a majority vote of the membership. An appointed Board Member
29 may be removed by a majority vote of the Board.
30
- 31 • **American Psychological Association --** If a standing board or committee believes that
32 there is reasonable cause to remove a member from said body, a vote may be taken by the
33 board or committee to petition the Board of Directors to remove said member. If, with the
34 exception of the individual in question, two-thirds of all members vote to remove said
35 member, then a petition requesting removal shall inform the Board of Directors of the basis
36 for, and the evidence supporting, said removal. The Board of Directors shall give said
37 member the opportunity to fully respond in writing to the petition. The Board of Directors,
38 by a two-thirds vote of all members, may remove said member if it determines that there is
39 reasonable cause for removal and that removal is in the best interest of the Association.
40
- 41 • **American Bar Association –** Bylaw 31.2 allows the President to replace any committee
42 member who does not participate in the activities of the committee.
43

44 In conclusion, the Council supports bylaw language that addresses removal of individuals currently
45 holding a position within the AMA in accordance with procedures approved by the House or the
46 Board of Trustees. While removal is already possible under Illinois statute, the Council would
47 support bylaw language for the sake of transparency.

1 RECOMMENDATIONS

2
3 The Council on Constitution and Bylaws recommends that the following recommendations be
4 adopted, that Policy D-610.997 be rescinded, and that the remainder of this report be filed.

- 5
6 1) That our AMA Bylaws be amended by insertion to add the following provisions. Adoption
7 requires the affirmative vote of two-thirds of the members of the House of Delegates
8 present and voting:
9

10 **3. Officers**

11 ***

12
13
14 **3.6 Vacancies.**

15 ***

16
17 **3.6.4 Absences.** If an officer misses 6 consecutive regular meetings of the Board,
18 this matter shall be reported to the House of Delegates by the Board of
19 Trustees and the office shall be considered vacant. The vacancy shall be filled
20 as provided in Bylaw 3.6.1 or Bylaw 3.6.3.

21
22 **3.6.5 Removal for Cause.** Any officer may be removed for cause in accordance
23 with procedures established by the House of Delegates.

24
25 **6. Councils**

26 ***

27
28
29 **6.0.1.4 Removal.** A Council member may be removed for cause in accordance with
30 procedures approved by the House of Delegates.

31
32 **7. Sections**

33 ***

34
35
36 **7.0.3.4 Removal.** A Governing Council member may be removed for cause in
37 accordance with procedures approved by the House of Delegates.

38
39 (Modify Bylaws)

- 40
41 2) That the Councils on Constitution and Bylaws, Long Range Planning and Development
42 and the Ethical and Judicial Affairs and the House develop the procedures to remove a
43 trustee, council member or governing council member for cause. (Directive to Take
44 Action)
45
46 3) That the Election Committee address the need for policy to remove candidates who are
47 found to violate AMA policy G-610.090, AMA Election Rules and Guiding Principles.
48 (Directive to Take Action)

Fiscal Note: No Significant Fiscal Impact

RELEVANT AMA POLICY

D-610.997, Criteria Regarding Removal of Elected Individuals or Candidates
Our American Medical Association will consider developing bylaw language regarding removal of elected individuals or candidates and the criteria by which this would be accomplished and to report back at A-24.

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 04-A-24

Subject: AMA Bylaw Amendments Pursuant to AIPSC (2nd ed.)

Presented by: Mark Bair, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 American Medical Association (AMA) Bylaw 11.1 states that “In the absence of any provisions to
2 the contrary in the Constitution and these Bylaws, all general meetings of the AMA and all
3 meetings of the House of Delegates, of the Board of Trustees, of Sections and of councils and
4 committees shall be governed by the parliamentary rules and usages contained in the then current
5 edition of The American Institute of Parliamentarians Standard Code of Parliamentary Procedure.”
6 The most recent edition of the AIP Standard Code [herein referred to as AIPSC (2nd ed.)] became
7 effective as of January 2024.

8
9 As noted in informational Speakers Report 3, AIPSC (2nd ed.) establishes electronic notice as the
10 default notification and there are several AMA bylaw provisions that specify notification by mail
11 and/or in writing. The Council has prepared bylaw language to ensure that our Bylaws and AIPSC
12 (2nd ed.) are consistent.

13
14 **RECOMMENDATIONS**

15
16 The Council on Constitution and Bylaws recommends that the following recommendations be
17 adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of
18 two-thirds of the members of the House of Delegates present and voting:

- 19
20 1) That our AMA Bylaws be amended by insertion and deletion as follows:

21
22 **2.12.2 Special Meetings of the House of Delegates.** Special Meetings of the House of
23 Delegates shall be called by the Speaker on ~~written or electronic~~ request by of one third of
24 the members of the House of Delegates, or on request of a majority of the Board of
25 Trustees. When a special meeting is called, the Executive Vice President of the AMA shall
26 notify ~~mail a notice to the last known address of~~ each member of the House of Delegates at
27 least 20 days before the special meeting is to be held. The notice shall specify the time and
28 place of meeting and the purpose for which it is called, and the House of Delegates shall
29 consider no business except that for which the meeting is called.

30
31 ***

32
33 **2.12.3.1 Invitation from Constituent Association.** A constituent association desiring a
34 meeting within its borders shall submit an invitation ~~in writing~~, together with significant
35 data, to the Board of Trustees. The dates and the city selected may be changed by action of

1 the Board of Trustees at any time, but not later than 60 days prior to the dates selected for
2 that meeting.

3 ****

4
5 **5.2.4 Notice of Meeting.** Notice is given if delivered in person, by telephone, ~~mail~~, or any
6 means of electronic communication approved by the Board of Trustees. Notice shall be
7 deemed to be received upon delivery to the Trustee's contact information then appearing
8 on the records of the AMA.

9
10 **5.2.4.1 Waiver of Notice.** ~~Notice of any meeting need not be given if waived in~~
11 ~~writing before, during or after such meeting.~~ Attendance at any meeting shall constitute
12 a waiver of notice of such meeting, except where such attendance is for the express
13 purpose of objecting to the transacting of any business because of a question as to the
14 legality of the calling or convening of the meeting.

15
16 ****

17
18 **12.3 Articles of Incorporation.** The Articles of Incorporation of the AMA may be
19 amended at any regular or special meeting of the House of Delegates by the approval of
20 two-thirds of the voting members of the House of Delegates registered at the meeting,
21 provided that the Board of Trustees shall have approved the amendment and provided it to
22 ~~submitted it in writing to~~ each member of the House of Delegates at least 5 days, but not
23 more than 60 days, prior to the meeting of the House of Delegates at which the amendment
24 is to be considered.

25
26 (Modify Bylaws)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 1-A-24

Subject: Short-Term Global Health Clinical Encounters

Presented by: David A. Fleming, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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

10
11 Ethics guidance can neither redress historical wrongs nor solve the underlying structural issues that
12 drive medical need in under-resourced settings. However, by making explicit the conditions under
13 which short-term global health clinical encounters are ethically sound and articulating the
14 fundamental ethical responsibilities of those who participate in and sponsor such trips, ethics
15 guidance can promote immediate benefit to individuals and sustainable benefit for host
16 communities. In addition, ethics guidance can highlight the ways in which power imbalances and
17 neo-colonial assumptions can shape these practices and so may undermine their moral
18 acceptability. This report by the Council on Ethical and Judicial Affairs (CEJA) explores the
19 challenges of short-term global health clinical encounters and offers guidance for physicians,
20 physicians in training, and sponsors to help them address the ethical challenges of providing
21 clinical care in under-resourced settings. The encounters and perspective of host communities may
22 reveal concerns not specifically addressed in this report. However, the guidance provided
23 emphasizes the critical importance of ethical intent and collaboration with host communities, thus
24 encouraging ongoing conversations between visiting medical teams and host communities
25 regarding cultural, ethical, and practical concerns.

26 27 THE APPEAL OF SHORT-TERM GLOBAL HEALTH CLINICAL ENCOUNTERS

28
29 Just how many clinicians and trainees volunteer to provide medical care in under-resourced settings
30 is difficult to estimate, but the number is large. By one estimate, in the U.S. some 21% of the
31 nearly 3 billion dollars' worth of participant hours spent in international efforts in 2007 were
32 medically related [2]. For trainees, in January 2015 the Consortium of Universities for Global
33 Health identified more than 180 websites relating to global health opportunities [3]. The

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

1 Association of American Medical Colleges found that among students who graduated in 2017–
2 2018 between 25% and 31% reported having had some “global health experience” during medical
3 school [4].
4

5 A variety of reasons motivate physicians and trainees to participate in these projects. For many,
6 compelling motivations include the opportunities to help address health inequities, improve their
7 diagnostic and technical skills as clinicians, or explore global health as a topic of study [2]. Global
8 health clinical encounters may also be pursued to serve the goals of building one’s resume,
9 improving one’s professional prospects, and gaining the esteem of peers and family [2].
10

11 A NOTE ON TERMINOLOGY

12

13 The literature is replete with different terms for the activity of traveling to an under-resourced
14 community to provide medical care on a volunteer basis, including “short-term medical
15 volunteerism” [5], “short-term medical missions” [6], “short-term medical service trips” [7,8],
16 “short-term experience in global health” [9,10], “global health field experience” [11], “global
17 health experience,” and “international health experience”[2].
18

19 The Council on Ethical and Judicial Affairs prefers “short-term global health clinical encounters.”
20 This identifier is generally accepted and encompasses both clinical and educational activities. It
21 also recognizes that such encounters are not exercises in pure altruism, but a mutually beneficial
22 collaboration between those planning and participating in these encounters and host communities.
23 The term also highlights the fact that these activities are limited in duration, which has implications
24 for the ethical obligations of participants and their impact on host communities.
25

26 MEDICAL CARE IN UNDER-RESOURCED SETTINGS

27

28 Traditionally, short-term global health clinical encounters focused on providing clinical care as a
29 charitable activity, not infrequently under the auspices of faith-based institutions, whose primary
30 goal was to address unmet medical needs [10]. Increasingly, such trips focus on the broader goal of
31 improving the health and well-being of host communities [9]. Many also offer training
32 opportunities for medical students, residents, and local healthcare professionals [9,10,11]. Ideally,
33 short-term global health clinical encounters are part of larger, long-term efforts to build capacity in
34 the health care systems being visited, and ultimately to reduce global health disparities [9,10].
35

36 The medical needs of host communities differ from those of participants’ home countries—
37 participants may encounter patients with medical conditions they have not seen before, or who
38 present at more advanced stages of disease, or are complicated by “conditions, such as severe
39 malnutrition, for which medical volunteers may have limited experience” [7]. At the same time,
40 available treatment options will often include medications, procedures or tools with which
41 participants are not familiar. As such, the practice of medicine in under-resourced communities
42 should be considered a unique area of expertise, requiring specific background and training in order
43 to be effective [12].
44

45 By definition, short-term global health clinical encounters typically take place in contexts of scarce
46 resources. The communities where these encounters take place often have limited access to health
47 care, often lack access to food, and often lack both economic and political power [7]. As a result,
48 they may feel unable to refuse assistance that is offered [10]. Moreover, short-term global health
49 clinical encounters take place under the long shadow of colonialism, including medicine’s role in
50 that [10], and have been critiqued as perpetuating the colonial legacy of racism, exploitation, and
51 dependency [1,10,13]. To avoid reproducing these injustices, participants and sponsors should

1 recognize that it is a privilege to practice and train in under-resourced communities, and that justice
2 requires reciprocity and equal respect among local and visiting staff, community members, and
3 patients in this context [9].
4

5 These realities define fundamental ethical responsibilities not only for those who volunteer, but
6 equally for the individuals and organizations that sponsor short-term global health clinical
7 encounters.
8

9 ETHICAL RESPONSIBILITIES IN SHORT-TERM GLOBAL HEALTH CLINICAL 10 ENCOUNTERS 11

12 Emerging guidelines identify the following ethical duties for participants of short-term global
13 health clinical encounters and organizations sponsoring them: (a) to produce good clinical
14 outcomes, (b) to promote justice and sustainability, (c) to minimize burdens on host communities,
15 and (d) to respect persons and local cultures [2,9,10,11].
16

17 Promoting Justice & Sustainability 18

19 If short-term global health clinical encounters are to achieve their goal of improving the health of
20 local host communities, they must commit not simply to addressing immediate, concrete needs, but
21 to helping the community build its own capacity to provide health care. To that end, the near and
22 longer-term goals of trips should be set in collaboration with the host community, not determined
23 in advance solely by the interests or intent of trip sponsors and participants [7,9]. Trips should seek
24 to balance community priorities with the training interests and abilities of participants [10], but in
25 the first instance benefits should be those desired by, and acceptable to, the host community [9].
26 Those involved with short-term global health clinical encounters have a responsibility to ask how
27 they can best use a trip's limited time and material resources to promote the long-term goal of
28 developing local capacity. Will the trip train local health care providers? Build local infrastructure?
29 [7]? Ideally, a short-term global health experience will be embedded in a longer-term strategy and
30 collaboratively planned with the host community [7,10].
31

32 Minimizing Harms & Burdens in Host Communities 33

34 Just as focusing on the overarching goal of promoting justice and sustainability is foundational to
35 ethically sound short-term global health clinical encounters, so too is identifying and minimizing
36 the burdens such trips place on the host communities.
37

38 Beyond lodging, food, and other direct costs of short-term global health clinical encounters, which
39 are usually reimbursed to host communities [9], such trips can place other, less visible burdens on
40 host communities. Physicians, trainees, and others who organize or participate in short-term global
41 health clinical encounters should be alert to possible unintended consequences that can undermine
42 the value of a trip. Trips should not detract from or place significant burdens on local clinicians and
43 resources, particularly in ways that negatively affect patients, jeopardize sustainability, or disrupt
44 relationships between trainees and their home institutions [9,11]. For example, the expectation that
45 local healthcare and support staff will be available to assist visiting clinicians in addition to (or in
46 place of) their usual duties can disrupt care for their existing patients. It should not be assumed that
47 host communities can absorb additional costs, even on a temporary basis [14]. Particular attention
48 should be paid to the follow-up care that burdens local practitioners and may result in harm to
49 patients in the aftermath of invasive procedures [15].

1 Sharing information beforehand as to how visiting health care professionals are expected to interact
2 with the host community, the team’s objectives, and the skill, and training they bring, can reveal
3 potential benefits and harms, thus allowing them to be discussed and addressed before the team
4 embarks on the experience. Likewise, selecting team members whose skills and experience map
5 onto the needs and expectations of the host community can help minimize disruptive effects on
6 local practice [11]. Advance preparation should include developing a plan to monitor and address
7 ongoing costs and benefits to patients, host communities and institutions, including local trainees
8 (when the trip includes providing training for the host community) [11].
9

10 Respecting Persons & Cultures

11
12 Physicians and trainees who participate in short-term global health clinical encounters face a host
13 of challenges. Some of them are practical, such as resource limitations, unfamiliar medical needs,
14 living conditions outside their experience, among many others. Others involve successfully
15 navigating language(s) and norms they may never have encountered before, or not encountered
16 with the same immediacy [1,2,9]. Striking a balance between Western medicine’s understanding of
17 professional ethics and the expectations of host communities rooted in other histories, traditions,
18 and social structures calls for a level of discernment, sensitivity, and humility that may more often
19 be seen as the skill set of an ethnographer than a clinician.
20

21 Individuals who travel to provide medical care in under-resourced settings should be aware that the
22 interactions they will have there will inevitably be cross-cultural. They should seek to become
23 broadly knowledgeable about the communities in which they will work, such as the primary
24 language(s) in which encounters will occur; predominant local understandings of health and illness;
25 local expectations for how health care professionals behave toward patients and toward one
26 another; and salient economic, political, and social dynamics. Participants should take advantage of
27 resources that can help them cultivate the cultural sensitivity they will need to provide safe,
28 respectful, patient-centered care in the context of the specific host community [7,10,11]. Further,
29 trip participants should be mindful that they bring with them their own unexamined cultural beliefs
30 and assumptions about under-resourced communities, some of which trace back to colonialist,
31 racialized attitudes. For instance, there is a widespread assumption that visiting physicians and
32 trainees possess universally applicable (and perhaps superior) skills and knowledge simply by
33 virtue of their association with Western medicine [19].
34

35 Individuals do not bear these responsibilities alone. Organizations and institutions that sponsor
36 short-term global health clinical encounters have a responsibility to make appropriate orientation
37 and training available to participants before they depart [11], in addition to working with host
38 communities to put in place appropriate services, such as interpreters or local mentors, to support
39 participants during the experience.
40

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

1 PREPARATION FOR THE EXPERIENCE

2
3 Fulfilling these fundamental ethical responsibilities requires meeting other obligations with respect
4 to organizing and carrying out short-term global health clinical encounters. Specifically, sponsoring
5 organizations and institutions have an obligation to ensure thoughtful, diligent preparation to
6 promote a trip's overall goals, including appropriately preparing participants for the experience.
7 Physicians and trainees, for their part, have an obligation to thoughtfully choose those programs
8 with which they affiliate themselves [1,2,9,11].
9

10 Prepare Diligently

11
12 Guidelines from the American College of Physicians recognize that “predeparture preparation is
13 itself an ethical obligation” even though this is far from a universal practice at present [9,cf. 2,12].
14 Collaborative planning can identify what material resources and clinical skills participants should
15 be expected to bring to the effort. For example, what activities participants should be assigned, or
16 whether local mentors are needed or desirable and how such relationships will be coordinated [11].
17

18 Supervision of trainees also needs to be explicitly arranged and followed up once they arrive in the
19 host community. Studies show that 20% of participants reported inadequate supervision during
20 their trips, and it is common for medical schools to allow “students to arrange encounters abroad
21 without faculty supervision and support” [18,12]. Allowing students to practice in under-resourced
22 settings without proper supervision is a clear violation of their fiduciary duty.
23

24 Thoughtful preparation includes determining what nonclinical skills and experience participants
25 should have to contribute to the overall success of the experience. For example, the goal of
26 supporting capacity building in the local community calls for participants who have “training
27 and/or familiarity with principles of international development, social determinants of health,
28 ...public health systems” and in some cases, health care administration [10,12]. Without this
29 background, interventions may result in “resource wasting and potentially poorer patient care”
30 [12].
31

32 Adequately preparing physicians and trainees for short-term global health clinical encounters
33 encompasses planning with respect to issues of personal safety, vaccinations, unique personal
34 health needs, travel, malpractice insurance, and local credentialing requirements [7]. Equally
35 important, to contribute effectively and minimize “culture shock” and distress, participants need a
36 basic understanding of the context in which they will be working [1,2,7]. Without expecting them
37 to become experts in local culture, participants should have access to resources that will orient
38 them to the language(s), traditions, norms, and expectations of the host community, not simply to
39 the resources and clinical challenges they are likely to face. Participants should have sufficient
40 knowledge to conduct themselves appropriately, whether that is in how they dress, how they
41 address or interact with different members of the community, or how they carry out their clinical
42 responsibilities [7]. They also need to know to whom they can turn for guidance. If at all possible,
43 this should be someone from outside the host community, since community members may be
44 reluctant to “push back” against the judgments and actions of participants [19].
45

46 Preparation should also include explicit attention to the possibility that participants will encounter
47 ethical dilemmas. Working in unfamiliar cultural settings and with limited resources introduces the
48 real possibility that physicians and trainees will encounter situations in which they “are unable to
49 act in ways that are consistent with ethics and their professional values” or “feel complicit in a
50 moral wrong” [9]. In particular, participants will be required to assess “how to balance risks and
51 benefits [for patients who have been economically marginalized and who are experiencing illnesses

1 with which they have little clinical experience] ... how to distribute limited medical resources, and
2 when non-intervention is the appropriate choice” [15]. In addition, participants may find that local
3 beliefs are inconsistent with their own ethical commitments. Having strategies in place to address
4 dilemmas when they arise and to debrief after the fact can help mitigate the impact of such
5 encounters. Physicians under stress due to difficult ethical situations experience emotional harm
6 and this may, in turn, affect the quality of patient care [12]. In cases of irreducible conflict with
7 local norms, participants may withdraw from care of an individual patient or from the project after
8 careful consideration of the effect withdrawing will have on patients, the medical team, and the
9 larger goals of the experience, in keeping with ethics guidance on the exercise of conscience. In
10 addition, participants should keep in mind that some care is not always better than no care, and
11 should ensure that they are able to provide safe, respectful, patient-centered care in the context of
12 the specific host community at all times. This context requires cultural respect and awareness on
13 the part of participants, as well as ongoing attention to the fact that certain treatment decisions may
14 become burdensome to the local medical community once the volunteers leave.

15 16 Choose Thoughtfully

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

30 31 Measure & Share Meaningful Outcomes

32
33 Organizations that sponsor short-term global health clinical encounters have a responsibility to
34 monitor and evaluate the effectiveness of their programs, and to disseminate their findings in a
35 transparent manner [7,9,10]. The measures used to evaluate program outcomes should be
36 appropriate to the program’s goals as defined proactively in collaboration with the host community
37 [9]. Prospective participants should affiliate themselves with programs that demonstrate
38 effectiveness in providing outcomes meaningful to the population they serve, rather than simple
39 measures of process such as number of procedures performed [7]. Since the success of procedures
40 and programs cannot reasonably be verified if even their medium-term outcomes cannot be
41 monitored, participants should prefer programs that can track patient results over an extended
42 timeframe, even if their own contribution is made in a short time.

43 44 RECOMMENDATION

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

48
49 Short-term global health clinical encounters, which send physicians and physicians in training
50 from wealthier communities to provide care in under-resourced settings for a period of days or
51 weeks, have been promoted as a strategy to provide needed care to individual patients and,

1 increasingly, as a means to address global health inequities. To the extent that such encounters
2 also provide training and educational opportunities, they may offer benefit both to the host
3 communities and the medical professionals and trainees who volunteer their time and clinical
4 skills.

5
6 Short-term global health clinical encounters typically take place in contexts of scarce resources
7 and in the shadow of colonial histories. These realities define fundamental ethical
8 responsibilities for participants, sponsors, and hosts to jointly prioritize activities to meet
9 mutually agreed-on goals; navigate day-to-day collaboration across differences of culture,
10 language, and history; and fairly allocate resources. Participants and sponsors must focus not
11 only on enabling good health outcomes for individual patients, but on promoting justice and
12 sustainability, minimizing burdens on host communities, and respecting persons and local
13 cultures. Responsibly carrying out short-term global health clinical encounters requires diligent
14 preparation on the part of participants and sponsors in collaboration with host communities.

15
16 Physicians and trainees who are involved with short-term global health clinical encounters
17 should ensure that the trips with which they are associated:

- 18
19 (a) Focus prominently on promoting justice and sustainability by collaborating with the host
20 community to define project parameters, including identifying community needs, project
21 goals, and how the visiting medical team will integrate with local health care professionals
22 and the local health care system. In collaboration with the host community, short-term
23 global health clinical encounters should prioritize efforts to support the community in
24 building health care capacity. Trips that also serve secondary goals, such as providing
25 educational opportunities for trainees, should prioritize benefits as defined by the host
26 community over benefits to members of the visiting medical team or the sponsoring
27 organization.
- 28
29 (b) Seek to proactively identify and minimize burdens the trip places on the host community,
30 including not only direct, material costs of hosting participants, but also possible adverse
31 effects the presence of participants could have for beneficial local practices and local
32 practitioners. Sponsors and participants should ensure that team members practice only
33 within their skill sets and experience.
- 34
35 (c) Provide resources that help them become broadly knowledgeable about the communities in
36 which they will work and to cultivate the cultural sensitivity they will need to provide safe,
37 respectful, patient-centered care in the context of the specific host community. Members of
38 the visiting medical team are expected to uphold the ethics standards of their profession
39 and participants should insist that strategies are in place to address ethical dilemmas as
40 they arise. In cases of irreducible conflict with local norms, participants may withdraw
41 from care of an individual patient or from the project after careful consideration of the
42 effect that will have on the patient, the medical team, and the project overall, in keeping
43 with ethics guidance on the exercise of conscience. Participants should be clear that they
44 may be ethically required to decline requests for treatment that cannot be provided safely
45 and effectively due to resource constraints.
- 46
47 (d) Are organized by sponsors that embrace a mission to promote justice, patient-centered
48 care, community welfare, and professional integrity. Physicians, as influential members of
49 their health care systems, are well positioned to influence the selection, planning and
50 preparation for short term encounters in global health. In addition, they can take key roles
51 in mentoring learners and others on teams to be deployed. Physicians can also offer

1 guidance regarding the evaluation process of the experience, in an effort to enhance and
2 improve the outcomes of future encounters.

3
4 Sponsors of short-term global health clinical encounters should:(e) Ensure that resources
5 needed to meet the defined goals of the trip will be in place, particularly resources that cannot
6 be assured locally. This includes arranging for local mentors, translation services, and
7 participants' personal health needs. It should not be assumed that host communities can absorb
8 additional costs, even on a temporary basis.

9
10 (f) Proactively define appropriate roles and permissible range of practice for members of the
11 visiting medical team, so that they can provide safe, high-quality care in the host
12 community. Team members should practice only within the limits of their training and
13 skills in keeping with professional standards they would deem acceptable in their ordinary
14 clinical practice, even if the host community's standards are more flexible or less
15 rigorously enforced.

16
17 (g) Ensure appropriate supervision of trainees, consistent with their training in their home
18 communities, and make certain that they are only permitted to practice independently in
19 ways commensurate with their level of experience in under-resourced settings.

20
21 (h) Ensure a mechanism for meaningful data collection is in place, consistent with recognized
22 standards for the conduct of health services research and quality improvement activities in
23 the sponsor's country.

24
25 (New HOD/CEJA Policy)

Fiscal Note: Less than \$500

REFERENCES

1. Bauer I. More harm than good? The questionable ethics of medical volunteering and student placements. *Tropical Diseases, Travel Medicine and Vaccines* 2017;3:5
2. Consortium of Universities for Global Health. Cough.org. Accessed January 10, 2020.
3. Association of American Medical Colleges. *Medical School Graduation Questionnaire 2018 All Schools Summary Report*. Available at: <https://www.aamc.org/system/files/reports/1/2018gqallschoolssummaryreport.pdf>. Accessed October 29, 2019.
4. DeCamp M. Ethical review of global short-term medical volunteerism. *HEC Forum*. 2011;23:91–103.
5. Roche SD, Ketheeswaran P, Wirtz VJ. International short-term medical missions: a systematic review of recommended practices. *Int J Public Health*. 2017;62:31–42.
6. Stone GS, Olson KR. The ethics of medical volunteerism. *Med Clin N Am*. 2016;100:237–246.
7. Sykes KJ. Short-term medical service trips: a systematic review of the evidence. *Am J Public Health*. 2014;104:e38–e48.
8. DeCamp M, Soleymani Lehmann L, Jaell P, et al. Ethical obligations regarding short-term global health clinical experiences: an American College of Physicians position paper. *Ann Intern Med*. 2018;160:651–657.
9. Melby MK, Loh LC, Evert J, et al. Beyond medical “missions” to impact-driven short-term experiences in global health (STEGHs): ethical principles to optimize community benefit and learner experience. *Acad Med*. 2016;91(5):633–638.
10. Keller RC. Geographies of power, legacies of mistrust: colonial medicine in the global present. *Historical Geography* 2006;34:26-48.
11. Snyder J, Dharamsi S, Crook VA. Fly-by medical care: conceptualizing the global social responsibilities of medical tourisms and physician voluntourists. *Globalization and Health* 2011;7:6.
12. Asgary, R and Junck, E. New trends of short-term humanitarian medical volunteerism: professional and ethical considerations. *J Med Ethics*. 2013;39:625–31.
13. Crump JA, Sugarman J. Global health training: ethics and best practice guidelines for training experiences in global health. *Am J Trop Med Hyg*. 2010;83(6):1178–118
14. Nouvet E, Chan E, Schwartz L. Looking good but doing harm? perceptions of short-term medical missions in Nicaragua. *Glob Public Health*. 2018;13(4):456–72.
15. Wall, A. The Context of Ethical Problems in Medical Volunteer Work. *HEC Forum*. 2011;23:79–90.
16. Freedman B. Offering truth: one ethical approach to the uninformed cancer patient. *Arch Intern Med*. 1983;153:572–576.
17. American Medical Association. *Code of Medical Ethics*, Opinion 1.1.7, Physician exercise of conscience. Available at <https://www.ama-assn.org/delivering-care/ethics/physician-exercise-conscience>. Accessed October 29, 2019.
18. Doobay-Persaud A, Evert J, DeCamp M et al. Extent, nature and consequences of performing outside scope of training in global health. *Glob. Health*. 2019; 15: 1-16.
19. Sullivan N. International clinical volunteering in Tanzania: A postcolonial analysis of global health business. *Glob Public Health*. 2018;13(3):310–24.
20. Bishop, Rachel and Litch, James. Medical tourism can do harm. *BMJ*. 2000;320.

REPORT 2 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-24)
Research Handling of De-Identified Patient Data
(D-315.969)

EXECUTIVE SUMMARY

In adopting policy D-315.969, “Research Handling of De-Identified Patient Data,” the House of Delegates directed the Council on Ethical and Judicial Affairs (CEJA) to examine guidance related to the use of de-identified patient data and the risks of re-identification.

This report articulates a series of recommendations on how best to respond to the increasing collection, sale, and use of de-identified patient data and the associated risks. The report outlines how health data exist within digital information ecosystems, how such complex ecosystems pose challenges to data privacy, how de-identified data functions as a public good for clinical research, and how de-identified data derived within the context of health care institutions lead to certain ethical standards for and protections of that data.

Because CEJA recognizes both the promise of de-identified datasets for advancing health and the concerns surrounding the use of de-identified patient data including the risks of re-identification that extend from the level of individual physicians collecting clinical data to hospitals and other health care institutions as repositories and stewards of data, this report proposes a new Code of Medical Ethics opinion be adopted in conjunction with amendments to four existing opinions to provide ethics guidance in this rapidly evolving digital health ecosystem.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-A-24

Subject: Research Handling of De-Identified Patient Data
(D-315.969)

Presented by: David A. Fleming, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Policy [D-315.969](#), “Research Handling of De-Identified Patient Data,” adopted by the American
2 Medical Association (AMA) House of Delegates in November 2021, asked the Council on Ethical
3 and Judicial Affairs (CEJA) to examine guidance related to the use of de-identified patient data and
4 the risks of re-identification.

5
6 In its informational report on de-identified data [[CEJA 6-A-23](#)], CEJA examined a range of
7 challenges that health care professionals and institutions are now confronted with as technological
8 innovations rapidly evolve both within and outside of health care, blurring the boundary
9 distinctions between these spheres. CEJA’s exploration suggested that in this dynamic environment,
10 foundational ethical concepts of privacy and consent likely need to be revisited to better reflect that
11 personal health information today exists in digital environments where responsibilities are
12 distributed among multiple stakeholders.

13
14 This report expands on the previous work to articulate a series of recommendations on how best to
15 respond to the increasing collection, sale, and use of de-identified patient data and the associated
16 risks. The report outlines how health data exist within digital information ecosystems, how such
17 ecosystems pose challenges to data privacy, what the *Code* says about data privacy and informed
18 consent, how de-identified data functions as a public good for clinical research, how privacy
19 scholars are reconceptualizing privacy as contextual integrity, and how de-identified data derived
20 within the context of health care institutions lead to certain ethical standards for and protections of
21 that data.

22
23 Because CEJA recognizes both the promise of de-identified datasets for advancing health and the
24 concerns surrounding the use of de-identified patient data including the risks of re-identification
25 that extend from the level of individual physicians collecting clinical data to hospitals and other
26 health care institutions as repositories and stewards of data, this report proposes a new ethics
27 opinion in conjunction with amendments to four existing opinions to provide ethics guidance in
28 this rapidly evolving digital health ecosystem.

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

1 HEALTH DATA & DIGITAL ECOSYSTEMS

2
3 De-identified patient data are a subset of health data that exists within larger digital health
4 information ecosystems [1]. Such ecosystems are highly dynamic and distributed, with health
5 information often being combined from multiple datasets and distributed among multiple
6 stakeholders [1]. Traditionally, health data has referred to patient health information produced from
7 patient–physician interactions and stored by health care organizations [2]. This type of data is
8 typically recorded as identifiable patient data and entered into the patient’s electronic medical
9 record (EMR); from there, it can be de-identified and bundled together with other patient data to
10 form an aggregated dataset. In the age of Big Data, however, where large datasets can reveal
11 complex patterns and trends, diverse sets of information are increasingly brought together. Health
12 data now extends to all health-relevant data, including data collected anywhere from individuals
13 both passively and actively that can reveal information about health and health care use [2].
14

15 Within digital health ecosystems, health-related data can be generated by health care systems (e.g.,
16 EMRs, prescriptions, laboratory data, radiology), the consumer health and wellness industry (e.g.,
17 wearable fitness tracking devices, wearable medical devices such as insulin pumps, home DNA
18 tests), digital exhaust from daily digital activities (e.g., social media posts, internet search histories,
19 location and proximity data), as well as non-health sources of data (e.g., non-medical records of
20 race, gender, education level, residential zip code, credit history) [2]. The ethical challenges raised
21 by such widely distributed data ecosystems, with their vast array of data types and multiple
22 stakeholders, require a holistic approach to the moral issues caused by digital innovation. Digital
23 ethics has arisen as a theoretical framework to analyze these recent challenges and examine such
24 ethical concerns from multiple levels of abstraction. The digital ethics framework takes into
25 account the general environment in which ethical concerns arise and examines ethical dilemmas as
26 they relate to information and data, algorithms, practices and infrastructure, and their impact on the
27 digital world [3].
28

29 CHALLENGES TO DATA PRIVACY

30
31 In the U.S., the Health Insurance Portability and Accountability Act (HIPAA) imposes constraints
32 on the sharing of “protected health information,” including individually identifiable health
33 information contained in the EMR, by “covered entities,” including physicians, hospitals,
34 pharmacies, and third-party payers. HIPAA’s scope is narrow and does not cover other health-
35 relevant data, such as data generated voluntarily by patients themselves, for example, through the
36 use of commercial health-related apps or devices, or identifiable data individuals provide to
37 municipal authorities, utilities, retailers, or on social media. Furthermore, information that began in
38 the medical record can take on a new, independent life when linked with personal information
39 widely available through datasets generated outside of health care. As McGraw and Mandl explain,
40 “since HIPAA’s coverage is about ‘who’ holds the data, but not what type of data, much of the
41 health-relevant data collected today are collected by entities outside of HIPAA’s coverage bubble
42 and thus resides outside of HIPAA’s protections” [2]. HIPAA is thus limited in its ability to protect
43 patient data within digital health information ecosystems.
44

45 Complicating the matter is the fact that once patient health data has been de-identified, it is no
46 longer protected by HIPAA, and can be freely bought, sold, and combined with other datasets.
47 Hospitals now frequently sell de-identified datasets to researchers and industry. Recent
48 developments in AI and its use within health care have similarly created new difficulties.
49

50 Patients, and patient privacy advocates, are often concerned about who has access to their data. As
51 data ecosystems have grown larger and more distributed, this has become increasingly more

1 difficult to ascertain. In the age of Big Data, the global sale of data has become a multibillion-
2 dollar industry, with individuals' data viewed by industry as "new oil" [1]. The global health care
3 data monetization market alone was valued at just over \$0.4 billion in 2022 and is expected to grow
4 to \$1.3 billion by 2030 [4]. Industry often purchases hospital datasets to improve marketing and
5 sales, predict consumer behaviors, and to resell to other entities. Within health care and research
6 settings, the massive datasets collected from clinical data—used initially in the care and treatment
7 of individual patients—have created the potential for secondary use as a means for quality
8 improvement and innovation that can be used for the benefit of future patients and patient
9 populations [5].

10
11 The dynamic and distributed nature of today's digital health information ecosystems challenges the
12 prevailing procedural model for protecting patient privacy: informed consent and de-identification.
13 In a world where the secondary use of patient data within large datasets can easily enter into a
14 global marketplace, the intended use is almost impossible to discern. Patients cannot be honestly
15 and accurately informed about the specific terms of interactions between their collected data and
16 the data collector and any potential risks that may emerge [1,6]. Therefore, patients are unable to
17 truly give informed consent. Furthermore, whether de-identifying datasets truly prevents individual
18 data subjects from being re-identified has been increasingly called into question. Removing the 18
19 identifiers specified in HIPAA does not ensure that the data subject cannot be re-identified by
20 triangulation with identifying information from other readily available datasets [7]. Machine
21 learning and AI technologies have advanced to the point that virtually all de-identified datasets risk
22 re-identification, such that "even when individuals are not 'identifiable', they may still be
23 'reachable'" [6].

24
25 A final avenue to consider with respect to private health information and patient privacy is the risk
26 of health care data breaches. Raghupathi et al note, "[h]ealthcare is a lucrative target for hackers.
27 As a result, the healthcare industry is suffering from massive data breaches" [8]. The number of
28 health care data breaches continues to increase every year, exposing the private health information
29 of millions of Americans. Despite being heavily targeted by cybercriminals, health care providing
30 institutions are widely considered by cybersecurity experts to lack sufficient security safeguards
31 [8]. Raghupathi et al note, "healthcare entities gathering and storing individual health data have a
32 fiduciary and regulatory duty to protect such data and, therefore, need to be proactive in
33 understanding the nature and dimensions of health data breaches" [8].

34 35 CLINICAL DATA AND PRIVACY

36
37 Within the *Code*, [Opinion 3.1.1](#), "Privacy in Health Care," distinguishes four aspects of privacy:

38
39 personal space (physical privacy), personal data (informational privacy), personal choices
40 including cultural and religious affiliations (decisional privacy), and personal relationships with
41 family members and other intimates (associational privacy).

42
43 The *Code* does not explicitly examine whether personal medical or health information are ethically
44 distinct from other kinds of personal information (e.g., financial records) or in what way. Current
45 guidance treats the importance of protecting privacy in all its forms as self-evident, holding that
46 respecting privacy in all its aspects is of fundamental importance, "an expression of respect for
47 autonomy and a prerequisite for trust" [Opinion 3.1.1]. However, [Opinion 3.3.3](#), "Breach of
48 Security in Electronic Medical Records," directly acknowledges that data security breaches create
49 potential "physical, emotional, and dignity harms" to patients. Similarly, [Opinion 7.3.7](#),
50 "Safeguards in the Use of DNA Databanks," states that breaches of confidential patient information

1 “may result in discrimination or stigmatization and may carry implications for important personal
2 choices.”

3
4 Violations of privacy can result in both harm—tangible negative consequences, such as
5 discrimination in insurance or employment or identity theft—and in wrongs that occur from the
6 fact of personal information being known without the subject’s awareness, even if the subject
7 suffers no tangible harm [7]. Price and Cohen note that privacy issues can arise not only when data
8 are known, but when data mining enables others to “generate knowledge about individuals through
9 the process of inference rather than direct observation or access” [7].

10 11 CLINICAL DATA AND INFORMED CONSENT

12
13 With respect to [Opinion 2.1.1](#), “Informed Consent,” in the *Code*, successful communication is seen
14 as essential to fostering trust that is fundamental to the patient–physician relationship and to
15 supporting shared decision making. Opinion 2.1.1 states: “[t]he process of informed consent occurs
16 when communication between a patient and physician results in the patient’s authorization or
17 agreement to undergo a specific medical intervention.” In seeking a patient’s informed consent,
18 physicians are directed to include information about “the burdens, risks, and expected benefits of
19 all options, including forgoing treatment” [Opinion 2.1.1]. It should be noted, however, that no
20 direct mention of patient data is discussed in the opinion, other than that documentation of consent
21 should be recorded in the patient’s medical record.

22 23 CLINICAL DATA, DATASETS, AND THE PUBLIC GOOD

24
25 Because aggregated clinical data has the potential for secondary use that can benefit all of society,
26 it has been argued that such data should be treated as a form of public good [5]. When clinical data
27 are de-identified and aggregated, the potential use for societal benefits through research and
28 development is an emergent, secondary side effect of electronic health records that goes beyond
29 individual benefit. Larson et al argue that not only does the public possess an interest in
30 safeguarding and promoting clinical data for societal benefits, but all those who participate in
31 health care systems have an ethical responsibility to treat such data as a form of public good [5].
32 They propose:

33
34 all individuals and entities with access to clinical data inherently take on the same fiduciary
35 obligations as those of medical professionals, including for-profit entities. For example, those
36 who are granted access to the data must accept responsibility for safeguarding protected health
37 information [5].

38
39 This entails that any entity that purchases private health information, whether or not it has been de-
40 identified, has an ethical obligation to adhere to the ethical standards of health care where such data
41 were produced. Hospitals thus have an ethical responsibility to ensure that their contracts of sale
42 for datasets insist that all entities that gain access to the data adhere to the ethical standards and
43 values of the health care industry.

44
45 This is particularly important when we recall that the wide distribution of digital health information
46 ecosystems increasingly includes non-health-related parties from industry that may have market
47 interests that conflict with the ethical obligations that follow health data. Within this framework,
48 the fiduciary duty to protect patient privacy as well as to society to improve future health care
49 follows the data and thus applies to all entities that use that data, such that all entities granted
50 access to the data become data stewards, including for-profit parties [5]. This also includes patients,
51 such that they bear a responsibility to allow their data to be used for the future improvement of

1 health care for society, especially when we recognize that current health care has already benefited
2 from past data collection [5].

3
4 While the re-identification of aggregated patient data should generally be prohibited, there are rare
5 exceptions. There may be occasions when researchers wish to re-identify a dataset, such as
6 sometimes occurs in the study of rare diseases that rely on international registries; in such
7 situations, all individuals must be re-contacted, and their consent obtained in order to re-identify
8 their data since this would represent a significant change to the initial research protocols and
9 respective risks [9]. Re-identification of datasets for research is uncommon, however, because
10 obtaining re-consent can be difficult and can lead to flawed research if data is lost because patients
11 do not re-consent. The other situation in which it may be permissible, or even obligatory, to re-
12 identify aggregated patient data is when doing so would be in the interest of the health of individual
13 patients, such as might occur in the study of a rare genetic disorder. Even within these exceptions,
14 the risks associated with re-identification remain and re-identified data should thus never be
15 published. Re-identification of de-identified patient data for any other purposes, by anyone inside
16 or outside of health care, must be avoided.

17 18 AN ALTERNATIVE APPROACH: PRIVACY AS CONTEXTUAL INTEGRITY

19
20 Within today's digital health information ecosystems, physicians and hospitals face several
21 challenges to protecting patient privacy. Barocas and Nissenbaum contend that "even if [prevailing
22 forms of consent and anonymization] were achievable, they would be ineffective against the novel
23 threats to privacy posed by big data" [6]. A more effective option, Nissenbaum has argued, would
24 understand privacy protection as a function of "contextual integrity," i.e., that in a given social
25 domain, information flows conform to the context-specific informational norms of that domain.
26 Whether a transmission of information is appropriate depends on "the type of information in
27 question, about whom it is, by whom and to whom it is transmitted, and conditions or constraints
28 under which this transmission takes place" [10]. The view of privacy as contextual integrity—that
29 our conception of privacy is contextual and governed by various norms of information flow—
30 recognizes that there exist different norms regarding privacy within different spheres of any
31 distributed digital ecosystem [7,11]. The challenge within health care, as we have seen, is how to
32 balance these various norms when they conflict and how to ensure that health care's ethical
33 standards and values are maintained throughout the distributed use of de-identified private health
34 information.

35 36 THE CONTEXTUAL INTEGRITY OF DE-IDENTIFIED HEALTH DATA

37
38 In handling patient data, individual physicians strive to balance supporting and respecting patient
39 privacy while also upholding ethical obligations to the betterment of public health. Through their
40 own actions, as well as through their membership organizations and through their health care
41 organizations, physicians should: (1) ensure that data entered into electronic records are accurate
42 and reliable to the best of their ability; (2) be transparent with patients regarding the limited extent
43 to which their data can be safely protected, how their data may be used, and why the use of such
44 data is crucial for improving health care outcomes within society; and (3) ensure that proper
45 oversight and protections of data are in place, including contractual provisions that any data sold or
46 shared with outside entities stay in alignment with the ethical standards of the medical profession,
47 and that meaningful sanctions or penalties are in place and enforced against any actors that violate
48 those ethical standards. It is critical to recognize, as is outlined in the *Code*, that the patient-
49 physician relationship is built on trust, and that this trust relies heavily on transparency.

1 It is important for both patient care and research that clinical data entered into the EMR be as
2 accurate and complete as possible. Some data capture practices, such as copying-and-pasting daily
3 progress notes from previous encounters, which may contribute to efficiency, can lead to
4 documentation errors [12]. One avenue for improving EMR accuracy is that, under HIPAA,
5 patients have the right to access their data and request any perceived errors be amended. While
6 there is no one solution to improving accuracy of EMR data, further study into how to improve
7 EMR accuracy is important. One challenge to both EMR accuracy and completeness is the limited
8 interoperability of different EMR systems. Matching digital health records for the same patient
9 across and within health care facilities can be a challenge, further contributing to the potential for
10 EMR errors. Standardization of recording data elements, such as capturing patient address and last
11 name in a consistent format, may improve matching of patient records and thus improve the
12 accuracy of the EMR [13].

13
14 Another challenge to EMR data quality is the risk of bias, primarily due to implicit bias in EMR
15 design and underrepresentation of patients from historically marginalized groups, low
16 socioeconomic status, and rural areas [14,15]. Critically important for research involving data
17 collected from EMRs, available EMR data only reflects those with access to health care in the first
18 place. While certain study designs and tools have been developed to reduce these biases in
19 research, physicians and health care institutions should be looking into ways to reduce bias within
20 EMRs, such as features to optimize effective EMR use and to consistently capture patient data,
21 especially data on race/ethnicity and social determinants of health that are often inconsistently and
22 inaccurately captured in EMR systems [14,15,16].

23
24 Patients have a right to know how and why their data are being used. While physicians should be
25 able to answer questions regarding patient data as they relate to HIPAA protections, it is the
26 responsibility of health care institutions to provide more detailed information regarding
27 expectations of data privacy, how patient data may be used, and why such use is important to
28 improve the future of health care. Health care systems may consider fulfilling this ethical
29 obligation by creating a patient notification of data use built into the patient registration process
30 (using language similar to the National Institutes of Health's (NIH) Introduction-Description
31 component, meant to provide prospective research participants with an introduction to and
32 description of the planned storage and sharing of data and biospecimens [17]).

33
34 As stewards of health data, health care institutions have an ethical responsibility to protect data
35 privacy. This fiduciary duty to patient data should be seen as following the data even after they are
36 de-identified and leave the institution where they were initially captured [5,8]. While hospitals and
37 health care organizations increasingly come under cyberattack, they consistently lag behind other
38 industries in cybersecurity [18]. With regards to protecting the data they maintain, health care
39 institutions have a responsibility to make more significant investments in cybersecurity.

40
41 In order to ensure that the ethical standards of health care are maintained even after data leaves
42 health care institutions, McGraw and Mandl propose that companies collecting or using health-
43 relevant data could be required to establish independent data ethics review boards [2]. They write
44 that such boards could be similar to Institutional Review Boards but should focus more on privacy
45 than on participant risk, evaluating proposed data projects for legal and ethical implications as well
46 as their potential to improve health and/or the health care system [2]. In practice, ethics review
47 boards involved with industry face challenges to both independence and efficacy. Independence
48 can be compromised by influences such as conflicts of interest, while efficacy can be compromised
49 by the absence of authority, procedures, and systems to enact recommendations made by these
50 review bodies. To be effective, data ethics review boards must be independent and free of conflicts
51 of interest from the company or organization whose data research proposal(s) they are evaluating

1 and have systems in place for both transparency and implementation of feedback for remediations
2 of privacy and other quality and ethics concerns. Though not a comprehensive solution,
3 independent data ethics review boards could be an effective safeguard against industry conflicts of
4 interest and should be considered as a required part of contracts of sale of health data, with
5 contracts stipulating that any future resale of the data also undergo review by a data ethics review
6 board.

7
8 An additional safeguard is the implementation of regular data audits to assess the quality and use of
9 shared data [19]. These regulatory measures could be implemented as requirements outlined in
10 Data Use Agreements or Data Sharing Agreements (DSAs). Such agreements have the potential to
11 establish data governance policies and practices within health care institutions regarding “what data
12 can be shared, with whom, under what conditions, and for what purposes.” In developing DSAs,
13 hospital administrators should engage all relevant stakeholders, require a neutral entity be
14 designated as an independent custodian of shared data, limit the types and/or characteristics of
15 shared data to certain purposes, and apply additional safeguards to protect the data [20].

16
17 The need for more transparent disclosure to patients regarding their data use as well as the
18 importance of building the values of medical ethics into the contracts of sale of aggregate datasets
19 created by hospitals highlights the fact that the ethical responsibilities to respond to the risks of de-
20 identified data should not be borne by physicians alone. Respecting patient privacy and their
21 informed consent are responsibilities that physician member organizations and health care
22 institutions must take on because the risks to these rights that patients face within digital health
23 ecosystems radiate far beyond the patient–physician relationship to areas where individual
24 physicians have little influence.

25 26 RECOMMENDATIONS

27
28 In light of the challenges considered with regard to constructing a framework for holding
29 stakeholders accountable within digital health information ecosystems, the Council on Ethical and
30 Judicial Affairs recommends:

31 32 1. That the following be adopted:

33
34 Within health care systems, identifiable private health information, initially derived from and
35 used in the care and treatment of individual patients, has led to the creation of massive de-
36 identified datasets. As aggregate datasets, clinical data takes on a secondary promising use as a
37 means for quality improvement and innovation that can be used for the benefit of future
38 patients and patient populations. While de-identification of data is meant to protect the privacy
39 of patients, there remains a risk of re-identification, so while patient anonymity can be
40 safeguarded it cannot be guaranteed. In handling patient data, individual physicians thus strive
41 to balance supporting and respecting patient privacy while also upholding ethical obligations to
42 the betterment of public health.

43
44 When clinical data are de-identified and aggregated, their potential use for societal benefits
45 through research and development is an emergent, secondary use of electronic health records
46 that goes beyond individual benefit. Such data, due to their potential to benefit public health,
47 should thus be treated as a form of public good, and the ethical standards and values of health
48 care should follow the data and be upheld and maintained even if the data are sold to entities
49 outside of health care. The medical profession’s responsibility to protect patient privacy as well
50 as to society to improve future health care should be recognized as inherently tied to these

1 datasets, such that all entities granted access to the data become data stewards with a duty to
2 uphold the ethical values of health care in which the data were produced.

3
4 As individuals or members of health care institutions, physicians should:

- 5
6 (a) Follow existing and emerging regulatory safety measures to protect patient privacy;
7
8 (b) Practice good data intake, including collecting patient data equitably to reduce bias in
9 datasets;
10
11 (c) Answer any patient questions about data use in an honest and transparent manner to the
12 best of their ability in accordance with current federal and state legal standards.

13
14 Health care entities, in interacting with patients, should adopt policies and practices that
15 provide patients with transparent information regarding:

- 16
17 (d) The high value that health care institutions place on protecting patient data;
18
19 (e) The reality that no data can be guaranteed to be permanently anonymized, and that risk of
20 re-identification does exist;
21
22 (f) How patient data may be used;
23
24 (g) The importance of de-identified aggregated data for improving the care of future patients.

25
26 Health care entities managing de-identified datasets, as health data stewards, should:

- 27
28 (h) Ensure appropriate data collection methods and practices that meet industry standards to
29 support the creation of high-quality datasets;
30
31 (i) Ensure proper oversight of patient data is in place, including Data Use/Data Sharing
32 Agreements for the use of de-identified datasets that may be shared, sold, or resold;
33
34 (j) Develop models for the ethical use of de-identified datasets when such provisions do not
35 exist, such as establishing and contractually requiring independent data ethics review
36 boards free of conflicts of interest and verifiable data audits, to evaluate the use, sale, and
37 potential resale of clinically-derived datasets;
38
39 (k) Take appropriate cyber security measures to seek to ensure the highest level of protection is
40 provided to patients and patient data;
41
42 (l) Develop proactive post-compromise planning strategies for use in the event of a data
43 breach to minimize additional harm to patients;
44
45 (m) Advocate that health- and non-health entities using any health data adopt the strongest
46 protections and seek to uphold the ethical values of the medical profession.

47
48 There is an inherent tension between the potential benefits and burdens of de-identified
49 datasets as both sources for quality improvement to care as well as risks to patient privacy. Re-
50 identification of data may be permissible, or even obligatory, in rare circumstances when done
51 in the interest of the health of individual patients. Re-identification of aggregated patient data

1 for other purposes without obtaining patients' express consent, by anyone outside or inside of
2 health care, is impermissible. (New HOD/CEJA Policy); and
3

4 2. That Opinion 2.1.1, "Informed Consent"; Opinion 3.1.1, "Privacy in Health Care"; Opinion
5 3.2.4, "Access to Medical Records by Data Collection Companies"; and Opinion 3.3.2,
6 "Confidentiality and Electronic Medical Records" be amended by addition as follows:
7

8 a. Opinion 2.1.1, Informed Consent
9

10 Informed consent to medical treatment is fundamental in both ethics and law. Patients have the
11 right to receive information and ask questions about recommended treatments so that they can
12 make well-considered decisions about care. Successful communication in the patient-physician
13 relationship fosters trust and supports shared decision making. Transparency with patients
14 regarding all medically appropriate options of treatment is critical to fostering trust and should
15 extend to any discussions regarding who has access to patients' health data and how data may
16 be used.
17

18 The process of informed consent occurs when communication between a patient and physician
19 results in the patient's authorization or agreement to undergo a specific medical intervention. In
20 seeking a patient's informed consent (or the consent of the patient's surrogate if the patient
21 lacks decision-making capacity or declines to participate in making decisions), physicians
22 should:
23

- 24 (a) Assess the patient's ability to understand relevant medical information and the implications
25 of treatment alternatives and to make an independent, voluntary decision.
26
27 (b) Present relevant information accurately and sensitively, in keeping with the patient's
28 preferences for receiving medical information. The physician should include information
29 about:
30
31 (i) the diagnosis (when known);
32
33 (ii) the nature and purpose of recommended interventions;
34
35 (iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
36
37 (c) Document the informed consent conversation and the patient's (or surrogate's) decision in
38 the medical record in some manner. When the patient/surrogate has provided specific
39 written consent, the consent form should be included in the record.
40

41 In emergencies, when a decision must be made urgently, the patient is not able to participate in
42 decision making, and the patient's surrogate is not available, physicians may initiate treatment
43 without prior informed consent. In such situations, the physician should inform the
44 patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in
45 keeping with these guidelines. (Modify HOD/CEJA Policy)
46

47 b. Opinion 3.1.1, Privacy in Health Care
48

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

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

5
6 Physicians must seek to protect patient privacy in all settings to the greatest extent possible and
7 should:

- 8
9 (a) Minimize intrusion on privacy when the patient's privacy must be balanced against other
10 factors.
11
12 (b) Inform the patient when there has been a significant infringement on privacy of which the
13 patient would otherwise not be aware.
14
15 (c) Be mindful that individual patients may have special concerns about privacy in any or all
16 of these areas.
17
18 (d) Be transparent with any inquiry about existing privacy safeguards for patient data but
19 acknowledge that anonymity cannot be guaranteed and that breaches can occur
20 notwithstanding best data safety practices. (Modify HOD/CEJA Policy)
21

22 c. Opinion 3.2.4, Access to Medical Records by Data Collection Companies
23

24 Information contained in patients' medical records about physicians' prescribing practices or
25 other treatment decisions can serve many valuable purposes, such as improving quality of care.
26 However, ethical concerns arise when access to such information is sought for marketing
27 purposes on behalf of commercial entities that have financial interests in physicians' treatment
28 recommendations, such as pharmaceutical or medical device companies.

29
30 Information gathered and recorded in association with the care of a patient is confidential.
31 Patients are entitled to expect that the sensitive personal information they divulge will be used
32 solely to enable their physician to most effectively provide needed services. Disclosing
33 information to third parties for commercial purposes without consent undermines trust, violates
34 principles of informed consent and confidentiality, and may harm the integrity of the patient-
35 physician relationship.

36
37 Physicians who propose to permit third-party access to specific patient information for
38 commercial purposes should:

- 39
40 (a) Only provide data that has been de-identified.
41
42 (b) Fully inform each patient whose record would be involved (or the patient's authorized
43 surrogate when the individual lacks decision-making capacity) about the purpose(s) for
44 which access would be granted.
45

46 Physicians who propose to permit third parties to access the patient's full medical record
47 should:

- 48
49 (c) Obtain the consent of the patient (or authorized surrogate) to permit access to the patient's
50 medical record.

1 (d) Prohibit access to or decline to provide information from individual medical records for
2 which consent has not been given.

3
4 (e) Decline incentives that constitute ethically inappropriate gifts, in keeping with ethics
5 guidance.

6
7 Because de-identified datasets are derived from patient data as a secondary source of data for
8 the public good, health care professionals and/or institutions who propose to permit third-party
9 access to such information have a responsibility to establish that any use of data derived from
10 health care adhere to the ethical standards of the medical profession. (Modify HOD/CEJA
11 Policy)

12
13 d. Opinion 3.3.2, Confidentiality and Electronic Medical Records

14
15 Information gathered and recorded in association with the care of a patient is confidential,
16 regardless of the form in which it is collected or stored.

17
18 Physicians who collect or store patient information electronically, whether on stand-alone
19 systems in their own practice or through contracts with service providers, must:

20
21 (a) Choose a system that conforms to acceptable industry practices and standards with respect
22 to:

23
24 (i) restriction of data entry and access to authorized personnel;

25
26 (ii) capacity to routinely monitor/audit access to records;

27
28 (iii) measures to ensure data security and integrity; and

29
30 (iv) policies and practices to address record retrieval, data sharing, third-party access and
31 release of information, and disposition of records (when outdated or on termination of
32 the service relationship) in keeping with ethics guidance.

33
34 (b) Describe how the confidentiality and integrity of information is protected if the patient
35 requests.

36
37 (c) Release patient information only in keeping with ethics guidance for confidentiality and
38 privacy. (Modify HOD/CEJA Policy); and

39
40 3. That the remainder of this report be filed.

Fiscal Note: Less than \$500

REFERENCES

1. Ruotsalainen P, Blobel B. Health information systems in the digital health ecosystem—problems and solutions for ethics, trust and privacy. *Int J of Envir Res and Pub health* 2020;17(9):3006.
2. McGraw D, Mandl KD. Privacy protections to encourage use of health-relevant digital data in a learning health system. *NPJ dig med* 2021;4(1):2.
3. Floridi L, Cath C, Taddeo M. Digital ethics: its nature and scope. *The 2018 yearbook of the digital ethics lab* 2019:9-17.
4. Data monetization in healthcare market size report, 2030. In: *Data Monetization In Healthcare Market Size Report, 2030*. <https://www.grandviewresearch.com/industry-analysis/data-monetization-healthcare-market-report>.
5. Larson DB, Magnus DC, Lungren MP, Shah NH, Langlotz CP. Ethics of using and sharing clinical imaging data for artificial intelligence: a proposed framework. *Radiology* 2020;295(3):675-82.
6. Barocas S, Nissenbaum H. Big data's end run around anonymity and consent. *Privacy, big data, and the public good: Frameworks for engagement* 2014;1:44-75.
7. Price WN II, Cohen IG. Privacy in the age of medical big data. *Nat Med* 2019;25:37–43.
8. Raghupathi W, Raghupathi V, Saharia A. Analyzing Health Data Breaches: A Visual Analytics Approach. *AppliedMath* 2023;3(1):175-99.
9. Hansson MG, Lochmüller H, Riess O, Schaefer F, Orth M, Rubinstein Y, Molster C, Dawkins H, Taruscio D, Posada M, Woods S. The risk of re-identification versus the need to identify individuals in rare disease research. *Eur J Hum Genet* 2016;24(11):1553-1558. doi:10.1038/ejhg.2016.52.
10. Nissenbaum, H. Respecting context to protect privacy: why meaning matters. *Sci Eng Ethics* 2018;24:831–52.
11. Nissenbaum H. Privacy as contextual integrity. *Wash. L. Rev* 2004;79:119-158.
12. Weng CY. Data Accuracy in Electronic Medical Record Documentation. *JAMA Ophthalmol* 2017;135(3):232–233. doi:10.1001/jamaophthalmol.2016.5562
13. Pew. Enhancing patient matching is critical to achieving full promise of digital health records: Accurately linking individuals with their health records essential to improving care. *Pew Trust Report* October 2, 2018. <https://www.pewtrusts.org/en/research-and-analysis/reports/2018/10/02/enhanced-patient-matching-critical-to-achieving-full-promise-of-digital-health-records>
14. Boyd AD, Gonzalez-Guarda R, Lawrence K, Patil CL, Ezenwa MO, O'Brien EC, Paek H, Braciszewski JM, Adeyemi O, Cuthel AM, Darby JE. Equity and bias in electronic health records data. *Contemp Clinic Trials* 2023;130:107238.
15. Boyd AD, Gonzalez-Guarda R, Lawrence K, Patil CL, Ezenwa MO, O'Brien EC, Paek H, Braciszewski JM, Adeyemi O, Cuthel AM, Darby JE. Potential bias and lack of generalizability in electronic health record data: reflections on health equity from the National Institutes of Health Pragmatic Trials Collaboratory. *J of the Am Medl Informat Ass* 2023:ocad115.
16. Khurshid S, Reeder C, Harrington LX, Singh P, Sarma G, Friedman SF, Di Achille P, Diamant N, Cunningham JW, Turner AC, Lau ES. Cohort design and natural language processing to reduce bias in electronic health records research. *NPJ Digital Med* 2022;5(1):47.
17. NIH. Informed consent for secondary research with data and biospecimens: Points to consider and sample language for future use and/or sharing. *NIH Office of Science Policy Office of Extramural Research* May 2020. <https://osp.od.nih.gov/wp-content/uploads/Informed-Consent-Resource-for-Secondary-Research-with-Data-and-Biospecimens.pdf>
18. Skahill E, West DM. Why hospitals and healthcare organizations need to take cybersecurity more seriously. *Brookings* August 9, 2021. <https://www.brookings.edu/articles/why-hospitals-and-healthcare-organizations-need-to-take-cybersecurity-more-seriously/>

19. Winter JS, Davidson E. Big Data Governance of personal health information and challenges to Contextual Integrity. *The Information Society* 35:36–51. doi: 10.1080/01972243.2018.1542648
20. Allen C, Des Jardins TR, Heider A, et al. Data Governance and data sharing agreements for community-wide health information exchange: Lessons from the Beacon Communities. *eGEMs (Generating Evidence & Methods to improve patient outcomes)* 2:5. doi: 10.13063/2327-9214.1057

REPORT 3 OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (A-24)
Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices
(D-140.951)

EXECUTIVE SUMMARY

In adopting policy D-140.951, “Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices,” the House of Delegates directed the Council on Ethical and Judicial Affairs (CEJA) to “study and clarify the ethical challenges and considerations regarding physician professionalism raised by the advent and expansion of private equity ownership”.

Increasing investments by private equity firms in health care raise ethical concerns regarding dual loyalties of physicians and competing interests between profits and patients. While not inherently unethical, private equity firms’ incursion into health care warrants caution. To respond to these issues, CEJA recommends amending Opinion 11.2.3, “Contracts to Deliver Health Care Services” to more clearly encompass partnerships with private equity firms and the ethical concerns that they raise for both physicians seeking capital to support their private practice as well as physicians entering into employment contracts with private equity-owned hospitals.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 3-A-24

Subject: Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices
(D-140.951)

Presented by: David A. Fleming, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 In response to [Policy D-140.951](#), “Establishing Ethical Principles for Physicians Involved in
2 Private Equity Owned Practices,” which instructs our American Medical Association (AMA) to
3 “study and clarify the ethical challenges and considerations regarding physician professionalism
4 raised by the advent and expansion of private equity ownership”, your Council on Ethical and
5 Judicial Affairs (CEJA) presented Report 02-A-23, which offered recommendations on amending
6 [Code Opinion 11.2.3](#), “Contracts to Deliver Health Care Services.” Testimony at the 2023 Annual
7 Meeting of the House of Delegates was predominantly in opposition to the report; concerns were
8 raised regarding the profit motives of private equity and the ethical implications of such
9 businesses’ involvement in health care. Overall, testimony expressed a desire that a stronger stance
10 be taken against private equity’s involvement in health care, and the report was referred back to
11 CEJA.

12

13 BACKGROUND

14

15 The past several decades have seen an increase in the corporatization, financialization, and
16 commercialization of health care [1,2]. Since 2018, more physicians now work as employees of
17 hospitals or health care systems rather than serving in private practice [3,4]. Our AMA reports that
18 this trend is continuing: “[e]mployed physicians were 50.2% of all patient care physicians in 2020,
19 up from 47.4% in 2018 and 41.8% in 2012. In contrast, self-employed physicians were 44% of all
20 patient care physicians in 2020, down from 45.9% in 2018 and 53.2% in 2012” [4]. A major factor
21 in these trends has been the incursion of private equity into health care. It is estimated that private
22 equity capital investment between 2000 and 2018 grew from \$5 billion to \$100 billion [1].
23 Between 2016 and 2017 alone, the global value of private equity deals in health care increased
24 17%, with health care deals comprising 18% of all private equity deals in 2017 [5].
25

26

27 Private equity firms use capital from institutional investors to purchase private practices, typically
28 utilizing a leveraged buy-out model that finances the majority of the purchase through loans for
29 which the physician practice serves as security, with the goal of selling the investment within 3 to 7
30 years and yielding a return of 20-30% [1,5,6]. However, private equity investment broadly
31 encompasses many types of investors and strategies, including venture capital firms that primarily
invest in early-stage companies for a minority ownership, growth equity firms that tend to partner

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

1 with promising later-stage ventures, and traditional private equity firms that borrow money through
2 a leveraged buyout to take a controlling stake of mature companies [7].
3

4 When ownership shifts from physicians to private equity firms, the firms typically seek to invest
5 resources to expand market share, increase revenue, and decrease costs to make the practice more
6 profitable before selling it to a large health care system, insurance company, another private equity
7 firm (as a secondary buyout), or the public via an initial public offering (IPO) [8]. To expand
8 market share, private equity typically employs a “platform and add-on” or “roll-up” approach in
9 which smaller add-ons are acquired after the initial purchase of a large, established practice,
10 allowing private equity firms to gain market power in a specific health care segment or sub-
11 segment [1,9]. These practices by private equity appear to be driving mergers and acquisitions
12 within health care, significantly contributing to the consolidation of the health care industry that
13 has dramatically increased over the past decade [9].
14

15 Proponents of private equity investments in health care claim that private equity provides access to
16 capital infusions, which may facilitate practice innovation and aid in the adoption of new
17 technological infrastructure [6,8]. Proponents also advocate that private equity can bring “valuable
18 managerial expertise, reduce operational inefficiencies, leverage economies of scale, and increase
19 healthcare access by synergistically aligning profit incentives with high quality care provision”
20 [10].
21

22 Critics argue that private equity’s focus on generating large, short-term profits likely establishes an
23 emphasis on profitability over patient care, which creates dual loyalties for physicians working as
24 employees at private equity-owned practices [5,6]. Critics further assert that prioritizing profits
25 likely jeopardizes patient outcomes, overburdens health care companies with debt, leads to an over-
26 emphasis on profitable services, limits access to care for certain patient populations (such as
27 uninsured individuals or individuals with lower rates of reimbursement such as Medicaid or
28 Medicare patients), and fundamentally limits physician control over the practice and clinical
29 decision making [5,8,10].
30

31 Despite strong opinions regarding private equity’s incursion into medicine, empirical research on
32 the effects of private equity investments in health care, and the impacts on patient outcomes, is
33 currently limited [8]. Zhu and Polsky explain that this lack of research is primarily because
34 “[p]rivate equity firms aren’t required to publicly disclose acquisitions or sales, and the widespread
35 use of nondisclosure agreements further contributes to opacity about practice ownership and the
36 nature of transactions” [6]. Private equity firms are emerging to be major employers of physicians.
37 Currently, it is estimated that 8% of all private hospitals in the U.S. and 22% of all proprietary for-
38 profit hospitals are owned by private equity firms [11].
39

40 ETHICAL ISSUE

41

42 Private equity firms’ commitment to ensuring high returns on their investments creates a potential
43 ethical dilemma when investing in health care. Whether or not it may be ethically permissible for
44 physicians to sell their practices to private equity firms or for physicians to work as employees for
45 such acquisitions largely depends on how private equity investments impact patient care and
46 outcomes. This report will examine how private equity investments in health care may be ethical,
47 the circumstance and factors to be weighed, as well as how physicians may ethically navigate
48 private equity buyouts and employment.

1 RELEVANT PRACTICAL MATTERS FOR CLINICAL PRACTICE

2
3 A major concern of physicians regarding private equity investments in health care is the potential
4 loss of autonomy, which physicians worry could translate into hospital policies designed for
5 profitability and that limit physicians' decision-making and their ability to care for patients [9].
6 Loss of autonomy is also associated with increased physician burnout [12]. There are also valid
7 concerns that private equity ownership leads to increased patient volumes and more expensive and
8 potentially unnecessary procedures [9].
9

10 REVIEW OF RELEVANT LITERATURE

11
12 *Empirical Evidence in Medical Literature*

13
14 More research is needed on the effects of private equity investments in the health care sector, as
15 little empirical evidence exists on how private equity impacts utilization, spending, or patient
16 outcomes. There is widespread concern among physicians that private equity-controlled practices
17 result in worse patient outcomes.
18

19 The best evidence that private equity acquisition of hospitals harms patients is a recent difference-
20 in differences study by Kannan et al of hospital-acquired adverse events and hospitalization
21 outcomes associated with private equity acquisitions of U.S. hospitals [13]. Data from 100%
22 Medicare Part A claims at 51 private equity-acquired hospitals were compared with data from 259
23 matched control hospitals (not acquired by private equity) for hospital stays between 2009 and
24 2019. While there was no differential change in mortality 30 days after hospital discharge, the
25 researchers did find that after private equity acquisition, Medicare beneficiaries admitted to private
26 equity-owned hospitals experienced a 25.4% increase in hospital-acquired conditions compared
27 with those treated at control hospitals. This increase in hospital-acquired conditions, which are
28 established measures of inpatient quality and are considered preventable, was largely driven by a
29 27.3% increase in falls and a 37.7% increase in central line-associated bloodstream infections at
30 private equity-acquired hospitals [13]. The increase in central-line associated infections after
31 private equity acquisition occurred even as these hospitals saw a 16% reduction in percutaneous
32 central line placement. Kannan et al hypothesize that such increases in hospital-acquired infections
33 could result from decreases in staffing, as such adverse events have been shown to be correlated
34 with staffing ratios among nurses and that private equity often will reduce staffing and change the
35 clinician labor mix at acquired hospitals as a cost-cutting strategy [13].
36

37 In another difference-in-differences study of 578 private equity-acquired practices in dermatology,
38 gastroenterology, and ophthalmology matched with a control group of 2,874 non-private equity-
39 acquired practices, Singh et al found a mean increase of 20.2% in charges per claim and a
40 consistent increase in patient utilization over the first eight quarters after acquisition, with the
41 increase in patient utilization primarily driven by a 37.9% increase in visits by new patients [14].
42 Overall, the researchers found that "private equity acquisition was associated with increases in
43 health care spending and several measures of utilization, and some evidence of greater intensity of
44 care" [14]. They also found increased coding intensity, and posit that this finding could be due to
45 either changes in coding and billing practices that have more efficient charge capture or,
46 conversely, could reflect upcoding to increase revenues [14]. The motivating factors behind this
47 impact on coding deserves further study.
48

49 In a systematic review of 55 studies evaluating trends in private equity ownership in health care
50 and the impacts on outcomes, costs, and quality, Borsa et al found that private equity ownership
51 was associated with an increase in cost to patients or payers, primarily from increased charges and

1 rates for services as well as inconclusive, mixed results on how private equity impacts quality of
2 care [10]. The majority of the studies (n=47) evaluated private equity ownership of health care
3 operations in the US, but represented a range of settings, the most common of which were nursing
4 homes (n=17), hospitals (n=9), dermatology (n=9), and ophthalmology (n=7). Only eight studies
5 included health outcomes, with two finding beneficial impacts, three findings harmful impacts, and
6 three finding neutral impacts; the three that found harmful impacts were all studies of nursing
7 homes [10]. These results suggest that private equity may impact segments of the health care
8 industry differently.

9
10 In their analysis of 281 private equity acquisitions involving 610 unique target hospitals, Gao et al
11 found that over an eight-year window, acquisitions were associated with increased profitability, no
12 change in the rate of closures, no statistically significant changes in mortality or readmission rates,
13 and that the percentage of Medicare and Medicaid patients stayed relatively the same [15]. Over
14 the eight year window, private equity-acquired hospitals increased their operating income by 7.4%.
15 Compared to their matched control groups, private equity-acquired hospitals were equally or more
16 likely to survive, contrary to the prevailing narrative. Private equity-acquired hospitals initially
17 experienced a 14% decrease in the number of core workers (medical workers that include
18 physicians, nurses, and pharmacists) over the first four years but over the next four years this
19 difference dissipates to only 2% and is not statistically significant. In contrast, the decline in
20 administrative workers is significant and persistent, with a reduction of 18% within the first four
21 years of acquisition and a 22% reduction by the end of eight years. This reduction in administrative
22 workers was most profound at nonprofit hospitals. Core workers' wages were not found to change,
23 while administrative workers' wages declined by 7%. No changes to patient mortality rates or
24 readmission were found, except for a 0.9% increase in readmission following pneumonia. In
25 looking at rates of stroke, complications and infections during hospitalization as measure of patient
26 outcomes, no statistically significant differences were found between private equity-acquired
27 hospitals, the control group, or non-private equity acquired hospitals. Private equity-acquired
28 hospitals appear to treat a higher number of resource-intensive patients and decrease their
29 outpatient ratio. Gao et al conclude: “[o]verall, our evidence suggests that PE acquirers improve the
30 operating efficiency of target hospitals without a compromise in healthcare quality” [15].

31 32 *Normative and Substantive Views in Ethics and Medical Literature*

33
34 The debate over private equity's incursion into health care often regards private equity acquisitions
35 through a lens of exceptionalism—either negatively or positively. However, although private
36 equity owned hospitals are different in their ownership structure and oversight compared to other
37 traditional health care investors, private equity-acquired hospitals may not be substantively
38 different from other for profit and non-profit hospitals in terms of their stated goals of both
39 solvency and patient care. Zhu and Polsky argue that private equity is not inherently unethical and
40 that there are likely good and bad actors as is the case in many sectors [6]. They add: “physicians
41 should be aware that private equity's growth is emblematic of broader disruptions in the physician-
42 practice ecosystem and is a symptom of medicine's transformation into a corporate enterprise” [6].

43
44 The corporatization of medicine is not without ethical and professional risks, of course. In their
45 ethical analysis of orthopaedic surgery practices owned by non-physicians, Moses et al note that
46 the incentives and goals of surgeons might be misaligned with those of the investors, pitting patient
47 care against profits; profit maximization might also lead to wasteful overtreatment as well as a loss
48 of physician autonomy within the practice as well as patient autonomy if physicians are encouraged
49 to be more paternalistic to achieve financial goals [3].

1 Veatch notes that business ethics and medical ethics are not inherently at odds but admits that
2 differences do exist [16]. Veatch highlights that physicians are uncomfortable with any removal of
3 professional control that may accompany the increasing commercialization of the physician's role.
4 Veatch points out that paradoxically, despite being open to the profit motive in the practice of
5 medicine, the practice as a whole has shown strong resistance to the commercialization of medical
6 practice. For Veatch, the crux of the issue is whether people perceive health care as a fundamental
7 right or a commodity like any other, adding that the notion of health care as a right jeopardizes any
8 profit motive in health care including traditional private practitioner fee-for-service models [16].
9

10 Pellegrino offers a similar analysis, arguing that health care is not a commodity but rather a human
11 good that society has an obligation to provide in some measure to all citizens [17]. Pellegrino
12 argues that health care is substantively different from traditional market goods—it is not fungible,
13 cannot be proprietary because medical knowledge is possible only due to collective achievements,
14 is realized in part through the patient's own body, and requires an intensely personal relationship—
15 and thus cannot be a commodity. Pellegrino warns that the commodification of health and medicine
16 turns any interaction between the patient and physician into a commercial transaction subject to the
17 laws and ethics of business rather than to medical and professional ethics. "In this view,"
18 Pellegrino writes, "inequities are unfortunate but not unjust [...]. In this view of health care,
19 physicians and patients become commodities too" [17]. Rather than claiming that health care is a
20 fundamental right, Pellegrino takes a position of distributive justice to argue that health care is a
21 collective good. Because a good society is one in which each citizen is enabled to flourish, and
22 good health is a condition of human flourishing, society has a moral responsibility to provide
23 health care to all citizens. In this light, health care is both an individual and a social good.
24 Pellegrino also refers to this view as one of "beneficent justice" and explains, "[t]reating health
25 care as a common good implies a notion of solidarity of humanity, i.e., the linkage of humans to
26 each other as social beings" [17]. Pellegrino concludes:
27

28 Understanding health care to be a commodity takes one down one arm of a bifurcating
29 pathway to the ethic of the marketplace and instrumental resolution of injustices. Taking
30 health care as a human good takes us down a divergent pathway to the resolution of
31 injustice through a moral ordering of societal and individual priorities [17].
32

33 Whether health care is understood as a commodity or a human good is of course not always so
34 clear in policy and in practice. What is evident, however, is that as health care has become
35 increasingly commodified, the ethical risks to patients and physicians are being realized as
36 physicians find themselves increasingly working as employees and worrying about the impact that
37 commercial enterprises—such as private equity investments—may be having on patients.
38

39 Private equity represents the latest and most extreme form of health care commercialization that
40 has escalated over the past few decades. This is the very reason why private equity firms became
41 interested in health care in the first place—they recognized that health care as a market was already
42 ripe for investment and future profitability. Private equity firms use the same investment models in
43 health care that they do in other industries—invest in fragmented markets, acquire the most
44 promising targets as a platform, expand through add-on acquisitions, and exit the market once a
45 significant consolidation of market share can secure a sale, secondary buyout, or IPO [9]. Each
46 individual acquisition is typically too small to require review by anti-trust regulators at the Federal
47 Trade Commission (FTC); at the same time, however, this practice is driving the trend of mergers
48 and acquisitions in the health care sector [9].

1 Fuse Brown and Hall explain, “[private equity] functions as a divining rod for finding market
2 failures—where PE has penetrated, there is likely a profit motive ripe for exploitation” [1]. They
3 continue that private equity investments pose three primary risks:

4
5 First, PE investment spurs health care consolidation, which increases prices and potentially
6 reduces quality and access. Second, the pressure from PE investors to increase revenue can
7 lead to exploitation of billing loopholes, overutilization, upcoding, aggressive risk-coding,
8 harming patients through unnecessary care, excessive bills, and increasing overall health
9 spending. Third, physicians acquired by PE companies may be subject to onerous
10 employment terms and lose autonomy over clinical decisions [1].
11

12 While the profit motive of private equity firms may drive them to take part in less than scrupulous
13 practices, such as private equity’s exploitation of out-of-network surprise billing, there is also
14 potential for private equity to play a more positive role in transforming health care practices [1,18].
15 Powers et al write:

16
17 Ultimately, private equity—a financing mechanism—is not inherently good or bad.
18 Instead, it acts to amplify the response to extant financial incentives. Within a fee-for-
19 service construct, this is intrinsically problematic. But value-based payment models can
20 serve as an important guardrail, helping to ensure that financial return to private equity
21 investors are appropriately aligned with system goals of access, quality, equity, and
22 affordability [18].
23

24 Private equity firms could help accelerate changes in health care payment and delivery towards
25 value-based models. With such models, where financial performance is tied to quality and value,
26 private equity may be incentivized to invest in changes that support better health and lower costs
27 [18].
28

29 While more research is needed on the impacts of private equity investments in health care, private
30 equity firms’ involvement in health care does not appear to be exceptional within the current
31 corporate transformation of the profession and thus is inherently no more or less ethical than this
32 current trend that has penetrated health care and the practice of medicine far beyond interactions
33 with private equity. As Fuse Brown and Hall point out, “PE investment in health care is just the
34 latest manifestation of the long trend of increasing commercialization of medicine. And so long as
35 the U.S. treats health care as a market commodity, profit-seeking will persist” [1].
36

37 Ikrum et al provide a balanced view of the situation and offer some recommendations for
38 partnering with private equity in health care:

39
40 While PE involvement in health care delivery invokes inherent concerns, it has provided
41 much-needed capital for many primary care practices to mitigate the effects of the
42 pandemic and to potentially undertake care delivery innovations such as population health
43 management under value-based payment models. To make partnerships with private
44 investors work, providers need to select the right investors, establish strategies upfront to
45 address misaligned objectives, and define a successful partnership by setting goals for and
46 transparently reporting on indicators that reflect both financial and clinical performance.
47 Safeguards and regulations on sales may also protect patients and providers [7].

1 RELEVANT LAWS

2
3 Fuse Brown and Hall write that despite the market consolidation that results from private
4 equity acquisitions within health care, these acquisitions generally go unreported and
5 unreviewed since they do not exceed the mandatory reporting threshold under the Hart-Scott-
6 Rodino (HSR) Act and that there are currently no legal guidelines for assessing the collective
7 market effects of add-on acquisitions. However, they do note:

8
9 Under Section 7 of the Clayton Act, federal antitrust authorities—the Federal Trade
10 Commission (FTC) and the Department of Justice (DOJ)—can sue to block mergers
11 and acquisitions where the effect of the transaction may be “substantially to lessen
12 competition, or to tend to create a monopoly.” To determine whether a transaction may
13 threaten competition, antitrust agencies analyze whether the transaction will enhance
14 the market power of the transacting parties in a given geographic and product market.
15 [...] Typically, the FTC oversees health care acquisitions (other than insurance) [1].
16

17 To protect patients from harmful billing practices, the federal government has passed the No
18 Surprise Act, the False Claims Act, Anti-Kickback Statute, and Stark Law. Additionally, most
19 states have similar laws, such as those barring fee-splitting and self-referral, and several states
20 have passed laws regulating or restricting the use of gag clauses in physician contracts. The
21 FTC has also recently proposed a rule banning noncompete clauses in all employment
22 contracts [1].
23

24 The federal Emergency Medical Treatment and Labor Act (EMTALA) ensures that hospitals
25 with an emergency department provide all patients access to emergency services regardless of
26 their ability to pay. Similarly, federal law requires nonprofit hospitals, which account for 58%
27 of community hospitals, provide some level of charity care as a condition for their tax-exempt
28 status, which the Internal Revenue Service (IRS) defines as “free or discounted health services
29 provided to persons who meet the organization’s eligibility criteria for financial assistance and
30 are unable to pay for all or a portion of the services” [19].
31

32 RELEVANT AMA POLICY PROVISIONS

33
34 Council on Medical Service Report 11-A-10 reviewed the scope and impact of private equity and
35 venture capital investment in health care, and its recommendations were adopted as Policy [H-
36 160.891](#), “Corporate Investors.” This policy delineates 11 factors that physicians should consider
37 before entering into partnership with corporate investors, including alignment of mission, vision,
38 and goals; the degree to which corporate partners may require physicians to cede control over
39 practice decision making; process for staff representation on the board of directors and medical
40 leadership selection; and retaining medical authority in patient care and supervision of
41 nonphysician practitioners.
42

43 Our AMA further developed and published materials to assist physicians contemplating partnering
44 with private equity and venture capital firms:
45

- 46 • [Venture Capital and Private Equity: How to Evaluate Contractual Agreements](#)
- 47 • [Model Checklist: Venture Capital and Private Equity Investments](#)
- 48 • [Snapshot: Venture Capital and Private Equity Investments](#)

1 Policy [H-310.901](#), “The Impact of Private Equity on Medical Training,” encourages GME training
2 institutions and programs to “demonstrate transparency on mergers and closures, especially as it
3 relates to private equity acquisition” and asserts that our AMA will “[s]upport publicly funded
4 independent research on the impact that private equity has on graduate medical education.”

5
6 RELEVANT *CODE* PROVISIONS

7
8 The AMA *Code of Medical Ethics* [Opinion 11.2.1](#), “Professionalism in Health Care Systems,”
9 acknowledges that “[p]ayment models and financial incentives can create conflicts of interest
10 among patients, health care organizations, and physicians” and offers recommendations for
11 physicians within leadership positions regarding the ethical use of payment models that influence
12 where and by whom care is delivered. Key elements include the need for transparency, fairness, a
13 primary commitment to patient care, and avoiding overreliance on financial incentives that may
14 undermine physician professionalism.

15
16 [Opinion 11.2.2](#), “Conflicts of Interest in Patient Care,” clearly states: “[t]he primary objective of
17 the medical profession is to render service to humanity; reward or financial gain is a subordinate
18 consideration. [...] When the economic interests of the hospital, health care organization, or other
19 entity are in conflict with patient welfare, patient welfare takes priority.”

20
21 [Opinion 11.2.3](#), “Contracts to Deliver Health Care Services,” stipulates that physicians’
22 fundamental ethical obligation to patient welfare requires physicians to carefully consider any
23 contract to deliver health care services they may enter into to ensure they do not create untenable
24 conflicts of interest. The opinion states that physicians should negotiate or remove “any terms that
25 unduly compromise physicians’ ability to uphold ethical standards.” However, it should be
26 acknowledged that physicians have little leverage in changing entire payment structures or
27 reimbursement mechanisms when negotiating their contracts with hospitals. Similarly, physicians
28 in private practice often feel that they have little leverage in negotiating the sale of their practice;
29 they simply receive an offer and are told they can take it or leave it.

30
31 [Opinion 11.2.3.1](#), “Restrictive Covenants,” states: “[c]ovenants-not-to-compete restrict
32 competition, can disrupt patient care, and may limit access to care” and that physicians should not
33 enter into covenants that “[u]nreasonably restrict the right of a physician to practice medicine for a
34 specified period of time or in a specified geographic area on termination of a contractual
35 relationship”. However, many hospitals and hospital systems today now routinely include
36 noncompete clauses as part of their physician contracts. These clauses put physicians at risk of
37 violation of professional obligations and their widespread use has the potential to undermine the
38 integrity of the profession as a whole.

39
40 ETHICAL ANALYSIS

41
42 The ethical concerns raised by private equity investments in health care are not unique but instead
43 represent ethical dilemmas that exist due to the very nature of treating health care as a commodity.
44 While private equity firms may choose to pursue financial incentives that are counter to the
45 physicians’ ethical and professional responsibilities, private equity’s investment in health care is
46 not inherently unethical. However, caution is warranted so it is crucial that policy guidelines be
47 developed to ensure that private equity-acquired hospitals, hospital systems, and physician
48 practices continue to function in an ethical manner that prioritizes patients and patient care over
49 profits. Policies that require greater transparency and disclosure of data on private equity
50 ownership, greater state regulatory control over private equity acquisitions, closing payment and
51 billing loopholes, rules requiring an independent clinical director on the Board of private equity

1 firms engaged in health care, and means for physicians to help set goals and measure outcomes to
 2 ensure the alignment of corporate and clinical values should be considered [7].

3
 4 Though the current literature is conflicting, there are valid concerns that private equity investment
 5 in health care might negatively impact patient outcomes. Since serious potential risks and conflicts
 6 of interest do exist, it is essential for physicians considering entering into partnership with private
 7 equity firms to evaluate their contracts and require that the agreements are consistent with the
 8 norms of medical ethics. Likewise, physicians considering entering into a contractual relation as an
 9 employee of a private equity-owned hospital should ensure that their contract does not place them
 10 in an untenable conflict of interest or compromise their ability to fulfill their ethical and
 11 professional obligations to patients [8].

12
 13 It is the conclusion of the Council on Ethical and Judicial Affairs (CEJA) that new ethics guidance
 14 specifically addressing private equity investment in health care is not needed. There already exists
 15 rich House policy and AMA published materials addressing private equity investments in health
 16 care. Furthermore, the ethical issues that private equity involvement raise are not limited to that
 17 specific sphere of health care investment. In light of the fact that private equity is not unique in the
 18 ethical concerns it raises, the Council finds that existing guidance in [Opinion 11.2.2](#), “Conflicts of
 19 Interest in Patient Care,” and [Opinion 11.2.3](#), “Contracts to Deliver Health Care Services,” are
 20 sufficient at the present time to address the concerns raised by the increasing investment by private
 21 equity in health care; however, it may be appropriate to amend current guidance to more clearly
 22 encompass partnerships with private equity firms and the ethical concerns that they raise for both
 23 physicians seeking capital to support their private practice as well as physicians entering into
 24 employment contracts with private equity-owned hospitals.

25 26 RECOMMENDATIONS

27
 28 In view of these deliberations, the Council on Ethical and Judicial Affairs recommends that
 29 Opinion 11.2.3, “Contracts to Deliver Health Care Services,” be amended by addition and deletion
 30 as follows and the remainder of this report be filed:

31
 32 Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other
 33 considerations, including personal financial interests. This obligation requires ~~them to that~~
 34 before entering into contracts to deliver health care services, physicians consider carefully the
 35 proposed contract to assure themselves that its terms and conditions of contracts to deliver
 36 health care services before entering into such contracts to ensure that those contracts do not
 37 create untenable conflicts of interest or compromise their ability to fulfill their ethical and
 38 professional obligations to patients.

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

47
 48 As physicians seek capital to support their practices or enter into various differently structured
 49 contracts to deliver health care services—with group practices, hospitals, health plans,
 50 investment firms, or other entities—they should be mindful that while ~~many some~~
 51 arrangements have the potential to promote desired improvements in care, some other

1 arrangements ~~also~~ have the potential to ~~impede~~ put patients' interests at risk and to interfere
2 with physician autonomy.

3
4 ~~When contracting-partnering with entities, or having a representative do so on their behalf, to~~
5 provide health care services, physicians should:

6
7 (a) Carefully review the terms of proposed contracts, preferably with the advice of legal and
8 ethics counsel, ~~or have a representative do so on their behalf~~ to assure themselves that the
9 arrangement:

10
11 (i) minimizes conflict of interest with respect to proposed reimbursement mechanisms,
12 financial or performance incentives, restrictions on care, or other mechanisms intended
13 to influence physicians' treatment recommendations or direct what care patients
14 receive, in keeping with ethics guidance;

15
16 (ii) does not compromise the physician's own financial well-being or ability to provide
17 high-quality care through unrealistic expectations regarding utilization of services or
18 terms that expose the physician to excessive financial risk;

19
20 (iii) ~~allows~~ ensures the physician can ~~to~~ appropriately exercise professional judgment;

21
22 (iv) includes a mechanism to address grievances and supports advocacy on behalf of
23 individual patients;

24
25 (v) is transparent and permits disclosure to patients.

26
27 (vi) enables physicians to have significant influence on, or preferably outright control of,
28 decisions that impact practice staffing.

29
30 (b) Negotiate modification or removal of any terms that unduly compromise physicians' ability
31 to uphold ethical or professional standards.

32
33 When entering into contracts as employees, preferably with the advice of legal and ethics
34 counsel, physicians must:

35
36 (c) Advocate for contract provisions to specifically address and uphold physician ethics and
37 professionalism.

38
39 (d) Advocate that contract provisions affecting practice align with the professional and ethical
40 obligations of physicians and negotiate to ensure that alignment.

41
42 (e) Advocate that contracts do not require the physician to practice beyond their professional
43 capacity and provide contractual avenues for addressing concerns related to good practice,
44 including burnout or related issues.

45
46
47 (Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

REFERENCES

1. Fuse Brown EC, Hall MA. Private Equity and the Corporatization of Health Care. *Stanford Law Review* 2024;76.
2. Crowley R, Atiq O, Hilden D, Health and Public Policy Committee of the American College of Physicians. Financial profit in medicine: A position paper from the American College of Physicians. *Annals of Internal Medicine* 2021;174(10):1447-9.
3. Moses MJ, Weiser LG, Bosco III JA. The corporate practice of medicine: Ethical implications of orthopaedic surgery practice ownership by non-physicians. *JBJS* 2020;102(11):e53.
4. AMA analysis shows most physicians work outside of private practice. In: American Medical Association. <https://www.ama-assn.org/press-center/press-releases/ama-analysis-shows-most-physicians-work-outside-private-practice#:~:text=Employment%20status,2018%20and%2053.2%25%20in%202012>.
5. Gondi S, Song Z. Potential implications of private equity investments in health care delivery. *JAMA* 2019;321(11):1047-8.
6. Zhu JM, Polsky D. Private equity and physician medical practices-navigating a changing ecosystem. *NEJM* 2021;384(11):981-3.
7. Ikram U, Aung KK, Song Z. Private equity and primary care: Lessons from the field. *NEJM Catalyst Innovations in Care Delivery* 2021;2(6).
8. DeCamp M, Snyder Sulmasy L, American College of Physicians Ethics, Professionalism and Human Rights Committee. Ethical and professionalism implications of physician employment and health care business practices: a policy paper from the American College of Physicians. *Ann of Intern Med* 2021;174(6):844-51.
9. Appelbaum E, Batt R. Private equity buyouts in healthcare: who wins, who loses? Institute for New Economic Thinking Working Paper Series 2020(118). doi.org/10.36687/inetwp118
10. Borsa A, Bejarano G, Ellen M, Bruch JD. Evaluating trends in private equity ownership and impacts on health outcomes, costs, and quality: systematic review. *BMJ* 2023;382.
11. PESP Private Equity Hospital tracker. In: Private Equity Stakeholder Project PESP. <https://pestakeholder.org/private-equity-hospital-tracker/>.
12. Dillon EC, Tai-Seale M, Meehan A, Martin V, Nordgren R, Lee T, Nauenberg T, Frosch DL. Frontline perspectives on physician burnout and strategies to improve well-being: interviews with physicians and health system leaders. *Journal of General Internal Medicine* 2020;35:261-7.
13. Kannan S, Bruch JD, Song Z. Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition. *JAMA*. 2023;330(24):2365–2375. doi:10.1001/jama.2023.23147
14. Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. Association of private equity acquisition of physician practices with changes in health care spending and utilization. *JAMA Health Forum* 2022;3(9):e222886-e222886.
15. Gao J, Sevilir M, Kim YS. Private equity in the hospital industry. *European Corporate Governance Institute–Finance Working Paper* 2021;787.
16. Veatch RM. Ethical dilemmas of for-profit enterprise in health care. In *The New Health Care for Profit: Doctors and Hospitals in a Competitive Environment*. Gray BH, ed. National Academy Press, Washington DC, 1983.
17. Pellegrino ED. The commodification of medical and health care: the moral consequences of a paradigm shift from a professional to a market ethic. *J Med Philos* 1999;24(3):243-266. doi:10.1076/jmep.24.3.243.2523
18. Powers BW, Shrank WH, Navathe AS. Private equity and health care delivery: value-based payment as a guardrail?. *JAMA* 2021;326(10):907-8.

19. Levinson Z, Hulver S, Neuman T. Hospital charity care: how it works and why it matters. KFF 2022 Nov 3. <https://www.kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and-why-it-matters/>

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 4-A-24

Subject: Physicians' Use of Social Media for Product Promotion and Compensation
(Resolution 25, A-22)

Presented by: David A. Fleming, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2022 Annual Meeting, the House of Delegates referred Resolution 025-A-22 (Resolution
2 025), "Use of Social Media for Product Promotion and Compensation" which asked that the
3 American Medical Association (AMA) "study the ethical issues of medical students, residents,
4 fellows, and physicians endorsing non-health related products through social and mainstream
5 media for personal or financial gain."

6
7 This report by the Council on Ethical and Judicial Affairs (CEJA) explores ethical issues posed by
8 this use of social media and reviews existing guidance in the AMA *Code of Medical Ethics (Code)*.
9

10 BACKGROUND

11
12 Resolution 025 details the recent phenomenon of physicians' involvement in promotions and
13 endorsements on social media. While Resolution 025 is limited to the context of physicians
14 promoting non-health related products through social media, this report encompasses the issue
15 broadly in the contexts of promoting both non-health related and/or health related products. The
16 concept of social media has changed dramatically in the last couple of decades and has altered how
17 consumer goods and services are advertised, promoted, and sold. Social media now accounts for a
18 broad range of communication—e.g., Tik Tok, Instagram, Facebook, X (formerly Twitter),
19 YouTube—that can reach millions of people, and now often involves "influencing", where
20 individuals promote or sell goods and services or promote themselves (e.g. their personality or
21 lifestyle) as a financial venture.
22

23 ETHICAL CONCERNS

24
25 Physicians' and medical students' sale and promotion of products or services and use of social
26 media raises several ethical concerns. (1) These practices may damage the patient-physician
27 relationship. If patients feel pressured to purchase products or services, this may undermine the
28 trust that grounds patient-physician relationships, since it raises questions about whether physicians
29 are fulfilling their fiduciary duty to put patients' interests above their own financial interests. (2) If
30 inappropriate pressure is applied, then selling and promotion of products may result in the
31 exploitation of patient vulnerability. (3) If physicians lend their credibility as medical professionals
32 to products or services that are not supported by peer-reviewed evidence or are of questionable

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

1 value, then they may put patient well-being and the integrity of the profession in jeopardy in the
2 interest of profit-making.

3 4 Welfare of the Patient and the Patient-Physician Relationship

5
6 The sale and promotion of goods and services by physicians has the potential to negatively affect
7 the welfare of patients. If a physician puts their financial interests above the interests of the
8 patients, then this undercuts the foundational ethical principle that physicians must regard their
9 “responsibility to the patient as paramount. [Principle VIII]. In addition, since patients are
10 “vulnerable and dependent on the doctor’s expertise” and there is an “asymmetry of knowledge”
11 between patients and physicians, there is a risk that patients may be exploited and this, in turn, can
12 “undermine a patient’s trust” [1]. Further, if patients find out about a physician’s financial
13 incentive to recommend certain products or services after the fact, they may feel that they have
14 been purposefully deceived, and so have reason to distrust both that individual physician and the
15 profession as a whole. It is therefore imperative that physicians conscientiously distinguish when
16 they are acting in their professional capacity by recommending products or services intended for
17 patient benefit or public health, and when they are acting as commercial agents independent of
18 their professional identity.

19 20 Integrity of the Profession

21
22 Physician sales and promotion of products and services may also damage the integrity of the
23 profession. Physicians have an ethical duty to uphold professional standards in their role as
24 physician in all areas of life. A key principle of professional integrity is that physicians should
25 recognize that they carry the authority of their professional role with them into other social spheres.
26 Physicians “engage in a number of roles” which include conveyors of information, advocates,
27 experts, and commentators on medically related issues [2]. For many physicians, “navigating
28 successfully among the potentially overlapping roles ...poses challenges.” [2] Physicians “carry
29 with them heightened expectations as trusted...representatives of the medical profession.” [2]
30 Physicians should be aware that these expectations cannot be entirely separated from their personal
31 identity either online or elsewhere and should take care to curate their social media presence
32 accordingly.

33 34 PROFESSIONALISM IN THE USE OF SOCIAL MEDIA

35
36 The concept of social media has changed since the technology’s first appearance and widespread
37 adoption. Today, social media platforms are broadly internet-enabled technologies that enable
38 individuals to have a presence online and ability to share opinions and self-generated media content
39 to a wide audience.

40
41 Opinion 2.3.2 “Professionalism in Social Media” reflects an outdated understanding of the types
42 and uses of social media, modeling its guidance on traditional sites such as Facebook, where the
43 primary purposes are social networking among friends and colleagues, and perhaps also
44 disseminating beneficial public health messages. While guidance that addresses these uses is still
45 necessary (and so should be retained), modifications are required to reflect the fact that social
46 media can now be used as a form of marketing intended to financially benefit individuals and
47 corporations. The ethical concerns that arise in this context mirror those that arise in other
48 situations where physicians are selling and promoting goods and services, that is, use of social
49 media by medical professionals can undermine trust and damage the integrity of patient-physician
50 relationships and the profession as a whole when physicians inappropriately use their social media
51 presence to promote personal interests.

1 CONCLUSION

2
3 Updating 2.3.2 “Professionalism in the Use of Social Media” so that it includes guidance on using
4 social media to sell and promote products makes it clear that the consolidated guidance clearly
5 applies to the concerns raised in Resolution 025. Revising this also provides an opportunity to
6 update language to reflect the current realities of technology and contemporary business practices.
7

8 RECOMMENDATION

9
10 In consideration of the foregoing, the Council on Ethical and Judicial Affairs recommends that:
11 Opinion 2.3.2, “Professionalism in the Use of Social Media” be amended by substitution to read as
12 follows and the remainder of this report be filed:
13

14 Social media—internet-enabled communication platforms—enable individual medical students
15 and physicians to have both a personal and a professional presence online. Social media can
16 foster collegiality and camaraderie within the profession as well as provide opportunities to
17 widely disseminate public health messages and other health communications. However, use of
18 social media by medical professionals can also undermine trust and damage the integrity of
19 patient-physician relationships and the profession as a whole, especially when medical students
20 and physicians use their social media presence to promote personal interests.
21

22 Physicians and medical students should be aware that they cannot realistically separate their
23 personal and professional personas entirely online and should curate their social media
24 presence accordingly. Physicians and medical students therefore should:
25

- 26 (a) When publishing any content, consider that even personal social media posts have the
27 potential to damage their professional reputation or even impugn the integrity of the
28 profession.
29
- 30 (b) Respect professional standards of patient privacy and confidentiality and refrain from
31 publishing patient information online without appropriate consent.
32
- 33 (c) Maintain appropriate boundaries of the patient-physician relationship in accordance with
34 ethics guidance if they interact with their patients through social media, just as they would
35 in any other context.
36
- 37 (d) Use privacy settings to safeguard personal information and content, but be aware that once
38 on the Internet, content is likely there permanently. They should routinely monitor their
39 social media presence to ensure that their personal and professional information and
40 content published about them by others is accurate and appropriate.
41
- 42 (e) Publicly disclose any financial interests related to their social media content, including, but
43 not limited to, paid partnerships and corporate sponsorships.
44
- 45 (f) When using social media platforms to disseminate medical health care information, ensure
46 that such information is useful and accurate based on professional medical judgment.
47

48 (Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

REFERENCES

1. Council on Ethical and Judicial Affairs, CEJA Report 5-I-97, "Sale of Non-Health Related Goods." <https://code-medical-ethics.ama-assn.org/sites/default/files/2022-08/9.6.5%20Sale%20of%20non-health-related%20goods%20--%20background%20reports.pdf>.
2. Council on Ethical and Judicial Affairs, CEJA Report 2-I-17, "Ethical Physician Conduct in the Media." <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-ethics-and-judicial-affairs/ceja-report-2-i17.pdf>.
3. Council on Ethical and Judicial Affairs, CEJA Report 1-A-99, "Sale of Health-Related Products form Physician's Offices." <https://code-medical-ethics.ama-assn.org/sites/default/files/2022-08/9.6.4%20Sale%20of%20health-related%20products%20--%20background%20reports.pdf>.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 5-A-24

Subject: CEJA’s Sunset Review of 2014 House Policies

Presented by: David A. Fleming, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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

- 5
6 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A
7 policy will typically sunset after ten years unless action is taken by the House of Delegates
8 to retain it. Any action of our AMA House that reaffirms or amends an existing policy
9 position shall reset the sunset “clock,” making the reaffirmed or amended policy viable for
10 another 10 years.
- 11
12 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
13 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
14 policies that are subject to review under the policy sunset mechanism; (b) Such policies
15 shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that
16 has been asked to review policies shall develop and submit a report to the House of
17 Delegates identifying policies that are scheduled to sunset; (d) For each policy under
18 review, the reviewing council can recommend one of the following actions: (i) retain the
19 policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with
20 more recent and like policy; (e) For each recommendation that it makes to retain a policy in
21 any fashion, the reviewing council shall provide a succinct, but cogent justification (f) The
22 Speakers shall determine the best way for the House of Delegates to handle the sunset
23 reports.
- 24
25 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy
26 earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more
27 current policy, or has been accomplished.
- 28
29 4. The AMA councils and the House of Delegates should conform to the following guidelines
30 for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or
31 directive has been accomplished; or (c) when the policy or directive is part of an
32 established AMA practice that is transparent to the House and codified elsewhere such as

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

1 the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies
2 and Practices.

3

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

5

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

7

8 RECOMMENDATION

9

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

Fiscal Note: Less than \$500.

APPENDIX – RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
H-140.898	Medical Profession Opposition to Physician Participation in Execution	Our AMA strongly reaffirms its opposition to physician participation in execution.	Retain; remains relevant.
H-140.950	Physician Participation in Capital Punishment	<p>Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed: Our AMA endorses the following:</p> <p>(1) Physician participation in evaluations of a prisoner's competence to be executed is ethical only when certain safeguards are in place. A physician can render a medical opinion regarding competency which should be merely one aspect of the information taken into account by the ultimate decision maker, a role that legally should be assumed by a judge or hearing officer. Prisoners' rights to due process at the competency hearings should be carefully observed.</p> <p>(2) When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner to restore competence unless a commutation order is issued before treatment begins.</p> <p>(3) If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. It will not always be easy to distinguish these situations from treatment for the purpose of restoring the prisoner's competence, and in particular, to determine when treatment initiated to reduce suffering should be stopped. However, there is no alternative at this time other than to rely upon the treating physician to exercise judgment in deciding when and to what extent treatment is necessary to reduce extreme suffering. The cumulative experience of physicians applying these principles over time may lead to future refinements.</p> <p>Treatment should be provided in a properly-secured, general medical or psychiatric facility, not in a cell block. The task of re-evaluating the prisoner's competence to be executed should be performed by an independent physician examiner.</p> <p>(4) Given the ethical conflicts involved, no physician, even if employed by the state, should be compelled to participate in the process of establishing a prisoner's competence to be executed if such activity is contrary to the physician's personal beliefs. Similarly, physicians</p>	Retain; remains relevant.

		who would prefer not to be involved with treatment of an incompetent, condemned prisoner should be excused or permitted to transfer care of the prisoner to another physician.	
H-140.963	Secrecy and Physician Participation in State Executions	The AMA opposes any and all attempts either in state laws or in rules and regulations that seek to enable or require physician participation in legal executions and/or which protect from disclosure the identity of physicians participating or performing direct or ancillary functions in an execution.	Retain; remains relevant.
H-140.999	Our AMA and Bioethics	Our AMA requests official representation on any federal advisory committee or commission dealing with ethical issues of interest to medicine.	Retain; remains relevant.
H-140.963	Secrecy and Physician Participation in State Executions	The AMA opposes any and all attempts either in state laws or in rules and regulations that seek to enable or require physician participation in legal executions and/or which protect from disclosure the identity of physicians participating or performing direct or ancillary functions in an execution.	Retain; remains relevant.
H-265.992	Expert Witness Testimony	Our AMA: (1) encourages each state medical society to work with its state licensing board toward the development of effective disciplinary measures for physicians who provide fraudulent testimony; (2) provides legal and advocacy support to those medical and specialty organizations who seek to devise programs designed to discipline physicians for unprofessional conduct relative to expert witness testimony; (3) continues to study and work with interested organizations to address the inherent difficulties in conducting the peer review of physicians who provide expert witness testimony; (4) continues to educate physicians about ethical guidelines and professional responsibility regarding the provision of expert witness testimony; (5) encourages each state medical society to work with its state licensing board to grant any out-of-state expert witness physician a temporary license at a nominal fee or at no cost for the express purpose of expert testimony on a per case basis, such that the expert witness is subject to the peer review process. (6) encourages each state medical society to assist its state licensing board in the peer review process of expert witnesses by providing an expert witness committee program similar to the one in the state of Florida; (7) works with the Federation of State Medical Boards to address problems regarding out-of-state expert witnesses; and	Retain; remains relevant.

		(8) acts as a clearinghouse for advice and support as the state medical associations develop their own expert witness committee programs.	
H-270.961	Medical Care Must Stay Confidential	Our AMA will strongly oppose any federal legislation requiring physicians to establish the immigration status of their patients.	Retain; remains relevant.
H-405.958	Physician Right to Conscience	Our AMA supports high standards of civility and respect among physicians amidst differing political beliefs, aspects of conscience and ethical views because debate and expression of disagreement is healthy and essential to the improvement of medicine, and physicians should communicate any differences in a civil and professional manner.	Retain; remains relevant.
H-65.997	Human Rights	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.	Retain; remains relevant.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(A-24)

Introduced by: Integrated Physician Practice Section

Subject: Using Personal and Biological Data to Enhance Professional Wellbeing and Reduce Burnout

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, the significance and incidence of physician and healthcare workforce burnout and
2 workplace stress has increased dramatically; and
3

4 Whereas, burnout among healthcare professional has shown to negatively impact the quality of
5 care, patient safety, and healthcare system operations; and
6

7 Whereas, there are many individual, systemic, and collective factors that contribute to physical
8 and mental health and, therefore, a sense of wellbeing or lack thereof, which may increase the
9 likelihood of burnout; and
10

11 Whereas, there is ongoing research to identify and better understand workplace and individual
12 stresses that contribute to burnout and can diminish an individual's sense of wellbeing; and
13

14 Whereas, individual health history and biological data can provide valuable insights into physical
15 and mental health, and the collection and use of personal and biological data offer potential
16 avenues to support the wellbeing of healthcare professionals, including the early identification of
17 burnout and developing prevention strategies; and
18

19 Whereas, the use of such data must be done in a manner that respects individual privacy rights
20 and ethical considerations; and
21

22 Whereas, the healthcare community currently lacks comprehensive, standardized guidelines for
23 the ethical collection and use of this data in the context of workforce wellbeing; and
24

25 Whereas, the management of such sensitive data raises significant privacy, security, and ethical
26 issues that must be carefully addressed to ensure the rights and interests of individuals are
27 protected; therefore be it
28

29 RESOLVED, that our American Medical Association monitor and report on the research
30 regarding technology, measures, and effective use of personal and biological data which
31 supports professional workforce wellbeing and mitigates burnout (Directive to Take Action); and
32 be it further
33

34 RESOLVED, that our AMA develop ethical guidelines on the collection, use, and protection of
35 personal and biological data for the professional workforce (Directive to Take Action).
36

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

Received: 4/17/2024

RELEVANT AMA POLICY

9.3.1 Physician Health & Wellness

When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress.

To fulfill this responsibility individually, physicians should:

(a) Maintain their own health and wellness by:

(i) following healthy lifestyle habits;

(ii) ensuring that they have a personal physician whose objectivity is not compromised.

(b) Take appropriate action when their health or wellness is compromised, including:

(i) engaging in honest assessment of their ability to continue practicing safely;

(ii) taking measures to mitigate the problem;

(iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease;

(iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition.

Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

[AMA Principles of Medical Ethics: I,II,IV](#)

Citation: Issued: 2016

Physician and Medical Student Burnout D-310.968

1. Our AMA recognizes that burnout, defined as emotional exhaustion, depersonalization, and a reduced sense of personal accomplishment or effectiveness, is a problem among residents, fellows, and medical students.

2. Our AMA will work with other interested groups to regularly inform the appropriate designated institutional officials, program directors, resident physicians, and attending faculty about resident, fellow, and medical student burnout (including recognition, treatment, and prevention of burnout) through appropriate media outlets.

3. Our AMA will encourage partnerships and collaborations with accrediting bodies (e.g., the Accreditation Council for Graduate Medical Education and the Liaison Committee on Medical Education) and other major medical organizations to address the recognition, treatment, and prevention of burnout among residents, fellows, and medical students and faculty.

4. Our AMA will encourage further studies and disseminate the results of studies on physician and medical student burnout to the medical education and physician community.

5. Our AMA will continue to monitor this issue and track its progress, including publication of peer-reviewed research and changes in accreditation requirements.

6. Our AMA encourages the utilization of mindfulness education as an effective intervention to address the problem of medical student and physician burnout.

7. Our AMA will encourage medical staffs and/or organizational leadership to anonymously survey physicians to identify local factors that may lead to physician demoralization.

8. Our AMA will continue to offer burnout assessment resources and develop guidance to help organizations and medical staffs implement organizational strategies that will help reduce the sources of physician demoralization and promote overall medical staff well-being.

9. Our AMA will continue to: (a) address the institutional causes of physician demoralization and burnout, such as the burden of documentation requirements, inefficient work flows and regulatory oversight; and (b) develop and promote mechanisms by which physicians in all practice settings can reduce the risk and effects of demoralization and burnout, including implementing targeted practice transformation interventions, validated assessment tools and promoting a culture of well-being.

Citation: CME Rep. 8, A-07; Modified: Res. 919, I-11; Modified: BOT Rep. 15, A-19; Reaffirmed: A-22

Factors Causing Burnout H-405.948

Our AMA recognizes 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.
Citation: Res. 208, I-22

Physician Health Programs H-405.961

1. Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.
2. Our AMA encourages state medical societies to collaborate with the state medical boards to: (a) develop strategies to destigmatize physician burnout; and (b) encourage physicians to participate in the state's physician health program without fear of loss of license or employment.
Citation: CSAPH Rep. 2, A-11; Reaffirmed in lieu of: Res. 412, A-12; Reaffirmed: BOT action in response to referred for decision Res. 402, A-12; Modified: BOT Rep. 15, A-19

Physician Burnout D-405.972

Our AMA will work with: (1) Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians; and (2) hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.
Citation: Res. 723, A-22; Reaffirmed: I-22

Peer Support Groups for Second Victims D-405.980

Our AMA: (1) encourages institutional, local, and state physician wellness programs to consider developing voluntary, confidential, and non-discoverable peer support groups to address the "second victim phenomenon"; and (2) will work with other interested organizations to encourage that any future surveys of physician burnout should incorporate questions about the prevalence and potential impact of the "second victim phenomenon" on our physician workforce.
Citation: Res. 702, A-19

Programs on Managing Physician Stress and Burnout H-405.957

1. Our American Medical Association supports existing programs to assist physicians in early identification and management of stress and the programs supported by the AMA to assist physicians in early identification and management of stress will concentrate on the physical, emotional and psychological aspects of responding to and handling stress in physicians' professional and personal lives, and when to seek professional assistance for stress-related difficulties.
2. Our AMA will review relevant modules of the STEPs Forward Program and also identify validated student-focused, high quality resources for professional well-being, and will encourage the Medical Student Section and Academic Physicians Section to promote these resources to medical students.
Citation: Res. 15, A-15; Appended: Res. 608, A-16; Reaffirmed: BOT Rep. 15, A-19

Physicians and Family Caregivers: Shared Responsibility H-210.980

Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden;
(2) continues to support health policies that facilitate and encourage health care in the home;
(3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care;
(4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and

(5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients.

Citation: Res. 308, I-98; Reaffirmed: A-02; Reaffirmed: CME Rep. 2, A-12; Appended: Res. 305, A-17

Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs H-295.993

Our AMA: (1) recognizes the need for appropriate mechanisms to include medical students and resident physicians in the monitoring and advocacy services of state physician health programs and wellness and other programs to prevent impairment and burnout; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available student assistance programs and other related services.

Citation: Sub. Res. 84, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed and Appended: CME Rep. 4, I-98; Reaffirmed: CME Rep. 2, A-08; Modified: CME Rep. 01, A-18

Study of Medical Student, Resident, and Physician Suicide D-345.983

Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and substance use disorders, and attempted and completed suicide among physicians, residents, and medical students; and (5) work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the collection of current wellness initiatives that institutions have in place to inform and promote meaningful mental health and wellness interventions in these populations.

Citation: CME Rep. 06, A-19; Modified: Res. 326, A-22

Resident/Fellow Clinical and Educational Work Hours H-310.907

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training:

1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as "duty hours").

2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents.

3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice.

4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities.

5. Our AMA encourages the ACGME to:

a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation.

b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits.

c) Use, where possible, recommendations from respective specialty societies and evidence-based

approaches to any future revision or introduction of clinical and educational work hour rules.

d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours.

6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to:

a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards.

b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor.

c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home.

d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue.

7. Our AMA supports the following statements related to clinical and educational work hours:

a) Total clinical and educational work hours must not exceed 80 hours per week, averaged over a four-week period (Note: "Total clinical and educational work hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients).

b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time.

c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks.

d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident.

e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period."

f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated.

g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty.

h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians.

i) Scheduled time providing patient care services of limited or no educational value should be minimized.

j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics.

k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians.

l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy.

m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program.

n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system.

o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations.

8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety.

9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

Citation: CME Rep. 5, A-14; Modified: CME Rep. 06, I-18; Reaffirmed: A-22

Physician and Medical Staff Member Bill of Rights H-225.942

Our AMA adopts and will distribute the following Medical Staff Rights and Responsibilities:

Preamble

The organized medical staff, hospital governing body, and administration are all integral to the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care and outcomes. They operate in distinct, highly expert fields to fulfill common goals, and are each responsible for carrying out primary responsibilities that cannot be delegated.

The organized medical staff consists of practicing physicians who not only have medical expertise but also possess a specialized knowledge that can be acquired only through daily experiences at the frontline of patient care. These personal interactions between medical staff physicians and their patients lead to an accountability distinct from that of other stakeholders in the hospital. This accountability requires that physicians remain answerable first and foremost to their patients.

Medical staff self-governance is vital in protecting the ability of physicians to act in their patients' best interest. Only within the confines of the principles and processes of self-governance can physicians ultimately ensure that all treatment decisions remain insulated from interference motivated by commercial or other interests that may threaten high-quality patient care.

From this fundamental understanding flow the following Medical Staff Rights and Responsibilities:

I. Our AMA recognizes the following fundamental responsibilities of the medical staff:

- a. The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the health care organization's governing body.
- b. The responsibility to provide leadership and work collaboratively with the health care organization's administration and governing body to continuously improve patient care and outcomes, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
- c. The responsibility to participate in the health care organization's operational and strategic planning to safeguard the interest of patients, the community, the health care organization, and the medical staff and its members.
- d. The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation.
- e. The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct.
- f. The responsibility to make appropriate recommendations to the health care organization's governing body regarding membership, privileging, patient care, and peer review.

II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff's ability to fulfill its responsibilities:

- a. The right to be self-governed, which includes but is not limited to (i) initiating, developing, and approving or disapproving of medical staff bylaws, rules and regulations, (ii) selecting and removing medical staff leaders, (iii) controlling the use of medical staff funds, (iv) being advised by independent legal counsel, and (v) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for non-physician members.
- b. The right to advocate for its members and their patients without fear of retaliation by the health care organization's administration or governing body, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
- c. The right to be provided with the resources necessary to continuously improve patient care and outcomes.
- d. The right to be well informed and share in the decision-making of the health care organization's operational and strategic planning, including involvement in decisions to grant exclusive contracts, close medical staff departments, or to transfer patients into, out of, or within the health care organization.
- e. The right to be represented and heard, with or without vote, at all meetings of the health care organization's governing body.
- f. The right to engage the health care organization's administration and governing body on professional matters involving their own interests.

III. Our AMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of employment or contractual status:

- a. The responsibility to work collaboratively with other members and with the health care organizations administration to improve quality and safety.
- b. The responsibility to provide patient care that meets the professional standards established by the medical staff.
- c. The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff.
- e. The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the health care organization, both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
- f. The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff.
- g. The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.
- h. The responsibility to utilize and advocate for clinically appropriate resources in a manner that reasonably includes the needs of the health care organization at large.

IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member's ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization:

- a. The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws.
- b. The right to make treatment decisions, including referrals, based on the best interest of the patient, subject to review only by peers.
- c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care, medical staff matters, or personal safety, including the right to refuse to work in unsafe situations, without fear of retaliation by the medical staff or the health care organization's administration or governing body, including advocacy both in collaboration with and independent of the organization's advocacy efforts with federal, state, and local government and other regulatory authorities.
- e. The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty.
- f. The right to full due process before the medical staff or health care organization takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments.

g. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities.

h. The right of access to resources necessary to provide clinically appropriate patient care, including the right to participate in advocacy efforts for the purpose of procuring such resources both in collaboration with and independent of the organization's advocacy efforts, without fear of retaliation by the medical staff or the health care organization's administration or governing body.

Citation: BOT Rep. 09, A-17; Modified: BOT Rep. 05, I-17; Appended: Res. 715, A-18; Reaffirmed: BOT Rep. 13, A-19; Modified: BOT Rep. 13, A-21; Modified: CMD Rep. 5, A-21; Reaffirmed: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(A-24)

Introduced by: Medical Student Section and Resident & Fellow Section

Subject: Removal of the Interim Meeting Resolution Committee

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, AMA Bylaws 2.12.1.1 and 2.13.13 indicate that the Interim Meeting Resolution
2 Committee limits consideration of resolutions to those that pertain to “advocacy and legislation”
3 or “ethics” or that “requir[e] action prior to the following Annual Meeting”; and
4

5 Whereas, six months after the Board of Trustees recommended formation of the Resolution
6 Committee, the Report of the Executive Vice President at Interim 2002 (I-02) noted that “while I
7 appreciate the need to streamline, I strongly believe that everything the AMA does is advocacy,”
8 and elaborated that “this includes activities you might not initially view as advocacy, like the
9 public stands we take on issues of public health and science”¹; and
10

11 Whereas, over the course of 8 years between I-12 and I-19 (up till the implementation of Special
12 Meetings during COVID), the average number of resolutions historically not considered based
13 on Resolution Committee recommendations was less than 7²; and
14

15 Whereas, from I-12 to I-19, the small number of items historically not considered based on
16 Resolution Committee recommendations ranged from 2 to 10 (2 at I-19, 8 at I-18, 4 at I-17, 3 at
17 I-16, 9 at I-15, 8 at I-14, 10 at I-13, and 9 at I-12)²; and
18

19 Whereas, the low number of resolutions historically screened out by the Interim Meeting
20 Resolution Committee indicates that the House has successfully managed its volume of
21 business without significant benefit from the Resolution Committee; and
22

23 Whereas, despite perceptions of increased resolution volume, we have concluded business
24 early at all 4 HODs since returning from COVID, including a full day earlier at A-23; and
25

26 Whereas, the use of the Interim Meeting Resolution Committee functionally means that
27 resolutions relating to meeting operations, Bylaws, task forces, and other organizational
28 initiatives and resolutions requesting studies should be withheld until the Annual Meeting, as
29 they would be unlikely to meet Resolution Committee criteria, unnecessarily delaying regular
30 functions of our HOD and AMA until those resolutions can be introduced in June; and
31

32 Whereas, the Resolution Committee does not meet at all to deliberate, as each member
33 individually and privately simply checks off whether they approve a resolution; and
34

35 Whereas, no criteria exist for whether resolutions should be considered if they relate to reports
36 or to other resolutions approved for consideration, leading to unclear rationale for decisions; and
37

38 Whereas, even resolutions clearly related to advocacy, ethics, or urgency (including titles
39 mentioning “Policy Reform,” “Regulation,” names of specific legislation, or issues pending

1 imminent Congressional votes or executive agency decisions with time-limited comment
2 periods) are regularly screened out, leading to unclear rationale for decisions; and

3
4 Whereas, while a majority vote can consider a screened-out resolution, smaller and newer
5 delegations are at baseline disadvantaged in overturning a negative decision, which conflicts
6 with democratic principles of fairness and protection of minority rights and views, a central tenet
7 of our House's parliamentary procedure to ensure all voices are heard; and

8
9 Whereas, many delegations' advocacy priorities were negatively affected by the narrow
10 resolution criteria at I-23 and several, not just the MSS and RFS, attempted extractions; and

11
12 Whereas, the removal of the Resolution Committee could better balance the load between the
13 Interim and Annual Meetings, rather than the Annual Meeting seeing an increased load due to
14 resolution resubmissions, which also leads to increased report load at subsequent Annual
15 Meetings for resolutions that were referred a year prior; and

16
17 Whereas, while the Interim Meeting is a day shorter, we still concluded business early the last
18 two years, many screened-out resolutions would likely be handled agreeably by Reference
19 Committees without extraction, and our House already uses other ways to effectively self-
20 regulate volume of debate (e.g., calling the question, shortening testimony time); and

21
22 Whereas, better methods to manage a modest increase in Interim Meeting business, without
23 needing to extend the meeting, could include using the same number of Reference Committees
24 as the Annual Meeting, since the Interim Meeting currently only uses 6 and the Annual
25 Meeting's 8 Reference Committees more evenly distribute additional business across additional
26 sessions on both Saturday afternoon and Sunday morning; therefore be it

27
28 RESOLVED, that our American Medical Association remove the Resolution Committee from
29 Interim Meetings by amending AMA Bylaw B-2.13.3, "Resolution Committee," by deletion as
30 follows:

31
32 **Resolution Committee. B-2.13.3**

33 ~~The Resolution Committee is responsible for reviewing resolutions~~
34 ~~submitted for consideration at an Interim Meeting and determining~~
35 ~~compliance of the resolutions with the purpose of the Interim~~
36 ~~Meeting.~~

37 ~~2.13.3.1 Appointment. The Speaker shall appoint the members of~~
38 ~~the committee. Membership on this committee is restricted to~~
39 ~~delegates.~~

40 ~~2.13.3.2 Size. The committee shall consist of a maximum of 31~~
41 ~~members.~~

42 ~~2.13.3.3 Term. The committee shall serve only during the meeting~~
43 ~~at which it is appointed, unless otherwise directed by the House of~~
44 ~~Delegates.~~

45 ~~2.13.3.4 Quorum. A majority of the members of the committee shall~~
46 ~~constitute a quorum.~~

47 ~~2.13.3.5 Meetings. The committee shall not be required to hold~~
48 ~~meetings. Action may be taken by written or electronic~~
49 ~~communications.~~

50 ~~2.13.3.6 Procedure. A resolution shall be accepted for~~
51 ~~consideration at an Interim Meeting upon majority vote of committee~~
52 ~~members voting. The Speaker shall only vote in the case of a tie. If~~

1 a resolution is not accepted, it may be submitted for consideration
2 at the next Annual Meeting in accordance with the procedure in
3 Bylaw 2.11.3.1.

4 ~~2.13.3.7 Report. The committee shall report to the Speaker. A~~
5 ~~report of the committee shall be presented to the House of~~
6 ~~Delegates at the call of the Speaker. (Modify Bylaws); and be it~~
7 further
8

9 RESOLVED, that our AMA remove constraints on the scope of business at Interim Meetings,
10 which is regulated by the Resolution Committee, by amending AMA Bylaw B-2.12.1.1,
11 "Business of Interim Meeting," by deletion as follows:
12

13 **2.12.1.1 Business of Interim Meeting**

14 ~~The business of an Interim Meeting shall be focused on advocacy~~
15 ~~and legislation. Resolutions pertaining to ethics, and opinions and~~
16 ~~reports of the Council on Ethical and Judicial Affairs, may also be~~
17 ~~considered at an Interim Meeting. Other business requiring action~~
18 ~~prior to the following Annual Meeting may also be considered at an~~
19 ~~Interim Meeting. In addition, any other business may be considered~~
20 ~~at an Interim Meeting by majority vote of delegates present and~~
21 ~~voting. (Modify Bylaws)~~

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

Received: 4/19/2024

REFERENCES

1. Report of the Executive Vice President, American Medical Association Interim 2002 House of Delegates. <https://ama.nmtvault.com/jsp/browse.jsp>. Accessed March 18, 2021.
2. American Medical Association Archives. <https://ama.nmtvault.com/jsp/browse.jsp>. Accessed March 18, 2021.

RELEVANT AMA Policy

B-11.1 Parliamentary Procedure

In the absence of any provisions to the contrary in the Constitution and these Bylaws, all general meetings of the AMA and all meetings of the House of Delegates, of the Board of Trustees, of Sections and of councils and committees shall be governed by the parliamentary rules and usages contained in the then current edition of The American Institute of Parliamentarians Standard Code of Parliamentary Procedure.

G-600.054 Procedures of the House of Delegates

1. Our AMA reaffirms The American Institute of Parliamentarians Standard Code of Parliamentary Procedure as our parliamentary authority, including the use of the motion to table and the motion to adopt in-lieu-of, and treat amendments by substitution as first-order amendments.
2. The rules and procedures of the House of Delegates will be amended as follows:
 - A. The motion to table a report or resolution that has not yet been referred to a reference committee is not permitted and will be ruled out of order.
 - B. A new motion is added to the House of Delegates Reference Manual, Object to Consideration. If a Delegate objects to consideration of an item of business by our HOD, the correct motion is to Object to Consideration. The motion cannot interrupt a speaker, requires a second, cannot be amended, takes precedence over all subsidiary motions and cannot be renewed. The motion requires a 3/4 vote for passage. Debate is restricted to why the item should not be considered.

3. The procedures of our House of Delegates distinguish between a motion to refer, which is equivalent to a motion to refer for report, and a motion to refer for decision and that the motion to refer for decision be one step higher in precedence.
4. The procedures of our House of Delegates specify that both sides must have been heard before a motion to close debate is in order and that absent an express reference to "all pending matters" the motion applies only to the matter under debate.
5. The procedures of our House of Delegates clarify that adjournment of any House of Delegates meeting finalizes all matters considered at that meeting, meaning that items from one meeting are not subject to a motion to recall from committee, a motion to reconsider or any other motion at a succeeding meeting.
6. The Council on Constitution and Bylaws, in consultation with the speakers, will review the House of Delegates Reference Manual and revise it accordingly. [Report of the Speakers: Rep. 02, A-16; Modified: CCB Rep. 01, A-17]

G-600.060 Introducing Business to the AMA House

AMA policy on introducing business to our AMA House includes the following:

1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and verify that the resolution is in compliance. The Resolution checklist shall be distributed to all delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD website.
2. An Information Statement can be used to bring an issue to the awareness of the HOD or the public, draw attention to existing policy for purposes of emphasis, or simply make a statement. Such items will be included in the section of the HOD Handbook for informational items and include appropriate attribution but will not go through the reference committee process, be voted on in the HOD or be incorporated into the Proceedings. If an information statement is extracted, however, it will be managed by the Speaker in an appropriate manner, which may include a simple editorial correction up to and including withdrawal of the information statement.
3. Required information on the budget will be provided to the HOD at a time and format more relevant to the AMA budget process.
4. At the time the resolution is submitted, delegates introducing an item of business for consideration of the House of Delegates must declare any commercial or financial conflict of interest they have as individuals and any such conflict of interest must be noted on the resolution at the time of its distribution.
5. The submission of resolutions calling for similar action to what is already existing AMA policy is discouraged. Organizations represented in the House of Delegates are responsible to search for alternative ways to obtain AMA action on established AMA policy, especially by communicating with the Executive Vice President. The EVP will submit a report to the House detailing the items of business received from organizations represented in the House which he or she considers significant or when requested to do so by the organization, and the actions taken in response to such contacts.
6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates and ensure that individual delegates are not barred from submitting a resolution directly to the House of Delegates.
7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint in submitting items on the day preceding the opening of the House.
8. Resolutions will be placed on the Reaffirmation Consent Calendar when they are identical or substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy Database identification number. When practical, the Reaffirmation Consent Calendar should also include a listing of the actions that have been taken on the current AMA policies that are equivalent to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the submitted resolution which resets the sunset clock for ten years.
9. Updates on referred resolutions are included in the chart entitled "Implementation of Resolutions," which is made available to the House. [Sub. Res. 120, A-84; BOT Rep. D and CLRPD Rep. C, I-91; CLRPD Rep. 3 - I-94; CLRPD Rep. 5, I-95; Res. 614, and Special Advisory Committee to the Speaker of the House of Delegates, I-99; Res. 604, I-00; Consolidated: CLRPD Rep. 3, I-01; Modified: CLRPD Rep. 2, A-03; Reaffirmed: BOT Rep. 19, A-04; CC&B Rep. 3, I-08; Modified: CCB/CLRPD Rep. 1, A-12]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(A-24)

Introduced by: Medical Student Section

Subject: Amendments to AMA Bylaws to Enable Medical Student Leadership
Continuity

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, terms on the Medical Student Section (MSS) Governing Council, as the medical
2 student member on an AMA Council or the AMA Board of Trustees, or as the MSS
3 representative on the Minority Affairs Section or Women Physicians Section Governing Councils
4 are one year in length and commence after the Annual Meeting; and
5

6 Whereas, the AMA Bylaws defining cessation of eligibility for these positions state that if the
7 medical student leader “graduates from an educational program within 90 days prior to an
8 Annual Meeting,” they shall be permitted to continue to serve “until the completion of the Annual
9 Meeting”; and
10

11 Whereas, some students graduate off-cycle during the fall semester rather than the spring
12 semester, including some in November, over 180 days prior to the AMA Annual Meeting; and
13

14 Whereas, graduation off-cycle is more common for students with disabilities or chronic illness,
15 students who have taken leave of absence for personal or familial reasons, students who have
16 overcome medical or personal challenges, students from underrepresented backgrounds,
17 students who have pursued unique opportunities, and students who have faced obstacles
18 during their educational journey; and
19

20 Whereas, students who graduate off-cycle would technically be forced under the AMA Bylaws to
21 vacate their AMA national leadership position, leading to discontinuity of Medical Student
22 Section leadership, disrupting MSS internal operations and priorities, and curtailing these
23 students’ opportunity to grow as leaders; and
24

25 Whereas, the MSS Assembly has repeatedly unanimously expressed their desire that students
26 who graduate off-cycle should be able to complete their leadership terms; therefore be it
27

28 RESOLVED, that our American Medical Association amend AMA Bylaws 3.5.6.3, 6.11, 7.3.2,
29 7.7.3.1, and 7.10.3.1 to allow medical students to serve on the Medical Student Section
30 Governing Council, on the AMA Board of Trustees, on AMA Councils, and as Section
31 Representatives on other Governing Councils for up to 200 days after graduation. (Modify
32 Bylaws)
33

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

Received: 4/5/2024

RELEVANT AMA POLICY

Medical Student Trustee - Cessation of Enrollment B-3.5.6.3

The term of the medical student trustee shall terminate and the position shall be declared vacant if the medical student trustee should cease to be eligible for medical student membership in the AMA by virtue of the termination of the trustee's enrollment in an educational program. If the medical student trustee graduates from an educational program within 90 days prior to an Annual Meeting, the trustee shall be permitted to continue to serve on the Board of Trustees until completion of the Annual Meeting.

Term of Resident/Fellow Physician or Medical Student Member B-6.11

A resident/fellow physician or medical student member of a Council who completes residency or fellowship or who graduates from an educational program within 90 days prior to an Annual Meeting shall be permitted to serve on the Council until the completion of the Annual Meeting. Service on a Council as a resident/fellow physician and/or medical student member shall not be counted in determining maximum Council tenure.

Medical Student Section - Cessation of Eligibility B-7.3.2

If any officer or Governing Council member ceases to meet the membership requirements of Bylaw 7.3.1 prior to the expiration of the term for which elected, the term of such officer or member shall terminate and the position shall be declared vacant. If the officer or member graduates from an educational program within 90 days prior to an Annual Meeting, the officer or member shall be permitted to continue to serve in office until the completion of the Annual Meeting.

Minority Affairs Section - Section Representatives on the Governing Council B-7.7.3.1

If a representative of the Medical Student Section, Resident and Fellow Section or Young Physicians Section ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which he or she ceases to meet the membership requirement of the respective section.

Women Physicians Section - Section Representatives on the Governing Council B-7.10.3.1

If a representative of the Medical Student Section, Resident and Fellow Section or Young Physicians Section ceases to meet the criteria for membership in the section from which elected within 90 days prior to the Annual Meeting, such member shall be permitted to serve in office until the conclusion of the Annual Meeting in the calendar year in which she or he ceases to meet the membership requirement of the respective section.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(A-24)

Introduced by: Thomas W. Eppes, MD, Mark D. Townsend, MD MHCM, and Billie L. Jackson, MD.

Subject: The Rights of Newborns that Survive Abortion

Referred to: Reference Committee on Amendments to Constitution and Bylaws

- 1 Whereas, our American Medical Association recognizes healthcare as a human right; and
2
3 Whereas, the AMA has policy 2.2.4(d) Treatment Decisions for the Seriously Ill Newborn, which
4 states, "Initiate life sustaining and life enhancing treatment when the child's prognosis is largely
5 uncertain"; and
6
7 Whereas, AMA Code 2.2.1(I) calls on the physician to seek consultation when there is a
8 reversible life-threatening condition and the patient (If capable) or parents or guardian refuses
9 treatment the physician believes is clearly the patient's best interest (ii) there is disagreement
10 about what the patient's best interest is; and
11
12 Whereas, CDC data shows from 2003-14 at least 143 babies died after being born alive after an
13 abortion procedure, but did not count newborns that survived attempted abortions; and
14
15 Whereas, the number of children that live after an abortion procedure is only reported now by
16 anecdotal reports; and
17
18 Whereas, cited in the Annotations section of the Code of Ethics, "Children Not Meant to Be:
19 Protecting the Interests of the Child When Abortion Results in Live Birth", 6 Quinnipiac Health
20 states in conclusion that "in these situations, abortive parents and physicians should not solely
21 decide the child's best interests."; therefore be it
22
23 RESOLVED, that our American Medical Association amend the current policy right for an
24 abortion to "a woman's right to abortion as only the right to terminate the pregnancy" (Modify
25 Current HOD Policy); and be it further
26
27 RESOLVED, a newborn that survives an abortion procedure has a right to reasonable medical
28 care. (New HOD Policy)

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

Received: 4/23/2024

Relevant AMA Policy:

AMA Policy 2.2.4 Treatment Decisions for Seriously Ill Newborns

Making treatment decisions for seriously ill newborns is emotionally and ethically challenging for both parents and health care professionals. Decisions must take into account the newborn's medical needs; the interests, needs, and resources of the family; and available treatment options. Decision makers must also assess whether the choice made for the newborn will abrogate a choice the future individual would want to make for him- or herself, i.e., whether the choice will undermine the child's right to an "open future." Providing information and other resources to support parents or guardians when they must make decisions about their child's care and future is a key responsibility for physicians and other health care professionals.

Decisions not to initiate care or to discontinue an intervention can be emotionally wrenching in any circumstance, but may be particularly so for a seriously ill newborn. Physicians are in a position to help parents, families, and fellow professionals understand that there is no ethical difference between withholding and withdrawing treatment—when an intervention no longer helps to achieve the goals of care or promote the quality of life desired for the patient, it is ethically appropriate to withdraw it.

To help parents formulate goals for their newborn's care and make decisions about life-sustaining treatment on their child's behalf, physicians should:

- a. Inform the parents about available therapeutic options, the nature of available interventions, and their child's expected prognosis with and without treatment.
- b. Help the parents formulate goals for care that will promote their child's best interests in light of:
 - i. the chance that the intervention will achieve the intended clinical benefit;
 - ii. the risks involved with treatment and nontreatment;
 - iii. the degree to which treatment can be expected to extend life;
 - iv. the pain and discomfort associated with the intervention; and
 - v. the quality of life the child can be expected to have with and without treatment.
- c. Discuss the option of initiating an intervention with the intention of evaluating its clinical effectiveness after a given amount of time to determine whether the intervention has led to improvement. Confirm that if the intervention has not achieved agreed-on goals, it may be withdrawn. Physicians should recognize, and help parents appreciate, that it is not necessary to have prognostic certainty to withdraw life-sustaining treatment, since prognostic certainty is often unattainable and may unnecessarily prolong the infant's suffering.
- d. Initiate life-sustaining and life-enhancing treatment when the child's prognosis is largely uncertain.
- e. Adhere to good clinical practice for palliative care when life-sustaining treatment is withheld or withdrawn.
- f. Provide access to counseling services or other resources to facilitate decision making and to enable parents opportunity to talk with others who have had to make similar decisions.
- g. Seek consultation through an ethics committee or other institutional resource when disagreement about the appropriate course of action persists.

AMA Policy 2.2.1 Pediatric Decision Making

As the persons best positioned to understand their child's unique needs and interests, parents (or guardians) are asked to fill the dual responsibility of protecting their children and, at the same time, empowering them and promoting development of children's capacity to become independent decision makers. In giving or withholding permission for medical treatment for their children, parents/guardians are expected to safeguard their children's physical health and well-being and to nurture their children's developing personhood and autonomy.

But parents' authority as decision makers does not mean children should have no role in the decision-making process. Respect and shared decision making remain important in the context of decisions for minors. Thus, physicians should evaluate minor patients to determine if they can understand the risks and benefits of proposed treatment and tailor disclosure accordingly. The more mature a minor patient is, the better able to understand what a decision will mean, and the more clearly the child can communicate preferences, the stronger the ethical obligation to seek minor patients' assent to treatment. Except when immediate intervention is essential to preserve life or avert serious, irreversible harm, physicians and

parents/guardians should respect a child's refusal to assent, and when circumstances permit should explore the child's reason for dissent.

For health care decisions involving minor patients, physicians should:

- a. Provide compassionate, humane care to all pediatric patients.
- b. Negotiate with parents/guardians a shared understanding of the patient's medical and psychosocial needs and interests in the context of family relationships and resources.
- c. Develop an individualized plan of care that will best serve the patient, basing treatment recommendations on the best available evidence and in general preferring alternatives that will not foreclose important future choices by the adolescent and adult the patient will become. Where there are questions about the efficacy or long-term impact of treatment alternatives, physicians should encourage ongoing collection of data to help clarify value to patients of different approaches to care.
- d. Work with parents/guardians to simplify complex treatment regimens whenever possible and educate parents/guardians in ways to avoid behaviors that will put the child or others at risk.
- e. Provide a supportive environment and encourage parents/guardians to discuss the child's health status with the patient, offering to facilitate the parent-child conversation for reluctant parents. Physicians should offer education and support to minimize the psychosocial impact of socially or culturally sensitive care, including putting the patient and parents/guardians in contact with others who have dealt with similar decisions and have volunteered their support as peers.
- f. When decisions involve life-sustaining treatment for a terminally ill child, ensure that patients have an opportunity to be involved in decision making in keeping with their ability to understand decisions and their desire to participate. Physicians should ensure that the patient and parents/guardians understand the prognosis (with and without treatment). They should discuss the option of initiating therapy with the intention of evaluating its clinical effectiveness for the patient after a specified time to determine whether it has led to improvement and confirm that if the intervention has not achieved agreed-on goals it may be discontinued.
- g. When it is not clear whether a specific intervention promotes the patient's interests, respect the decision of the patient (if the patient has capacity and is able to express a preference) and parents/guardians.
- h. When there is ongoing disagreement about patient's best interest or treatment recommendations, seek consultation with an ethics committee or other institutional resource. (IV, VIII)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(A-24)

Introduced by: Mississippi

Subject: AMA Executive Vice President

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, our American Medical Association (AMA) is the most powerful voice for physicians in
2 the nation; and
3
4 Whereas, the Executive Vice President (EVP) of the AMA is thus a position of extreme
5 importance to the physician community; and
6
7 Whereas, the tradition of our AMA has been to have a physician EVP; and
8
9 Whereas, our AMA should select the most qualified physician leader possible for the EVP
10 position; and
11
12 Whereas, at any given time that best physician leader may be serving or have recently served in
13 the AMA physician leadership; and
14
15 Whereas, physician leaders who are serving or recently served in AMA leadership are
16 sometimes the most knowledgeable and experienced in addressing the current issues facing
17 the House of Medicine; and
18
19 Whereas, many physician leaders serving in the AMA would be extremely qualified candidates
20 for the AMA EVP based on their AMA leadership experience and their own medical practice and
21 medical administration leadership experiences; and
22
23 Whereas, the Mississippi State Medical Association (MSMA) had a similar situation and was
24 able to hire a physician and past President and Chair of the Board of our MSMA as our
25 Executive Director during a difficult time for our organization; and
26
27 Whereas, the MSMA board wanted the ability to hire the best qualified candidate as Executive
28 Director without the restriction even if they had served or were currently serving in a leadership
29 role at MSMA; and
30
31 Whereas, physicians who may be serving or have recently served in the AMA physician
32 leadership as an officer or trustee are currently ineligible for consideration for the AMA EVP
33 position under AMA Code Section B-5.3.6.4 until three years after their AMA service; and
34
35 Whereas, no comparable physician or health care organization has such a strict limitation on
36 who can be considered for their EVP position; therefore be it
37
38 RESOLVED, that our American Medical Association delete the AMA Board of Trustees Duties
39 and Privileges Code B-5.3.6.4 as follows:

- 1 ~~No individual who has served as an AMA officer or trustee shall be selected or serve as~~
- 2 ~~Executive Vice President until three years following completion of the term of the AMA office.”~~
- 3 (Modify Bylaws)

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

Received: 4/23/2024

RELEVANT AMA POLICY

Board of Trustees Duties and Privileges. B-5.3

In addition to the rights and duties conferred or imposed upon the Board of Trustees by law and custom and elsewhere in the Constitution and Bylaws, the Board of Trustees shall:

5.3.1 Management. Manage or direct the management of the property and conduct the affairs, work and activities of the AMA consistent with the policy actions and directives adopted by the House of Delegates, except as may be otherwise provided in the Constitution or these Bylaws.

5.3.1.1 The Board is the principal governing body of the AMA and it exercises broad oversight and guidance for the AMA with respect to the management systems and risk management program of the AMA through its oversight of the AMA's Executive Vice President.

5.3.1.2 Board of Trustee actions should be based on policies and directives approved by the House of Delegates. In the absence of specifically applicable House policies or directives and to the extent feasible, the Board shall determine AMA positions based on the tenor of past policy and other actions that may be related in subject matter.

5.3.2 Planning. Serve as the principal planning agent for the AMA.

5.3.2.1 Planning focuses on the AMA's goals and objectives and involves decision-making over allocation of resources and strategy development. Planning is a collaborative process involving all of the AMA's Councils, Sections, and other appropriate AMA components.

5.3.2.2 The House of Delegates and the Council on Long Range Planning and Development have key roles in identifying and making recommendations to the Board regarding important strategic issues and directions related to the AMA's vision, goals, and priorities.

5.3.3 Fulfillment of House of Delegates Charge. Review all resolutions and recommendations adopted by the House of Delegates to determine how to fulfill the charge from the House. Resolutions and recommendations pertaining to the expenditure of funds also shall be reviewed. If it is decided that the expenditure is inadvisable, the Board shall report, at its earliest convenience, to the House the reasons for its decisions.

5.3.3.1 In determining expenditure advisability, the Board will consider the scope of the proposed expenditure and whether it is consistent with the AMA's vision, goals, and priorities. Where the Board recommends that a proposed expenditure is not prudent and is inadvisable, the Board will present alternative actions, if feasible, in its report to the House.

5.3.4 Publication. Within the policies adopted by the House of Delegates, provide for the publication of The Journal of the American Medical Association and such specialty journals, periodicals, and other publications and electronic media information as it may deem to be desirable in the best interests of the public and the medical profession.

5.3.5 Election of Secretary. Select a Secretary from one of its members annually.

5.3.6 Selection of Executive Vice President. Select and evaluate an Executive Vice President.

5.3.6.1 The Executive Vice President is the chief executive officer of the AMA and as such is responsible for AMA management and performance in accordance with the vision, goals, and priorities of the AMA. The Executive Vice President is both a key leader for the organization and the bridge between AMA management and the Board of Trustees.

5.3.6.2 The Executive Vice President shall manage and direct the day-to-day duties of the AMA, including advocacy activities, and perform the duties commonly required of the chief executive officer of a corporation.

5.3.6.3 The Executive Vice President shall ensure that there is an active and effective risk management program.

5.3.6.4 No individual who has served as an AMA Officer or Trustee shall be selected or serve as Executive Vice President until 3 years following completion of the term of the AMA office.

5.3.7 Finances. Maintain the financial health of the AMA. The Board shall:

5.3.7.1 Oversee the development and approve the annual budget for the AMA, consistent with the AMA's vision, goals, and priorities.

5.3.7.2 Ensure that the AMA's resource allocations are aligned with the AMA's plan and budget.

5.3.7.3 Evaluate membership dues levels and make related recommendations to the House of Delegates.

5.3.7.4 Review and approve financial and business decisions that significantly affect the AMA's revenues and expenses.

5.3.7.5 Have the accounts of the AMA audited at least annually.

5.3.8 Financial Reporting. Make proper financial reports concerning AMA affairs to the House of Delegates at its Annual Meeting.

5.3.9 Appointment of Committees. Appoint such committees as necessary to carry out the purposes of the AMA.

5.3.9.1 An advisory committee will be constituted for purposes of education and advocacy.

5.3.9.1.1 It will have a governing council and a direct reporting relationship to the Board.

5.3.9.1.2 An advisory committee will not have representation in the House of Delegates.

5.3.9.1.3 An advisory committee will operate under a charter that will be subject to review and renewal by the Board at least every four years.

5.3.9.2 An ad hoc committee will be constituted as a special committee, workgroup or taskforce.

5.3.9.2.1 It will operate for a specific purpose and for a prescribed period of time.

5.3.10 Committee Vacancies. Fill vacancies in any committee where such authority is not delegated elsewhere by these Bylaws.

5.3.11 Litigation. Initiate, defend, settle, or otherwise dispose of litigation involving the interests of the AMA.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(A-24)

Introduced by: Missouri

Subject: Treatment of Family Members

Referred to: Reference Committee on Amendments to Constitution and Bylaws

- 1 Whereas, the code of ethics of the American Medical Association (AMA) was written in the 19th
2 century AD; and
3
- 4 Whereas, the practice of medicine has taken giant steps since then in areas of diagnostic
5 testing, medical records recordings, patient safety measures, documentations, verifications,
6 consents, hospitals and outpatients credentialing of surgeons and procedurists, etc.; and
7
- 8 Whereas, concerns about appropriateness of care, indications, and proper training of physicians
9 performing a procedure, or a physician treating any patient has become a legal and ethical
10 process witnessed by office, hospital, and medical facilities' staff including medical and non-
11 medical personnel recording, and reviewing appropriateness of care besides the treating
12 physicians; and
13
- 14 Whereas, multiple documented surveys of specialists and PCPs showed that a large number of
15 these physicians admitted treating family members when they felt comfortable and confident
16 they can provide the best care for them; and
17
- 18 Whereas, a much larger percentages of plastic, head and neck surgeons, dermatologists, have
19 admitted treating their family members; and
20
- 21 Whereas, the current code of ethics, as it is currently written, sadly label these physicians acts
22 as unethical; and
23
- 24 Whereas, many hospitals, and surgery centers have "discovered" lately this part of the code of
25 ethics, and started enforcing it, therefore forcing the physicians to seek other venues to treat
26 family members; and
27
- 28 Whereas, rendering care or performing procedures outside approved facilities such as an
29 uncredited office procedure room or un-accredited other facilities endanger the life and well-
30 being of the patients; and
31
- 32 Whereas, physicians ultimate concern is their patient's safety and wellbeing whether the patient
33 is a family member, a staff person, a friend or none of these; therefore be it
34
- 35 RESOLVED, that our American Medical Association asks CEJA to review and revise the current
36 code of ethics as it relates to treating family members (Directive to Take Action); and be it
37 further
38
- 39 RESOLVED, that our AMA ask CEJA to report back to the HOD on this issue at the next interim
40 meeting I-24. (Directive to Take Action)

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

Received: 4/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(A-24)

Introduced by: American Association of Public Health Physicians

Subject: AMA Supports a Strategy for Eliminating Nuclear Weapons

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, AMA policies concerning weapons, which were modified last in 2015, voice clear
2 “opposition to nuclear war” (Ref 1) and support for “the elimination by all nations of nuclear
3 weapons and other weapons of mass and indiscriminate destruction” (Ref 2); and
4

5 Whereas, millions have been sickened or killed by nuclear weapons testing around the world
6 since 1945, yet the United Nation’s Comprehensive Nuclear Test Ban Treaty, adopted by the
7 UN General Assembly in 1996 and ratified by 178 countries as of March 2024, has failed to
8 enter into force because the United States and other nuclear weapons possessing countries
9 have not ratified it and because, ominously, Vladimir Putin’s government withdrew its ratification
10 in 2023 (Ref 3); and
11

12 Whereas, AMA policy supports a “comprehensive nuclear test ban” and encourages the US
13 Government to “to continue the process of bilateral and verifiable nuclear arms reduction”, (Ref
14 4 & 5) but that process has stalled; and
15

16 Whereas, seventy-six years after the 1945 bombs that killed hundreds of thousands of innocent
17 civilians in Japan, the United Nation’s Treaty of the Prohibition of Nuclear Weapons at last
18 became international law in 2021, though the Treaty is not ratified yet by any country that
19 possesses nuclear weapons, (Ref 6); and
20

21 Whereas, the US government plans to spend \$1.7-3 trillion over the next thirty years to update
22 its thousands of nuclear bombs and delivery systems, money that the concepts of intersectional
23 justice (Ref 7) dictate should be better spent on healthcare, education, housing and other
24 needs; and
25

26 Whereas, a strategy towards implementing the Treaty on the Prohibition of Nuclear Weapons
27 has been enunciated (Ref 8); and
28

29 Whereas, this strategy has been endorsed by hundreds of local governments, civil society
30 organizations, and medical organizations, including the Maine Medical Association, American
31 Public Health Association, Physicians for Social Responsibility, and Union of Concerned
32 Scientists, (Ref 9); and
33

34 Whereas, the ongoing conflicts in Ukraine, the Middle East, and the Indo-Pakistani region
35 involving nuclear weapons possessing countries are raising the risk of an intentional or
36 accidental nuclear war with devastating health consequences; therefore be it
37

38 RESOLVED, that our American Medical Association calls for the United States and the other
39 nuclear weapons states to sign and ratify the United Nations Treaty on the Prohibition of

1 Nuclear Weapons and to pursue good-faith negotiations on effective measures relating to the
2 cessation of the nuclear arms race (Directive to Take Action); and be it further

3
4 RESOLVED, that our AMA calls for the United States to renounce the option to be the first
5 country to use nuclear weapons (“first use”) during a conflict (Directive to Take Action); and be it
6 further

7
8 RESOLVED, that our AMA supports a process whereby multiple individuals, rather than solely
9 the President, are required to approve a nuclear attack, while still allowing a swift response
10 when needed (New HOD Policy); and be it further

11
12 RESOLVED, that our AMA calls on the US government to cancel plans to rebuild its entire
13 nuclear arsenal and instead to reassess its true strategic needs for the types and numbers of
14 nuclear weapons and delivery systems. (Directive to Take Action)

15
Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 4/24/2024

REFERENCES

1. H-520.999 Opposition to Nuclear War
The AMA recognizes the catastrophic dangers to all life in the event of nuclear war and supports efforts for the prevention of such a nuclear holocaust.
2. H-520.988 Abolition of Nuclear Weapons and Other Weapons of Mass and Indiscriminate Destruction
The AMA supports the elimination by all nations of nuclear weapons and other weapons of mass and indiscriminate destruction.
3. https://en.wikipedia.org/wiki/Comprehensive_Nuclear-Test-Ban_Treaty Accessed 3.28.2024
4. H-520.994 Nuclear Test Ban
The AMA acknowledges the threat from nuclear weapons to the health of the people of the world and favors the establishment of a mutual, verifiable, and comprehensive nuclear test ban
5. D-440.972 Safety from Nuclear Weapons and Medical Consequences of Nuclear War
Our AMA will support legislation that would protect public health and safety, should the testing of nuclear weapons by the United States be resumed.
Our AMA will urge the U.S. and all national governments to continue to work to ban and eliminate nuclear weapons and will collaborate with relevant stakeholders to increase public awareness and education on the topic of the medical and environmental consequences of nuclear war.
6. <https://disarmament.unoda.org/wmd/nuclear/tpnw/> Accessed 3.28.2024
7. Intersectional Justice: <https://psr.org/wp-content/uploads/2023/11/intersectional-justice.pdf>. Accessed 3.28.2024
8. Back from the Brink. Our five policy solution. Available at: <https://www.preventnuclearwar.org/our-five-policy-solutions/>. Accessed 3.28.2024
9. APHA Policy 20209: <https://www.apha.org/Policies-and-Advocacy/Public-Health-Policy-Statements/Policy-Database/2021/01/13/Toward-a-World-Free-of-Nuclear-Weapons> . Accessed 3.28.2024

RELEVANT AMA POLICY

H-520.999 Opposition to Nuclear War

The AMA recognizes the catastrophic dangers to all life in the event of nuclear war and supports efforts for the prevention of such a nuclear holocaust.

Citation: (Sub. Res. 82, A-81; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: Res. 524, A-15)

H-520.988 Abolition of Nuclear Weapons and Other Weapons of Mass and Indiscriminate Destruction

The AMA supports the elimination by all nations of nuclear weapons and other weapons of mass and indiscriminate destruction.

Res. 617, I-96 Reaffirmed: CLRPD Rep. 2, A-06 Reaffirmed: Res. 524, A-15

H-520.994 Nuclear Test Ban

The AMA acknowledges the threat from nuclear weapons to the health of the people of the world and favors the establishment of a mutual, verifiable, and comprehensive nuclear test ban.

Res. 90, I-88 Reaffirmed: Sunset Report, I-98 Reaffirmed: CSAPH Rep. 2, A-08 Reaffirmed: Res. 524, A-15

D-440.972 Safety from Nuclear Weapons and Medical Consequences of Nuclear War

1. Our AMA will support legislation that would protect public health and safety, should the testing of nuclear weapons by the United States be resumed.

2. Our AMA will urge the U.S. and all national governments to continue to work to ban and eliminate nuclear weapons and will collaborate with relevant stakeholders to increase public awareness and education on the topic of the medical and environmental consequences of nuclear war.

Res. 436, A-05 Appended: Res. 524, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 008
(A-24)

Introduced by: Barbara L. McAneny, MD

Subject: Consolidated Health Care Market

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, the American Medical Association has long warned the nation about the problems
2 that can be associated with a consolidated health care market and has opposed insurance
3 company mergers; and
4

5 Whereas, Optum acquired Change Health over the objections of the Federal Trade
6 Commission; and
7

8 Whereas, on February 21, 2024, Optum and Change Health suffered a ransomware attack and
9 shut down all operations, including the electronic claims submission, electronic remittance, prior
10 authorization and documentation of patient eligibility; and
11

12 Whereas, across the country, medical practices, hospitals, pharmacies and many other health
13 care businesses had their revenue cycle disrupted, and cash flow interrupted, putting their
14 economic viability at risk; and
15

16 Whereas, Optum and its parent company United Health Group continued to collect premiums
17 and had the opportunity to retain significant amounts of money as no claims were being paid,
18 and therefore had the opportunity to collect interest and investment gains on money that should
19 have been paid to practices and other entities, raising the question of unjust enrichment; and
20

21 Whereas, Optum is the largest employer of physicians and has acquired practices when the
22 ransomware disruption made those practices unable to survive without acquisition; and
23

24 Whereas, even the practices that survive will have ongoing damages including but not limited to
25 denials related to giving therapy when it was impossible to obtain prior authorization, from using
26 lines of credit and having to pay interest, from having billing departments and others work
27 overtime to submit claims, to losing key employees from inability to make payroll; and
28

29 Whereas, oncology practices were particularly hard hit because of the need to purchase
30 chemotherapy without being able to be paid for the chemotherapy and are being charged late
31 payments for those purchases; and
32

33 Whereas, the AMA has a long history of defending practices against unfair business practices
34 by insurance companies and their subsidiaries; therefore be it
35

36 RESOLVED, that our American Medical Association investigate the possibility of filing a class
37 action lawsuit against Optum, United Health Group and Change Health to recoup the damages
38 from the disruption caused by the breach, and to distribute the unfair enrichment profits made
39 by Optum et al to the practices whose retained payments allowed them to generate interest and
40 investment profits (Directive to Take Action); and be it further

- 1 RESOLVED, that our AMA investigate the acquisition of practices by Optum in the aftermath of
- 2 the breach and determine if the independence of those practices can be resurrected, and if not,
- 3 if damages are due to the physician owners of the acquired practices. (Directive to Take Action)

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

Received: 4/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(A-24)

Introduced by: Resident and Fellow Section

Subject: Updating Language Regarding Families and Pregnant Persons

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, current AMA policy includes gendered language such as “mother” and “pregnant
2 woman” when discussing families and persons in need of obstetric and gynecologic care such
3 as in H-20.917, H-320.954, H-420.950, H-420.962, H-420.969, and more; and
4

5 Whereas, the Human Rights Campaign (HRC) definition of “family” when used in hospital
6 visitation policy is stated as: “‘Family’ means any person(s) who plays a significant role in an
7 individual’s life. This may include a person(s) not legally related to the individual. Members of
8 ‘family’ include spouses, domestic partners, and both different-sex and same-sex significant
9 others. ‘Family’ includes a minor patient’s parents, regardless of the gender of either parent.”¹;
10 and
11

12 Whereas, in 2022 the American College of Obstetricians and Gynecologists (ACOG) published
13 a policy statement stating “To be inclusive of women and all patients in need of obstetric and
14 gynecologic care, ACOG will move beyond the exclusive use of gendered language and
15 definitions”¹; and
16

17 Whereas, the World Professional Association for Transgender Health (WPATH)’s *Standards of*
18 *Care - version 8*, published in 2022, includes guideline 1.2 which states that “We recommend
19 health care professionals use language in health care settings that uphold the principles of
20 safety, dignity, and respect”³; and
21

22 Whereas, AMA policy H-65.942, adopted in June 2023, strongly encourages the use of gender-
23 neutral language supports the use of gender-neutral language in AMA policies and
24 communications, but as written this policy does not apply to other resources the AMA creates
25 and distributes; therefore be it
26

27 RESOLVED, that our American Medical Association review and update the language used in
28 AMA policy and other resources and communications to ensure that the language used to
29 describe families and persons in need of obstetric and gynecologic care is inclusive of all
30 genders and family structures. (Directive to Take Action)

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

Received: 4/24/2024

REFERENCES:

1. The Human Rights Campaign Foundation. LGBTQ+ inclusive definitions of family. HRC Foundation. <https://www.thehrcfoundation.org/professional-resources/lgbtq--inclusive-definitions-of-family>. Accessed April 17, 2023.
2. The American College of Obstetricians and Gynecologists. Inclusive language: Statement of Policy. ACOG. <https://www.acog.org/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language>. Published February 2022. Accessed April 17, 2023.

3. E. Coleman, A. E. Radix, W. P. Bouman, G. R. Brown, A. L. C. de Vries, M. B. Deutsch, R. Ettner, L. Fraser, M. Goodman, J. Green, A. B. Hancock, T. W. Johnson, D. H. Karasic, G. A. Knudson, S. F. Leibowitz, H. F. L. Meyer-Bahlburg, S. J. Monstrey, J. Motmans, L. Nahata, T. O. Nieder, S. L. Reisner, C. Richards, L. S. Schechter, V. Tangpricha, A. C. Tishelman, M. A. A. Van Trotsenburg, S. Winter, K. Ducheny, N. J. Adams, T. M. Adrián, L. R. Allen, D. Azul, H. Bagga, K. Başar, D. S. Bathory, J. J. Belinky, D. R. Berg, J. U. Berli, R. O. Bluebond-Langner, M.- B. Bouman, M. L. Bowers, P. J. Brassard, J. Byrne, L. Capitán, C. J. Cargill, J. M. Carswell, S. C. Chang, G. Chelvakumar, T. Corneil, K. B. Dalke, G. De Cuypere, E. de Vries, M. Den Heijer, A. H. Devor, C. Dhejne, A. D'Marco, E. K. Edmiston, L. Edwards-Leeper, R. Ehrbar, D. Ehrensaft, J. Eisfeld, E. Elaut, L. Erickson-Schroth, J. L. Feldman, A. D. Fisher, M. M. Garcia, L. Gijs, S. E. Green, B. P. Hall, T. L. D. Hardy, M. S. Irwig, L. A. Jacobs, A. C. Janssen, K. Johnson, D. T. Klink, B. P. C. Kreukels, L. E. Kuper, E. J. Kvach, M. A. Malouf, R. Massey, T. Mazur, C. McLachlan, S. D. Morrison, S. W. Mosser, P. M. Neira, U. Nygren, J. M. Oates, J. Obedin-Maliver, G. Pagkalos, J. Patton, N. Phanuphak, K. Rachlin, T. Reed, G. N. Rider, J. Ristori, S. Robbins-Cherry, S. A. Roberts, K. A. Rodriguez-Wallberg, S. M. Rosenthal, K. Sabir, J. D. Safer, A. I. Scheim, L. J. Seal, T. J. Sehoole, K. Spencer, C. St. Amand, T. D. Steensma, J. F. Strang, G. B. Taylor, K. Tillemann, G. G. T'Sjoen, L. N. Vala, N. M. Van Mello, J. F. Veale, J. A. Vencill, B. Vincent, L. M. Wesp, M. A. West & J. Arcelus (2022) Standards of Care for the Health of Transgender and Gender Diverse People, Version 8, International Journal of Transgender Health, 23:sup1, S1-S259, DOI: 10.1080/26895269.2022.2100644

Relevant AMA Policy:

HIV/AIDS and Substance Abuse H-20.903

Our AMA: (1) urges federal, state, and local governments to increase funding for drug treatment so that drug abusers have immediate access to appropriate care, regardless of ability to pay. Experts in the field agree that this is the most important step that can be taken to reduce the spread of HIV infection among intravenous drug abusers; (2) advocates development of regulations and incentives to encourage retention of HIV-positive and AIDS-symptomatic patients in drug treatment programs so long as such placement is clinically appropriate; (3) encourages the availability of opioid maintenance for persons addicted to opioids. Federal and state regulations governing opioid maintenance and treatment of drug dependent persons should be reevaluated to determine whether they meet the special needs of intravenous drug abusers, particularly those who are HIV infected or AIDS symptomatic. Federal and state regulations that are based on incomplete or inaccurate scientific and medical data that restrict or inhibit opioid maintenance therapy should be removed; and (4) urges development of educational, medical, and social support programs for intravenous drug abusers and their sexual or needle-sharing partners to reduce risk of HIV infection, as well as risk of other bloodborne and sexually transmissible diseases. Such efforts must target (a) pregnant intravenous drug abusers and those who may become pregnant to address the current and future health care needs of both mothers and newborns and (b) adolescent substance abusers, especially homeless, runaway, and detained adolescents who are seropositive or AIDS symptomatic and those whose lifestyles place them at risk for contracting HIV infection. [CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13]

Maternal HIV Screening and Treatment to Reduce the Risk of Perinatal HIV Transmission H-20.918

In view of the significance of the finding that treatment of HIV-infected pregnant women with appropriate antiretroviral therapy can reduce the risk of transmission of HIV to their infants, our AMA recommends the following statements:

- (1) Given the prevalence and distribution of HIV infection among women in the United States, the potential for effective early treatment of HIV infection in both women and their infants, and the significant reduction in perinatal HIV transmission with treatment of pregnant women with appropriate antiretroviral therapy, routine education about HIV infection and testing should be part of a comprehensive health care program for all women. The ideal would be for all women to know their HIV status before considering pregnancy.
- (2) Universal HIV testing of all pregnant women, with patient notification of the right of refusal, should be a routine component of perinatal care. Basic counseling on HIV prevention and treatment should also be provided to the patient, consistent with the principles of informed consent.
- (3) The final decision about accepting HIV testing is the responsibility of the woman. The decision to consent to or refuse an HIV test should be voluntary. When the choice is to reject testing, the patient's refusal should be recorded. Test results should be confidential within the limits of existing law and the need to provide appropriate medical care for the woman and her infant.
- (4) To assure that the intended results are being achieved, the proportion of pregnant women who have accepted or rejected HIV testing and follow-up care should be monitored and reviewed periodically at the appropriate practice, program or institutional level. Programs in which the proportion of women accepting HIV testing is low should evaluate their methods to determine how they can achieve greater success.

(5) Women who are not seen by a health care professional for prenatal care until late in pregnancy or after the onset of labor should be offered HIV testing at the earliest practical time, but not later than during the immediate postpartum period.

(6) When HIV infection is documented in a pregnant woman, proper post-test counseling should be provided. The patient should be given an appropriate medical evaluation of the stage of infection and full information about the recommended management plan for her own health. Information should be provided about the potential for reducing the risk of perinatal transmission of HIV infection to her infant through the use of antiretroviral therapy, and about the potential but unknown long-term risks to herself and her infant from the treatment course. The final decision to accept or reject antiretroviral treatment recommended for herself and her infant is the right and responsibility of the woman. When the woman's serostatus is either unknown or known to be positive, appropriate counseling should also be given regarding the risks associated with breastfeeding for both her own disease progression and disease transmission to the infant.

(7) Appropriate medical treatment for HIV-infected pregnant women should be determined on an individual basis using the latest published Centers for Disease Control and Prevention recommendations. The most appropriate care should be available regardless of the stage of HIV infection or the time during gestation at which the woman presents for prenatal or intrapartum care.

(8) To facilitate optimal medical care for women and their infants, HIV test results (both positive and negative) and associated management information should be available to the physicians taking care of both mother and infant. Ideally, this information will be included in the confidential medical records. Physicians providing care for a woman or her infant should obtain the appropriate consent and should notify the other involved physicians of the HIV status of and management information about the mother and infant, consistent with applicable state law.

(9) Continued research into new interventions is essential to further reduce the perinatal transmission of HIV, particularly the use of rapid HIV testing for women presenting in labor and for women presenting in the prenatal setting who may not return for test results. The long-term effects of antiretroviral therapy during pregnancy and the intrapartum period for both women and their infants also must be evaluated. For both infected and uninfected infants exposed to perinatal antiretroviral treatment, long-term follow-up studies are needed to assess potential complications such as organ system toxicity, neurodevelopmental problems, pubertal development problems, reproductive capacity, and development of neoplasms.

(10) Health care professionals should be educated about the benefits of universal HIV testing, with patient notification of the right of refusal, as a routine component of prenatal care, and barriers that may prevent implementation of universal HIV testing as a routine component of prenatal care should be addressed and removed. Federal funding for efforts to prevent perinatal HIV transmission, including both prenatal testing and appropriate care of HIV-infected women, should be maintained. [CSA Rep. 4, A-03; Reaffirmed: CEJA Rep. 3, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan H-60.918

1. Our AMA will advocate for biologic (including hematological) and neurodevelopmental monitoring at established intervals for children exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure.

2. Our AMA will urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL.

3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed children. Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow.

4. Our AMA promotes screening, diagnosis and acceptable treatment of lead exposure and iron deficiency in all people exposed to lead contaminated water. [Res. 428, A-16]

Reducing Lead Poisoning H-60.924

1. Our AMA: (a) supports regulations and policies designed to protect young children from exposure to lead; (b) urges the Centers for Disease Control and Prevention to give priority to examining the current

weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure; (c) encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories; (d) promotes community awareness of the hazard of lead-based paints; and (e) urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.

2. Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level $>5 \mu\text{g/dL}$ ($>50 \text{ ppb}$) by 2021, and (b) eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level $>1 \mu\text{g/dL}$ (10 ppb).

3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: (a) adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment; (b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed; (c) continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services; (d) eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions; (e) provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and (f) establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above $1 \mu\text{g/dL}$ (10 ppb).

4. Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply. [CCB/CLRPD Rep. 3, A-14; Appended: Res. 926, I-16; Appended: Res. 412, A-17]

Provision of Health Care and Parenting Classes to Adolescent Parents H-60.973

1. It is the policy of the AMA (A) to encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings which provide health care for infant and mother, and child development classes in addition to current high school courses and (B) to support programs directed toward increasing high school graduation rates, improving parenting skills and decreasing future social service dependence of teenage parents.

2. Our AMA will actively provide information underscoring the increased risk of poverty after adolescent pregnancy without marriage when combined with failure to complete high school. [Res. 422, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Appended: Res. 422, A-13]

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]

Accuracy, Importance, and Application of Data from the US Vital Statistics System H-85.961

Our AMA encourages physicians to provide complete and accurate information on prenatal care and hospital patient records of the mother and infant, as this information is the basis for the health and medical information on birth certificates. [CSA Rep. 6, I-00; Reaffirmed: Sub. Res. 419, A-02; Modified: CSAPH Rep. 1, A-12; Reaffirmed: CSAPH Rep. 1, A-22]

Addiction and Unhealthy Substance Use H-95.976

Our AMA is committed to efforts that can help the national problem of addiction and unhealthy substance use from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:

- (1) supports cooperation in activities of organizations in fostering education, research, prevention, and treatment of addiction;
- (2) encourages the development of addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;
- (3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;
- (4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;
- (5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Substance Abuse and Mental Health Services Administration to continue to support research and demonstration projects around effective prevention and intervention strategies;
- (6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco use disorder as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;
- (7) affirms the concept that addiction is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and
- (8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction. [BOT Rep. Y, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09; Modified: CSAPH Rep. 01, A-19]

Mercury and Fish Consumption: Medical and Public Health Issues H-150.947

AMA policy is that: (1) Women who might become pregnant, are pregnant, or who are nursing should follow federal, state or local advisories on fish consumption. Because some types of fish are known to have much lower than average levels of methylmercury and can be safely consumed more often and in larger amounts, women should also seek specific consumption recommendations from those authorities regarding locally caught or sold fish. (2) Physicians should (a) assist in educating patients about the relative mercury content of fish and shellfish products; (b) make patients aware of the advice contained in both national and regional consumer fish consumption advisories; and (c) have sample materials available, or direct patients to where they can access information on national and regional fish consumption advisories. (3) Testing of the mercury content of fish should be continued by appropriate agencies; results should be publicly accessible and reported in a consumer-friendly format. [CSA Rep. 13, A-04; Modified: Res. 538, A-05; Modified: CSAPH Rep. 1, A-15]

AMA Support for Breastfeeding H-245.982

1. Our AMA: (a) recognizes that breastfeeding is the optimal form of nutrition for most infants; (b) endorses the 2012 policy statement of American Academy of Pediatrics on Breastfeeding and the use of Human Milk, which delineates various ways in which physicians and hospitals can promote, protect, and support breastfeeding practices; (c) supports working with other interested organizations in actively seeking to promote increased breastfeeding by Supplemental Nutrition Program for Women, Infants, and Children (WIC Program) recipients, without reduction in other benefits; (d) supports the availability and appropriate use of breast pumps as a cost-effective tool to promote breast feeding; and (e) encourages

public facilities to provide designated areas for breastfeeding and breast pumping; mothers nursing babies should not be singled out and discouraged from nursing their infants in public places.

2. Our AMA: (a) promotes education on breastfeeding in undergraduate, graduate, and continuing medical education curricula; (b) encourages all medical schools and graduate medical education programs to support all residents, medical students and faculty who provide breast milk for their infants, including appropriate time and facilities to express and store breast milk during the working day; (c) encourages the education of patients during prenatal care on the benefits of breastfeeding; (d) supports breastfeeding in the health care system by encouraging hospitals to provide written breastfeeding policy that is communicated to health care staff; (e) encourages hospitals to train staff in the skills needed to implement written breastfeeding policy, to educate pregnant women about the benefits and management of breastfeeding, to attempt early initiation of breastfeeding, to practice "rooming-in," to educate mothers on how to breastfeed and maintain lactation, and to foster breastfeeding support groups and services; (f) supports curtailing formula promotional practices by encouraging perinatal care providers and hospitals to ensure that physicians or other appropriately trained medical personnel authorize distribution of infant formula as a medical sample only after appropriate infant feeding education, to specifically include education of parents about the medical benefits of breastfeeding and encouragement of its practice, and education of parents about formula and bottle-feeding options; and (g) supports the concept that the parent's decision to use infant formula, as well as the choice of which formula, should be preceded by consultation with a physician.

3. Our AMA: (a) supports the implementation of the WHO/UNICEF Ten Steps to Successful Breastfeeding at all birthing facilities; (b) endorses implementation of the Joint Commission Perinatal Care Core Measures Set for Exclusive Breast Milk Feeding for all maternity care facilities in the US as measures of breastfeeding initiation, exclusivity and continuation which should be continuously tracked by the nation, and social and demographic disparities should be addressed and eliminated; (c) recommends exclusive breastfeeding for about six months, followed by continued breastfeeding as complementary food are introduced, with continuation of breastfeeding for 1 year or longer as mutually desired by mother and infant; (d) recommends the adoption of employer programs which support breastfeeding mothers so that they may safely and privately express breast milk at work or take time to feed their infants; and (e) encourages employers in all fields of healthcare to serve as role models to improve the public health by supporting mothers providing breast milk to their infants beyond the postpartum period.

4. Our AMA supports the evaluation and grading of primary care interventions to support breastfeeding, as developed by the United States Preventive Services Task Force (USPSTF).

5. Our AMA's Opioid Task Force promotes educational resources for mothers who are breastfeeding on the benefits and risks of using opioids or medication-assisted therapy for opioid use disorder, based on the most recent guidelines. [CSA Rep. 2, A-05; Res. 325, A-05; Reaffirmation A-07; Reaffirmation A-12; Modified in lieu of Res. 409, A-12 and Res. 410, A-12; Appended: Res. 410, A-16; Appended: Res. 906, I-17; Reaffirmation: I-18]

Accommodating Lactating Mothers Taking Medical Examinations H-295.861

Our AMA: (1) urges all medical licensing, certification and board examination agencies, and all board proctoring centers, to grant special requests to give breastfeeding individuals additional break time and a suitable environment during examinations to express milk; and (2) encourages that such accommodations to breastfeeding individuals include necessary time per exam day, in addition to the standard pool of scheduled break time found in the specific exam, as well as access to a private, non-bathroom location on the testing center site with an electrical outlet for individuals to breast pump. [Sub. Res. 903, I-14; Modified: Res. 310, A-17]

Protecting Trainees' Breastfeeding Rights D-310.950

Our AMA will: (1) work with appropriate bodies, such as the Accreditation Council for Graduate Medical Education (ACGME) and the Liaison Committee on Medical Education (LCME), to include language in housestaff manuals or similar policy references of all training programs regarding protected times and locations for milk expression and secure storage of breast milk; and (2) work with appropriate bodies, such as the LCME, ACGME, and Association of American Medical Colleges (AAMC), to include language related to the learning and work environments for breastfeeding mothers in regular program reviews. [Res. 302, I-16]

Post-Partum Hospital Stay and Nurse Home Visits H-320.954

The AMA: (1) opposes the imposition by third party payers of mandatory constraints on hospital stays for vaginal deliveries and cesarean sections as arbitrary and as detrimental to the health of the mother and of

the newborn; and (2) urges that payers provide payment for appropriate follow-up care for the mother and newborn. [Sub. Res. 105, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16]

Substance Use Disorders During Pregnancy H-420.950

Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual's family structure, (b) the patient's treatment status, and (c) current impairment status when substance use is suspected. [Res. 209, A-18; Modified: Res. 520, A-19]

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953

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

Shackling of Pregnant Women in Labor H-420.957

1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:

- An immediate and serious threat of harm to herself, staff or others; or
- A substantial flight risk and cannot be reasonably contained by other means.

If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used."

2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist. [Res. 203, A-10; Reaffirmed: BOT Rep. 04, A-20]

Perinatal Addiction - Issues in Care and Prevention H-420.962

Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care. [CSA Rep. G, A-92; Reaffirmation A-99; Reaffirmation A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Modified: Alt. Res. 507, A-16; Modified: Res. 906, I-17; Reaffirmed: Res. 514, A-19]

Fetal Alcohol Syndrome Educational Program H-420.964

Our AMA supports informing physicians about Fetal Alcohol Syndrome and the referral and treatment of alcohol abuse by pregnant women or women at risk of becoming pregnant. [Res. 122, A-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

Universal Hepatitis B Virus (HBV) Antigen Screening for Pregnant Women H-420.968

It is the policy of the AMA to communicate the available guidelines for testing all pregnant women for HBV infection. [Res. 19, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

Legal Interventions During Pregnancy H-420.969

Court Ordered Medical Treatments And Legal Penalties For Potentially Harmful Behavior By Pregnant Women:

- (1) Judicial intervention is inappropriate when a woman has made an informed refusal of a medical treatment designed to benefit her fetus. If an exceptional circumstance could be found in which a medical treatment poses an insignificant or no health risk to the woman, entails a minimal invasion of her bodily integrity, and would clearly prevent substantial and irreversible harm to her fetus, it might be appropriate for a physician to seek judicial intervention. However, the fundamental principle against compelled medical procedures should control in all cases which do not present such exceptional circumstances.
- (2) The physician's duty is to provide appropriate information, such that the pregnant woman may make an informed and thoughtful decision, not to dictate the woman's decision.
- (3) A physician should not be liable for honoring a pregnant woman's informed refusal of medical treatment designed to benefit the fetus.
- (4) Criminal sanctions or civil liability for harmful behavior by the pregnant woman toward her fetus are inappropriate.
- (5) Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs.
- (6) To minimize the risk of legal action by a pregnant patient or an injured fetus, the physician should document medical recommendations made including the consequences of failure to comply with the physician's recommendation. [BOT Rep. OO, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: Res. 507, A-16; Reaffirmed: Res. 209, A-18]

AMA Statement on Family and Medical Leave H-420.979

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:

- (1) medical leave for the employee, including pregnancy, abortion, and stillbirth;
- (2) maternity leave for the employee-mother;
- (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and
- (4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. [BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: CMS Rep. 03, A-16; Modified: Res. 302, I-22]

Research into Preterm Birth and Related Cardiovascular and Cerebrovascular Risks in Women D-420.992

Our AMA will advocate for more research on ways to identify risk factors linking preterm birth to cardiovascular or cerebrovascular disease in pregnant women. [Res. 504, A-17]

Bonding Programs for Women Prisoners and their Newborn Children H-430.990

Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. However, since there are established benefits of breast milk for infants and breast milk expression for mothers, the AMA advocates for policy and legislation that extends the right to breastfeed directly and/or privately pump and safely store breast milk to include incarcerated mothers. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of incarcerated females who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills and breastfeeding/breast pumping training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children. [CSA Rep. 3, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17; Modified: Res. 431, A-22]

7.3.4 Maternal-Fetal Research

Maternal-fetal research, i.e., research intended to benefit pregnant women and/or their fetuses, must balance the health and safety of the woman who participates and the well-being of the fetus with the desire to develop new and innovative therapies. One challenge in such research is that pregnant women may face external pressure or expectations to enroll from partners, family members, or others that may compromise their ability to make a fully voluntary decision about whether to participate.

Physicians engaged in maternal-fetal research should demonstrate the same care and concern for the pregnant woman and fetus that they would in providing clinical care.

In addition to adhering to general guidelines for the ethical conduct of research and applicable law, physicians who are involved in maternal-fetal research should:

- (a) Base studies on scientifically sound clinical research with animals and nonpregnant human participants that has been carried out prior to conducting maternal-fetal research whenever possible.
- (b) Enroll a pregnant woman in maternal-fetal research only when there is no simpler, safer intervention available to promote the well-being of the woman or fetus.
- (c) Obtain the informed, voluntary consent of the pregnant woman.
- (d) Minimize risks to the fetus to the greatest extent possible, especially when the intervention under study is intended primarily to benefit the pregnant woman. [Issued: 2016]

Supporting the Use of Gender-Neutral Language H-65.942

Our American Medical Association will (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) prospectively amend all current AMA policy, where appropriate, to include gender-neutral language by way of the reaffirmation and sunset processes, (3) utilize gender-neutral language in future policies¹ 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, and (6) support the use of gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse individuals. [Res. 602, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(A-24)

Introduced by: Mississippi

Subject: Ethical Pricing Procedures that Protect Insured Patients

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, healthcare organizations that provide direct care (such as clinics, pharmacies,
2 hospitals, and the like) are operating on increasingly small profit margins and many are on the
3 brink of bankruptcy; and
4

5 Whereas, the health insurance industry as a whole is consistently posting significant profits; and
6

7 Whereas, many health insurance companies are publicly traded and, thusly, their directors hold
8 a fiduciary duty to their shareholders to make decisions based on the company's best financial
9 interests for the end of increased profit margins without sufficient regard to the beneficiaries (the
10 insureds) that pay for their services; and
11

12 Whereas, the process of pricing medications for consumers is increasingly complicated,
13 involving many middlemen and questionable practices that are not disclosed to the public under
14 the guise of "proprietary means"; and
15

16 Whereas, this complicated process has been manipulated by health insurance companies,
17 pharmaceutical manufacturers, pharmacy benefit managers, and other stakeholders to
18 negotiate terms that offer benefits for themselves without sufficient regard to the best interests
19 of their insured patients; and
20

21 Whereas, under the current system, insured patients pay a monthly premium in good faith
22 believing that their health insurer will arrange for medications to be bought by them (the
23 insureds) at a lower cost point than could otherwise be achieved without insurance or some
24 other non-paid service; and
25

26 Whereas, the current system has betrayed the aforementioned good faith of the insured patients
27 by utilizing a pricing process that results in higher prices to the patient for many medications
28 than could be achieved without insurance coverage (cash price) or with the aid of a free
29 "discount card" (such as GoodRX); and
30

31 Whereas, this betrayal of the insured patients' good faith represents a flaw of the system that is
32 woefully unethical and should be identified as such by insureds as well as their advocates (the
33 House of Medicine) and should be addressed by lawmakers for consumer and patient
34 protection; and
35

36 Whereas, physicians are a cornerstone in the House of Medicine and, by nature of their
37 profession, are fierce patient advocates, safeguarding the patient's best interests; and
38

39 Whereas, the American Medical Association (AMA) is the most prominent and powerful unified
40 voice of Physicians; therefore be it

1 RESOLVED, that our American Medical Association advocate for policies that limit the cost of a
2 medication to an insured patient with medication coverage to the lower range of prices that a
3 non-covered patient can achieve at cash price either before or after application of a non-
4 manufacturer's free discount card (such as GoodRx) (Directive to Take Action); and be it further
5

6 RESOLVED, that our AMA write a letter to lawmakers and other pertinent stakeholders
7 describing the ethical dilemma of the medication pricing process and how it adversely affects
8 insured patients. (Directive to Take Action)
9

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

Received: 4/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 013
(A-24)

Introduced by: American College of Obstetricians and Gynecologists
Subject: Ethical Impetus for Research in Pregnant and Lactating Individuals
Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, each year 3.6 million¹ individuals give birth in the United States and 3 million people
2 are lactating; and
3
4 Whereas, 70% of pregnant and lactating people² take some kind of medication when they are
5 pregnant or lactating; and
6
7 Whereas, pregnant and lactating people are generally excluded in clinical research³, there is a
8 dearth of data about the appropriate safety, dosage, and efficacy of most medical interventions
9 in pregnant and lactating individuals; and
10
11 Whereas, the lack of data results in patients and clinicians choosing to (a) forego an intervention
12 which may result in harm from an un(der) treated condition or (b) use an intervention which may
13 carry an uncertain risk of harm for an unknown potential benefit; and
14
15 Whereas, lack of access to research exacerbates health inequities in pregnant and lactating
16 individuals⁴; and
17
18 Whereas, the harm from excluding pregnant individuals from clinical research was very
19 apparent during the COVID-19 pandemic and contributed to vaccine hesitancy and resulted in
20 unnecessary and avoidable maternal and infant mortality and morbidity^{5,6,7}; and
21
22 Whereas, recent initiatives from the White House⁸, National Institutes of Health⁹, and the
23 National Academies of Science, Engineering, and Medicine¹⁰ have emphasized the need for
24 further research in pregnant and lactating individuals; and
25
26 Whereas, the American College of Obstetricians and Gynecologists¹¹, National Academies of
27 Science, Engineering, and Medicine¹⁰, and the U.S. Department of Health and Human Services
28 have moved from an overly protectionist ethic that prioritizes minimization of fetal risk to one
29 that recognizes the scientific, legal, and ethical complexities of research including the risks to
30 the pregnant/lactating individual, fetus, and/or neonate of NOT doing research; and
31
32 Whereas, the HHS Task Force on Research Specific to Pregnant Women and Lactating Women
33 released detailed recommendations, along with an implementation plan, to protect pregnant and
34 lactating individuals through research, rather than from research^{12,13}; and
35
36 Whereas, as this national policy discussion unfolds, the ethical guidance of our profession must
37 undergird this discussion; and

1 Whereas, the existing Code of Medical Ethics Opinion 7.3.4 Maternal-Fetal Research extracts
2 content from both the Code modernization process of 2016 with foundational original material
3 stemming from the “Medical applications of fetal tissue transplantation” opinion passed in 1989;
4 and

5
6 Whereas, much in women’s health, research infrastructure, ethical frameworks, and liability
7 landscape has changed since 1989 and the ethics of research in lactation is not discussed in
8 the Code; therefore be it

9
10 RESOLVED, that our American Medical Association Council on Ethical and Judicial Affairs
11 consider updating its ethical guidance on research in pregnant and lactating individuals.
12 (Directive to Take Action)

13
Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 4/24/2024

REFERENCES

1. Osterman, M. J. K., Hamilton, B. E., Martin, J. A., Driscoll, A. K., Valenzuela, C. P., & Division of Vital Statistics. 2023. Births: Final Data for 2021. <https://www.cdc.gov/nchs/data/nvsr/nvsr72/nvsr72-01.pdf>.
2. Centers for Disease Control. 2024. Research. Medicine and Pregnancy. <https://www.cdc.gov/pregnancy/meds/treatingfortwo/research.html>.
3. National Academies of Sciences, Engineering, and Medicine. 2023. Inclusion of Pregnant and Lactating Persons in Clinical Trials: Proceedings of a Workshop. Washington, DC: The National Academies Press. <https://doi.org/10.17226/26790>.
4. Hill, L., S. Artiga, and U. Ranji. 2022. Racial disparities in maternal and infant health: Current status and efforts to address them. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/>.
5. Kasehagen L, Byers P, Taylor K, et al. 2021. COVID-19–Associated Deaths After SARS-CoV-2 Infection During Pregnancy — Mississippi, March 1, 2020–October 6, 2021. *MMWR Morb Mortal Wkly Rep* 2021;70:1646–1648. DOI: <http://dx.doi.org/10.15585/mmwr.mm7047e2>.
6. Man, O.M., Azamor, T., Cambou, M.C. et al. 2024. *Respiratory distress in SARS-CoV-2 exposed uninfected neonates followed in the COVID Outcomes in Mother-Infant Pairs (COMP) Study*. *Nat Commun* 15,399. <https://doi.org/10.1038/s41467-023-44549-5>.
7. Razzaghi H, Meghani M, Pingali C, et al. 2021. *COVID-19 Vaccination Coverage Among Pregnant Women During Pregnancy — Eight Integrated Health Care Organizations, United States, December 14, 2020–May 8, 2021*. *MMWR Morb Mortal Wkly Rep* 2021;70:895–899. https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e2.htm?s_cid=mm7024e2_w.
8. The White House. 2024. *Executive Order on Advancing Women’s Health Research and Innovation*. <https://www.whitehouse.gov/briefing-room/presidential-actions/2024/03/18/executive-order-on-advancing-womens-health-research-and-innovation/>.
9. Eunice Kennedy Shriver National Institute of Child Health and Human Development, NIH , HHS. 2023. *Task Force on Research Specific to Pregnant Women and Lactating Women (PRGLAC) (2017-2021)*. <https://www.nichd.nih.gov/about/advisory/PRGLAC>.
10. National Academies of Sciences, Engineering, and Medicine. 2024. *Advancing Clinical Research with Pregnant and Lactating Populations: Overcoming Real and Perceived Liability Risks*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/27595>.
11. American College of Obstetricians and Gynecologists. 2015. *Ethical considerations for including women as research participants*. Committee Opinion No. 646. *Obstet Gynecol* 2015;126:e100–7. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2015/11/ethical-considerations-for-including-women-as-research-participants>.
12. Eunice Kennedy Shriver National Institute of Child Health and Human Development, NIH , HHS. 2018. *Task Force on Research Specific to Pregnant Women and Lactating Women. Report to Secretary, Health and Human Services Congress*. https://www.nichd.nih.gov/sites/default/files/2018-09/PRGLAC_Report.pdf.
13. Eunice Kennedy Shriver National Institute of Child Health and Human Development, NIH, HHS. 2020. *Task Force on Research Specific to Pregnant Women and Lactating Women. Report Implementation Plan To the Secretary, Health and Human Services*. https://www.nichd.nih.gov/sites/default/files/inline-files/PRGLAC_Implement_Plan_083120.pdf.

RELEVANT AMA POLICY

7.3.4 Maternal-Fetal Research

Maternal-fetal research, i.e., research intended to benefit pregnant women and/or their fetuses, must balance the health and safety of the woman who participates and the well-being of the fetus with the desire to develop new and innovative therapies. One challenge in such research is that pregnant women may face external pressure or expectations to enroll from partners, family members, or others that may compromise their ability to make a fully voluntary decision about whether to participate.

Physicians engaged in maternal-fetal research should demonstrate the same care and concern for the pregnant woman and fetus that they would in providing clinical care.

In addition to adhering to general guidelines for the ethical conduct of research and applicable law, physicians who are involved in maternal-fetal research should:

- (a) Base studies on scientifically sound clinical research with animals and nonpregnant human participants that has been carried out prior to conducting maternal-fetal research whenever possible.
- (b) Enroll a pregnant woman in maternal-fetal research only when there is no simpler, safer intervention available to promote the well-being of the woman or fetus.
- (c) Obtain the informed, voluntary consent of the pregnant woman.
- (d) Minimize risks to the fetus to the greatest extent possible, especially when the intervention under study is intended primarily to benefit the pregnant woman.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014
(A-24)

Introduced by: New England

Subject: The Preservation of the Primary Care Relationship

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, large health systems are restricting access to specialty care unless patients change
2 their primary care physician to a physician, physician associate (PA), or nurse practitioner (NP)
3 employed by their system, resulting in the extreme disruption of well-established patient
4 physician relationships; and

5
6 Whereas, the Institute of Medicine has declared that continuity is foundational to the
7 effectiveness of the patient physician relationship in primary care, with decades of research
8 concluding that coordination of care is essential to building a trusting relationship¹; and

9
10 Whereas, the Commonwealth Fund and the Agency for Healthcare Research and Quality
11 underscore the critical role of high-quality primary care in enhancing health system
12 effectiveness, advocating for increased financial investment, shifting to hybrid or capitated
13 payment approaches, and emphasizing the adoption of patient-centered medical homes to
14 address existing challenges and ensure accessibility, efficiency, and quality in healthcare^{2,3}; and

15
16 Whereas, maintaining outpatient continuity with a primary care physician reduces emergency
17 department use and hospitalizations, lowers costs, and increases patient and physician
18 satisfaction, while discontinuity is linked to higher post discharge costs and readmission rates^{4,5};
19 and

20
21 Whereas, value-based care contracting financially incentivizes systems to “capture” large
22 numbers of patients which has led to the practice of large health systems coercing patients to
23 abandon their primary care physician of choice, establishing with one of their employed
24 physicians, NPs or PAs in order to access specialty care; and

25
26 Whereas, hospital consolidations have also been scrutinized for boosting costs, narrowing
27 access, and potentially impacting care quality, where these consolidations can lead to increased
28 prices and may not necessarily improve the quality of care patients receive⁶; and

29
30 Whereas, due to national and regional differences in access to both specialty and primary care,
31 in addition to variations in the expansiveness of large health care systems, there is a lack of
32 transparency and data on the impact of these restrictive practices and necessitates further
33 study⁷; and

34
35 Whereas, there is a current crisis in healthcare with limited access to primary care and certain
36 specialties, further, given this limited access, it is important that patients are able to obtain care
37 across networks, and limiting this access harms both the patients and the physicians; and

1 Whereas, CEJA Report 1-A-01, The Patient-Physician Relationship, states that “The medical
2 profession must strive to preserve the trust patients hold in their physicians. It cannot abandon
3 ethical standards to economic force”⁸; therefore be it
4

5 RESOLVED, that our American Medical Association opposes health systems requiring patients
6 to switch to primary care physicians within a health system in order to access specialty care
7 (New HOD Policy); and be it further
8

9 RESOLVED that our AMA requests the Council on Ethical and Judicial Affairs review the ethical
10 implications of health systems requiring patients to change to primary care clinicians employed
11 by their system to access specialists (Directive to Take Action); and be it further
12

13 RESOLVED, that our AMA advocates for policies that promote patient choice, ensure continuity
14 of care, and uphold the sanctity of the patient-physician relationship, irrespective of healthcare
15 system pressures or economic incentives. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 5/7/2024

REFERENCES

1. "Institute of Medicine (US) Committee on the Future of Primary Care, Donaldson MS, Yordy KD, Lohr KN, Vanselow NA, eds. Primary Care: America's Health in a New Era. Washington (DC): National Academies Press (US); 1996."
2. Evidence-Based Strategies for Strengthening Primary Care in the U.S. www.commonwealthfund.org. Published August 5, 2022. <https://www.commonwealthfund.org/blog/2022/evidence-based-strategies-strengthening-primary-care-us>
3. Bazemore A, Grunert T. Sailing the 7C's: Starfield Revisited as a Foundation of Family Medicine Residency Redesign. Family Medicine. Published online May 6, 2021. doi:<https://doi.org/10.22454/fammed.2021.383659>
4. Goodwin JS. Continuity of Care Matters in All Health Care Settings. JAMA Network Open. 2021;4(3):e213842. doi:10.1001/jamanetworkopen.2021.3842
5. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457-502. doi:10.1111/j.1468-0009.2005.00409.x
6. US D Department of Health and Human Services. Access to Health Services. health.gov. Published 2020. <https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-health-services>
7. Naylor KB, Tootoo J, Yakusheva O, Shipman SA, Bynum JPW, Davis MA. Geographic variation in spatial accessibility of U.S. healthcare providers. PLoS One. 2019;14(4):e0215016. Published 2019 Apr 9. doi:10.1371/journal.pone.0215016
8. Opinion 1.1.1 Patient-Physician Relationships. Accessed March 11, 2024. https://code-medical-ethics.ama-assn.org/sites/amacoedb/files/2022-08/1.1.1.%20Patient-physician%20relationships--background%20reports_0.pdf

RELEVANT AMA POLICY

Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care H-160.901

Our AMA supports: (1) policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians; (2) the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care when appropriate care is not available within a limited network of providers; and (3) policies that encourage patients to return to their established primary care provider after emergency department visits, hospitalization or specialty consultation.

Disease Management and Demand Management H-285.944

The AMA strongly encourages health insurance plans and managed care organizations that provide disease management to involve the patient's current primary or principal care physician in the disease management process as much as possible, and to minimize arrangements that may impair the continuity of a patient's care across different settings.

1.1.1 Patient-physician relationships--background reports_0.pdf (ama-assn.org)

Relevant AMA Correspondences

RE: The Acquisition of Aetna, Inc. by CVS Health Corporation 2018, to the United States Department of Justice

We are writing to provide our views regarding the proposed merger of CVS Health Corporation (CVS), the largest retail pharmacy chain and specialty pharmacy in the U.S. and one of the two largest pharmacy benefit managers (PBM), and Aetna, Inc. (Aetna), the third largest U.S. health insurer. The AMA has studied this merger, an analysis that started almost as soon as the merger was officially announced. The AMA has sought the views of prominent health economists, health policy and antitrust experts—some of whom testified in a California Department of Insurance hearing on this merger. After very carefully considering this merger over the past months, the AMA has come to the conclusion that this merger would likely substantially lessen competition in many health care markets, to the detriment of patients. Accordingly, based on the mutually confirming analyses and conclusions presented by the nationally recognized experts and other experts, as well as extensive research, the AMA is now convinced that the proposed CVS-Aetna merger should be blocked.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 015
(A-24)

Introduced by: New England

Subject: Health and Racial Equity in Medical Education to Combat Workforce Disparities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

- 1 Whereas, achieving health equity requires valuing everyone equally with focused and ongoing
2 societal efforts to address avoidable inequalities, historical and contemporary injustices, and
3 social determinants of health — to eliminate disparities in health and health care¹; and
4
- 5 Whereas, the road to achieving health equity requires a diverse and equitable workforce that is
6 essential to optimizing health care access and the quality of patient care; and
7
- 8 Whereas, many barriers remain and unique challenges persist for some diverse groups
9 attempting to enter the medical field and successfully matriculate through the profession of
10 medicine. This is strongly indicated in demographics of currently practicing physicians; and
11
- 12 Whereas, among active physicians, 56.2% identified as White, 17.1% identified as Asian, 5.8%
13 identified as Hispanic, and ~5.0% identified as Black or African American²; and
14
- 15 Whereas, in 2015, the percentage of matriculants from racial/ethnic groups underrepresented in
16 medicine remained low: Black at 6.5%, Hispanic, Latino, or Spanish at 6.4% and American
17 Indian at 0.3%. The data is especially concerning as the Hispanic population is expected to
18 increase by 26% by 2030^{3,4}; and
19
- 20 Whereas, black people account for roughly 13 percent of the US population, they make up only
21 5.5 percent of the physician workforce and 7.3 percent of medical students. In 1940, when
22 9.7% of the total population was Black, 2.8% of physicians at that time were Black. These
23 representational disparities have not changed appreciably in decades;^{3,4} and
24
- 25 Whereas, additional barriers exists for certain minority groups. Black trainees face higher rates
26 of remedial intervention and dismissal from their programs than their White counterparts, thus
27 leading to concerns of over-policing in medical education; and
28
- 29 Whereas, over-policing in education begins as early as primary school and continues through
30 high school, college, medical education, and into the workforce. In graduate medical
31 education, biased scrutiny begins with the use of metrics that disadvantage Black applicants in
32 the residency selection process;⁵ and
33
- 34 Whereas, black residents account for about 5% of all residents, yet they accounted for nearly
35 20% of those who were dismissed in 2015;⁷and
36
- 37 Whereas, increased scrutiny and expectations can lead to damaging effects such as symptoms
38 of depression and anxiety among minority students, residents and physicians. This often leads

1 to reducing practice hours or leaving medicine, creating even greater workforce
2 disparities;⁵ therefore be it

3
4 RESOLVED, that our American Medical Association further study and track the prevalence of
5 attending physicians' and trainees' dismissals and remedial interventions, based on race,
6 gender, and ethnicity as well as the disproportionate impacts this has on workforce disparities
7 (Directive to Take Action); and be it further

8
9 RESOLVED, that our AMA engage stakeholders to study and report back how to effectively
10 support underrepresented groups in medicine to level the playing field for those most affected
11 by bias and historical harms (Directive to Take Action); and be it further

12
13 RESOLVED, that our AMA work with stakeholders to make recommendations on a review and
14 appeals process that will enable physicians and trainees to receive a fair and equitable due
15 process in defense of alleged shortcomings. (Directive to Take Action)

16
Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 5/7/2024

REFERENCES

1. U.S. Department of Health and Human Services. (n.d.). Achieving health equity. Healthy People 2030. Retrieved from <https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030#:~:text=Achieving%20health%20equity%20requires%20valuing,in%20health%20and%20health%20care>
2. Association of American Medical Colleges. (2018). Percentage of All Active Physicians by Race/Ethnicity: 2018. Retrieved from <https://www.aamc.org/data-reports/workforce/data/figure-18-percentage-all-active-physicians-race/ethnicity-2018#:~:text=Among%20active%20physicians%2C%2056.2%25%20identified,subgroup%20after%20White%20and%20Asian>
3. Johnson, T. (2023, March 23). Analysis: Racism in academic medicine is hindering progress toward health equity. California Health Report. Retrieved from <https://www.calhealthreport.org/2023/03/23/analysis-racism-in-academic-medicine-is-hindering-progress-toward-health-equity/>
4. University of California, Los Angeles. (n.d.). Proportion of Black Physicians Shows Little Change. Retrieved from <https://newsroom.ucla.edu/releases/proportion-black-physicians-little-change>
5. Health Care News. (n.d.). Dismantling the overpolicing of Black residents. Retrieved from <https://hcn.health/hcn-trends-story/dismantling-the-overpolicing-of-black-residents/>
6. Commonwealth Fund. (2024, February). Revealing disparities: Health care workers' observations. Retrieved from <https://www.commonwealthfund.org/publications/issue-briefs/2024/feb/revealing-disparities-health-care-workers-observations>
7. Ryan, P. (2022, June 20). Black doctors forced out of training programs at far higher rates than white residents. STAT. Retrieved from <https://www.statnews.com/2022/06/20/black-doctors-forced-out-of-training-programs-at-far-higher-rates-than-white-residents/>
8. Ryan, P. (2022, June 21). What will it take to level the playing field for Black residents? STAT. Retrieved from <https://www.statnews.com/2022/06/21/what-will-it-take-to-level-the-playing-field-for-black-residents/>
9. Jha, A. K. (2022). Structural racism and inequity in medicine. *New England Journal of Medicine*, 386(14), 1353-1356. doi: 10.1056/NEJMp2304559
10. Wadhwa, R. K., & Yeh, R. W. (2022). Addressing racism in medicine — toward a more equitable future. *New England Journal of Medicine*, 386(18), 1743-1746. doi: 10.1056/NEJMp2306195

RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed

care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

CME Rep. 1, I-06 Reaffirmed: CME Rep. 7, A-08 Reaffirmed: CCB/CLRPD Rep. 4, A-13 Modified: CME Rep. 01, A-16 Reaffirmation A-16 Modified: Res. 009, A-21 Modified: CME Rep. 5, A-21

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its 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; (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; (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; (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty; (8) recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts; and (9) collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure.

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 Appended: Res. 319, A-22 Modified: Res. 319, A-23

Diversity in the Physician Workforce and Access to Care D-200.982

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting.

CME Rep. 7, A-08 Reaffirmation A-13 Reaffirmation: A-16 Reaffirmed: CME Rep. 5, A-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 unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population.

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 Modified: Res. 320, A-23

American Medical Association House of Delegates

Resolution: 016
(A-24)

Introduced by: New York

Subject: Guiding Principles for the Healthcare of Migrants

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, there has been a recent increase in migrants and asylum seekers in the United States
2 that has garnered New York City, New York State and National media attention ¹; and
3

4 Whereas, this recent increase in migrants and asylum seekers has overwhelmed multiple areas
5 of the United States, including southern border states such as Texas and Arizona, and has
6 resulted in their coordinated transportation to cities that have “right to shelter” laws, such as
7 New York City, Chicago, Denver and Washington D.C. ^{2,3}, and
8

9 Whereas, from April 2022 to December 2023, more than 150,000 migrants have arrived in New
10 York City;¹ and
11

12 Whereas, the Mayor of the City of New York declared an “Asylum Seeker State of Emergency”
13 on 10/7/22, calling for increased aid from State and Federal governments⁴; and
14

15 Whereas, the 2022-2023 New York City budgets did not account for this recent increase in
16 migrants and asylum seekers, yet New York City has attempted to divert adequate resources to
17 the New York City Health and Hospital System, which operates the Humanitarian Emergency
18 Response and Relief Centers (HERRCs) which process the intake, screening, shelter,
19 healthcare and other needs of migrants and asylum seekers ⁵; and
20

21 Whereas, the diversion of funds from the New York City budget to HERRCs and other
22 associated costs of the recent increase in migrants and asylum seekers has resulted in a
23 decreased funding of other New York City municipal services, such as public libraries, public
24 schools and law enforcement⁶; and
25

26 Whereas, New York State has declared a Disaster Emergency via Executive Order No. 28.7 in
27 response to the recent increase in migrants and asylum seekers in New York State ⁷, and
28

29 Whereas, despite a \$1 Billion addition to the New York State 2024 Budget allocated for
30 response for migrants and asylum seekers, as well as mobilization of 1,500 National Guard
31 Members and an Executive Order mobilizing additional resources, the New York State Governor
32 is requesting additional support and resources from the Federal Government, including FEMA,
33 the U.S. Department of Defense, and the National Parks Service ^{8, 9, 10}; and
34

35 Whereas, New York City has become so financially overwhelmed with the recent increase in
36 migrants and asylum seekers that it has requested discontinuation of its “right to shelter”
37 statutes, and has reverted to litigating bus transportation companies for costs associated with
38 the healthcare and housing of asylum seekers they have brought ^{11, 12}; and

1 Whereas, Federal legislators are considering massive overhauls to immigration policy, but only
2 at the expense of continued financial aid in the international conflict between Russia and
3 Ukraine ¹³; and
4

5 Whereas, having adequate policy regarding the guiding principles of the healthcare for migrants
6 and asylum seekers will allow organized medicine groups to adequately respond to future
7 legislation or executive actions regarding the present migration crisis and future migration
8 issues; and
9

10 Whereas, the First District Branch of MSSNY has “RESOLVED, that the First District Branch will
11 collaborate together to write a resolution ... to advocate for increased federal funding, and other
12 federal solutions, to address the public health needs of the recent 2023 increase in asylum-
13 seeking migrants.”, but has no other standing policy on migrants and asylum seekers; and
14

15 Whereas, the Medical Society of the State of New York does not have any present relevant
16 policy regarding providing healthcare for migrant and asylum seekers, and
17

18 Whereas, the American Medical Association policy D-350.975 “Immigration Status is a Public
19 Health Issue” does recognize “immigration status is a public health issue” and “will support the
20 development and implementation of public health policies and programs that aim to improve
21 access to healthcare and minimize systemic health barriers for immigrant communities”, and
22 AMA policy H-350.957 “Addressing Immigrant Health Disparities” addresses a limited scope of
23 issues related to the healthcare of migrants, without reference to many important principles and
24 priorities as identified by the World Health Organization ^{14, 15, 16, 17}; and
25

26 Whereas, while the current migrant crisis being faced in the United States is causing recent
27 local, state and national attention to this issue, other groups dedicated to the study and policy
28 development of the healthcare of migrants at the international level report that this is indeed a
29 part of a larger global migration trend, with the World Health Organization noting that from “2000
30 - 2017, the total number of international migrants rose from 173 million to 258 million, an
31 increase of 49%” ¹⁶; and
32

33 Whereas, migrants face many unique health challenges and vulnerabilities including but not
34 limited to; inadequate access to healthcare, increased need for mental health services,
35 inadequate disease prevention, inadequate provision of care, lack of financial protection,
36 discrimination, language and cultural barriers, increased risk of encountering communicable
37 diseases, poor access to vaccination, inadequate continuity of care, inadequate health record
38 portability, food insecurity, malnutrition, sexual and gender-based violence including abuse and
39 trafficking and unsafe work conditions ¹⁶, therefore be it
40

41 RESOLVED, that our American Medical Association advocate for the development of adequate
42 policies and / or legislation to address the healthcare needs of migrants and asylum seekers in
43 cooperation with relevant legislators and stakeholders based on the following guiding principles,
44 adapted from the High-level meeting of the Global Consultation on Migrant Health, i.e. the
45 “Colombo Statement” (Directive to Take Action); and be it further
46

47 RESOLVED, that our AMA recognizes that migration status is a social determinant of health
48 (New HOD Policy); and be it further

1 RESOLVED, that our AMA affirms the importance of multi-sectoral coordination and inter-
2 country engagement and partnership in enhancing the means of addressing health aspects of
3 migration (New HOD Policy); and be it further
4

5 RESOLVED, that our AMA recognizes that the enhancement of migrants' health status relies on
6 an equitable and non-discriminatory access to and coverage of health care and cross-border
7 continuity of care at an affordable cost avoiding severe financial consequences for migrants, as
8 well as for their families (New HOD Policy); and be it further
9

10 RESOLVED, that our AMA recognizes that investment in migrant health provides positive
11 dividends compared to public health costs due to exclusion and neglect, and therefore
12 underscore the need for financing mechanisms that mobilize different sectors of society,
13 innovation, identification and sharing of good practices in this regard, and be it further
14

15 RESOLVED, that our AMA recognizes that the promotion of the physical and mental health of
16 migrants as defined by the following select objectives from the World Health Organization's
17 72nd World Health Assembly, Global action plan on promoting the health of refugees and
18 migrants, 2019-2023, is accomplished by
19

- 20 1. Ensuring that essential components, such as vaccination of children and adults and the
21 provision of health promotion, disease prevention, timely diagnosis and treatment,
22 rehabilitation and palliative services for acute, chronic and infectious diseases, injuries,
23 mental and behavioral disorders, and sexual and reproductive health care for women,
24 are addressed.
25
- 26 2. Improving the quality, acceptability, availability and accessibility of health care services,
27 for instance by overcoming physical, financial, information, linguistic and other cultural
28 barriers, with particular attention to services for chronic conditions and mental health,
29 which are often inadequately addressed or followed up during the migration and
30 displacement process, and by working to prevent occupational and work-related
31 diseases and injuries among migrant workers and their families by improving the
32 coverage, accessibility and quality of occupational and primary health care services and
33 social protection systems.
34
- 35 3. Ensuring that the social determinants of migrants' health are addressed through joint,
36 coherent multisectoral actions in all public health policy responses, especially ensuring
37 promotion of well-being for all at all ages, and facilitating orderly, safe, and responsible
38 migration and mobility of people, including through implementation of planned and well-
39 managed migration policies, as defined in the Sustainable Development Goals of the
40 United Nations.
41
- 42 4. Ensuring that information and disaggregated data at global, regional and country levels
43 are generated and that adequate, standardized, comparable records on the health of
44 migrants are available to support policy-makers and decision-makers to develop more
45 evidence-based policies, plans and interventions.
46
- 47 5. Providing accurate information and dispelling fears and misperceptions among migrant
48 and host populations about the health impacts of migration and displacement on migrant
49 populations and on the health of local communities and health systems. (New HOD
50 Policy)

Fiscal Note: Moderate - between \$5,000 - \$10,000

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REFERENCES

1. New York Times. (2022). NYC Migrant Crisis Explained. Retrieved from <https://www.nytimes.com/article/nyc-migrant-crisis-explained.html>
2. Associated Press. (2022). Biden, Chicago Mayor Lightfoot Discuss Texas Immigration. Retrieved from <https://apnews.com/article/biden-chicago-lori-lightfoot-texas-immigration-1b5892758ea8a350198db55b9295ba65>
3. NBC News. (2022). Texas Gov. Greg Abbott Divides Democrats on Immigration and Migrant Busing. Retrieved from <https://www.nbcnews.com/politics/politics-news/texas-gov-greg-abbott-divided-democrats-immigration-migrant-busing-rcna128815>
4. City of New York. (2022). Mayor Eric Adams Declares Asylum Seeker State of Emergency. Retrieved from <https://www.nyc.gov/office-of-the-mayor/news/729-22/transcript-mayor-eric-adams-declares-asylum-seeker-state-emergency-calls-urgent-aid-from>
5. Office of the State Comptroller. (2024). Review of the Financial Plan of The City of New York. Retrieved from <https://www.osc.ny.gov/files/reports/osdc/pdf/report-4-2024.pdf>
6. New York Times. (2023). NYC Budget Cuts Impact on Schools, Police, and Trash Collection. Retrieved from <https://www.nytimes.com/2023/11/16/nyregion/nyc-budget-cuts-schools-police-trash.html>
7. Office of the Governor of New York. (2022). Executive Order No. 287: Declaring Disaster Emergency in the State of New York. Retrieved from <https://www.governor.ny.gov/executive-order/no-287-declaring-disaster-emergency-state-new-york>
8. Office of the Governor of New York. (2022). Title 42 Expires: Governor Hochul Issues Executive Order Providing State and Municipalities. Retrieved from <https://www.governor.ny.gov/news/title-42-expires-governor-hochul-issues-executive-order-providing-state-and-municipalities>
9. Office of the Governor of New York. (2022). Governor Hochul Announces Highlights of FY 2024 Executive Budget. Retrieved from <https://www.governor.ny.gov/news/governor-hochul-announces-highlights-fy-2024-executive-budget>
10. Office of the Governor of New York. (2022). Governor Hochul Urges President Biden to Mobilize Federal Government for Shelter. Retrieved from <https://www.governor.ny.gov/news/governor-hochul-urges-president-biden-mobilize-federal-government-provide-shelter-asylum>
11. New York Times. (2023). Eric Adams' Right to Shelter Amid Migrant Crisis. Retrieved from <https://www.nytimes.com/2023/10/04/nyregion/eric-adams-right-to-shelter-migrant-crisis.html>
12. Associated Press. (2022). Mayor Eric Adams Plans to Bus Migrants, Challenges Gov. Greg Abbott. Retrieved from <https://apnews.com/article/mayor-eric-adams-bus-migrants-greg-abbott-cc9b1f7a7b1adf0fcd5c4e448a44dfac>
13. The Hill. (2022). 5 Things to Know About Border Bill HR2 and GOP Shutdown Threats. Retrieved from <https://thehill.com/homenews/house/4390204-5-things-to-know-about-border-bill-hr2-gop-shutdown-threats/>
14. American Medical Association. (2023). Immigration Status is a Public Health Issue (Resolution D-350.975). Retrieved from <https://policysearch.ama-assn.org/policyfinder/detail/%22Immigration%20Status%20is%20a%20Public%20Health%20Issue%20D-350.975%22?uri=%2FAMADoc%2Fdirectives.xml-D-350.975.xml>
15. American Medical Association. (2019). Addressing Immigrant Health Disparities (Resolution H-350.957). Retrieved from <https://policysearch.ama-assn.org/policyfinder/detail/asylum?uri=%2FAMADoc%2FHOD.xml-0-3007.xml>
16. World Health Organization. (2019). Seventy-Second World Health Assembly. Retrieved from https://iris.who.int/bitstream/handle/10665/331821/A72_REC1-en.pdf?sequence=1
17. International Organization for Migration. (2017). Colombo Statement on Migration Health. Retrieved from https://www.iom.int/sites/g/files/tmzbd1486/files/our_work/DMM/Migration-Health/colombo_statement.pdf

American Medical Association House of Delegates

Resolution: 017
(A-24)

Introduced by: New York

Subject: Addressing the Historical Injustices of Anatomical Specimen Use

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, in the wake of the recent Harvard Anatomical Donation scandal, there is a clear need
2 to reform rules and regulations surrounding the use of anatomical specimens in medical
3 education, anthropological study, and related disciplines; and ^{1,2,3}
4

5 Whereas, America has a long and well-documented history of exploitation against American
6 Indians, Alaska Natives, people of color, immigrants, those with disabilities, incarcerated people,
7 non-Christian, and poor citizens, who historically have not been afforded the same rights as
8 white, able-bodied Americans; and ⁴⁻⁷
9

10 Whereas, preserved and skeletal anatomical specimens from as far back as the 1800s are still
11 held by medical schools and used for educational purposes today; and ⁸⁻¹²
12

13 Whereas, the need for anatomical specimens has long since outpaced supply now and even
14 more in the distant past; and ¹³
15

16 Whereas, in the 1800s the theft of the bodies of minority populations like that of indigenous,
17 enslaved, and free Black citizens was a common practice increasing supply of anatomical
18 specimens without attracting scrutiny from legal entities; and ¹⁴⁻¹⁶
19

20 Whereas, some institutions have begun decommissioning, cremating, or returning remains of
21 some slaves or minority populations; and ¹⁷⁻¹⁹
22

23 Whereas, other institutions have fought to hold on to remains like those of mother Bessie
24 Wilborn, who had Paget's disease, whose skeleton still hangs at the University of Georgia
25 against the wishes of her family; and ²⁰⁻²¹
26

27 Whereas, despite laws such as the Native American Graves and Repatriation Act, which
28 "requires federal agencies and institutions that receive federal funding to return Native American
29 "cultural items" to lineal descendants and culturally affiliated American Indian tribes, Alaska
30 Native villages, and Native Hawaiian organizations", museums and institutions of higher
31 learning have not complied with these laws; and ^{30, 31}
32

33 Whereas, Harvard holds human remains of 19 likely enslaved individuals and thousands of
34 Native Americans according to a recent report ²⁹⁻³⁰; and
35

36 Whereas, the Peabody Museum at Harvard stewards a collection of hair samples, and often
37 names, taken from Indigenous people including clippings of hair from approximately 700 Native
38 American children attending federal Indian Boarding Schools²⁹; and

1 Whereas, the final manifestation of medical racism is the use of patient's bodies without their
2 consent and the repatriation of these specimens is an important step toward healing minorities'
3 distrust in medicine²¹; and
4

5 Whereas, today many states have presumed consent laws that still allow for bodies that haven't
6 been claimed in as short as few days to be donated for dissection; and ^{27, 28}
7

8 Whereas, the majority of unclaimed bodies are non-white person, persons with mental health
9 issues, or are the bodies of low- income individuals; and ²⁶⁻²⁸
10

11 Whereas, the medical ethics community in America has expressed concern about presumed
12 consent in the case of organ donation due to potential for damage the relationship of trust
13 between clinicians caring for patients at the end of life and their families and loss of autonomy
14 especially amongst those least capable of registering objections; and ^{25, 26}
15

16 Whereas, AMA Code of Ethics 6.1.4. cautions against the practice of presumed consent for
17 deceased organ donation, but the AMA has no current policy on what constitutes ethical
18 consent processes for donation of cadavers or body parts following death for educational
19 purposes; and
20

21 Whereas, AMA Code of Ethics 6.1.3 provides guidelines on financial incentives for cadaveric
22 donations; however both opinions were developed in reports in 2002 and 2005 respectively, and
23 do not consider the issues from a lens of medical racism; and
24

25 Whereas, MSSNY recently passed comprehensive new policy at its 2024 HOD calling for
26 several actions to address the historical injustices of anatomical specimen use in NY State and
27 for forwarding proposed policy to the AMA; therefore be it
28

29 RESOLVED, that Our American Medical Association advocate to AAMC (Association of
30 American Medical Colleges) and other appropriate bodies for the return of human remains to
31 living family members, or, if none exist, the burial of anatomical specimens older than 2 years
32 where consent for permanent donation cannot be proven (Directive to Take Action); and be it
33 further
34

35 RESOLVED, that our AMA advocate that medical schools and teaching hospitals in the US
36 review their anatomical collections for remains of American Indian, Hawaiian Native, and Alaska
37 Native remains and immediately return remains and skeletal collections to tribal governments;
38 as required by laws such as the Native American Graves and Repatriation Act (Directive to
39 Take Action); and be it further
40

41 RESOLVED, that our AMA advocate that medical schools and teaching hospitals in the US
42 review their anatomical collections for remains of Black and Brown people and other minority
43 groups, and return remains and skeletal collections to living family members, or, if none exist,
44 then respectful burial of anatomical specimens or remains (Directive to Take Action); and be it
45 further
46

47 RESOLVED, that Our AMA seek legislation or regulation that requires the return of anatomic
48 specimens of American Indian, Hawaiian Natives, Alaskan Natives and other minority groups
49 (Directive to Take Action); and be it further

1 RESOLVED, that Our AMA support the creation of a national anatomical specimen database
2 that includes registry demographics (New HOD Policy); and be it further

3
4 RESOLVED, that our AMA study and develop recommendations regarding regulations for
5 ethical body donations including, but not limited to guidelines for informed and presumed
6 consent; care and use of cadavers, body parts, and tissue (Directive to Take Action); and be it
7 further

8
9 RESOLVED, that our AMA amend policy 6.1.4 Presumed Consent & Mandated Choice for
10 Organs from Deceased Donors should be amended as follows:

- 11 ○ Physicians who propose to develop or participate in pilot studies of presumed
12 consent or mandated choice should ensure that the study adheres to the
13 following guidelines:
 - 14 ■ (a) Is scientifically well designed and defines clear, measurable outcomes
15 in a written protocol.
 - 16 ■ (b) Has been developed in consultation with the population among whom
17 it is to be carried out.
 - 18 ■ (c) Has been reviewed and approved by an appropriate oversight body
19 and is carried out in keeping with guidelines for ethical research.
- 20 ○ ~~Unless there are data that suggest a positive effect on donation, n~~ Neither
21 presumed consent nor mandated choice for cadaveric organ donation should be
22 widely implemented.

23 (Modify Current HOD Policy); and be it further

24
25 RESOLVED, that our AMA believes that, for purpose of differentiation and clarity, anatomical
26 specimens, tissues and other human material that were collected and maintained for purposes
27 of diagnosis and compliance under Clinical Laboratory Improvement Act (CLIA) where informed
28 consent has been obtained are consistent with the goals of this resolution, and that
29 biospecimens donated for research, education, and transplantation with informed consents of
30 donors (or, if available, next of kin if deceased) are consistent with the goals of this resolution as
31 such materials can advance medical knowledge, improve the quality of healthcare and save
32 lives. (New HOD Policy)

Fiscal Note: To Be Determined

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REFERENCES:

1. McColgan, F. (2023, August 6). *New lawsuit against Harvard in wake of body part trafficking allegations puts victims first in complaint*. Spokesman.com. <https://www.spokesman.com/stories/2023/aug/06/new-lawsuit-against-harvard-in-wake-of-body-part-t/>
2. Li, D. K. (2023, June 14). *Harvard morgue theft ring stole body parts, sold brains and turned human flesh into leather*. NBC News. <https://www.nbcnews.com/news/us-news/4-charged-stealing-selling-human-body-parts-harvard-medical-school-mor-rcna89357>
3. Stelloh, T. (2023, June 22). *Harvard human remains case highlights need for body donation regulations, experts say*. NBC News. <https://www.nbcnews.com/news/us-news/harvard-human-remains-case-highlights-need-body-donation-regulations-e-rcna90524>
4. Hawkins, D. S. (2023, August 8). *Medical exploitation of Black people in America goes far beyond the cells stolen from Henrietta Lacks that produced modern day miracles*. The Conversation. <https://theconversation.com/medical-exploitation-of-black-people-in-america-goes-far-beyond-the-cells-stolen-from-henrietta-lacks-that-produced-modern-day-miracles-200220>
5. Christopher PP, Stein MD, Johnson JE, Rich JD, Friedmann PD, Clarke J, Lidz CW. Exploitation of Prisoners in Clinical Research: Perceptions of Study Participants. IRB. 2016 Jan-Feb;38(1):7-12. PMID: 26964404; PMCID: PMC4793400.

6. Sacks, T. K., Savin, K., & Walton, Q. L. (2021, February). *How ancestral trauma informs patients' health decision making*. Journal of Ethics | American Medical Association. <https://journalofethics.ama-assn.org/article/how-ancestral-trauma-informs-patients-health-decision-making/2021-02>
7. Ouellette, A. R. (2019). People with disabilities in human subjects research: A history of exploitation, a problem of exclusion. SSRN Electronic Journal. <https://doi.org/10.2139/ssrn.3492078>
8. Human dissection in the early years of medical education at UNC. (2016, April 27). UNC Libraries Blogs. <https://blogs.lib.unc.edu/uarms/2016/04/27/human-dissection-in-the-early-years-of-medical-education-at-unc/>
9. Research guides: Searching the Warren anatomical Museum collection: Home. (2023). Research Guides at Harvard Library. <https://guides.library.harvard.edu/c.php?g=311035>
10. History. (2023). University of Pennsylvania | Pathology and Laboratory Medicine. <https://pathology.med.upenn.edu/department/about-the-department/history>
11. Strydhorst, N. (2017, June 21). "New lives for old specimens" illuminates research with historical samples. Yale School of Medicine. <https://medicine.yale.edu/news-article/new-lives-for-old-specimens-illuminates-research-with-historical-samples/>
12. About. (2023). Mütter Museum Mütter Museum. <https://muttermuseum.org/about/overview>
13. Tward AD, Patterson HA. From Grave Robbing to Gifting: Cadaver Supply in the United States. JAMA. 2002;287(9):1183. doi:10.1001/jama.287.9.1183-JMS0306-6-1
14. Hawkins, D. S. (2023, August 8). *Medical exploitation of Black people in America goes far beyond the cells stolen from Henrietta Lacks that produced modern day miracles*. Stamford Advocate. <https://www.stamfordadvocate.com/news/article/medical-exploitation-of-black-people-in-america-18284630.php>
15. Hammond, K. (2023, February 8). *VCU's medical college history found to be 'intimately connected' with slavery, report finds*. WRIC ABC 8News. <https://www.wric.com/news/local-news/richmond/vcus-medical-college-history-found-to-be-intimately-connected-with-slavery-report-finds/>
16. Meier, A. (2019, February 18). *Grave robbing, Black cemeteries, and the American medical school*. JSTOR Daily. <https://daily.jstor.org/grave-robbing-black-cemeteries-and-the-american-medical-school/>
17. Reed, B. (2022, August 7). *Ivy League university set to rebury skulls of Black people kept for centuries*. The Guardian. <https://www.theguardian.com/us-news/2022/aug/07/us-university-plans-repatriation-black-american-remains>
18. Crimmins, P. (2021, April 27). *Penn Museum apologizes for 'Unethical possession of human remains'*. NPR. <https://www.npr.org/2021/04/27/988972736/penn-museum-apologizes-for-unethical-possession-of-human-remains>
19. Cheng, C. (2022, June 1). Harvard holds human remains of 19 likely enslaved individuals, thousands of Native Americans, draft report says. The Harvard Crimson. <https://www.thecrimson.com/article/2022/6/1/draft-human-remains-report/>
20. BOARD OF REGENTS OF THE UNIVERSITY SYSTEM OF GEORGIA. v. OGLESBY. No. A03A1375. (Court of Appeals of Georgia, November 21, 2003) <https://caselaw.findlaw.com/court/ga-court-of-appeals/1228176.html>
21. Washington, H. A. (2008). *Medical apartheid: The dark history of medical experimentation on Black Americans from colonial times to the present*. Anchor.
22. Zink, S., Zeelandelaar, R., & Wertlieb, S. (2005, September). *Presumed vs expressed consent in the US and internationally*. Journal of Ethics | American Medical Association. <https://journalofethics.ama-assn.org/article/presumed-vs-expressed-consent-us-and-internationally/2005-09>
23. An evaluation of the ethics of presumed consent. A Report of the Presumed Consent Subcommittee of the Ethics Committee (June 1993). (1993, June). Organ Procurement and Transplantation Network. <https://optn.transplant.hrsa.gov/professionals/by-topic/ethical-considerations/an-evaluation-of-the-ethics-of-presumed-consent/>
24. Peeler, M. (2020). An unexpected education — Unclaimed bodies in the anatomy lab. *New England Journal of Medicine*, 383(21), 2002-2004. <https://doi.org/10.1056/nejimp2015975>
25. This is what happens to unclaimed bodies in America. (2022, December 19). *TalkDeath*. <https://www.talkdeath.com/this-is-what-happens-to-unclaimed-bodies-in-america/>
26. Jordan, M., & Sullivan, K. (2021, September 17). Alone in death-Tens of thousands die each year in the United States and no one claims their bodies. The Washington Post. <https://www.washingtonpost.com/nation/2021/09/17/alone-death/>
27. Sohn H, Timmermans S, Prickett PJ. Loneliness in life and in death? Social and demographic patterns of unclaimed deaths. *PLoS One*. 2020 Sep 16;15(9):e0238348. doi: 10.1371/journal.pone.0238348. PMID: 32936820; PMCID: PMC7494098.
28. Quinet, K., Nunn, S. and Ballew, A. (2016), Who are the Unclaimed Dead?. *J Forensic Sci*, 61: S131-S139. <https://doi.org/10.1111/1556-4029.12973>
29. Woodbury collection. (2023). Peabody Museum. <https://peabody.harvard.edu/woodbury-collection>
30. Jaffe, L., Hudetz, M., Ngu, A., & Brewer, G. L. (2023, January 11). America's biggest museums fail to return Native American human remains. ProPublica. <https://www.propublica.org/article/repatriation-nagpra-museums-human-remains>
31. Collins, B. (2018, September 18). *Mayo issues an apology 156 years in the making*. NewsCut. <https://newscut.mprnews.org/2018/09/mayo-issues-an-apology-156-years-in-the-making/index.html>

RELEVANT AMA POLICY

Improving Body Donation Regulation H-460.890

Our AMA recognizes the need for ethical, transparent, and consistent body and body part donation regulations.

Organ Donation and Honoring Organ Donor Wishes H-370.998

Our AMA:

- (1) continues to urge the citizenry to sign donor cards and supports continued efforts to educate the public on the desirability of, and the need for, organ donations, as well as the importance of discussing personal wishes regarding organ donation with appropriate family members
- (2) when a good faith effort has been made to contact the family, actively encourage Organ Procurement Organizations and physicians to adhere to provisions of the Uniform Anatomical Gift Act which allows for the procurement of organs when the family is absent and there is a signed organ donor card or advanced directive stating the decedent's desire to donate the organs.

Medical Ethics and Continuing Medical Education H-300.964

The AMA encourages accredited continuing medical education sponsors to plan and conduct programs and conferences emphasizing ethical principles in medical decision making.

Accelerating Change in Medical Education: Strategies for Medical Education Reform H-295.871

Our AMA continues to recognize the need for transformation of medical education across the continuum from premedical preparation through continuing physician professional development and the need to involve multiple stakeholders in the transformation process, while taking an appropriate leadership and coordinating role.

6.1.4 Presumed Consent & Mandated Choice for Organs from Deceased Donors

Physicians who propose to develop or participate in pilot studies of presumed consent or mandated choice should ensure that the study adheres to the following guidelines:

- (a) Is scientifically well designed and defines clear, measurable outcomes in a written protocol.
- (b) Has been developed in consultation with the population among whom it is to be carried out.
- (c) Has been reviewed and approved by an appropriate oversight body and is carried out in keeping with guidelines for ethical research.

Unless there are data that suggest a positive effect on donation, neither presumed consent nor mandated choice for cadaveric organ donation should be widely implemented.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 018
(A-24)

Introduced by: New York

Subject: Opposing Violence, Terrorism, Discrimination, and Hate Speech

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, the American Medical Association represents hundreds of thousands of physicians
2 across the United States; and
3
4 Whereas, the AMA is committed to promoting the health and well-being of all individuals and
5 communities; and
6
7 Whereas, the AMA recognizes the inherent dignity and worth of every person, regardless of
8 race, ethnicity, gender, disability, religious affiliation, cultural affiliation, sexual orientation, or
9 other factor; and
10
11 Whereas, the AMA condemns all forms of violence, terrorism, discrimination, and hate speech
12 perpetrated against any group or individual; and
13
14 Whereas, the AMA acknowledges the ongoing conflicts and persecution faced by numerous
15 groups around the world, including but not limited to:
16
17 • Ethnic minorities such as the Rohingya in Myanmar, the Uighurs in China, and the Kurds
18
19 • Religious communities such as Jews, Muslims, Christians, Yazidis, etc.
20
21 • Indigenous populations
22
23 • LGBTQ+ individuals
24
25 • Refugees and asylum seekers in many countries
26
27 Whereas, current events including but not limited to the conflicts in the Middle East and Ukraine-
28 Russia provide context for this resolution and demonstrate the AMA's awareness of global
29 issues; and
30
31 Whereas, it is imperative for the AMA to address issues of recognition and commemoration in a
32 manner that fosters unity, understanding, and healing among all communities; therefore be it
33
34 RESOLVED, that our American Medical Association strongly condemns all acts of violence,
35 terrorism, discrimination, and hate speech against any group or individual, regardless of race,
36 ethnicity, religious affiliation, cultural affiliation, gender, sexual orientation, disability, or other
37 factor (New HOD Policy); and be it further

1 RESOLVED, that our AMA affirms its commitment to promoting dialogue, empathy, and mutual
2 respect among diverse communities, recognizing the importance of fostering understanding and
3 reconciliation (New HOD Policy); and be it further

4
5 RESOLVED, that our AMA recognizes the importance of commemorating and honoring the
6 victims of tragedies throughout human history, in a manner that respects the dignity and
7 sensitivities of all affected communities (New HOD Policy); and be it further

8
9 RESOLVED, that our AMA encourages initiatives that promote education, awareness, and
10 solidarity to prevent future acts of violence and promote social cohesion (New HOD Policy); and
11 be it further

12
13 RESOLVED, that our AMA acknowledges the diverse perspectives and experiences within its
14 membership and commits to facilitating constructive dialogue and engagement on sensitive and
15 polarizing issues (New HOD Policy); and be it further

16
17 RESOLVED, that our AMA calls for continued collaboration and partnership with organizations
18 representing diverse communities. (Directive to Take Action)

19
Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/8/2024

AMERICAN MEDICAL ASSOCIATION MINORITY AFFAIRS SECTION

Resolution 019
(A-24)

Introduced by: Minority Affairs Section

Subject: Supporting the Health of Our Democracy

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, our American Medical Association “acknowledges voting is a social determinant of
2 health and significantly contributes to the analyses of other social determinants of health as a
3 key metric”; and
4

5 Whereas, our AMA “recognizes that gerrymandering which disenfranchises
6 individuals/communities limits access to health care, including but not limited to the expansion
7 of comprehensive medical insurance coverage, and negatively impacts health outcomes”; and
8

9 Whereas, our AMA “will collaborate with appropriate stakeholders and provide resources to
10 firmly establish a relationship between voter participation and health outcomes”; and
11

12 Whereas, the Association of American Medical Colleges (AAMC) supports medical schools and
13 teaching hospitals facilitating nonpartisan voter registration efforts¹; and
14

15 Whereas, a growing body of research demonstrates the relationship between the political
16 determinants of health (including voter rates, government participation, and policy engagement)
17 and other social determinants, including how votes lost to morbidity and mortality in
18 underrepresented populations impact electoral and policy outcomes²⁻⁴; and
19

20 Whereas, lower voter rates among elderly patients, patients with disabilities, patients who are
21 socially isolated, and low-income patients are associated with poor reported health, and
22 increased voter rates are associated with healthier lifestyle behaviors and improved mental
23 health, even when controlling for income inequality⁴⁻¹⁰; and
24

25 Whereas, health facilities’ nonpartisan voter registration efforts demonstrate improved civic
26 engagement and are protected by the National Voter Registration Act and IRS code¹¹⁻¹⁴; and
27

28 Whereas, emergency absentee ballot access for people experiencing or managing medical
29 emergencies is variable across states, with only 23 offering coverage for patients’ relatives and
30 only 17 extending protections to healthcare workers¹²; and
31

32 Whereas, physician voter rates are lower than the general public, often due to work conflicts,
33 although rates are higher in states with universal mail ballots¹⁵⁻¹⁶; and
34

35 Whereas, President Biden’s Executive Order on Promoting Access to Voting strongly
36 encourages federal agencies, including Veterans Health Administration (VHA) and Indian Health
37 Service sites to seek designation as voter registration sites¹⁷; and

1 Whereas, other federal health and social programs such as the VHA, Medicaid, and SNAP/WIC
2 offer voter registration services, and the Health Resources and Services Administration even
3 offers guidance for Federally Qualified Health Centers to organize such efforts^{12,18-19}; and
4

5 Whereas, civic engagement efforts are limited at Indian Health Service, Tribal, and Urban Indian
6 Health Programs, which are crucial interfaces with Native American patients and Tribal
7 governments²⁰⁻²¹; and
8

9 Whereas, gerrymandering disenfranchises voters, especially voters of color and low-income
10 voters, resulting in electoral outcomes that do not accurately reflect popular votes and
11 subsequent governments who often limit ballot access once in power²²⁻²⁴; and
12

13 Whereas, increased gerrymandering and barriers to ballot access are associated with lower life
14 expectancies, obstruction of Medicaid expansion, and perpetuation of systemic racial health
15 inequities, especially among Black, Latine, and Native American populations^{3,23-24}; and
16

17 Whereas, the primary solution to gerrymandering is the creation of independent, nonpartisan
18 redistricting commissions, so if our AMA recognizes that gerrymandering is a threat to health
19 outcomes, then we should support solutions to mitigate this problem²⁵; therefore be it
20

21 RESOLVED, that our American Medical Association support policies that ensure safe and
22 equitable access to voting and opposes the institutional barriers to both the process of voter
23 registration and the act of casting a vote (New HOD Policy); and be it further
24

25 RESOLVED, that our AMA encourage physicians and medical trainees to vote, oppose barriers
26 to their participation in the electoral process, and support their and other healthcare workers'
27 engagement in nonpartisan voter registration efforts in healthcare settings, including emergency
28 absentee ballot procedures for qualifying patients, visitors, and healthcare workers (New HOD
29 Policy); and be it further
30

31 RESOLVED, that our AMA support the use of independent, nonpartisan commissions to draw
32 districts for both federal and state elections. (New HOD Policy)

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

Date Received: 5/8/2024

REFERENCES

1. Fact Sheet for Nonpartisan Voter Registration at Health Care Institutions. AAMC. Accessed May 14, 2023. <https://www.aamc.org/advocacy-policy/voterregistration>
2. Social Determinants of Health. Office of Disease Prevention and Health Promotion. <https://health.gov/healthypeople/priority-areas/social-determinants-health>. Accessed June 6, 2023.
3. Syed Q, Schmidt S, Powell R, Henry T, Connolly N, Cowart J, Newby C. Gerrymandering and Political Determinants of Health. Mary Ann Liebert, Inc. Published Aug 8, 2022. <https://doi.org/10.1089/pop.2021.0362>
4. Brown CL, Raza D, Pinto AD. Voting, health and interventions in healthcare settings: a scoping review. Public Health Rev. 2020;41:16.
5. Nelson MH. Explaining socioeconomic disparities in electoral participation: The role of health in the SES-voting relationship. Soc Sci Med. 2023;320:115718. doi:10.1016/j.socscimed.2023.115718
6. Ballard PJ, Hoyt LT, Pachucki MC. Impacts of adolescent and young adult civic engagement on health and socioeconomic status in adulthood. Child Dev 2018;00(0):1-17. Available from:<http://doi.wiley.com/10.1111/cdev.12998>.
7. Arah OA. Effect of voting abstention and life course socioeconomic position on self-reported health. J Epidemiol Community Health. 2008;62(8):759-60. <https://doi.org/10.1136/jech.2007.071100>.
8. Ballard PJ, Hoyt LT, Pachucki MC. Impacts of adolescent and young adult civic engagement on health and socioeconomic status in adulthood. Child Dev 2018;00(0):1-17. Available from:<http://doi.wiley.com/10.1111/cdev.12998>.

9. Bergstresser SM, Brown IS, Colesante A. Political engagement as an element of social recovery: a qualitative study. *Psychiatr Serv.* 2013;64(8):819-21 Available from:<http://psychiatryonline.org/doi/abs/10.1176/appi.ps.004142012>.
10. Kawachi I, Kennedy BP, Gupta V, Prothrow-Stith D. Women's status and the health of women and men: a view from the States. *Soc Sci Med.* 1999;48(1):21-32.
11. The National Voter Registration Act Of 1993 (NVRA). US Department of Justice. Published online July 20, 2022. <https://www.justice.gov/crt/national-voter-registration-act-1993-nvra>
12. Tang OY, Wong KE, Ganguli R, et al. Emergency Absentee Voting for Hospitalized Patients and Voting During COVID-19: A 50-State Study. *West J Emerg Med.* 2021;22(4):1000-1009. Published 2021 Jul 15. doi:10.5811/westjem.2021.4.50884
13. Lickiss S, Lowery L, Triemstra JD. Voter Registration and Engagement in an Adolescent and Young Adult Primary Care Clinic. *J Adolesc Health.* 2020;66(6):747-749. doi:10.1016/j.jadohealth.2019.11.316
14. Chamberlain C, Jaime H, Wohler D. Emergency Patient Voting Initiative in a Community Hospital During a Global Pandemic:: Lessons and a Call-to-Action for Expanded Voter Access. *Delaware J Public Health.* 2021;7(1):76-77. Published 2021 Jan 21. doi:10.32481/djph.2021.01.015
15. Solnick RE, Choi H, Kocher KE. Voting Behavior of Physicians and Healthcare Professionals. *J Gen Intern Med.* 2021;36(4):1169-1171. doi:10.1007/s11606-020-06461-2
16. Ahmed A, Chouairi F, Li X. Analysis of Reported Voting Behaviors of US Physicians, 2000-2020. *JAMA Netw Open.* 2022;5(1):e2142527. doi:10.1001/jamanetworkopen.2021.42527
17. Biden J. Executive Order on Promoting Access to Voting. The White House. Published online March 7, 2021. <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/03/07/executive-order-on-promoting-access-to-voting>
18. VA promotes greater access to voter information to Veterans and families. Veterans Affairs. Published online March 24, 2022. <https://news.va.gov/press-room/va-promotes-greater-access-to-voter-information-to-veterans-and-families>
19. Hess D. Using Medicaid Automatic Voter Registration to Address Persistent Voter Registration Problems: Helping the National Voter Registration Act Achieve its Potential. Institute for Responsive Government. Published online June 23, 2023. <https://responsivegoverning.org/research/using-medicaid-automatic-voter-registration-to-address-persistent-voter-registration-problems-helping-the-national-voter-registration-act-achieve-its-potential>
20. Title I | Office of Direct Service and Contracting Tribes. Title I | Office of Direct Service and Contracting Tribes. Office of Direct Service and Contracting Tribes. Current as of 2023. <https://www.ihs.gov/odsct/title1/>
21. Martin A, Raja A, Meese H. Health care-based voter registration: a new kind of healing. *International Journal of Emergency Medicine.* Published online April 30, 2021. doi:<https://doi.org/10.1186/s12245-021-00351-y>
22. Cavell S. Why Gerrymandering Matters. Harvard University Press. July 9, 2018. Accessed May 28, 2023. https://harvardpress.typepad.com/hup_publicity/2018/07/why-gerrymandering-matters-allan-lichtman.html
23. Tausanovitch A and Root D. How Partisan Gerrymandering Limits Voting Rights. The Center for American Progress. July 8, 2020. Accessed May 28, 2023. <https://www.americanprogress.org/article/partisan-gerrymandering-limits-voting-rights/>
24. Study Finds Residents with Reduced Voter Access and in Gerrymandered States Have Worse Health Outcomes. Union of Concerned Scientists. Nov 7, 2019. Accessed on May 28, 2023. <https://www.ucsusa.org/about/news/study-finds-residents-reduced-voter-access-and-gerrymandered-states-have-worse-health>
25. Independent Redistricting Commissions. Campaign Law Center. Accessed on Sep 18, 2023. <https://campaignlegal.org/democracyu/accountability/independent-redistricting-commissions>

RELEVANT AMA POLICY

Support for Safe and Equitable Access to Voting H-440.805

1. Our AMA supports measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to: (a) extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail-in ballot postage that is free or prepaid by the government; (e) adequate resourcing of the United States Postal Service and election operational procedures; (f) improved access to drop off locations for mail-in or early ballots; and (g) use of a P.O. box for voter registration.
2. Our AMA opposes requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail.
3. Our AMA: (a) acknowledges voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric; (b) recognizes that gerrymandering which disenfranchises individuals/communities limits access to health care, including but not limited to the expansion of comprehensive medical insurance coverage, and negatively impacts health outcomes; and (c) will collaborate with appropriate stakeholders and provide resources to firmly establish a relationship between voter participation and health outcomes.

Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections D-65.982

Our AMA will: (1) study the rate of voter turnout in physicians, residents, fellows, and medical students in federal and state elections without regard to political party affiliation or voting record, as a step towards understanding political participation in the medical community; and (2) work with appropriate stakeholders to ensure that medical students, residents, fellows and physicians are allowed time to vote without penalty on Election Days.

AMERICAN MEDICAL ASSOCIATION MINORITY AFFAIRS SECTION

Resolution: 020
(A-24)

Introduced by: Minority Affairs Section

Subject: Voter Protections During and After Incarceration

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, our American Medical Association “acknowledges voting is a social determinant of
2 health and significantly contributes to the analyses of other social determinants of health as a
3 key metric”; and
4
5 Whereas, our AMA “recognizes that gerrymandering which disenfranchises
6 individuals/communities limits access to health care, including but not limited to the expansion
7 of comprehensive medical insurance coverage, and negatively impacts health outcomes”; and
8
9 Whereas, our AMA “will collaborate with appropriate stakeholders and provide resources to
10 firmly establish a relationship between voter participation and health outcomes”; and
11
12 Whereas, states that increase access to voting experience stronger public health outcomes and
13 better self-reported health status of individuals, while reduced access to voting has been linked
14 to poorer health outcomes and decreased health coverage¹⁻⁴; and
15
16 Whereas, barriers to voting in the United States have been associated with an increased
17 likelihood of not having access to health care coverage, thereby making the government less
18 accountable to the needs of its people⁵; and
19
20 Whereas, past expansion of suffrage resulted in improved maternal outcomes following
21 women’s suffrage in 1920 and reduced Black infant mortality correlated with the Voting Rights
22 Act of 1965, due to policies passed by legislators after the addition of these voters⁶; and
23
24 Whereas, 48 states currently restrict the right to vote of 4.6 million citizens convicted beyond a
25 misdemeanor, and many states permanently bar them from voting⁷⁻⁹; and
26
27 Whereas, the Fifth Circuit Court of Appeals ruled in August 2023 that a state violated the US
28 Constitution by inflicting cruel and unusual punishment by stripping the right to vote from
29 citizens who were convicted¹⁰; and
30
31 Whereas, since 2020, 7 states passed laws allowing citizens to vote while on parole⁷; and
32
33 Whereas, Black and Latine people are imprisoned 5 times and 1.3 times as much as white
34 people, respectively¹¹; and
35
36 Whereas, racial inequities in incarceration extend to voter rights for citizens who are
37 incarcerated as well, with 5.3% of Black incarcerated citizens banned compared to 1.5% of non-
38 Black incarcerated citizens⁹; and

1 Whereas, Black men comprise over one-third of the total disenfranchised population, are
 2 disproportionately impacted by policing and overrepresented in the carceral system, and could
 3 comprise as much as 40% in states that restrict incarcerated citizens' right to vote,
 4 demonstrating that restriction of voter rights in incarceration substantially contributes to the
 5 disenfranchisement of Black citizens¹²; therefore be it
 6

7 RESOLVED, that our American Medical Association support the continuation and restoration of
 8 voting rights for citizens currently or formerly incarcerated, support efforts ensuring their ability
 9 to exercise their vote during and after incarceration, and oppose efforts to restrict their voting
 10 rights (New HOD Policy); and be it further

11
 12 RESOLVED, that our AMA research the impact of disproportionate policing in and incarceration
 13 of minoritized communities on voter participation and health outcomes (Directive to Take
 14 Action); and be it further

15
 16 RESOLVED, that our AMA develop educational materials and programming to educate medical
 17 trainees and physicians on the impact of incarceration on voting and health outcomes. (Directive
 18 to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Date Received: 5/8/2024

REFERENCES

1. Schraufnagel S, Pomante li MJ, Li Q. Cost of Voting in the American States: 2020. *Election Law J Rules Polit Policy*. 2020;19(4):503-509. doi:10.1089/elj.2020.0666
2. Ganguly A, Morelli D, Bhavan KP. Voting As a Social Determinant of Health: Leveraging Health Systems to Increase Access to Voting. *Catal Non-Issue Content*. 2023;4(1). doi:10.1056/CAT.22.0368
3. Kim S, Kim C yup, You MS. Civic Participation and Self-rated Health: A Cross-national Multi-level Analysis Using the World Value Survey. *J Prev Med Pub Health*. 2015;48(1):18-27. doi:10.3961/jpmph.14.031
4. Pabayo R, Liu SY, Grinshteyn E, Cook DM, Muennig P. Barriers to Voting and Access to Health Insurance Among US Adults: A Cross-Sectional Study. *Lancet Reg Health - Am*. 2021;2:100026. doi:10.1016/j.lana.2021.100026
5. Brown CL, Raza D, Pinto AD. Voting, health and interventions in healthcare settings: a scoping review. *Public Health Rev*. 2020;41:16. doi:10.1186/s40985-020-00133-6
6. Ehlinger EP, Nevarez CR. Safe and Accessible Voting: The Role of Public Health. *Am J Public Health*. 2021;111(1):45-46. doi:10.2105/AJPH.2020.306011
7. Felon Voting Rights. Accessed August 27, 2023. <https://www.ncsl.org/elections-and-campaigns/felon-voting-rights>
8. Felony Disenfranchisement Laws (Map). American Civil Liberties Union. Accessed August 27, 2023. <https://www.aclu.org/issues/voting-rights/felony-disenfranchisement-laws-map>
9. Stewart CU Ryan Larson, Sarah Shannon and Robert. Locked Out 2022: Estimates of People Denied Voting Rights. The Sentencing Project. Published October 26, 2022. Accessed August 27, 2023. <https://www.sentencingproject.org/reports/locked-out-2022-estimates-of-people-denied-voting-rights>
10. Press TA. An appeals court blocks Mississippi's permanent ban on voting after certain felonies. *NPR*. <https://www.npr.org/2023/08/04/1192295228/mississippi-felon-voting-law-blocked>. Published August 4, 2023. Accessed August 27, 2023.
11. Nellis A. The Color of Justice: Racial and Ethnic Disparity in State Prisons. The Sentencing Project. Published October 13, 2021. Accessed August 27, 2023. <https://www.sentencingproject.org/reports/the-color-of-justice-racial-and-ethnic-disparity-in-state-prisons-the-sentencing-project>
12. Overview and Summary Losing the Vote: The Impact of Felony Disenfranchisement Laws in the United States. Accessed August 27, 2023. <https://www.hrw.org/legacy/reports98/vote/usvot98o.htm>
13. Homan PA, Brown TH. Sick And Tired Of Being Excluded: Structural Racism In Disenfranchisement As A Threat To Population Health Equity. *Health Affairs*. 2022;41(2):219-227. doi:10.1377/hlthaff.2021.01414

RELEVANT AMA POLICY

Mental Illness and the Right to Vote H-65.971

Our AMA will advocate for the repeal of laws that deny persons with mental illness the right to vote based on membership in a class based on illness.

Support for Safe and Equitable Access to Voting H-440.805

1. Our AMA supports measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to: (a) extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail-in ballot postage that is free or prepaid by the government; (e) adequate resourcing of the United States Postal Service and election operational procedures; (f) improved access to drop off locations for mail-in or early ballots; and (g) use of a P.O. box for voter registration.
2. Our AMA opposes requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail.
3. Our AMA: (a) acknowledges voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric; (b) recognizes that gerrymandering which disenfranchises individuals/communities limits access to health care, including but not limited to the expansion of comprehensive medical insurance coverage, and negatively impacts health outcomes; and (c) will collaborate with appropriate stakeholders and provide resources to firmly establish a relationship between voter participation and health outcomes.

Support for Democracy H-65.947

Our AMA: (1) unequivocally supports the democratic process, wherein representatives are regularly chosen through free and fair elections, as essential for maximizing the health and well-being of all Americans; (2) will strongly oppose attempts to subvert the democratic process; and (3) asserts that every candidate for political office and every officeholder in the public trust must support the democratic process and never take steps or support steps by others to subvert it.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 021
(A-24)

Introduced by: Minority Affairs Section

Subject: Opposition to Capital Punishment

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, the principle of medicine “to help and do no harm” is related to beneficence, which
2 speaks to the obligation of the physician to act for the benefit of the patient and remove
3 conditions that will cause harm, and nonmaleficence, which is concerned with weighing the
4 benefits and burdens of medical interventions and proceeding with the best choice for the
5 patient that minimizes harm and suffering;¹ and
6

7 Whereas, capital punishment, or the death penalty, is defined by the United States Bureau of
8 Justice Statistics as “the process of sentencing convicted offenders to death for the most
9 serious crimes (capital crimes) and carrying out that sentence” where the specific offenses are
10 “defined by statute and are prescribed by Congress or any state legislature”;² and
11

12 Whereas, forms of capital punishment used in the United States include electrocution, lethal
13 injection, and firing squad;^{3,4} and
14

15 Whereas, 24 individuals in 5 states (Texas, Oklahoma, Missouri, Alabama, and Florida) executed
16 in 2023;^{2,5} and
17

18 Whereas, supporters of capital punishment argue that the practice saves on costs of
19 incarceration, but these arguments have also proven to be categorically false, as many states
20 actively spend millions of additional dollars annually to uphold these policies;⁶⁻¹⁰ and
21

22 Whereas, 23 states have abolished capital punishment without significant changes in crime or
23 murder rates, challenging the argument that it effectively deters serious crimes;¹¹⁻¹⁷ and
24

25 Whereas, in response to drug shortages, manufacturing changes, high cost, and manufacturer
26 reluctance to sell drugs for execution, prisons are introducing novel forms of capital punishment
27 including nitrogen hypoxia and midazolam (in lieu of phenobarbital), in addition to attempts to
28 procure drugs for lethal injection from illegal and untraceable sources;¹⁸⁻²⁰ and
29

30 Whereas, current methods of capital punishment used in the United States have been
31 associated with severe, distressful symptoms, in addition to the inherent harm caused by the act
32 of capital punishment itself;²¹⁻²³ and
33

34 Whereas, nitrogen hypoxia is opposed as a use of euthanasia by the American Veterinary
35 Medical Association due to its ability to cause distress in nonhuman animals;²⁴ and
36

37 Whereas, the threshold for an acceptable amount of suffering in humans is widely considered to
38 be lower than for suffering in nonhuman animals;²⁵ and
39

40 Whereas, the AMA’s amicus brief in the 2018 Supreme Court case *Bucklew v. Precythe* relating

1 to novel forms of capital punishment states “Society wants to delude itself into a belief that
2 capital punishment no longer represents a weighted moral choice, but is now somehow
3 scientific—nearly antiseptic. This delusion, however, cheapens life and makes its extinction
4 easier. The medical profession, whose ‘essential quality’ is an interest in humanity and which
5 reveres human life should have no part in this charade.”;²⁶ and
6

7 Whereas, AMA Code of Medical Ethics Opinion 9.7.3 Capital Punishment states clearly that “as
8 a member of a profession dedicated to preserving life when there is hope of doing so, a
9 physician must not participate in a legally authorized execution”; and
10

11 Whereas, AMA Code 9.7.3 only addresses physician participation in executions and does not
12 address the AMA’s advocacy stance on capital punishment, so an attempt to change the AMA’s
13 advocacy stance on this issue does not require an amendment to the Code; therefore be it
14

15 RESOLVED, that our American Medical Association amend H-140.896, “Moratorium on Capital
16 Punishment,” by addition and deletion as follows:
17

18 **Opposition to Moratorium on Capital Punishment H-140.896**

19 Our AMA: (1) opposes all forms of ~~does not take a position~~ on
20 capital punishment; and (2) urges appropriate legislative and legal
21 authorities to continue to implement changes in the system of
22 administration of capital punishment, if used at all, and to promote
23 its fair and impartial administration in accordance with basic
24 requirements of due process.

25 (Modify Current HOD Policy)

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

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REFERENCES

1. Varkey B. Principles of Clinical Ethics and Their Application to Practice. Med Princ Pract. 2021;30(1):17-28. doi:10.1159/000509119
2. Bureau of Justice Statistics. Capital Punishment. Bureau of Justice Statistics. Published February 18, 2021. <https://bjs.ojp.gov/topics/corrections/capital-punishment>
3. Tarm M. Why executions by firing squad may be coming back in the US. AP News. Published March 24, 2023. <https://apnews.com/article/death-penalty-executions-firing-squads-idaho-74803c0de8a50a512bdb52dae4974570>
4. Death Penalty Information Center. Methods of Execution. Death Penalty Information Center. Published 2023. <https://deathpenaltyinfo.org/executions/methods-of-execution>
5. Cason M. Only 4 states besides Alabama have carried out executions in 2023. Al.com. Published December 1, 2023. Accessed March 4, 2024. <https://www.al.com/news/2023/12/only-4-states-besides-alabama-have-carried-out-executions-in-2023.html>
6. Death Penalty Cost. Amnesty International USA. Published June 26, 2023. Accessed March 1, 2024. [https://www.amnestyusa.org/issues/death-penalty/death-penalty-facts/death-penalty-cost/#:~:text=\(%24232.7%20million%20per%20year](https://www.amnestyusa.org/issues/death-penalty/death-penalty-facts/death-penalty-cost/#:~:text=(%24232.7%20million%20per%20year)
7. Death Penalty Information Center. Costs. Death Penalty Information Center. Published 2023. <https://deathpenaltyinfo.org/policy-issues/costs>
8. Death Penalty Information Center. Costs: Louisiana Spent \$7.7 Million on Death Penalty Defense in One Year. It Hasn't Executed Anyone in 13 Years. Death Penalty Information Center. Published March 27, 2023. <https://deathpenaltyinfo.org/news/costs-louisiana-spent-7-7-million-on-death-penalty-defense-in-one-year-it-hasnt-executed-anyone-in-13-years>
9. Death Penalty Information Center. State Studies on Monetary Costs. Death Penalty Information Center. Published 2022. <https://deathpenaltyinfo.org/policy-issues/costs/summary-of-states-death-penalty>
10. Yost D. 2022 Ohio Capital Crimes Annual Report. Ohio Attorney General's Office; 2023. Accessed March 1, 2024. <https://www.ohioattorneygeneral.gov/Files/Reports/Capital-Crimes-Annual-Reports/2022CapitalCrimesAnnualReport>
11. Oliphant SN. Estimating the effect of death penalty moratoriums on homicide rates using the synthetic control method. Criminology & Public Policy. 2022;21(4). doi:https://doi.org/10.1111/1745-9133.12601
12. Death Penalty Information Center. Murder Rate of Death Penalty States Compared to Non-Death Penalty States. Death Penalty Information Center. Published 2020. <https://deathpenaltyinfo.org/facts-and-research/murder-rates/murder-rate-of-death-penalty-states-compared-to-non-death-penalty-states>

13. Nagin DS. Deterrence in the Twenty-First Century. *Crime and Justice*. 2013;42(1):199-263. doi:<https://doi.org/10.1086/670398>
14. National Institute of Justice. Five Things about Deterrence; 2016:1-2. <https://www.ojp.gov/pdffiles1/nij/247350.pdf>
15. Parker B. Death Penalty Statutes and Murder Rates: Evidence From Synthetic Controls. *Journal of Empirical Legal Studies*. 2021;18(3):488-533. doi:<https://doi.org/10.1111/jels.12291>
16. Heflin J. The Impact of Execution Moratoriums on Homicide Rates. *Social Science Research Network*. 2023;(4525716).doi:<https://doi.org/10.2139/ssrn.4525716>
17. Amnesty International. Does the Death Penalty Deter Crime? Amnesty International; 2021. <https://www.amnesty.org/en/wp-content/uploads/2021/06/act500062008en.pdf>
18. Death Penalty Information Center. Arizona DoC Paid \$1.5 Million for Execution Drugs While Facing a Budget Crisis. Death Penalty Information Center. Published April 15, 2021. <https://deathpenaltyinfo.org/news/arizona-doc-paid-1-5-million-for-execution-drugs-while-facing-a-budget-shortfall>
19. Death Penalty Information Center. Overview of Lethal Injection Protocols. Death Penalty Information Center. Published 2024. <https://deathpenaltyinfo.org/executions/lethal-injection/overview-of-lethal-injection-protocols>
20. Fixler K. Idaho found lethal injection drugs for an execution. Here's how much they cost taxpayers. *Idaho Statesman*. <https://www.idahostatesman.com/news/northwest/idaho/article281926143.html>. Published December 15, 2023. Accessed March 1, 2024.
21. Caldwell N, Chang A, Myers J. Gasping For Air: Autopsies Reveal Troubling Effects Of Lethal Injection. NPR. Published September 21, 2020. <https://www.npr.org/2020/09/21/793177589/gasping-for-air-autopsies-reveal-troubling-effects-of-lethal-injection>
22. Thomson-DeVeaux A. Is The Firing Squad More Humane Than Lethal Injection? *FiveThirtyEight*. Published March 2, 2017. <https://fivethirtyeight.com/features/is-the-firing-squad-more-humane-than-lethal-injection/#:~:text=A%20study%20conducted%20in%201993>
23. Death Penalty Information Center. Description of Each Execution Method. Death Penalty Information Center. Published 2024. <https://deathpenaltyinfo.org/executions/methods-of-execution/description-of-each-method>
24. Leary S, Johnson C. AVMA Guidelines for the Euthanasia of Animals: 2020 Edition; Members of the Panel on Euthanasia AVMA Staff Consultants; 2020. <https://www.avma.org/sites/default/files/2020-02/Guidelines-on-Euthanasia-2020.pdf>
25. Wendler D. Degrees of Moral Status: The Problem of Relevance and the Need for a Threshold. *Erkenntnis*. Published online November 14, 2023. doi:<https://doi.org/10.1007/s10670-023-00737-9>
26. *Bucklew v. Precythe* (S.Ct.). American Medical Association. Published 2018. Accessed March 25, 2024. https://searchlhf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fcase%2FCase-Summary_Bucklew-v-Precythe.pdf

RELEVANT AMA Policy

H-140.896 Moratorium on Capital Punishment

Our AMA: (1) does not take a position on capital punishment; and (2) urges appropriate legislative and legal authorities to continue to implement changes in the system of administration of capital punishment, if used at all, and to promote its fair and impartial administration in accordance with basic requirements of due process. [Sub. Res. 8, A-01; Reaffirmation A-04; Reaffirmation A-07; Reaffirmed: CEJA Rep. 04, A-17]

Code of Medical Ethics 9.7.3 Capital Punishment

Debate over capital punishment has occurred for centuries and remains a volatile social, political, and legal issue. An individual's opinion on capital punishment is the personal moral decision of the individual. However, as a member of a profession dedicated to preserving life when there is hope of doing so, a physician must not participate in a legally authorized execution.

Physician participation in execution is defined as actions that fall into one or more of the following categories:

- (a) Would directly cause the death of the condemned.
- (b) Would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned.
- (c) Could automatically cause an execution to be carried out on a condemned prisoner. These include, but are not limited to:
 - (d) Determining a prisoner's competence to be executed. A physician's medical opinion should be merely one aspect of the information taken into account by a legal decision maker, such as a judge or hearing officer.
 - (e) Treating a condemned prisoner who has been declared incompetent to be executed for the purpose of restoring competence, unless a commutation order is issued before treatment begins. The task of re-evaluating the prisoner should be performed by an independent medical examiner.
 - (f) Prescribing or administering tranquilizers and other psychotropic agents and medications that

are part of the execution procedure.

- (g) Monitoring vital signs on site or remotely (including monitoring electrocardiograms).
- (h) Attending or observing an execution as a physician.
- (i) Rendering of technical advice regarding execution.

and, when the method of execution is lethal injection:

- (j) Selecting injection sites.
- (k) Starting intravenous lines as a port for a lethal injection device.
- (l) Prescribing, preparing, administering, or supervising injection drugs or their doses or types.
- (m) Inspecting, testing, or maintaining lethal injection devices.
- (n) Consulting with or supervising lethal injection personnel. 20

The following actions do not constitute physician participation in execution:

- (o) Testifying as to the prisoner's medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying as to medical diagnoses as they relate to the legal assessment of competence for execution.
- (p) Certifying death, provided that the condemned has been declared dead by another person.
- (q) Witnessing an execution in a totally nonprofessional capacity.
- (r) Witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a nonprofessional capacity.
- (s) Relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.
- (t) Providing medical intervention to mitigate suffering when an incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness.

No physician should be compelled to participate in the process of establishing a prisoner's competence or be involved with treatment of an incompetent, condemned prisoner if such activity is contrary to the physician's personal beliefs. Under those circumstances, physicians should be permitted to transfer care of the prisoner to another physician.

Organ donation by condemned prisoners is permissible only if:

- (u) The decision to donate was made before the prisoner's conviction.
- (v) The donated tissue is harvested after the prisoner has been pronounced dead and the body removed from the death chamber.
- (w) Physicians do not provide advice on modifying the method of execution for any individual to facilitate donation. [AMA Principles of Medical Ethics: I; Issued: 2016]

H-140.950 Physician Participation in Capital Punishment

Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed: Our AMA endorses the following: (1) Physician participation in evaluations of a prisoner's competence to be executed is ethical only when certain safeguards are in place. A physician can render a medical opinion regarding competency which should be merely one aspect of the information taken into account by the ultimate decision maker, a role that legally should be assumed by a judge or hearing officer. Prisoners' rights to due process at the competency hearings should be carefully observed. (2) When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner to restore competence unless a commutation order is issued before treatment begins. (3) If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. It will not always be easy to distinguish these situations from treatment for the purpose of restoring the prisoner's competence, and in particular, to determine when treatment initiated to reduce suffering should be stopped. However, there is no alternative at this time other than to rely upon the treating physician to exercise judgment in deciding when and to what extent treatment is necessary to reduce extreme suffering. The cumulative experience of physicians applying these principles over time may lead to future refinements. Treatment should be provided in a properly-secured, general medical or psychiatric facility, not

in a cell block. The task of re-evaluating the prisoner's competence to be executed should be performed by an independent physician examiner.

(4) Given the ethical conflicts involved, no physician, even if employed by the state, should be compelled to participate in the process of establishing a prisoner's competence to be executed if such activity is contrary to the physician's personal beliefs. Similarly, physicians who would prefer not to be involved with treatment of an incompetent, condemned prisoner should be excused or permitted to transfer care of the prisoner to another physician. [CEJA Rep. 6, A-95; Reaffirmation A-04; Reaffirmed: CEJA Rep. 8, A-14; Reaffirmed in lieu of Res. 7, A-14]

H-140.898 Medical Profession Opposition to Physician Participation in Execution

Our AMA strongly reaffirms its opposition to physician participation in execution. [Res. 10, A-02; Reaffirmation A-04; Reaffirmed: CEJA Rep. 8, A-14]

D-140.991 Continuing Efforts to Exclude Physicians from State Executions Protocols

Our AMA will remind all state medical societies to review their state execution statutes to ensure that physician participation is not required. [Res. 3, A-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: CEJA Rep. 01, A-20]

H-140.963 Secrecy and Physician Participation in State Executions

The AMA opposes any and all attempts either in state laws or in rules and regulations that seek to enable or require physician participation in legal executions and/or which protect from disclosure the identity of physicians participating or performing direct or ancillary functions in an execution. [Res. 6, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmation A-04; Reaffirmed: CEJA Rep. 8, A-14]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 022
(A-24)

Introduced by: Minority Affairs Section

Subject: Health and Racial Equity in Medical Education to Combat Workforce Disparities

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, achieving health equity requires valuing everyone equally with focused and ongoing
2 societal efforts to address avoidable inequalities, historical and contemporary injustices, and
3 social determinants of health — to eliminate disparities in health and health care¹; and
4

5 Whereas, the road to achieving health equity requires a diverse and equitable workforce that is
6 essential to optimizing health care access and the quality of patient care; and
7

8 Whereas, many barriers remain and unique challenges persist for some diverse groups
9 attempting to enter the medical field and successfully matriculate through the profession of
10 medicine. This is strongly indicated in demographics of currently practicing physicians; and
11

12 Whereas, among active physicians, 56.2% identified as White, 17.1% identified as Asian, 5.8%
13 identified as Hispanic, and ~5.0% identified as Black or African American²; and
14

15 Whereas, in 2015, the percentage of matriculants from racial/ethnic groups underrepresented in
16 medicine remained low: Black at 6.5%, Hispanic, Latino, or Spanish at 6.4% and American
17 Indian at 0.3%. The data is especially concerning as the Hispanic population is expected to
18 increase by 26% by 2030;^{3,4} and
19

20 Whereas, black people account for roughly 13 percent of the US population, they make up only
21 5.5 percent of the physician workforce and 7.3 percent of medical students. In 1940, when
22 9.7% of the total population was Black, 2.8% of physicians at that time were Black. These
23 representational disparities have not changed appreciably in decades;^{3,4} and
24

25 Whereas, additional barriers exists for certain minority groups. Black trainees face higher rates
26 of remedial intervention and dismissal from their programs than their White counterparts, thus
27 leading to concerns of over-policing in medical education; and
28

29 Whereas, over-policing in education begins as early as primary school and continues through
30 high school, college, medical education, and into the workforce. In graduate medical
31 education, biased scrutiny begins with the use of metrics that disadvantage Black applicants in
32 the residency selection process;⁵ and
33

34 Whereas, black residents account for about 5% of all residents, yet they accounted for nearly
35 20% of those who were dismissed in 2015;⁷and
36

37 Whereas, increased scrutiny and expectations can lead to damaging effects such as symptoms
38 of depression and anxiety among minority students, residents and physicians. This often leads

1 to reducing practice hours or leaving medicine, creating even greater workforce
2 disparities;⁵ therefore be it

3
4 RESOLVED, that our American Medical Association further study and track the prevalence of
5 attending physicians' and trainees' dismissals and remedial interventions, based on race,
6 gender, and ethnicity as well as the disproportionate impacts this has on workforce disparities
7 (Directive to Take Action); and be it further

8
9 RESOLVED, that our AMA engage stakeholders to study and report back how to effectively
10 support underrepresented groups in medicine to level the playing field for those most affected
11 by bias and historical harms (Directive to Take Action); and be it further

12
13 RESOLVED, that our AMA work with stakeholders to make recommendations on a review and
14 appeals process that will enable physicians and trainees to receive a fair and equitable due
15 process in defense of alleged shortcomings. (Directive to Take Action)

16
Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/8/2024

REFERENCES

1. U.S. Department of Health and Human Services. (n.d.). Achieving health equity. Healthy People 2030. Retrieved from <https://health.gov/healthypeople/priority-areas/health-equity-healthy-people-2030#:~:text=Achieving%20health%20equity%20requires%20valuing,in%20health%20and%20health%20care>
2. Association of American Medical Colleges. (2018). Percentage of All Active Physicians by Race/Ethnicity: 2018. Retrieved from <https://www.aamc.org/data-reports/workforce/data/figure-18-percentage-all-active-physicians-race/ethnicity-2018#:~:text=Among%20active%20physicians%2C%2056.2%25%20identified,subgroup%20after%20White%20and%20Asian>
3. Johnson, T. (2023, March 23). Analysis: Racism in academic medicine is hindering progress toward health equity. California Health Report. Retrieved from <https://www.calhealthreport.org/2023/03/23/analysis-racism-in-academic-medicine-is-hindering-progress-toward-health-equity/>
4. University of California, Los Angeles. (n.d.). Proportion of Black Physicians Shows Little Change. Retrieved from <https://newsroom.ucla.edu/releases/proportion-black-physicians-little-change>
5. Health Care News. (n.d.). Dismantling the overpolicing of Black residents. Retrieved from <https://hcn.health/hcn-trends-story/dismantling-the-overpolicing-of-black-residents/>
6. Commonwealth Fund. (2024, February). Revealing disparities: Health care workers' observations. Retrieved from <https://www.commonwealthfund.org/publications/issue-briefs/2024/feb/revealing-disparities-health-care-workers-observations>
7. Ryan, P. (2022, June 20). Black doctors forced out of training programs at far higher rates than white residents. STAT. Retrieved from <https://www.statnews.com/2022/06/20/black-doctors-forced-out-of-training-programs-at-far-higher-rates-than-white-residents/>
8. Ryan, P. (2022, June 21). What will it take to level the playing field for Black residents? STAT. Retrieved from <https://www.statnews.com/2022/06/21/what-will-it-take-to-level-the-playing-field-for-black-residents/>
9. Jha, A. K. (2022). Structural racism and inequity in medicine. *New England Journal of Medicine*, 386(14), 1353-1356. doi: 10.1056/NEJMp2304559
10. Wadhwa, R. K., & Yeh, R. W. (2022). Addressing racism in medicine — toward a more equitable future. *New England Journal of Medicine*, 386(18), 1743-1746. doi: 10.1056/NEJMp2306195

RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support

individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations. [CME Rep. 1, I-06 Reaffirmed: CME Rep. 7, A-08 Reaffirmed: CCB/CLRPD Rep. 4, A-13 Modified: CME Rep. 01, A-16 Reaffirmation A-16 Modified: Res. 009, A-21 Modified: CME Rep. 5, A-21]

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its 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; (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; (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; (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty; (8) recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts; and (9) collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure. [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 Appended: Res. 319, A-22 Modified: Res. 319, A-23]

Diversity in the Physician Workforce and Access to Care D-200.982

Our AMA will: (1) continue to advocate for programs that promote diversity in the US medical workforce, such as pipeline programs to medical schools; (2) continue to advocate for adequate funding for federal and state programs that promote interest in practice in underserved areas, such as those under Title VII of the Public Health Service Act, scholarship and loan repayment programs under the National Health Services Corps and state programs, state Area Health Education Centers, and Conrad 30, and also encourage the development of a centralized database of scholarship and loan repayment programs; and (3) continue to study the factors that support and those that act against the choice to practice in an underserved area, and report the findings and solutions at the 2008 Interim Meeting. [CME Rep. 7, A-08 Reaffirmation A-13 Reaffirmation: A-16 Reaffirmed: CME Rep. 5, A-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 unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population.
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 Modified: Res. 320, A-23]

Reference Committee A

Report(s) of the Council on Medical Service

- 02 Improving Affordability of Employment-Based Health Coverage
- 03 Review of Payment Options for Traditional Healing Services
- 07 Ensuring Privacy in Retail Health Care Settings
- 08 Sustainable Payment for Community Practices

Resolutions

- 101 Infertility Coverage
- 102 Medicaid & CHIP Benefit Improvements
- 103 Medicare Advantage Plans
- 104 Medicaid Estate Recovery Reform
- 105 Medigap Patient Protections
- 106 Incorporating Surveillance Colonoscopy into the Colorectal Cancer Screening Continuum
- 107 Requiring Government Agencies to Contract Only with Not-For-Profit Insurance Companies
- 108 Requiring Payments for Physician Signatures
- 109 Coverage for Dental Services Medically Necessary for Cancer Care
- 110 Coverage for Shoes and Shoe Modifications for Pediatrics Patients Who Require Lower Extremity Orthoses
- 111 Protections for “Guarantee Issue” of Medigap Insurance and Traditional Medicare
- 112 Private and Public Insurance Coverage for Adaptive Sports Equipment including Prostheses and Orthoses
- 113 Support Prescription Medication Price Negotiation
- 114 Breast Cancer Screening/Clinical Breast Exam Coverage
- 115 Payments by Medicare Secondary or Supplemental plans

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (A-24)
Improving Affordability of Employment-Based Health Coverage
(Resolution 103-A-23)
(Reference Committee A)

EXECUTIVE SUMMARY

To expand coverage to all Americans, the American Medical Association has long advocated for the promotion of individually selected and owned health insurance; the maintenance of the safety net that Medicaid and CHIP provide; and the preservation of employer-sponsored coverage to the extent the market demands it. As highlighted in this report, ESI remains the dominant source of health coverage in this country and most people seem satisfied with it. However, because of shortcomings inherent to the ESI system—namely equity and affordability concerns, and rising costs—it does not work well for everyone. Some workers, especially those with lower incomes, may be contributing more for an employer plan than they would pay for subsidized marketplace coverage because a provision in the Affordable Care Act (ACA), known as the firewall, prohibits workers with affordable ESI offers from receiving premium tax credits to purchase marketplace plans.

The Council's main concerns about eliminating the firewall abruptly and in full include the potential impacts on ESI stability, which may not be wholly understood, and potential costs to the federal government, since allowing all ESI enrollees access to ACA marketplace subsidies might prove to be prohibitively expensive. Instead, the Council supports incrementally reducing the affordability threshold so that it benefits workers most in need, and then monitoring the effects of this change over time. Accordingly, the Council recommends amending Policy H-165.828[1] to support lowering the threshold that determines whether an employee's premium contribution is affordable to the maximum percentage of income they would be required to pay, after accounting for subsidies, towards premiums for an ACA benchmark plan (second-lowest-cost silver plan).

Additional recommendations are intended to strengthen the quality and affordability of ESI. To help address the needs of ESI enrollees with lower incomes, who are more likely to report difficulties covering the costs of medical care and who may not know if they are firewalled, the Council recommends amending Policy H-165.843 to encourage employers to 1) implement programs that improve affordability of ESI premiums and/or cost-sharing; 2) provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of ESI; and 3) provide employees with information regarding available health plan options, including the plans' cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs. The Council also recommends supporting efforts to strengthen employer coverage offerings, such as by requiring a higher minimum actuarial value or more robust benefit standards.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-24

Subject: Improving Affordability of Employment-Based Health Coverage
(Resolution 103-A-23)

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee A

1 At the June 2023 Annual Meeting, the House of Delegates referred Resolution 103, which was
2 sponsored by the Medical Student Section and asked the American Medical Association (AMA) to:
3 (1) recognize the inefficiencies and complexity of the employer-sponsored health insurance system
4 and the existence of alternative models that better align incentives to facilitate access to high
5 quality health care; (2) support movement toward a health care system that does not rely on
6 employer-sponsored health insurance and enables universal access to high quality health care; (3)
7 amend Policy H-165.828[1], “Health Insurance Affordability,” by addition and deletion to read as
8 follows:

9
10 Health Insurance Affordability H-165.828[1]

11 ~~1. Our AMA supports modifying the eligibility criteria for premium credits and cost sharing~~
12 ~~subsidies for those offered employer-sponsored coverage by lowering the threshold that determines~~
13 ~~whether an employee's premium contribution is affordable to that which applies to the exemption~~
14 ~~from the individual mandate of the Affordable Care Act (ACA). Our AMA advocates for the~~
15 ~~elimination of the employer-sponsored insurance firewall such that no individual would be~~
16 ~~ineligible for premium tax credits and cost-sharing assistance for marketplace coverage solely on~~
17 ~~the basis of having access to employer-sponsored health insurance.~~

18
19 and (4) amend Policy H-165.823[2] by deletion to read as follows:

20
21 Options to Maximize Coverage Under the AMA Proposal for Reform H-165.823[2]

22 2. Our AMA will advocate that any public option to expand health insurance coverage must meet
23 the following standards:

24 a. The primary goals of establishing a public option are to maximize patient choice of health plan
25 and maximize health plan marketplace competition.

26 ~~b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is~~
27 ~~restricted to individuals without access to affordable employer-sponsored coverage that meets~~
28 ~~standards for minimum value of benefits.~~

29 ~~b~~e. Physician payments under the public option are established through meaningful negotiations
30 and contracts. Physician payments under the public option must be higher than prevailing Medicare
31 rates and at rates sufficient to sustain the costs of medical practice.

32 ~~c~~d. Physicians have the freedom to choose whether to participate in the public option. Public option
33 proposals should not require provider participation and/or tie participation in Medicare, Medicaid
34 and/or any commercial product to participation in the public option.

35 ~~d~~e. The public option is financially self-sustaining and has uniform solvency requirements.

1 ef. The public option does not receive advantageous government subsidies in comparison to those
 2 provided to other health plans.

3 fg. The public option shall be made available to uninsured individuals who fall into the “coverage
 4 gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but
 5 below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal
 6 cost.

7
 8 The Board of Trustees assigned this item to the Council on Medical Service for a report back to the
 9 House of Delegates. This report discusses policy options for addressing employer-sponsored health
 10 insurance (ESI) affordability, summarizes relevant AMA policy, and presents recommendations.

11
 12 **BACKGROUND**

13
 14 Almost a decade and a half after enactment of the ACA, ESI continues to be the dominant source
 15 of health coverage for Americans under 65 years of age. In 2023, the Congressional Budget Office
 16 (CBO) estimated that 155 million people under age 65—or 57.3 percent of the nonelderly
 17 population—had health insurance coverage through their employer, a number the CBO predicts
 18 will remain steady through 2025 and increase in the years thereafter.¹ Although ESI is the most
 19 common type of health insurance, coverage varies significantly by income as well as race and
 20 ethnicity. While nearly all individuals with incomes at or above 400 percent of the federal poverty
 21 level (FPL) have ESI, it covers just over half of people with incomes between 150 to 400 percent
 22 FPL and fewer than one-quarter of individuals with incomes below 150 percent FPL.²
 23 Additionally, larger percentages of white and Asian people have ESI while individuals who are
 24 African American and Latino are less likely to have employer-based coverage, raising equity
 25 concerns.^{3,4}

26
 27 Overall, most Americans appear satisfied with employment-based coverage.⁵ According to KFF’s
 28 survey of consumer experiences with health insurance, in 2023, 80 percent of adults with ESI and
 29 73 percent of those with marketplace coverage rated their health coverage as “excellent” or “good”
 30 although people in poorer health gave more negative ratings across all plan types. Regardless of
 31 health status, enrollees in marketplace plans were most likely to rate their experiences with health
 32 insurance as fair or poor.⁶ Ninety-three percent of workers responding to a 2022 poll sponsored by
 33 the U.S. Chamber of Commerce expressed high rates of satisfaction with ESI, with a large majority
 34 (89 percent) expressing a preference for ESI over other types of coverage.⁷ Eighty percent of
 35 respondents to this survey ranked health insurance as the most important workplace benefit
 36 provided to them, and a majority cited “affordability” and “high quality” as ESI’s most critical
 37 features.⁸

38
 39 Although ESI is popular, it has become increasingly costly for employers and employees,
 40 especially small firms and lower-income workers. According to 2023 data from the KFF’s
 41 Employer Health Benefits Survey:

- 42
- 43 • Fifty-three percent of all firms offered health benefits, down slightly from five years ago (57
 - 44 percent). Almost all (98 percent) large employers (those with 200 or more workers) offered
 - 45 coverage to at least some workers while just over half (53 percent) of smaller firms (those with
 - 46 three to 199 workers) did so.
 - 47 • Seventy-five percent of eligible employees took up coverage when it was offered to them, a
 - 48 slight decrease from 2013 (80 percent) and a more sizeable decrease from 2003 (84 percent).⁹
 - 49 • Annual health insurance premiums averaged \$8,435 for individual coverage and \$23,968 for
 - 50 family coverage, a seven percent increase over 2022. Notably, premiums for family coverage

1 have increased on average 22 percent since 2018 and 47 percent since 2013. Workers pay, on
 2 average, \$6,575 annually toward the cost of family premiums.

- 3 • Most (77 percent) firms offered only one type of plan, and PPOs were the most common plan
 4 type offered. Large employers were more likely than smaller firms to offer more than one
 5 plan.¹⁰

6
 7 In addition to premium contributions, most workers with ESI are responsible for cost-sharing
 8 expenses, including plan deductibles, copayments, and coinsurance. According to KFF's 2023
 9 Employer Health Benefits Survey, the average annual deductible for employees with single
 10 coverage was \$1,735, a figure that has increased more than 50 percent over the course of 10
 11 years.¹¹ Overall, nearly a third of employees had plan deductibles of \$2,000 or more, including
 12 almost half (47 percent) of workers at small firms, whose average annual deductible was \$2,434
 13 compared to \$1,478 for employees of larger firms.¹²

14
 15 ESI Affordability

16
 17 KFF has also highlighted the lack of affordable family coverage options for workers at smaller
 18 firms employing fewer than 200 people. These employees pay on average \$8,334 towards family
 19 coverage premiums each year with a quarter paying at least \$12,000 annually, not including
 20 deductibles and other cost-sharing expenses.¹³ A KFF analysis of data from its 2023 survey of
 21 consumer experiences with health insurance found that adults with incomes below 200 percent FPL
 22 who have ESI were significantly more likely than higher-income peers to report difficulties paying
 23 for medical care; treatment delays and declines in health due to insurance problems, such as prior
 24 authorization; dissatisfaction with the availability and quality of health providers in their plan's
 25 network; and more difficulty comparing plans and signing up for coverage.¹⁴

26
 27 Several analyses have pointed out that workers with lower incomes are disproportionately
 28 burdened by ESI costs and usually pay a greater share of income toward employer plan premiums
 29 and other out-of-pocket expenses.^{15 16 17} KFF research from 2022 found that, on average, families
 30 with incomes below 200 percent FPL pay approximately 10.4 percent of income toward health care
 31 premiums and out-of-pocket expenses (7.7 percent for premiums) while those with incomes at or
 32 above 400 percent FPL pay about 3.5 percent toward premiums and medical expenses (2.3 percent
 33 for premiums).¹⁸ More workers (over 20 percent, according to a 2019 KFF survey)¹⁹ are covered
 34 by high-deductible plans, which can present additional challenges to lower-income employees even
 35 if a health savings account or health reimbursement account option is available to them. Though
 36 employers could utilize health benefit design strategies to address affordability issues facing lower-
 37 income workers, few seem to do so; in 2022, 10 percent of large firms reportedly had programs that
 38 lowered premium costs for lower-income employees while only five percent reported programs to
 39 lower their cost-sharing expenses.²⁰ COBRA coverage may also be too costly for some workers
 40 who are leaving a job.

41
 42 Though many workers mistakenly think otherwise, they—not the firms they work for—pay the
 43 majority of ESI costs, both directly through contributions and indirectly through wage adjustments
 44 made to cover employers' health care costs.²¹ Building on the literature linking growth in health
 45 insurance costs to stagnant wages, a 2023 *JAMA* analysis suggests a likely association between
 46 increased premium costs for workers with ESI family coverage and decreased earnings and
 47 increased income inequality.²² Because workers earning lower wages contribute a greater share of
 48 income toward ESI premiums, the analysis posits that making employer plans more affordable for
 49 lower-wage workers could help address earnings inequality. This study also identified large
 50 disparities in premium costs as a percentage of income by race (African American and Latino
 51 families paid higher percentages of earnings toward premium costs than white families), and found

1 that over 30 years, families with ESI may have cumulatively lost, on average, more than \$125,000
 2 in earnings due to increases in premium costs.²³

3 ACA Provisions on Affordability and Employer Shared Responsibility
 4

5 Under the ACA, individuals are not eligible for marketplace premium tax credits if they are eligible
 6 for “minimum essential coverage,” which is broadly defined to include Medicare, Medicaid, and
 7 other public programs as well as ESI. Accordingly, individuals with offers of coverage from an
 8 employer do not qualify for ACA marketplace subsidies unless their ESI offer is deemed either
 9 unaffordable or inadequate. In 2023, an employer plan was considered unaffordable if an
 10 employee’s premium contribution exceeded 9.12 percent of that person’s household income. This
 11 percentage threshold is adjusted annually for inflation and is 8.39 percent in 2024.²⁴ To be
 12 considered adequate, a plan must cover at least 60 percent of average costs (actuarial value);
 13 anything less is deemed inadequate.²⁵ The ACA provision making workers with affordable and
 14 adequate ESI offers ineligible to receive advance premium tax credits to purchase marketplace
 15 coverage is colloquially referred to as “the firewall.” This affordability threshold was established to
 16 address multiple concerns with the landmark legislation; namely, to prevent disruption to the ESI
 17 market and prevent prohibitive increases in federal spending (for marketplace subsidies) while
 18 preserving ESI’s position as the principal source of health coverage in this country.
 19

20 As explained in a [2014 Council on Medical Service Report](#) on the future of ESI, the ACA aimed to
 21 build upon the ESI framework and provide low-income, non-elderly individuals without access to
 22 ESI with either Medicaid coverage or subsidized private coverage offered through the nongroup
 23 marketplace. As such, provisions in the ACA statute included incentives and penalties intended to
 24 prevent disruption to the ESI market. For example, to incentivize employers to continue offering
 25 coverage, the ACA contained an “employer shared responsibility” provision, also called the
 26 “employer mandate,” which requires employers with 50 or more full-time employees to either offer
 27 affordable minimum essential coverage to full-time employees and their dependents or pay a
 28 penalty to the Internal Revenue Service (IRS).²⁶ Under this provision, employers face two potential
 29 penalties:²⁷
 30

- 31 • If an employer does not offer minimum essential coverage to at least 95 percent of its full-
 32 time employees and dependents, and at least one employee receives a premium tax credit
 33 for coverage offered through an ACA exchange, the employer faces a penalty that is based
 34 on all full-time employees (except 30), including those who have ESI or coverage from
 35 another source. In 2024, the penalty is \$2,970 per employee.²⁸
- 36 • If an employer offers coverage to at least 95 percent of its employees but at least one
 37 employee obtains a premium tax credit for ACA coverage due to the employer’s coverage
 38 not being “affordable” or “adequate,” the employer must pay a penalty for each employee
 39 who receives the premium tax credit. In 2024, the penalty is \$4,460 per employee.²⁹
 40

41 AMA Policy on the ACA Affordability Threshold
 42

43 In the early years of ACA implementation, a [2015 Council on Medical Service report](#) on health
 44 insurance affordability recommended making changes to how affordable coverage is defined under
 45 the law in order to provide more workers and their families with access to marketplace plans when
 46 those plans are more affordable than employer plans. This report established Policy H-165.828,
 47 which included several provisions calling for the ACA’s “family glitch” to be fixed and capping
 48 the tax exclusion for ESI as a funding stream to improve insurance affordability. Policy H-
 49 165.828[1] as originally written (prior to being amended in 2021) established AMA support for:
 50

1 ... modifying the eligibility criteria for premium credits and cost-sharing subsidies for those
 2 offered ESI by lowering the threshold that determines whether an employee’s premium
 3 contribution is affordable to that which applies to the exemption from the individual mandate
 4 of the ACA.

5
 6 In 2015 when this policy was adopted, individuals were deemed exempt from the ACA’s individual
 7 mandate—which was repealed in 2017—if the lowest-priced coverage available to them cost more
 8 than 8.05 percent of their household income. The same year, individuals with employer coverage
 9 offers were eligible for ACA marketplace plan premium tax credits if their ESI premium
 10 contributions exceeded 9.56 percent of income. The aforementioned Policy H-165.828[1] was
 11 crafted to align the definitions of affordability with respect to being exempt from the individual
 12 mandate (>8.05 percent) and premium tax credit eligibility for individuals with ESI offers (>9.56
 13 percent).

14
 15 Policy H-165.828[1] was amended via adoption of the recommendations in a [2021 Council on](#)
 16 [Medical Service report](#) to address new inconsistencies between the definition of affordability
 17 pertaining to premium tax credit eligibility and provisions in the American Rescue Plan Act of
 18 2021 (ARPA), which extended eligibility for premium subsidies to people with incomes greater
 19 than 400 percent FPL and capped premiums for those with the highest incomes at 8.5 percent of
 20 their income. ARPA increased the generosity of premium tax credits and lowered the cap on the
 21 percentage of income individuals are required to pay for premiums of the benchmark (second-
 22 lowest-cost silver) plan for everyone. At the time the report was written, in 2021, employer
 23 coverage with an employee share of the premium less than 9.83 percent of income was considered
 24 “affordable.” To open the door to premium tax credit eligibility to individuals with ESI premiums
 25 that were above the maximum affordability threshold applied to subsidized marketplace plans,
 26 Policy H-165.828[1] was amended to establish AMA support for:

27
 28 ... modifying the eligibility criteria for premium credits and cost-sharing subsidies for
 29 those offered ESI by lowering the threshold that determines whether an employee’s
 30 premium contribution is affordable to the level at which premiums are capped for
 31 individuals with the highest incomes eligible for subsidized ACA coverage.

32
 33 Federal Subsidies for ACA Premium Tax Credits/Cost-Sharing and ESI Tax Benefits

34
 35 In 2023, the federal government subsidized coverage obtained through the ACA marketplaces and
 36 the Basic Health Program (BHP) at a cost of \$92 billion.³⁰ This figure includes ARPA federal
 37 subsidy enhancements for premium tax credits and cost-sharing reductions that were extended
 38 through 2025 by the Inflation Reduction Act (IRA). Prior to ARPA, required premium contribution
 39 percentages ranged from about two percent of household income for people with poverty level
 40 income to nearly 10 percent of income for people with incomes between 300 to 400 percent FPL;
 41 people earning more than 400 percent FPL were not eligible for premium tax credits.³¹ This year,
 42 as shown in Table 1, required premium contribution percentages range from zero for people with
 43 less than 150 percent FPL to 8.5 percent for those making around 400 percent FPL or more.

44
 45 Table 1: Required Individual Contribution Percentage for 2024^{32,33}

<u>Household income percentage of Federal poverty line:</u>	<u>% at start of range</u>	<u>% at top of range</u>
Less than 150%	0.00%	0.00%
At least 150% but less than 200%	0.00%	2.00%
At least 200% but less than 250%	2.00%	4.00%
At least 250% but less than 300%	4.00%	6.00%

At least 300% but less than 400%	6.00%	8.50%
At least 400% and higher	8.50%	8.50%

1 Premium tax credits for ACA marketplace coverage are calculated by subtracting the required
 2 contribution from the actual cost of the “benchmark” plan, though the credit can be applied toward
 3 any marketplace plan except catastrophic coverage.³⁴ People with incomes below 250 percent FPL
 4 also receive subsidies for cost-sharing expenses that are based on income, so that people with
 5 incomes between 100 and 150 percent FPL receive the most generous subsidies.³⁵ These cost-
 6 sharing reductions are only available to those enrolled in silver plans. According to the CBO, in
 7 2023 the average federal subsidy per ACA marketplace/BHP enrollee was \$5,990.³⁶ The range of
 8 subsidy amounts is considerable, with small subsidy amounts provided to people with incomes
 9 around 400 or more percent of the FPL and subsidies worth around \$15,000 for families with the
 10 lowest incomes.

11
 12 The federal government subsidizes ESI via tax benefits provided to employers and employees that
 13 exclude premium contributions from federal income and payroll taxes. The amount of an
 14 individual’s subsidy depends on that person’s marginal tax rate that would be owed if employer-
 15 paid premiums were taxed as wages. Accordingly, people with greater incomes and higher
 16 marginal tax rates receive larger federal ESI subsidies than people with lower-incomes and lower
 17 tax rates.³⁷ According to the CBO, the average federal subsidy per ESI enrollee in 2023 was
 18 \$2,170.³⁸

19
 20 In part due to the enhanced subsidies for marketplace enrollees established by ARPA and extended
 21 by the IRA, several analysts have observed the growing disparity between federal subsidies that
 22 help defray ACA marketplace plan costs, and subsidies for ESI coverage. To illustrate this
 23 expanding gap, a 2024 American Enterprise Institute (AEI) paper calculated the value of subsidies
 24 that would be received by a family of four with \$75,000 in income, depending on whether they
 25 purchased ESI or marketplace coverage. According to AEI, if the family enrolled in an employer-
 26 based plan, their tax subsidy would be around \$4,100, compared to the more than \$15,000 in
 27 federal premium subsidies the family would be eligible for if enrolled in a marketplace plan.³⁹
 28 Other analyses have noted that workers with lower incomes may be contributing more for an
 29 employer-based plan than they would pay for coverage under a subsidized marketplace plan, and
 30 that it would be financially advantageous for these workers to move to the marketplace.⁴⁰

31
 32 Some employees who would be financially incentivized to enroll in a marketplace plan if the
 33 firewall is repealed might opt to retain ESI coverage if they are satisfied with their plan and able to
 34 see the physicians they want in a timely manner. The Centers for Medicare & Medicaid Services
 35 (CMS) has previously acknowledged the proliferation of narrow networks among ACA exchange
 36 plans, and several studies have demonstrated varying degrees of challenges facing marketplace
 37 enrollees attempting to access in-network providers, most commonly mental health specialists. A
 38 2020 *JAMA* study found that provider networks were broader in ESI plans and narrower in
 39 marketplace plans but that networks may also be limited in lower-quality employer plans.⁴¹ The
 40 Council has previously observed that, while marketplace plans may be attractive to some people
 41 because their premium prices are lower, purchasers may not be aware that a plan’s provider
 42 network could be narrower and that they may have trouble getting needed care from in-network
 43 physicians, hospitals, and other providers. Therefore, some workers with ESI coverage who would
 44 become newly eligible for marketplace subsidies if the firewall is repealed may decide to keep their
 45 employer plan to avoid possible care disruptions and to preserve relationships with their treating
 46 physicians. Depending on income and a range of other factors, this could be true for some
 47 employees who utilize more services and medications or who have a family member on their plan
 48 who has a health condition that requires timely access to specialty care.

1 POLICY OPTIONS ADDRESSING ESI AFFORDABILITY

2
 3 During the development of this report, the Council reviewed papers from a broad spectrum of
 4 organizations and also met with subject matter experts who suggested a range of approaches to
 5 improving affordability in ESI and nongroup markets. Review of the literature uncovered a handful
 6 of data analyses and a range of conflicting opinions on the best way forward. The studies generally
 7 agreed that lifting the firewall would increase access to lower cost insurance for people with low
 8 incomes. However, they differed in their assessment of the percent of the population that would
 9 move from ESI to the ACA marketplace, the impact of employer behavior, and their willingness to
 10 support increased federal health spending. These studies are summarized below in alphabetical
 11 order.

12
 13 *American Enterprise Institute (AEI)*: A 2020 paper published by AEI recognizes both the value of
 14 ESI to many Americans as well as its flaws, including rising costs for both employers and
 15 employees. AEI asserts that ESI is worth preserving and suggests tax reforms as the centerpiece of
 16 a framework for a more stable ESI system, including the provision of a tax benefit for employers
 17 that would be applied to employee premiums. According to AEI, such firm-level tax credits could
 18 provide greater support to lower-income employees but less support to those with higher
 19 incomes.⁴²

20
 21 *Bipartisan Policy Center (BPC)*: A 2022 BPC report recognizes that ESI is less affordable for
 22 lower-wage workers but suggests that fully eliminating the firewall would be quite costly for the
 23 federal government. Instead, BPC recommends that Congress adjust the affordability threshold to
 24 align with the percentage cap on premium contributions for marketplace plans.⁴³

25
 26 *Center on Budget and Policy Priorities (CBPP)*: A 2019 CBPP analysis acknowledged that
 27 eliminating the firewall would improve equity but concluded that a full repeal would be too costly
 28 to recommend. Instead, the CBPP suggested strengthening the standards for employer coverage
 29 offers, such as by raising the minimum value standard (from 60 to 70 percent) or establishing more
 30 robust benefit standards for ESI plans.⁴⁴

31
 32 *Commonwealth Fund*: A 2020 analysis found that, depending on marketplace subsidy amounts in
 33 place, between six and 13 percent of people with ESI would pay lower premium amounts if they
 34 were able to switch to marketplace plans. Importantly, the paper pointed out that people with the
 35 lowest incomes would benefit the most from lower marketplace premiums, as would African
 36 American, Latino, American Indian and Alaska Native individuals. According to the brief, much is
 37 unknown about potential employer responses to elimination of the firewall, including whether
 38 firms will incentivize sicker workers to move to exchange plans or stop offering coverage
 39 altogether.⁴⁵

40
 41 A 2024 Commonwealth Fund paper on automatic enrollment in health insurance posits that 1.2
 42 million people with incomes below 150 percent of FPL and 6.5 million people with income
 43 between 150 percent and 200 percent of FPL would become eligible for marketplace subsidies if
 44 the firewall were eliminated. The analysis states that “most” of these newly eligible individuals
 45 currently have ESI although some are paying full premiums for nongroup plans.⁴⁶

46
 47 *Congressional Budget Office (CBO)*: In 2020, the CBO estimated that approximately 25 percent of
 48 workers with ESI would become eligible for marketplace subsidies if the firewall was repealed. For
 49 20 percent of those newly eligible, post-subsidy premiums for marketplace plans would be lower
 50 than ESI premiums, thus making the nongroup market an attractive option. The CBO maintained

1 that, although firms would respond differently to a lifting of the firewall, most of the savings
 2 incurred would likely be passed on to employees and adverse selection would be minimized.⁴⁷
 3 *Urban Institute*: Data presented to the Council but not yet published at the time this report was
 4 written estimated that eliminating the firewall would decrease ESI coverage by two percent or less,
 5 increase federal spending by about \$20 billion, decrease the number of uninsured individuals,
 6 slightly increase provider revenue, and decrease employer spending and household spending.⁴⁸
 7

8 RELEVANT AMA POLICY
 9

10 Policy H-165.829 encourages the development of state waivers to develop and test different models
 11 for transforming employer-provided health insurance coverage, including giving employees a
 12 choice between employer-sponsored coverage and individual coverage offered through health
 13 insurance exchanges, and allowing employers to purchase or subsidize coverage for their
 14 employees on the individual exchanges. Among its many provisions, Policy H-165.920 supports:
 15

- 16 • A system where individually owned health insurance is the preferred option but employer-
 17 provided coverage is still available to the extent the market demands it;
- 18 • An individual’s right to select his/her health insurance plan and to receive the same tax
 19 treatment for individually purchased coverage, for contributions toward employer-provided
 20 coverage, and for completely employer-provided coverage; and
- 21 • A replacement of the present federal income tax exclusion from employee’s taxable
 22 income of employer-provided insurance coverage with tax credits for individuals and
 23 families.
 24

25 Under Policy H-165.851, the AMA supports incremental steps toward financing individual tax
 26 credits for the purchase of health insurance, including but not limited to capping the tax exclusion
 27 for employment-based health insurance. Policy H-165.843 encourages employers to promote
 28 greater individual choice and ownership of plans; enhance employee education regarding how to
 29 choose health plans that meet their needs; and support increased fairness and uniformity in the
 30 health insurance market. Policy H-165.881 advocates for equal-dollar contributions by employers
 31 irrespective of an employee’s health plan choice. Policy H-165.854 supports Health
 32 Reimbursement Arrangements (HRAs)—account-based health plans that employers can offer to
 33 reimburse employees for their medical expenses—as one mechanism for empowering patients to
 34 have greater control over health care decision-making.
 35

36 Policy H-165.824 supports improving affordability in health insurance exchanges by expanding
 37 eligibility for premium tax credits beyond 400 percent FPL; increasing the generosity of premium
 38 tax credits; expanding eligibility for cost-sharing reductions; and increasing the size of cost-sharing
 39 reductions. Policy H-165.828, which as previously noted addresses the affordability threshold
 40 (firewall), also supports capping the tax exclusion for employment-based health insurance as a
 41 funding stream to improve health insurance affordability.
 42

43 Policy H-165.823 supports a pluralistic health care system and advocates that eligibility for
 44 premium tax credit and cost-sharing assistance to purchase a public option be restricted to
 45 individuals without access to affordable employer-sponsored coverage that meets standards for
 46 minimum value of benefits. This policy sets additional standards for supporting a public option and
 47 states that it shall be made available to uninsured individuals who fall into the “coverage gap” in
 48 states that do not expand Medicaid at no or nominal cost.

1 DISCUSSION

2
3 The AMA has long supported health system reform alternatives that are consistent with AMA
4 policies concerning pluralism, freedom of choice, freedom of practice, and universal access for
5 patients. To expand coverage to all Americans, the AMA has advocated for the promotion of
6 individually selected and owned health insurance; the maintenance of the safety net that Medicaid
7 and CHIP provide; and the preservation of employer-sponsored coverage to the extent the market
8 demands it. As ESI continues to be the dominant source of health coverage for people under 65
9 years of age, most people who have employment-based coverage seem satisfied with it. Still, the
10 Council acknowledges that because of shortcomings inherent to the ESI system—including equity
11 and affordability concerns, and rising costs—it does not work well for everyone, especially
12 workers with lower incomes and those at smaller firms paying for costly family coverage.
13

14 As explained in this report, people with higher earnings receive larger federal ESI subsidies than
15 their lower-income peers and employees with lower incomes pay a greater share of earnings
16 towards ESI expenses. The Council recognizes that federal tax benefits available to ESI subscribers
17 most in need are not nearly as generous as the enhanced subsidies available to many low- and
18 moderate-income individuals enrolled in ACA marketplace plans. Because the disparity between
19 subsidy amounts for people with ESI and those with marketplace coverage has widened as
20 marketplace subsidies have increased and ESI costs have continued to grow, the Council agrees
21 that it is an appropriate time to revisit AMA policy on the firewall (Policy H-165.828[1]), which
22 supports lowering the affordability threshold to the level at which premiums are capped for
23 individuals with the highest incomes eligible for subsidized coverage (currently 8.5 percent).
24

25 During the development of this report, the Council reviewed the literature and heard from experts
26 holding an array of views on the potential impacts of fully eliminating the firewall, which is the
27 policy change requested by referred Resolution 103-A-23. Although the Council cannot estimate
28 with certainty how many people would switch from ESI to exchange plans over time if the firewall
29 was repealed, the impact on coverage patterns could be significant. Even less is known about
30 potential employer responses to a repeal, which cannot be predicted and will likely vary, with some
31 firms possibly shifting certain employees to the marketplace or ceasing to offer health coverage
32 altogether, and without assurances that employer savings would be passed along to workers. Still,
33 we understand that the firewall is problematic for some employees, including lower-income
34 workers who may be contributing more for an employer plan than they would pay for marketplace
35 coverage and those whose firms offer little to no choice of health plans. Even among employees
36 who would benefit financially from transitioning to the marketplace, some may opt to retain ESI
37 coverage if they are satisfied with that plan, concerned about the network breadth of exchange
38 plans, or interested in preserving relationships with their treating physicians.
39

40 The impact of eliminating the firewall on physician payment rates is also difficult to predict, since
41 payment rates in the nongroup market tend to vary, though they are generally lower than rates paid
42 in the ESI market. The Council's main concerns about eliminating the firewall abruptly and in full
43 include the potential impacts on ESI stability, which may not be wholly understood, and the
44 potential substantial costs that would be incurred by the federal government, which already spends
45 upwards of \$1.8 trillion on health insurance subsidies—across all coverage programs—each year.⁴⁹
46 Allowing all ESI enrollees access to ACA marketplace subsidies might prove to be prohibitively
47 expensive. We cannot estimate the exact costs of eliminating the firewall, which would depend on
48 how many workers ultimately move to exchange plans but the costs easily total tens of billions of
49 dollars or more per year, especially if enhanced federal marketplace subsidies remain in place after

1 2025. We believe that budgetary considerations may make the full repeal option unrealistic,
2 financially, and also politically since it would be unpopular with ESI proponents, including
3 employers using health coverage offers as recruiting tools. For these reasons, the Council supports
4 incrementally reducing the affordability threshold so that it benefits workers most in need, and then
5 monitoring the effects of this change on coverage patterns, federal and consumer health spending,
6 and employer behavior. Accordingly, the Council recommends amending Policy H-165.828[1] to
7 support lowering the threshold that determines whether an employee's premium contribution is
8 affordable to the maximum percentage of income they would be required to pay, after accounting
9 for subsidies, towards premiums for an ACA benchmark plan (second-lowest-cost silver plan). The
10 Council is optimistic that this change, if enacted, may also encourage some employers to offer
11 more affordable coverage in order to keep attracting workers.

12
13 The Council also suggests additional recommendations that are intended to strengthen the quality
14 and affordability of ESI. To help address the needs of ESI enrollees with lower incomes, who are
15 more likely to report difficulties covering the costs of medical care and who may not know if they
16 are firewalled, the Council recommends amending Policy H-165.843 to encourage employers to: 1)
17 implement programs that improve affordability of ESI premiums and/or cost-sharing; 2) provide
18 employees with user-friendly information regarding their eligibility for subsidized ACA
19 marketplace plans based on their offer of ESI; and 3) provide employees with information
20 regarding available health plan options, including the plans' cost, network breadth, and prior
21 authorization requirements, which will help them choose a plan that meets their needs. The Council
22 recognizes that employers are already required to provide employees with notice about the ACA
23 marketplace and that, depending on income and ESI offer, they may be eligible for lower-cost
24 coverage in the marketplace. However, it may be challenging for some employees to determine
25 whether they are eligible for marketplace subsidies without tools to help them do so.

26
27 The Council also notes that large employers are subject to a 60 percent actuarial value standard
28 compared to the 70 percent standard required of silver plans on the marketplace (an 80 percent
29 actuarial standard is required for gold plans; 60 percent for bronze). Notably, marketplace plans are
30 also subject to more rigorous essential health benefits standards. To address these disparities in
31 standards, the Council recommends general support for efforts to strengthen employer coverage
32 offerings, such as by requiring a higher minimum actuarial value or more robust benefit standards.
33 Finally, the Council recommends reaffirmation of AMA policies most relevant to this report:
34 Policy H-165.881, which directs the AMA to pursue strategies for expanding patient choice in the
35 private sector by advocating for greater choice of health plans by consumers, equal-dollar
36 contributions by employers irrespective of an employee's health plan choice, and expanded
37 individual selection and ownership of health insurance; and Policy H-165.920, which supports
38 principles related to individually purchased and owned health insurance coverage as the preferred
39 option, although employer-provided coverage is still available to the extent the market demands it.

40 41 RECOMMENDATIONS

42
43 The Council on Medical Service recommends that the following recommendations be adopted in
44 lieu of Resolution 103-A-23, and that the remainder of the report be filed.

- 45
46 1. That our American Medical Association (AMA) amend Policy H-165.828[1] by addition
47 and deletion to read:

48
49 Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing
50 subsidies for those offered employer-sponsored coverage by lowering the threshold that
51 determines whether an employee's premium contribution is affordable to the level at which

1 ~~premiums are capped for individuals with the highest incomes eligible for subsidized~~
2 ~~coverage~~ maximum percentage of income they would be required to pay towards premiums
3 after accounting for subsidies in for an Affordable Care Act (ACA) marketplaces
4 benchmark plan. (Modify HOD Policy)

- 5
6 2. That our AMA amend Policy H-165.843 by addition and deletion to read:

7
8 Our AMA encourages employers to:

9 a) promote greater individual choice and ownership of plans;

10 b) implement plans to improve affordability of premiums and/or cost-sharing, especially
11 expenses for employees with lower incomes and those who may qualify for Affordable
12 Care Act marketplace plans based on affordability criteria;

13 ~~c) help employees determine if their employer coverage offer makes them ineligible or~~
14 ~~eligible for federal marketplace subsidies~~ provide employees with user-friendly
15 information regarding their eligibility for subsidized ACA marketplace plans based on their
16 offer of employer-sponsored insurance;

17 ~~bd) enhance employee education regarding available health plan options and how to choose~~
18 ~~health plans that meet their needs~~ provide employees with information regarding available
19 health plan options, including the plan's cost, network breadth, and prior authorization
20 requirements, which will help them choose a plan that meets their needs;

21 ee) offer information and decision-making tools to assist employees in developing and
22 managing their individual health care choices;

23 ~~df) support increased fairness and uniformity in the health insurance market; and~~

24 eg) promote mechanisms that encourage their employees to pre-fund future costs related to
25 retiree health care and long-term care. (Modify HOD Policy)

- 26
27 3. That our AMA support efforts to strengthen employer coverage offerings, such as by
28 requiring a higher minimum actuarial value or more robust benefit standards, like those
29 required of nongroup marketplace plans. (New HOD Policy)

- 30
31 4. That our AMA reaffirm Policy H-165.881, which directs the AMA to pursue strategies for
32 expanding patient choice in the private sector by advocating for greater choice of health
33 plans by consumers, equal-dollar contributions by employers irrespective of an employee's
34 health plan choice and expanded individual selection and ownership of health insurance.
35 (Reaffirm HOD Policy)

- 36
37 5. That our AMA reaffirm Policy H-165.920, which supports individually purchased and
38 owned health insurance coverage as the preferred option, although employer-provided
39 coverage is still available to the extent the market demands it, and other principles related
40 to health insurance. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

¹ Hanson, C, Hou, C, Percy A et al. Health Insurance for People Younger Than Age 65: Expiration of Temporary Policies Projected to Reshuffle Coverage, 2023-2033 (CBO Estimates). Health Affairs Vol. 42, No. 6, June 2023. Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00325>

² *Ibid.*

³ *Ibid.*

⁴ Straw Tara. Trapped by the Firewall: Policy Changes Are Needed to Improve Health Coverage for Low-Income Workers. Center on Budget and Policy Priorities. December 3, 2019. Available at: <https://www.cbpp.org/research/trapped-by-the-firewall-policy-changes-are-needed-to-improve-health-coverage-for-low-income>

⁵ Hager K, Emanuel E, and Mozaffarian D. Employer-Sponsored Health Insurance Premium Cost Growth and Its Association with Earnings Inequality Among US Families. *JAMA Network Open* January 16, 2024. Available at: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2813927>

⁶ KFF. Survey of Consumer Experiences with Health Insurance. June 15, 2023. Available at: <https://www.kff.org/private-insurance/poll-finding/kf-survey-of-consumer-experiences-with-health-insurance/>

⁷ U.S. Chamber of Commerce. New poll of American workers reveals tremendous value placed on workplace health benefits. December 15, 2022. Available at: <https://www.uschamber.com/health-care/new-poll-of-american-workers-reveals-tremendous-value-placed-on-workplace-health-benefits>

⁸ *Ibid.*

⁹ KFF. 2023 Employer Health Benefits Survey, Section 3: Employee Coverage, Eligibility, and Participation. October 18, 2023. Available at: <https://www.kff.org/report-section/ehbs-2023-section-3-employee-coverage-eligibility-and-participation/#figure31>

¹⁰ KFF. 2023 Employer Health Benefits Survey. 2023. Available at:

<https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2023-Annual-Survey.pdf>

¹¹ KFF. 2023 Employer Health Benefits Survey, Section 7: Employee Cost Sharing. October 18, 2023. Available at: <https://www.kff.org/report-section/ehbs-2023-section-7-employee-cost-sharing/>

¹² *Ibid.*

¹³ Altman Drew. Family Health Insurance Is No Longer Affordable Through Small Employers. KFF. November 28, 2024. Available at: <https://www.kff.org/health-costs/perspective/family-health-insurance-is-no-longer-affordable-through-small-employers/>

¹⁴ KFF. Lower Income Adults with Employer Sponsored Insurance Face Unique Challenges with Coverage Compared to Higher Income Adults. December 19, 2023. Available at: <https://www.kff.org/private-insurance/issue-brief/lower-income-adults-with-employer-sponsored-insurance-face-unique-challenges-with-coverage-compared-to-higher-income-adults/>

¹⁵ Straw, *supra* note 4.

¹⁶ Hager, *supra* note 5.

¹⁷ The Peterson Center on Healthcare and KFF. Health System Tracker: How affordability of employer coverage varies by family income. March 10, 2022. Available at:

<https://www.healthsystemtracker.org/brief/how-affordability-of-health-care-varies-by-income-among-people-with-employer-coverage/#Average%20share%20of%20family%20income%20going%20toward%20employer-based%20health%20insurance%20premium%20contributions%20and%20out-of-pocket%20costs.%202020>

¹⁸ *Ibid.*

¹⁹ KFF/LA Times Survey Of Adults With Employer-Sponsored Insurance. Section 1: Profile of adults with employer-sponsored health insurance and overall views of coverage. May 2, 2019. Available at:

<https://www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-section-1-profile-of-adults-with-employer-sponsored-health-insurance-and-overall-views-of-coverage/>

²⁰ KFF *supra* note 14.

²¹ Capretta James C. The Widening Gap between ACA and ESI Subsidies. AEI Ideas, January 29, 2024. Available at: <https://www.aei.org/economics/the-widening-gap-between-aca-and-esi-subsidies/>

²² Hager *supra* note 5.

²³ *Ibid.*

²⁴ Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight. What Employers Need to Know About the Rule Change For Affordability of Employer Coverage for Family Members of Employees For Purposes of Eligibility for the Premium Tax Credit. 2023. Available at:

<https://www.cms.gov/files/document/affordability-employer-coverage-family-members-employees.pdf>

²⁵ Congressional Research Service. Health Insurance Premium Tax Credit and Cost-Sharing Reductions. Updated February 14, 2024. Available at: <https://crsreports.congress.gov/product/pdf/R/R44425>

²⁶ Internal Revenue Service (IRS). Webpage: Employer Shared Responsibility Provisions. Available at: <https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions>

- ²⁷ Internal Revenue Service (IRS). Webpage: Employer Shared Responsibility Provisions. Available at: <https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions>
- ²⁸ Internal Revenue Service. 26 CFR 601.601: Rules and Regulations. Available at: <https://www.irs.gov/pub/irs-drop/rp-23-17.pdf>
- ²⁹ *Ibid.*
- ³⁰ Congressional Budget Office (CBO). Federal Subsidies for Health Insurance: 2023 to 2033. September 2023. Available at: <https://www.cbo.gov/system/files/2023-09/59273-health-coverage.pdf>
- ³¹ KFF. Explaining Health Care Reform: Questions About Health Insurance Subsidies. October 6, 2023. Available at: [https://www.kff.org/affordable-care-act/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/#:~:text=This%20%E2%80%9Crequired%20individual%20contribution%E2%80%9D%20is,household%20income%20\(Table%20\).](https://www.kff.org/affordable-care-act/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/#:~:text=This%20%E2%80%9Crequired%20individual%20contribution%E2%80%9D%20is,household%20income%20(Table%20).)
- ³² Internal Revenue Bulletin: 2021-35. August 30, 2021. Available at: https://www.irs.gov/irb/2021-35_IRB#REV-PROC-2021-36
- ³³ KFF *supra* note 29.
- ³⁴ *Ibid.*
- ³⁵ *Ibid.*
- ³⁶ CBO *supra* note 28.
- ³⁷ *Ibid.*
- ³⁸ *Ibid.*
- ³⁹ Capretta *supra* note 21.
- ⁴⁰ Straw *supra* note 4.
- ⁴¹ Graves JA, Nshuti L, Everson J et al. Breadth and Exclusivity of Hospital and Physician Networks in US Insurance Markets. *JAMA Network Open*. December 17, 2020. Available at: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774285>
- ⁴² Capretta James C. The Future of Employer-Sponsored Health Insurance. AEI Economic Perspectives. November 2020. Available at: <https://www.aei.org/wp-content/uploads/2020/12/The-Future-of-Employer-Sponsored-Health-Insurance.pdf?x91208>
- ⁴³ Bipartisan Policy Center. Improving and Strengthening Employer-Sponsored Insurance. October 2022. Available at: <https://bipartisanpolicy.org/wp-content/uploads/2022/10/BPC-Improving-and-Strengthening-Employer-Sponsored-Insurance-Oct-2022.pdf>
- ⁴⁴ Straw *supra* note 4.
- ⁴⁵ The Commonwealth Fund. Removing the Firewall Between Employer Insurance and the ACA Marketplaces: Who Could Benefit? December 15, 2020. Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2020/dec/removing-firewall-employer-insurance-aca-marketplaces>
- ⁴⁶ The Commonwealth Fund. Automatic Enrollment in Health Insurance: A Pathway to Increased Coverage for People with Low Income. March 11, 2024. Available at: <https://www.commonwealthfund.org/publications/fund-reports/2024/mar/automatic-enrollment-health-insurance-pathway-increased-coverage>
- ⁴⁷ Congressional Budget Office. Answers to Questions for the Record Following a Hearing Conducted by the Senate Committee on the Budget on CBO's Budget Projections. December 18, 2020. Available at: <https://www.cbo.gov/publication/56912>
- ⁴⁸ Banthin J, Skopec L and Ramchandani, U. Improving the Affordability of Insurance by Eliminating the Firewall Between Employer and Individual Markets. Urban Institute, forthcoming. Available at: <https://www.urban.org/policy-centers/health-policy-center>
- ⁴⁹ Congressional Budget Office Testimony before the Senate Subcommittee on Health, Committee on Energy and Commerce. January 31, 2024. Available at: https://d1dth6e84htgma.cloudfront.net/Chapin_White_Witness_Testimony_01_31_2024_1318e7a8de.pdf

Appendix

Policies Recommended for Amendment and Reaffirmation

Health Insurance Affordability H-165.828

1. 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 the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
2. 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 and household income.
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.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace. (CMS Rep. 8, I-15 Reaffirmed in lieu of: Res. 121, A-16 Reaffirmation: A-17 Reaffirmed: CMS Rep. 09, A-19 Reaffirmed: CMS Rep. 02, A-19 Reaffirmed in lieu of: Res. 101, A-19 Reaffirmed: CMS Rep. 01, I-20 Reaffirmed: CMS Rep. 2, I-20 Modified: CMS Rep. 3, I-21 Appended: Res. 701, I-21)

Trends in Employer-Sponsored Health Insurance H-165.843

Our AMA encourages employers to:

- a) promote greater individual choice and ownership of plans;
- b) enhance employee education regarding how to choose health plans that meet their needs;
- c) offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
- d) support increased fairness and uniformity in the health insurance market; and
- e) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care. (CMS Rep. 4, I-07 Reaffirmed: CMS Rep. 01, A-17)

Expanding Choice in the Private Sector H-165.881

Our AMA will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by

employers irrespective of an employee's health plan choice and expanded individual selection and ownership of health insurance where plans are truly accountable to patients. (BOT Rep. 23, A-97 Reaffirmed BOT Rep. 6, A-98 Reaffirmation A-02 Reaffirmed: CMS Rep. 4, A-12 Reaffirmation: A-19)

Individual Health Insurance H-165.920

Our AMA:

- (1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;
- (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;
- (3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:
 - (a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;
 - (b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;
 - (c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and
 - (d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;
- (4) will identify any further means through which universal coverage and access can be achieved;
- (5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;
- (6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;
- (7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;
- (8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;
- (9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;

- (10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;
- (11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;
- (12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;
- (13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and
- (14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.
- (15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution. (BOT Rep. 41, I-93 CMS Rep. 11, I-94 Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95 Amended by CMS Rep. 2, I-96 Amended and Reaffirmed by CMS Rep. 7, A-97 Reaffirmation A-97 Reaffirmed: CMS Rep. 5, I-97 Res. 212, I-97 Appended and Amended by CMS Rep. 9, A-98 Reaffirmation I-98 Reaffirmation I-98 Res. 105 & 108, A-99 Reaffirmation A-99 Reaffirmed: CMS Rep. 5 and 7, I-99 Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00 Reaffirmation I-00 Reaffirmed: CMS Rep. 2, I-01 Reaffirmed CMS Rep. 5, A-02 Reaffirmation A-03 Reaffirmed: CMS Rep. 1 and 3, A-02 Reaffirmed: CMS Rep. 3, I-02 Reaffirmed: CMS Rep. 3, A-03 Reaffirmation I-03 Reaffirmation A-04 Consolidated: CMS Rep. 7, I-05 Modified: CMS Rep. 3, A-06 Reaffirmed in lieu of Res. 105, A-06 Reaffirmation A-07 Appended and Modified: CMS Rep. 5, A-08 Modified: CMS Rep. 8, A-08 Reaffirmation A-10 Reaffirmed: CMS Rep. 9, A-11 Reaffirmation A-11 Reaffirmed: Res. 239, A-12 Appended: Res. 239, A-12 Reaffirmed: CMS Rep. 6, A-12 Reaffirmed: CMS Rep. 9, A-14 Reaffirmed in lieu of: Res. 805, I-17)

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (A-24)
Review of Payment Options for Traditional Healing Services
(Resolution 106-A-23)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates referred Resolution 106, which was sponsored by the Medical Student Section and asked for the American Medical Association to “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.”

In 1883, the federal government established the Code of Indian Offenses to prosecute American Indians who participated in traditional ceremonies. The cultural identity of American Indian Tribes was restricted by such methods until 1978, when the American Indian Religious Freedom Act legalized traditional spirituality and ceremonies. As the cornerstone legal authority for the provision of health care to American Indians and Alaska Natives (AI/AN), the Indian Health Care Improvement Act (IHCA) was permanently authorized in 2010 to promote traditional health care practices, fulfill special trust responsibilities, and ensure the highest possible health status by providing all resources necessary to implement that policy.

Federal officials have called for Medicaid to improve its ability to provide culturally competent services to AI/AN beneficiaries and many Tribes have incorporated traditional healing services into their health care delivery. While Congress granted the Indian Health Service the ability to bill Medicaid, traditional healing services are not currently a Medicaid covered service. Accordingly, Section 1115 waivers provide a path forward. Currently, four states are pursuing Medicaid Section 1115 demonstration authority to cover traditional healing services furnished by Indian health providers to AI/AN Medicaid beneficiaries. The waiver requests seek the maximum amount of discretion to be given to Native and Indigenous communities to establish relevant programs for each community, while incorporating minimal federal requirements upon approval of the requests. The Council supports monitoring of Medicaid Section 1115 waivers that recognize the value of traditional AI/AN healing services as a mechanism for improving patient-centered care and health equity among AI/AN populations when coordinated with physician-led care.

For AI/AN communities, traditional healing practices are a fundamental element of Indian health care that helps individuals achieve wellness and restores emotional balance and one’s relationship with the environment. While traditional healing services are recognized by the IHCA, there is no statutory definition for traditional healing services, as they vary considerably among Tribes. The Council supports consultation with Tribes to facilitate the development of best practices and coordination of AI/AN traditional healing providers with the physician-led care team.

The value of traditional healing services is not easily quantified by a culture grounded in conventional medicine as it represents a spiritual tradition tied to lifestyle, community, sovereignty issues, and land and culture preservation. The history of AI/AN Tribes in the US involves dislocation and upheaval followed by sustained disregard for effective Indigenous practices based on a historic preference for conventional evidence-based medicine. As a result, barriers to traditional care services have been created by a lack of cultural competence among systems of care that fail to question how evidence has historically been defined.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-24

Subject: Review of Payment Options for Traditional Healing Services
(Resolution 106-A-23)

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee A

1 At the 2023 Annual Meeting, the House of Delegates referred Resolution 106, which was
2 sponsored by the Medical Student Section. Resolution 106-A-23 asked for the American Medical
3 Association (AMA) to “study the impact of Medicaid waivers for managed care demonstration
4 projects regarding implementation and reimbursement for traditional American Indian and Alaska
5 Native (AI/AN) healing practices provided in concert with physician-led healthcare teams.”
6 Testimony was mixed for Resolution 106, with some recommending alternate language asking our
7 AMA to support Medicaid payment for traditional healing services and encourage involved
8 communities to adhere to a series of principles addressing traditional provider/facility
9 arrangements, covered services, and qualified providers. Others supported the resolution as written,
10 albeit with further study to recognize the need for cultural relevance while ensuring patient safety.
11 This report focuses on health equity and cultural competence in providing care for AI/AN
12 populations, examines coverage considerations, summarizes relevant Medicaid Section 1115
13 waiver requests, and presents new policy recommendations.

14 15 BACKGROUND

16
17 The [Office of Management and Budget](#) (OMB) defines an AI/AN individual as “a person having
18 origins in any of the original peoples of North and South America (including Central America) and
19 who maintains Tribal affiliation or community attachment.” American Indians and Alaska Natives
20 are a United States (US) census-defined racial group that also has a specific political and legal
21 classification. From 1778 to 1871, US relations with individual American Indian Nations
22 indigenous to what is now the US were established through the treaty-making process. The treaties
23 recognized unique sets of rights, benefits, and conditions for the Tribes who agreed to surrender
24 millions of acres to the U.S. in return for its protection. The US-American Indian treaties are
25 considered to be the foundation upon which federal Indian law and the [federal Indian trust
26 responsibility](#) is based. In *Seminole Nation v. United States (1942)*, the US “charged itself with
27 moral obligations of the highest responsibility and trust” toward Indian Tribes and accepted a
28 legally enforceable fiduciary obligation to protect Tribal treaty rights, lands, assets, and resources,
29 as well as a duty to carry out the mandates of federal law with respect to AI/AN Tribes and
30 villages.¹

31
32 In 1954, the [Transfer Act](#) moved responsibility for Indian health care from the Bureau of Indian
33 Affairs to the United States Public Health Service in the former Department of Health, Education,
34 and Welfare, currently known as the Department of Health and Human Services (HHS), creating
35 the Indian Health Service (IHS). The IHS was formed to provide federal health care services to

1 AI/AN populations based on the unique government-to-government relationship between the
 2 federal government and the Tribes established by treaties and codified in [Article I, Section 8 of the](#)
 3 [US Constitution](#). IHS funds and delivers health services through a network of programs and
 4 facilities, providing services free of charge to eligible individuals. IHS provides an array of direct
 5 health care services at its facilities and also refers beneficiaries to private providers for care through
 6 the Purchased/Referred Care Program when needed services are not available at IHS facilities.
 7 Eligibility is generally restricted to members of [federally recognized Tribes](#) and their descendants
 8 who live within the geographic service area of an IHS or Tribally operated facility, typically on or
 9 near a reservation or other trust land area.

10
 11 The [Snyder Act of 1921](#) provided explicit legislative authorization for federal health programs for
 12 AI/AN individuals by mandating the expenditure of funds for “the relief of distress and
 13 conservation of health...(and) for the employment of...physicians...for Indian Tribes.” The 1976
 14 [Indian Health Care Improvement Act](#) (IHCA) is the cornerstone legal authority for the provision
 15 of health care to AI/AN populations. It was permanently authorized in March 2010 as part of the
 16 Patient Protection and Affordable Care Act (ACA) with the goal to “promote traditional health care
 17 practices of the Indian Tribes served consistent with the Service standards for the provision of
 18 health care, health promotion, and disease prevention” and “fulfill special trust responsibilities and
 19 legal obligations to Indians...to ensure the highest possible health status for Indians and urban
 20 Indians and to provide all resources necessary to effect that policy.”² The ACA included many
 21 AI/AN-specific provisions, such as greater flexibility in health insurance enrollment in the
 22 individual marketplace exchanges, limited or elimination of cost-sharing for health plans based on
 23 income, improved payment to IHS hospitals through Medicare, and promotion of traditional
 24 healing services. The legislation additionally facilitated the expansion of Medicaid, to the benefit of
 25 many AI/AN individuals. The Snyder Act and the permanent authorization of the IHCA provide
 26 legislative authority for Congress to appropriate funds specifically for the health care of Indian
 27 people.

28
 29 Since Indian Tribes are political entities, they are considered sovereign nations participating in a
 30 government-to-government relationship with the US separate from the state regulatory structure.
 31 The federal government honors this unique relationship by adhering to 2021 [Executive Order](#)
 32 [13175](#), which requires federal agencies to engage in meaningful Tribal consultation. As a result of
 33 the Executive Order, HHS and the Centers for Medicare & Medicaid Services (CMS) each have a
 34 Tribal consultation policy. Depending on the nature of the policy at issue, states are subject to
 35 varying levels of Tribal consultation requirements. For example, [Section 5006 of the American](#)
 36 [Recovery and Reinvestment Act](#) requires that states must seek advice from designees of Indian
 37 health programs and urban Indian organizations in the state when Medicaid and Children’s Health
 38 Insurance Program (CHIP) matters have a direct effect on Indians, Indian health programs, or
 39 urban Indian programs. States are also required to describe the process for seeking advice from
 40 Indian health programs and urban Indian organizations in the Medicaid and CHIP state plans.

41
 42 IHS does not provide insurance coverage or offer a defined benefit package. Further, because it is
 43 not an entitlement program, IHS offers services to the extent permitted by its annual federal
 44 appropriation and a limited amount of revenue from other sources (e.g., payment from insurers
 45 such as Medicaid). While IHS was previously the only federal health program without advance
 46 appropriations, HHS successfully secured advance appropriations for IHS starting in 2024, which
 47 means that the majority of IHS-funded programs, including Tribal health programs and urban
 48 Indian organizations, will remain funded and operational in the event of an expiration of
 49 appropriations. The [Indian Health Manual](#) sets forth the policies, standards, and procedures for
 50 determining who falls within the scope of the IHS health care program. Generally, in order to
 51 receive IHS services, an individual must be a member of a federally recognized Tribe or an [Alaska](#)

1 [Native Claims Settlement Act](#) shareholder. Health care services unavailable at an
 2 IHS/Tribal/Urban facility can be provided by non-IHS health care facilities through the
 3 [Purchased/Referred Care \(PRC\) program](#). Since PRC payments are authorized based on clearly
 4 defined guidelines subject to availability of funds, services obtained under PRC must be prioritized,
 5 with life-threatening illnesses or injuries being given highest priority. Although there are no
 6 deductibles, coinsurance, or copayments for IHS services, insurance allows coverage for things
 7 such as specialty care, services without IHS PRC authorization, and care when away from home.

8
 9 AI/AN individuals who are eligible for health care through the IHS are also entitled to
 10 Medicaid/CHIP coverage if they meet the categorical and financial eligibility requirements of the
 11 Medicaid/CHIP program in the state in which they reside. When AI/AN individuals enroll in
 12 Medicaid/CHIP or a qualified health plan (QHP) available through the Marketplace, they can
 13 continue to receive services from their local Indian health care provider and can also access
 14 services from non-IHS providers that are participating providers in Medicaid/CHIP or the QHP
 15 provider network, respectively. [IHS and Tribal providers can generally bill QHP issuers or](#)
 16 [Medicaid/CHIP for services](#) provided to their patients, and these revenues can be used to pay for
 17 costs such as hiring health professionals, purchasing equipment, and meeting accreditation
 18 requirements. Medicaid plays a secondary but significant role in financing health services for the
 19 AI/AN population, as it provides health insurance coverage for many AI/AN people.³ In 2020, over
 20 1.8 million AI/AN individuals were enrolled in Medicaid, meaning almost one-fifth of the AI/AN
 21 population was covered by Medicaid.⁴ Services provided by IHS and Tribal physicians are also
 22 subject to a 100 percent Federal Medical Assistance Percentage. As such, Medicaid is an essential
 23 source of revenue for the facilities and programs that make up the IHS health care delivery system.

24
 25 AMERICAN INDIAN/ALASKA NATIVE TRADITIONAL HEALING SERVICES

26
 27 The value of AI/AN traditional healing services is often measured against modern medicine, or
 28 allopathy. Allopathy is the treatment of disease by conventional means and translates to “other than
 29 the disease.” Traditional healing is holistic and spiritual, with a focus on well-being and the
 30 promotion of health through ceremony-assisted treatments. Many modern medicines and treatments
 31 have Indigenous equivalents (e.g., aspirin is closely related to salicin found in willow bark) and
 32 studies have found that traditional healing is currently in wide-spread use,⁵ with documented
 33 effectiveness in diabetes mellitus populations.⁶

34
 35 A scoping review of the literature provides robust data regarding the utilization of AI/AN
 36 traditional healing services, integration of traditional and Western medicine systems, ceremonial
 37 practice for healing, and traditional healer perspectives.⁷ However, published systematic reviews
 38 appear limited to determining the effectiveness of AI/AN traditional healing in treating mental
 39 illness or substance use disorders. A 2016 systematic review searched four databases and reference
 40 lists for papers that explicitly measured the effectiveness of traditional healers on mental illness
 41 and psychological distress. While there was some evidence that traditional healers can provide an
 42 effective psychosocial intervention by helping to relieve distress and improve mild symptoms in
 43 common mental disorders such as depression and anxiety, they found little evidence to suggest that
 44 traditional healers change the course of severe mental illnesses such as bipolar and psychotic
 45 disorders.⁸ A 2023 systematic review assessed the feasibility of AI/AN traditional ceremonial
 46 practices to address substance use disorders in both reservation and urban settings. Between
 47 September 2021, and January 2022, culturally specific review protocols were applied to articles
 48 retrieved from over 160 electronic databases, with 10 studies meeting the criteria for inclusion in
 49 the review. While all 10 studies reported some type of quantitative data showing a reduction of
 50 substance use associated with traditional ceremonial practices, the fact that the current status of the
 51 literature is emerging did not allow for meta-analysis of existing studies.⁹

1 For AI/AN communities, traditional healing practices are a [fundamental element](#) of Indian health
2 care that helps individuals achieve wellness and restores emotional balance and one’s relationship
3 with the environment. While traditional healing services are recognized by the IHCIA, there is no
4 statutory definition for traditional healing services. Some Tribes believe that a health problem is an
5 imbalance between an individual and the community and there are seven natural ways of emotional
6 discharge and healing to address that imbalance: shaking, crying, laughing, sweating, voicing (i.e.,
7 talking, singing, hollering, yelling, screaming), kicking, and hitting, all of which must be done in a
8 constructive manner so as to not harm another spirit.¹⁰ Accordingly, Traditional AI/AN healing
9 services might include a range of services such as (but not limited to):

- 10
- 11 • Sweat lodges
- 12 • Healing hands
- 13 • Prayer
- 14 • Smudging and purification rituals
- 15 • Song and dance
- 16 • Use of herbal remedies
- 17 • Culturally sensitive and supportive counseling
- 18 • Shamanism
- 19

20 Traditional healers are often identified in their Tribal community by their innate gift of healing.
21 They typically work informally but may continue to uncover their unique gift through
22 apprenticeship and by observing more experienced healers. Many traditional healers do not charge
23 for their services but are given gifts as an expression of gratitude. Some healers will not accept
24 payment at all, especially when originating from a third-party.

25 HEALTH EQUITY CONSIDERATIONS

26
27 In 1883, the federal government established the [Code of Indian Offenses](#) to prosecute American
28 Indians who participated in traditional ceremonies in order to replace them with Christianity.¹¹
29 This was one of several methods utilized to restrict the cultural identity of American Indian Tribes
30 throughout US history. In 1978, the [American Indian Religious Freedom Act](#) (AIRFA) was a
31 pivotal turning point in addressing concerns regarding separation of church and state, legalizing
32 traditional spirituality and ceremonies, and overturning local and state regulations that had banned
33 AI/AN spiritual practices. In 1994, AIRFA was expanded to increase access to traditional healing
34 services such that “when an Indian Health Service patient requests assistance in obtaining the
35 services of a native practitioner, every effort will be made to comply...such efforts might include
36 contacting a native practitioner, providing space or privacy within a hospital room for a ceremony,
37 and/or the authorization of contract health care funds to pay for native healer consultation when
38 necessary.”
39

40
41 More recently, Congress recognized “provid[ing] the resources, processes, and structure that will
42 enable Indian Tribes and Tribal members to obtain the quantity and quality of health care services
43 and opportunities to eradicating health disparities between Indians and the general population of
44 the United States,” as a top national priority. After President Biden issued [Executive Order 13985](#)
45 in 2021 to establish equity as a cornerstone of Administration policy, the National Indian Health
46 Board (NIHB), supported by CMS and the CMS Tribal Technical Advisory Group (TTAG),
47 convened AI/AN leaders to consider what health equity means from a Tribal perspective. The
48 resulting [2022 NIHB report](#) similarly concluded that traditional healing is essential to advancing
49 health equity. The federal government issued a [second Executive Order](#) in 2023, to further build
50 equity into the business of government.

1 The 2022 NIHB report established that in pursuit of honoring Indigenous knowledge, traditional
 2 healing services should be paid utilizing paths to credentialing and billing that are Tribally led and
 3 approached with sensitivity and cultural humility. In [September 2023](#), the CMS TTAG wrote to the
 4 CMS Administrator urging the Biden-Harris Administration to develop CMS policy in support of
 5 funding and payment for traditional healing, which would “allow Tribes to use the additional third-
 6 party revenue to expand traditional healing services, coordinate the services within the facility, hire
 7 additional healers as appropriate, and create a space for ceremonial practices.”

8
 9 LESSONS LEARNED IN FOSTERING CULTURAL COMPETENCE

10
 11 In January 1952, two anthropologists and a physician from Cornell Medical College learned that
 12 tuberculosis raged untreated on the Navajo Reservation in Arizona. Recognizing a valuable
 13 opportunity for medical research, they designed and administered a ten-year demonstration to
 14 evaluate the efficacy of new antibiotics and test the power of modern medicine to improve the
 15 health conditions of a marginalized rural society. In 1970, they published a book detailing the
 16 demonstration and deeming the project a success, as it established a mechanism for effective,
 17 continued community control and elicited full participation by community members who expressed
 18 satisfaction with the care they received.¹² A 2002 analysis of the demonstration drew different
 19 conclusions, where “researchers exploited the opportunities made possible by the ill-health of a
 20 marginalized population...(and) erected an intrusive system of outpatient surveillance that failed to
 21 reduce the dominant causes of morbidity and mortality...(where) every act of treatment became an
 22 experiment (and) risked undermining the trust on which research and clinical care depended.”¹³
 23 However, the demonstration’s exploration of AI/AN traditional healing is perhaps the only
 24 semiquantitative approach to the subject and provides insights that remain useful today, as the
 25 demonstration recognized that “First, it must be realized that this is not a situation of compromising
 26 alternatives. Rather, there is belief on the part of patients that both systems have something to offer,
 27 they both ‘work.’”¹⁴

28
 29 Humility, which is at the core of AI/AN traditional healing, requires commitment to cultural
 30 connectedness, particularly when traditional healing services are provided in concert with
 31 allopathic/osteopathic care. While validated cultural connectedness measurement scales are
 32 available,¹⁵ there are tenets of traditional healing that can be successfully incorporated into any care
 33 coordination paradigm, such as providing multigenerational visits and home visits to reinforce the
 34 value of community-and family-based care or supporting a holistic approach to care through hands-
 35 on healing, physical body manipulation, and use of Indigenous diets to promote food as medicine.
 36 More AI/AN patients are embracing the opportunity to benefit from coordination between
 37 traditional healing and allopathic/osteopathic care. For example, in the Navajo Tribe, use of healers
 38 overlaps with use of medical providers for common medical conditions and patients rarely perceive
 39 conflict between the Native healer and conventional medicine.¹⁶ If traditional healing services are
 40 allied with the health system, care can be coordinated to accommodate individuals’ needs, leading
 41 to improved health outcomes.¹⁷ Furthermore, coordination, open communication, and transparency
 42 are critical to overcoming medical mistrust in modern medicine among AI/AN individuals.

43
 44 There are two areas where it is particularly important to further cultural sensitivity in the provision
 45 of traditional healing services:

- 46
 47 (1) Collecting data: While Indigenous Peoples need health data to help identify populations at risk
 48 and monitor the effectiveness of programs, health care centers and public health institutions
 49 [regularly overlook the AI/AN community when collecting data](#) and conducting research. Because
 50 some AI/AN patients are hesitant to allow the collection of their health care data by non-
 51 Indigenous individuals due to a lack of trust in how it might be used, this underrepresentation can

1 be magnified. Additionally, because Western research protocols do not prioritize providing benefits
 2 to the entire community, randomized clinical trials are often perceived as unacceptable and unfair
 3 as true randomization is difficult to apply when investigators have legacy relationships with certain
 4 individuals over others. The perception that control-group communities are receiving a lesser
 5 intervention, or none at all, can result in an ethical and cultural, and often stressful, struggle for
 6 both academic and community investigators.¹⁸

7
 8 (2) Credentialing traditional healers: As non-AI/AN protocols cannot be easily applied in
 9 determining necessary qualifications when it comes to traditional healing services, many Tribes
 10 have established distinct processes for credentialing traditional healers. A Tribal credentialing
 11 process might involve a multi-level training program where applications are reviewed by Tribal
 12 Elders, who then interview candidates before being considered by the Council of Elders. Given the
 13 wide variation among Tribes, many agree that it would be impractical to standardize the
 14 credentialing process. Furthermore, if traditional healing is governmentally regulated and licensed,
 15 then licensing boards will tell traditional healers what conditions they can and cannot treat, what
 16 methods are acceptable, and determine who is qualified, possibly challenging Tribal sovereignty.

17
 18 EFFORTS TO INTEGRATE TRADITIONAL HEALING SERVICES AND CONVENTIONAL
 19 MEDICINE

20
 21 Due to the fact that traditional healing services exist outside the paradigm of conventional medicine
 22 and vary across Tribes, they do not necessarily adhere to a conventional evidence-based standard of
 23 care. Ensuring patient safety and quality of care through the delivery of evidence-based medicine
 24 remains a top priority for the AMA. Accordingly, when it comes to traditional healing services or
 25 integrative medicine services, it is important to distinguish between welcoming the benefits of
 26 culturally competent/sensitive care as adjunctive or supportive and full acceptance of non-
 27 evidence-based medicine practices as substitutes for evidence-based medicine-derived treatments.
 28 In Canada and the US, there is a growing movement toward combining traditional healing services
 29 with conventional medicine. The “[wise practices](#)” model incorporates local knowledge, culture,
 30 language, and values into program design, implementation, and evaluation. This ensures that the
 31 local context is a formal component of determining program success, allowing for improved
 32 community engagement and increased community acceptance of programs. Wise practices allow
 33 Indigenous knowledge and principles to be incorporated into public health, academic, and policy
 34 settings.

35
 36 In 2020, the University of North Dakota launched the first of its kind [doctoral program in](#)
 37 [Indigenous health](#), offering students a deeper understanding of the unique health challenges faced
 38 by Indigenous communities. The training is focused on getting to know the community and its
 39 history to allow the provision of health care on reservations that is both evidence-based and
 40 culturally competent. That same year, [KFF](#) reported that IHS facilities were actively seeking job
 41 applicants for traditional healers toward rebuilding trust and recouping Indigenous expertise. In
 42 2022, a Federal Indian Health Insurance Plan was proposed in *Preventive Medicine Reports* that
 43 would offer a culturally competent, comprehensive health insurance product that would include
 44 payment for traditional healing services and eliminate premiums and all other forms of cost-sharing
 45 regardless of income.¹⁹ To-date, its legislative status is unknown.

46
 47 LEARNING FROM PAST CONSIDERATIONS OF ALTERNATIVE TREATMENT OPTIONS

48
 49 Developing an infrastructure to allow coverage for AI/AN traditional healing services could be
 50 informed by coverage considerations for other types of traditional healing services or integrative

1 medicine services, which have varying degrees of success in being covered by insurance and
2 differing evidence bases, many of which are still evolving as coverage expands.

3
4 Considerations surrounding coverage and payment for other types of alternative treatment include:

- 5
6
 - Patient safety/quality and outcomes oversight
 - 7 • Training, licensing, credentialing of providers
 - 8 • Benefit design and payment structure
 - 9 • Utilization uptake

10
11 Due to these and other considerations, insurance plans often have measures in place to ensure
12 patient safety and clinical effectiveness in exchange for payment. For example, many plans only
13 cover these services if prescribed by a physician or licensed practitioner as a demonstration of
14 clinical benefit to the patient. Most insurance plans utilize a team of clinical experts to review
15 which services meet their requirements for safety and effectiveness before offering coverage.

16
17 PURSUING PAYMENT FOR AI/AN TRADITIONAL HEALING SERVICES

18
19 Payment for the provision of AI/AN traditional healing services offers pathways for
20 complementary practices, improvements in safety of care coordination, and trust-building between
21 physicians and patients rooted in cultural sensitivity. Allowing payment for traditional healing
22 services will likely increase access for AI/AN patients. In situations where traditional healers are
23 unable to accept payment directly from patients, the payment can be given to the IHS facility,
24 which can utilize the funds to procure medical supplies, invest in capital (e.g., build a Navajo
25 Hogan), and pay the healers and other health care providers employed by the IHS.

26
27 During the August 2023 [Traditional Medicine Global Summit](#), the World Health Organization
28 (WHO) presented results from the third global survey on traditional medicine, which included
29 questions on financing of traditional medicine, health of Indigenous Peoples, evidence-based
30 traditional medicine, integration, and patient safety. In addition to informing the development of
31 [WHO's 2025-2034 traditional medicine strategy](#), these findings outline how standardization of
32 traditional medicine condition documentation and coding in routine health information systems is a
33 pre-requisite for effective implementation of traditional medicine in health care systems.

34
35 Payment for any health service usually requires establishing a coding infrastructure to allow
36 reporting in a standardized manner. The infrastructure includes both procedural and diagnosis
37 codes to answer the “what” and “why” of patient encounters, respectively. While there are
38 currently no procedure codes for AI/AN traditional healing services, in May 2023, Blue Cross Blue
39 Shield of Minnesota (BCBS MN) submitted an application for a [Healthcare Common Procedural
40 Coding System \(HCPCS\) Level II code](#) to allow AI/AN Medicaid and dual-eligible members to
41 receive and bill the health plan for traditional healing services. While approval of the code is
42 currently pending a decision by CMS, BCBS MN will plan to pilot it with four Native-led clinics
43 using an Indigenous evaluator to determine patient satisfaction, leaving it up to each clinic as to the
44 level of physician involvement. Each Native-led clinic will validate the traditional healing services
45 through its Elder in Residence, Elders Council, or Elders Advisory Board. The HCPCS Level II
46 code will be used to pay a capitated fee, viewed as administrative remuneration to offset the grant
47 amount. BCBS MN is currently required to use an unlisted Current Procedural Terminology
48 (CPT®) code to allow reporting of traditional healing services, which necessitates review of each
49 paper claim submission. The HCPCS Level II nomenclature includes code *S9900, Services by a
50 journal-listed Christian science practitioner for the purpose of healing, per diem*, which may serve
51 as a precedent to assist CMS in its decision. Another option could be a standard encounter fee, such

1 as the IHS [All Inclusive Rate](#) (AIR), which is the amount paid to IHS and Tribal facilities by CMS
 2 for Medicaid covered services per encounter (not per specific service). IHS reviews annual cost
 3 reports before submitting recommended rates to OMB for final approval through HHS. The
 4 approved AIRs are published in the *Federal Register* to allow annual updates to IHS systems. In
 5 lieu of a discrete HCPCS/CPT code, traditional healing services could be paid using an AIR.

6
 7 The WHO's *International Classification of Diseases, 11th Edition* (ICD-11) allows reporting of
 8 traditional medicine diagnoses, representing a formative step for the integration of traditional
 9 medicine conditions into a classification standard used in conventional medicine. As a tool for
 10 counting and comparing traditional medicine conditions, the ICD-11 [Traditional Medicine Chapter](#)
 11 can provide the means for doing research and evaluation to establish efficacy of traditional
 12 medicine and collect morbidity data (e.g., payment, patient safety, research).²⁰

13
 14 Additionally, the *International Classification of Diseases, 10th Edition, Clinical Modification*
 15 (ICD-10-CM), which is the Health Insurance Portability & Accountability Act diagnosis code set
 16 standard, includes social determinants of health (SDOH)-related Z codes (Z55-Z65). The Z codes
 17 can be reported when documentation specifies that a patient has an associated problem or risk
 18 factor that influences their health (e.g., housing insecurity or extreme poverty), thereby helping to
 19 improve equity in health care delivery and research by:

- 20
 21 • Empowering physicians to identify and address health disparities (e.g., care coordination
 22 and referrals)
 23 • Supporting planning and implementation of social needs interventions
 24 • Identifying community and population needs
 25 • Monitoring SDOH intervention effectiveness for patient outcomes
 26 • Utilizing data to advocate for updating and creating new policies

27
 28 Payment processes for traditional healing services should be culturally sensitive, to allow
 29 individuals to “recover one’s wholeness.” [The Anti-Deficiency Act](#) prevents the IHS from
 30 participating in risk-based contracts, as it prohibits expenditures in excess of amounts available in
 31 appropriations. Furthermore, a bundled payment model would not be logical as healers cannot be
 32 put at risk based on outcomes in an environment where collection of demographic-based outcome
 33 data is suspect. There are several possible options for a payment model, including:

- 34
 35 • Standard Encounter Fee: IHS, Tribal, or Urban Indian health facilities paid at the AIR per
 36 encounter rate available for Medicaid inpatient and outpatient hospital services for covered
 37 traditional healing services, with hospital services billed on a Uniform Billing Form (UB-
 38 04) at the OMB AIR using with the current rate published in the *Federal Register*.
 39 • Fee-for-Service: Payment based on traditional healing services provided to an individual
 40 AI/AN patient and reported by a HCPCS/CPT code(s) (e.g., BCBS MN pilot)
 41 • Member Benefit Allowance: Each eligible AI/AN patient receives an added value benefit
 42 to be spent on traditional healing services at their determination. This option could
 43 circumvent some Tribes’ inability to accept payment from a third party. The self-directed
 44 community benefit is currently utilized by the New Mexico Centennial Care 2.0 Medicaid
 45 Section 1115 waiver. Native American Healers is among the specialized therapies under
 46 the member-managed annual \$2,000 budget, allowing Tribal members to have access to an
 47 annual sum to use for traditional healing services.
 48 • Medicaid Section 1115 Waivers.

1 MEDICAID SECTION 1115 WAIVER REQUESTS

2
 3 Medicaid Section 1115 waivers may provide another path forward for payment of traditional
 4 healing services through conventional health care systems. While federal officials have called for
 5 state Medicaid programs to improve their ability to provide culturally competent services to AI/AN
 6 beneficiaries²¹ and Congress granted IHS the ability to bill Medicaid, traditional healing services
 7 are not currently a Medicaid nationally covered service. However, [Section 1115\(a\) of the Social](#)
 8 [Security Act](#) (SSA) authorizes the Secretary of HHS to waive provisions of Section 1902 of the
 9 SSA and grant expenditure authority to treat demonstration costs as federally matchable
 10 expenditures under Section 1903 of the SSA. The Secretary’s approval of experimental, pilot, or
 11 demonstration projects is discretionary and must be based on a finding that the demonstration is
 12 likely to assist in promoting the objectives of the Medicaid program.

13
 14 Medicaid Section 1115 waivers are initially approved for five years and renewable for three years
 15 at a time. The waivers are required to be budget-neutral, meaning that federal spending under the
 16 waiver cannot exceed what it would have been in absence of the waiver. Although not defined by
 17 federal statute or regulations, this requirement has been in practice for many years. Over time, CMS
 18 has allowed states to calculate budget neutrality in multiple ways, although [in 2018 it provided](#)
 19 [states with additional information](#) on agency policies regarding calculating budget neutrality.

20
 21 To date, four states (i.e., Arizona, California, New Mexico, and Oregon) have pursued Medicaid
 22 Section 1115 demonstration authority to cover traditional healing services furnished by Indian
 23 health providers to AI/AN Medicaid beneficiaries. In general, the waiver requests seek that the
 24 maximum amount of discretion be given to Native and Indigenous communities to establish
 25 relevant programs for each community, while allowing HHS to enact certain federal oversight
 26 requirements to ensure patient safety and program requirements are being met (e.g., background
 27 checks, verification of training, etc.) upon approval of the requests. The Center for Medicaid &
 28 CHIP Services (CMCS) is the agency charged with reviewing the state waiver requests with the
 29 goal of supporting cultural alignment of providers and patients toward reducing health disparities in
 30 the AI/AN community. CMCS has acknowledged the importance of incorporating Tribal
 31 leadership into the review process since traditional healing services vary across Tribes. Below is a
 32 summary of the current status of each state’s waiver application request.

33
 34 Arizona

35 It is expected that the Arizona waiver application will be considered by CMCS first – and then
 36 serve as the template for the other three states. The Arizona Health Care Cost Containment System
 37 (AHCCCS) initially submitted its [waiver request](#) in 2015 and then again in 2020, consulting with
 38 Tribal leadership prior to each submission. AHCCCS is requesting permission to pay for traditional
 39 healing services using [Title 19](#) dollars, maximizing individual Tribal communities’ discretion to
 40 define traditional healing services and qualifications for traditional healers. The request limits
 41 services to individuals served by the IHS and urban Indian facilities and proposes paying the AIR,
 42 which is annually established by the federal government. It also includes specific service
 43 parameters toward maximizing patient benefit and safety.

44
 45 California

46 The California Department of Health Care Services (DHCS) has requested authority to cover
 47 Traditional Healer and Natural Helper services under the Drug Medi-Cal Organized Delivery
 48 System (DMC-ODS) in 2017, 2020, and again in 2021. The most recent request includes
 49 Traditional Healer and Natural Helper services under the DMC-ODS as part of the comprehensive
 50 [California Advancing and Innovating Medi-Cal](#) initiative. The purpose of the request is to provide
 51 culturally appropriate options and improve access to substance use disorder (SUD) treatment for

1 AI/AN Medi-Cal members receiving SUD treatment services through Indian health care providers.
2 Meanwhile, DHCS provides funding and technical assistance resources to Tribal and urban Indian
3 health programs through the [Tribal MAT Project](#), including the [Tribal and Urban Indian](#)
4 [Community Defined Best Practices](#) program. Described by its lead entities as “a unified response to
5 the opioid crisis in California Indian Country,” the Tribal MAT Project was designed to meet the
6 specific opioid use disorder prevention, treatment, and recovery needs of California’s Tribal and
7 Urban Indian communities with special consideration for Tribal and urban Indian values, culture,
8 and treatments.

9
10 New Mexico

11 Since 2019, New Mexico’s [Centennial Care 2.0](#) Section 1115 demonstration has provided a self-
12 directed community budget for specialized therapies to members with a nursing-facility level of
13 care need (NF LOC) and who receive home and community-based services (HCBS). Native
14 American Healing is among the specialized therapies under the member-managed annual
15 \$2,000/member budget. All Tribal members with an NF LOC need are mandatorily enrolled in a
16 health plan. Tribal members ineligible for HCBS and who have enrolled in a health plan may have
17 access to an annual sum to use for traditional healing services; this arrangement is considered a
18 “value-added service”²² subject to the health plan to provide or place parameters on the benefit. In
19 2022, the New Mexico Human Services Department (HSD) submitted a waiver renewal application
20 seeking federal approval to renew and enhance the Centennial Care 2.0 waiver to expand the
21 availability of culturally competent, traditional healing benefits to AI/AN members enrolled in
22 managed care, up to \$500/member for traditional healing services to each Tribal member enrolled
23 in managed care and lacking an NF LOC need. HSD has hosted Tribal Listening Sessions to gather
24 feedback on the new Member-Directed Traditional Healing Benefits for Native Americans.

25
26 Oregon

27 In 2022, the [Oregon Health Plan](#) (OHP) submitted a Section 1115 waiver request to continue
28 foundational elements of the OHP with a substantial refocus on addressing health inequities,
29 including expanding benefits for AI/AN OHP members to include Tribal-based practices as a
30 covered service, and waive prior authorization criteria for Tribal members. The Oregon Health
31 Authority and the Oregon Tribes implemented a process by which [Tribal-based practices](#) are
32 developed and approved by the Tribal-Based Practice Review Panel, which is comprised of Tribal
33 representatives.

34
35 In reviewing the applications across the four states, CMCS’ goal is to identify commonality of
36 services that can be covered under Medicaid, provided by traditional healers who have been
37 credentialed within their communities. CMCS plans to pay for traditional healing services through
38 certified IHS facilities, who will then decide how the traditional healers are paid. It is not
39 anticipated that traditional healing will require a referral or prior authorization, as this limits access
40 to the service. CMCS is currently undergoing robust consultation with Tribes and IHS to identify
41 common traditional healing services, facilities where those services are being provided, and
42 providers who will provide them. Pending approval of the waivers, CMCS has expressed that it
43 would require each state to develop and report on benchmarks to demonstrate how it is improving
44 outcomes and reducing disparities, thereby requiring demonstration of value while allowing for
45 variation by state and by Tribe.

46
47 AMA POLICY

48
49 AMA Policy H-290.987 generally supports Section 1115 waivers that assist in promoting the goals
50 of the Medicaid program and have sufficient payment levels to secure adequate access to providers.

1 Policy H-350.949 encourages Medicaid managed care organizations to follow the CMS TTAG's
2 recommendations to improve care coordination and payment agreements with Indian health care
3 providers.
4

5 The AMA has several policies outlining the integral and culturally necessary role that traditional
6 healing services play in delivering health care to AI/AN individuals, including:
7

- 8 • Policy H-350.948, which advocates for increased funding to the IHS Purchased/Referred
9 Care Program and the Urban Indian Health Program to enable the programs to fully meet
10 the health care needs of AI/AN patients;
- 11 • Policy H-350.976, which recognizes the “medicine man” as an integral and culturally
12 necessary individual in delivering health care to American Indians and Alaska Natives; and
- 13 • Policy H-350.977, which supports expanding the role of the American Indian in their own
14 health care and increased involvement of private practitioners and facilities in American
15 Indian care.
16

17 The AMA has long-standing policy identifying, evaluating, and working to close health care
18 disparities, including:
19

- 20 • Policy D-350.995, which calls for a study of health system opportunities and barriers to
21 eliminating racial and ethnic disparities in health care;
- 22 • Policy D-350.996, which calls for the AMA to continue to identify and incorporate
23 strategies specific to the elimination of minority health care disparities in its ongoing
24 advocacy and public health efforts;
- 25 • Policy H-200.954, which supports efforts to quantify the geographic maldistribution of
26 physicians and encourages medical schools and residency programs to consider developing
27 admissions policies and practices and targeted educational efforts aimed at attracting
28 physicians to practice in underserved areas and to provide care to underserved populations;
29 and
- 30 • Policy H-350.974, which encourages the development of evidence-based performance
31 measures that adequately identify socioeconomic and racial/ethnic disparities in quality and
32 supports the use of evidence-based guidelines to promote the consistency and equity of
33 care for all persons.
34

35 Further, Policy H-480.973 encourages the National Center for Complementary and Integrative
36 Health to determine by objective and scientific evaluation the efficacy and safety of practices and
37 procedures of unconventional medicine.
38

39 DISCUSSION

40

41 Resolution 106-A-23 calls for the AMA to study the impact of using Medicaid Section 1115
42 waivers for demonstration projects regarding payment for AI/AN traditional healing services. The
43 Council recognizes the value of traditional healing services for AI/AN patients and understands the
44 need for state flexibility to design Medicaid programs that best respond to the health care needs of
45 their enrollees. The purpose of Section 1115 waivers, which give states additional flexibility to
46 design and improve their Medicaid programs, is to demonstrate and evaluate state-specific policy
47 approaches to better serving that state's unique population of Medicaid enrollees, including AI/AN
48 individuals. The Council acknowledges the importance of cultural competence, particularly with
49 regard to understanding traditional healing and its economic impact in the Section 1115 waiver
50 program, as it requires regular monitoring and independent evaluation of outcomes, which is

1 challenging to do while respecting Tribal data sovereignty. Additionally, it is uncertain how
2 generalizable outcomes might be given the vast differences among Tribes.

3 The Council understands the importance of distinguishing between culturally competent/sensitive
4 care as adjunctive or supportive and full acceptance of non-evidence-based medicine practices as
5 substitutes for evidence-based medicine-derived treatments. Further, with the Medicaid Section
6 1115 waiver demonstrations, we may find novel programs that are based on evidence. While
7 support of guidelines for coordinating traditional healing services as part of the physician-led
8 health care team was requested by Resolution 106-A-23 and is consistent with AMA policy,
9 decisions should be made in concert with Tribes in order to ensure inclusive and culturally relevant
10 care. Experts with whom the Council agrees have recommended that each Tribe be responsible for
11 verifying that valid traditional healing services have been performed by credentialed healers, taking
12 into account the “medical necessity” of the service along with the appropriate site of service (e.g.,
13 hogan versus hospital).

14
15 With many AI/AN patients utilizing traditional healing services,²³ patient safety will be maximized
16 if there is care coordination between Indigenous healers and physicians. The Council appreciates
17 the value of traditional healing services for AI/AN patients when provided in coordination with
18 evidence-based conventional medicine, and believes such coordination may allow the culturally
19 competent physician-led health care team to address Tribal social determinants of health while
20 building trust in conventional care systems among the AI/AN community. What cannot be
21 overlooked, however, is the substantial shortage of physicians [identifying as AI/AN](#). As of 2021,
22 fewer than 3,000 physicians – or 0.4 percent of total physicians – identified as American Indian or
23 Alaska Native, according to the latest statistics from the Association of American Medical Colleges
24 [Physician Specialty Data Report](#). The [US Government Accountability Office](#) published a report
25 outlining an average vacancy rate for IHS physicians, nurses, and other care providers of 25
26 percent. There would need to be more physicians who identify as AI/AN if the U.S. is to provide
27 culturally sensitive care implemented by a physician-led team utilizing a traditional healing model.
28

29 AI/AN traditional healing represents a spiritual tradition tied to lifestyle, community, sovereignty
30 issues, and land and culture preservation not easily explained by Western medicine. The history of
31 AI/AN Tribes in the US involves dislocation and upheaval followed by sustained disregard for
32 effective Indigenous practices based on a historic preference for conventional evidence-based
33 medicine. Barriers to care have been created by a lack of cultural competence among systems of
34 care that fail to question how evidence is defined.
35

36 It is critically important to remember that the US has a special responsibility to AI/AN populations
37 due to treaty obligations and sovereign nation status which differentiate AI/AN traditional healing
38 from other forms of traditional healing. The IHCIA and resulting creation of the IHS establish clear
39 federal law plus a mandate to ensure the highest possible health status and to provide all resources
40 necessary for AI/AN populations.
41

42 RECOMMENDATIONS

43
44 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
45 106-A-23, and the remainder of the report be filed:

- 46
47 1. That our American Medical Association (AMA) amend Policy H-350.976 by addition and
48 deletion, and modify the title by addition, as follows:

49
50 Improving Health Care of American Indians and Alaska Natives H-350.976

- 1 (1) Our AMA recommends that: (1) All individuals, special interest groups, and levels of
2 government recognize the American Indian and Alaska Native people as full citizens of the
3 US, entitled to the same equal rights and privileges as other US citizens.
- 4 (2) The federal government provide sufficient funds to support needed health services for
5 American Indians and Alaska Natives.
- 6 (3) State and local governments give special attention to the health and health-related needs of
7 nonreservation American Indians and Alaska Natives in an effort to improve their quality of
8 life.
- 9 (4) American Indian and Alaska Native religious and cultural beliefs be recognized and
10 respected by those responsible for planning and providing services in Indian health programs.
- 11 (5) Our AMA recognize practitioners of Indigenous medicine as an integral and culturally
12 necessary individual in delivering health care to American Indians and Alaska Natives.
- 13 (6) Our AMA support monitoring of Medicaid Section 1115 waivers that recognize the value
14 of traditional American Indian and Alaska Native healing services as a mechanism for
15 improving patient-centered care and health equity among American Indian and Alaska Native
16 populations when coordinated with physician-led care.
- 17 (7) Our AMA support consultation with Tribes to facilitate the development of best practices,
18 including but not limited to culturally sensitive data collection, safety monitoring, the
19 development of payment methodologies, healer credentialing, and tracking of traditional
20 healing services utilization at Indian Health Service, Tribal, and Urban Indian Health
21 Programs.
- 22 ~~(68)~~ Strong emphasis be given to mental health programs for American Indians and Alaska
23 Natives in an effort to reduce the high incidence of alcoholism, homicide, suicide, and
24 accidents.
- 25 ~~(79)~~ A team approach drawing from traditional health providers supplemented by psychiatric
26 social workers, health aides, visiting nurses, and health educators be utilized in solving these
27 problems.
- 28 ~~(810)~~ Our AMA continue its liaison with the Indian Health Service and the National Indian
29 Health Board and establish a liaison with the Association of American Indian Physicians.
- 30 ~~(911)~~ State and county medical associations establish liaisons with intertribal health councils in
31 those states where American Indians and Alaska Natives reside.
- 32 ~~(1012)~~ Our AMA supports and encourages further development and use of innovative delivery
33 systems and staffing configurations to meet American Indian and Alaska Native health needs
34 but opposes overemphasis on research for the sake of research, particularly if needed federal
35 funds are diverted from direct services for American Indians and Alaska Natives.
- 36 ~~(1113)~~ Our AMA strongly supports those bills before Congressional committees that aim to
37 improve the health of and health-related services provided to American Indians and Alaska
38 Natives and further recommends that members of appropriate AMA councils and committees
39 provide testimony in favor of effective legislation and proposed regulations. (Modify HOD
40 Policy)
- 41
- 42 2. That our AMA reaffirm Policy D-350.996, which states that the AMA will continue to identify
43 and incorporate strategies specific to the elimination of minority health care disparities in its
44 ongoing advocacy and public health efforts. (Reaffirm HOD Policy)
- 45
- 46 3. That our AMA reaffirm Policy H-200.954, which supports efforts to quantify the geographic
47 maldistribution of physicians and encourages medical schools and residency programs to
48 consider developing admissions policies and practices and targeted educational efforts aimed at
49 attracting physicians to practice in underserved areas and to provide care to underserved
50 populations. (Reaffirm HOD Policy)

- 1 4. That our AMA reaffirm Policy H-350.949, which encourages state Medicaid agencies to follow
2 the Centers for Medicare & Medicaid Services Tribal Technical Advisory Group’s
3 recommendations to improve care coordination and payment agreements between Medicaid
4 managed care organizations and Indian health care providers. (Reaffirm HOD Policy)
5
- 6 5. That our AMA reaffirm Policy H-350.977, which supports expanding the American Indian role
7 in their own health care and increased involvement of private practitioners and facilities in
8 American Indian health care through such mechanisms as agreements with Tribal leaders or
9 Indian Health Service contracts, as well as normal private practice relationships. (Reaffirm
10 HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

- ¹ Allen, C, US Department of the Interior, Indian Affairs, “What is the Federal Trust Responsibility?” November 2017. Available at: <https://www.bia.gov/faqs/what-federal-indian-trust-responsibility>
- ² Declaration of national Indian health policy, U.S. Code 25 (2022), § 1602.
<https://www.govinfo.gov/app/details/USCODE-2022-title25/USCODE-2022-title25-chap18-other-sec1602>.
- ³ Medicaid’s Role in Health Care for American Indians and Alaska Natives (Issue Brief) Medicaid and CHIP Payment and Access Commission; Washington, D.C.: 2021. Advising Congress on Medicaid and CHIP Policy. Available at: <https://www.macpac.gov/wp-content/uploads/2021/02/Medicoids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf>
- ⁴ Smith, H, National Council of Urban Indian Health, “An Overview of the Impact of Medicaid on Health Care of American Indians and Alaska Natives,” June 2023. Available at: <https://ncuih.org/2023/06/12/resource-an-overview-of-the-impact-of-medicoid-on-health-care-of-american-indians-and-alaska-natives/#:~:text=Medicaid%20Coverage%20in%20AI%20FAN%20Communities&text=In%202020%2C%20over%201.8%20million,the%20ages%20of%2019%2D64>
- ⁵ Redvers N, Blondin B (2020) Traditional Indigenous medicine in North America: A scoping review. PLoS ONE 15(8): e0237531. <https://doi.org/10.1371/journal.pone.0237531>
- ⁶ Oster, R.T., Grier, A., Lightning, R. et al. Cultural continuity, traditional Indigenous language, and diabetes in Alberta First Nations: a mixed methods study. Int J Equity Health 13, 92 (2014). <https://doi.org/10.1186/s12939-014-0092-4>
- ⁷ Redvers N, Blondin B (2020) Traditional Indigenous medicine in North America: A scoping review. PLoS ONE 15(8): e0237531. <https://doi.org/10.1371/journal.pone.0237531>
- ⁸ Nortje G, Oladeji B, Gureje O, Seedat S. Effectiveness of traditional healers in treating mental disorders: a systematic review. Lancet Psychiatry. 2016 Feb;3(2):154-70. doi: 10.1016/S2215-0366(15)00515-5. PMID: 26851329.
- ⁹ Chase-Begay DM, Peterson JC, Liddell J, Belcourt A. Traditional Ceremonial Practices as a Strategy to Reduce Problem Substance Use in American Indian Communities: A Systematic Review. J Integr Complement Med. 2023 Jun-Jul;29(6-7):408-419. doi: 10.1089/jicm.2022.0655. Epub 2023 Apr 10. PMID: 37229620; PMCID: PMC10280199.
- ¹⁰ Hill, G, Lyle S. Hallman Faculty of Social Work, “A holistic aboriginal framework for individual healing,” 2014. Available at: https://scholars.wlu.ca/cgi/viewcontent.cgi?article=1023&context=scwk_faculty#:~:text=There%20are%20seven%20natural%20ways,%20kicking%20and%20hitting.
- ¹¹ Price, Hiram. Rules Governing The Court of Indian Offenses. March 30, 1883. <https://commons.und.edu/indigenous-gov-docs/131/>.
- ¹² Adair J, Deuschle KW, Barnett CR. The People’s Health—Anthropology and Medicine in a Navajo Community. Albuquerque, NM: University of New Mexico Press; 1988.

- ¹³ Jones DS. The health care experiments at Many Farms: the Navajo, tuberculosis, and the limits of modern medicine, 1952-1962. *Bull Hist Med.* 2002 Winter;76(4):749-90. doi: 10.1353/bhm.2002.0186. PMID: 124469g78.
- ¹⁴ Virtual Mentor. 2009;11(10):793-798. doi: 10.1001/virtualmentor.2009.11.10.mhst1-0910. Available at: <https://journalofethics.ama-assn.org/article/indian-health-service-and-traditional-indian-medicine/2009-10>
- ¹⁵ King J, Masotti P, Dennem J, Hadani S, Linton J, Lockhart B, Bartgis J. The Culture is Prevention Project: adapting the cultural connectedness scale for multi-tribal communities. *Am Indian Alsk Native Ment Health Res.* 2019:104–35. <https://doi.org/10.5820/aian.2603.2019.104>.
- ¹⁶ Kim C, Kwok YS. Navajo Use of Native Healers. *Arch Intern Med.* 1998;158(20):2245–2249. doi:10.1001/archinte.158.20.2245. Available at: <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/210290>
- ¹⁷ Krah E, de Kruijf J, Ragno L. Integrating Traditional Healers into the Health Care System: Challenges and Opportunities in Rural Northern Ghana. *J Community Health.* 2018 Feb;43(1):157-163. doi: 10.1007/s10900-017-0398-4. PMID: 28681282; PMCID: PMC5767209. Available at: <https://pubmed.ncbi.nlm.nih.gov/28681282/>
- ¹⁸ DL. Dickerson, J. Baldwin, A. Belcourt, L. Belone, J. Gittelsohn, K. Kaholokula, N. Wallerstein, Encompassing cultural contexts within scientific research methodologies in the development of health promotion interventions, *Prevention Science* (2018), 10.1007/s11121-018-0926-1, (PMCID: PMC6311146 doi: 10.1007/s11121-018-0926-1).
- ¹⁹ Khetpal V, Roosevelt J Jr, Adashi EY. A Federal Indian Health Insurance Plan: Fulfilling a solemn obligation to American Indians and Alaska Natives in the United States. *Prev Med Rep.* 2021 Dec 16;25:101669. doi: 10.1016/j.pmedr.2021.101669. PMID: 34976706; PMCID: PMC8688870. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8688870/>
- ²⁰ Reddy B, Fan AY. Incorporation of complementary and traditional medicine in ICD-11. *BMC Med Inform Decis Mak.* 2022 Jun 30;21(Suppl 6):381. doi: 10.1186/s12911-022-01913-7. PMID: 35773641; PMCID: PMC9248085. Available at: <https://pubmed.ncbi.nlm.nih.gov/35773641/>
- ²¹ MACPAC Issue Brief, “Medicaid’s Role in Health Care for American Indians and Alaska Natives,” February 2021. Available at: <https://www.macpac.gov/wp-content/uploads/2021/02/Medicoids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf>
- ²² Additional specialized therapies include acupuncture, biofeedback, chiropractic services, hippotherapy, massage therapy, and naprapathy.
- ²³ Buchwald D, Beals J, Manson SM. Use of traditional health practices among Native Americans in a primary care setting. *Med Care.* 2000 Dec;38(12):1191-9. doi: 10.1097/00005650-200012000-00006. PMID: 11186298.

**Council on Medical Service Report 3-A-24
Review of Payment Options for Traditional Healing Services
Policy Appendix**

Strategies for Eliminating Minority Health Care Disparities D-350.996

Our American Medical Association (AMA) 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.

Res. 731, I-02 Modified: CCB/CLRPD Rep. 4, A-12 Reaffirmed: CCB/CLRPD Rep. 1, A-22

US Physician Shortage H-200.954

Our AMA:

- (1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
- (2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
- (3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
- (4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
- (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
- (6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
- (7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
- (8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
- (9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
- (10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
- (11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
- (12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
- (13) will work to augment the impact of initiatives to address rural physician workforce shortages.

(14) supports 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

Res. 807, I-03 Reaffirmation I-06 Reaffirmed: CME Rep. 7, A-08 Appended: CME Rep. 4, A-10 Appended: CME Rep. 16, A-10 Reaffirmation: I-12 Reaffirmation A-13 Appended: Res. 922, I-13 Modified: [CME Rep. 7, A-14 Reaffirmed: CME Rep. 03, A-16](#) Appended: Res. 323, A-19 Appended: [CME Rep. 3, I-21](#) Reaffirmation: I-22 Appended: Res. 105, A-23 Reaffirmed: BOT Rep. 11, A-23

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. (BOT Rep. 24, A-95; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-04; Modified: CMS Rep. 1, A-14)

Medicaid Managed Care for Indian Health Care Providers H-350.949

Our AMA will: (1) support 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 in compliance with their legal obligations to Indian health care providers; and (2) encourage state Medicaid agencies to follow the Centers 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.

Res. 208, A-23

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 US, 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 religious 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.

CLRPD Rep. 3, I-98 Reaffirmed: Res. 221, A-07 Reaffirmation A-12 Reaffirmed: Res. 233, A-13 Reaffirmed: BOT Rep. 09, A-23

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

(6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.

(7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.

CLRPD Rep. 3, I-98 Reaffirmed: CLRPD Rep. 1, A-08 Reaffirmation A-12 Reaffirmed: Res. 233, A-13 Appended: Res. 305, A-23 Reaffirmed: BOT Rep. 09, A-23

REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-24)
Ensuring Privacy in Retail Health Care Settings
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates adopted [Policy H-315.960](#), which asks our American Medical Association to “study privacy protections, privacy consent practices, the potential for data breaches, and the use of health data for non-clinical purposes in retail health care settings.”

The growth in retail health care clinics makes them a significant player in the \$4 trillion US health care system. Retail health care is a term used to describe two discrete models of care: 1) walk-in clinics that provide treatment from employed non-physician practitioners; or 2) services that connect patients with participating online clinics. This distinction is important as it has implications in deciphering responsibilities of covered entities and business associates, respectively.

While the Health Insurance Portability and Accountability Act (HIPAA) has been in place since 1996, misconceptions have muddied the waters around what is and is not a covered entity or business associate, and what is or is not protected health information (PHI). Furthermore, there is confusion surrounding retail health care companies’ HIPAA status, as they require patients to read and comprehend several documents together in order to understand their rights. For these reasons, the Council has developed recommended guardrails surrounding retail health care companies’ handling of PHI.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-24

Subject: Ensuring Privacy in Retail Health Care Settings

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee A

1 At the 2023 Annual Meeting, the House of Delegates adopted [Policy H-315.960](#), which asks our
2 American Medical Association (AMA) to “study privacy protections, privacy consent practices, the
3 potential for data breaches, and the use of health data for non-clinical purposes in retail health care
4 settings.” Testimony at the 2023 Annual Meeting regarding the resolution was unanimously
5 supportive, highlighting a strong commitment to patient privacy as well as expansion to include
6 health data for nonclinical purposes and all retail health care settings. This report focuses on
7 current privacy practices in retail health care settings, highlights AMA advocacy efforts and
8 essential policy, and presents new policy recommendations.

9 10 BACKGROUND

11
12 As of March 2023, there were 1,801 active retail health care clinics in 44 states, predominantly in
13 major metropolitan areas. While only two percent of retail health care clinics are in rural areas,
14 CVS Health owns half of those as well as 63 percent of all retail health care clinics. Kroger Health
15 is the second largest, at 12 percent market share, with more than 220 retail clinics in 35 states, and
16 Walgreens is the third largest at eight percent.¹ Other participants include Walmart, Amazon, Best
17 Buy, and Dollar General. Most retail clinics are in the Southeast and the Midwest, which account
18 for 62 percent of locations. Nearly half (49.1 percent) of all retail clinics are concentrated in seven
19 states: Texas, Florida, Ohio, California, Georgia, Illinois, and Tennessee, which can be attributed to
20 population density. Retail health care clinics have seen a 202 percent increase in utilization from
21 2021 to 2022,² which is a greater growth percentage than seen by urgent care centers, primary care
22 practices, and hospital emergency departments. While retail health care has been around since the
23 early 2000s, it is now a significant player in the \$4 trillion U.S. health care system.³ Retailers’
24 substantial financial resources and far reach allow them to push a customized consumer experience
25 focused on convenience and driven by digital health products, permitting them to get closer to
26 consumers as e-commerce erodes their traditional business. Companies such as CVS Health,
27 Walgreens, Costco, and Amazon continue to expand their services, pulling together different
28 technology-enabled services such as urgent, primary, home, and specialty care along with
29 pharmacy and, in some cases, full integration with an insurer, prompting anti-trust and privacy
30 concerns.

31
32 A [2022 AMA survey](#) found that while 92 percent of people believe that privacy of their health data
33 is a right, most are unclear about the rules relevant to their privacy. The AMA is concerned that
34 health data are increasingly vulnerable and has called for regulations for an individual’s right to
35 control, access, and delete personal data collected about them. The issue is further exacerbated by
36 the Supreme Court’s decision to overturn *Roe v. Wade*, which challenges the right to privacy by

1 potentially enabling law enforcement to gain access to health data related to abortion care and
2 pregnancy.⁴ As such, the [AMA has outlined five privacy principles for a national privacy](#)
3 [framework](#), including:

- 4
- 5 • Individual rights
- 6 • Equity
- 7 • Entity responsibility
- 8 • Applicability
- 9 • Enforcement

10 11 SNAPSHOT OF CURRENT RETAIL HEALTH CARE MARKET

12
13 Walmart is reportedly in negotiations with ChenMed, which touts itself as “family-owned, family-
14 oriented organization committed to bringing superior health care to moderate-to-low-income
15 seniors.” Walgreens recently announced that it is teaming up with technology company Pearl
16 Health, which has a platform to enable value-based care. The collaboration will merge Pearl’s
17 operating system capabilities with Walgreens’ care delivery assets, allowing Walgreens to function
18 as a management services organization for physicians and hospitals. Costco is partnering with the
19 online platform Sesame, which operates outside of insurance networks in order to cater to patients
20 with high-deductible health plans and to the uninsured. Costco will be able to offer same-day
21 telehealth primary care visits for \$29, as well as video prescription refills, mental health consults,
22 and in-person visits for urgent care, among other services. In 2018, Amazon acquired start-up
23 PillPack, which later became Amazon Pharmacy. In November 2022, the company launched
24 Amazon Clinic, a virtual health service that provides users with 24/7 access to physicians and nurse
25 practitioners on Amazon’s website and mobile application (app). In February 2023, Amazon
26 purchased One Medical, which is a membership-based, tech-integrated primary care platform.
27 Amazon is now piloting delivery of medications via drone, airlifting certain common medicines to
28 homes within 60 minutes.⁵ Most recently, Amazon introduced its [Health Conditions Programs](#), an
29 initiative that enables customers to discover digital health benefits to help manage chronic
30 conditions such as diabetes and hypertension. Customers answer questions to determine if their
31 insurance covers a program and if they are clinically eligible for that program, for which they gain
32 access to specific services (e.g., virtual health coaching) and devices (e.g., continuous glucose
33 monitors) covered by their plan. CVS Health owns Aetna, Oak Street Health, and Caremark. In
34 December 2017, CVS announced its merger with Aetna, representing the biggest health care
35 merger in US history, involving both a horizontal and a vertical merger. While the AMA led
36 advocacy efforts to block the union, it was eventually approved.

37 38 FEDERAL DATA PRIVACY LAWS

39
40 The [Health Insurance Portability and Accountability Act](#) (HIPAA) was enacted in 1996,
41 establishing a comprehensive set of standards for protecting sensitive patient health information.
42 The HIPAA [Privacy Rule](#) establishes national standards to protect individuals’ medical records and
43 other individually identifiable patient health information (collectively defined as “protected health
44 information” or PHI). It requires appropriate safeguards to protect the privacy of PHI and sets
45 limits and conditions on the uses and disclosures that may be made of such information without an
46 individual’s authorization.

47
48 PHI is any individually identifiable health information created, received, maintained, or transmitted
49 by a covered entity or business associate that:

- 1 • Relates to the past, present, or future physical or mental health or condition of an individual,
- 2 • The provision of health care to an individual, or
- 3 • The past, present, or future payment for the provision of health care to an individual.

4
5 The United States does not have a federal law that affirms who owns medical records. Under
6 HIPAA, patients have the right to access data medical information in their medical records. The
7 HIPAA Privacy Rule requires appropriate safeguards to protect the privacy of PHI and sets limits
8 and conditions on the uses and disclosures that may be made of such information without an
9 individual's authorization. The HIPAA Privacy Rule also gives individuals rights over their PHI,
10 including rights to examine and obtain a copy of their health records, to direct a covered entity to
11 transmit to a third-party an electronic copy of their protected health information in an electronic
12 health record, and to request corrections. It applies to all entities that fall within the definition of a
13 "[covered entity](#)," which includes health plans, health care clearinghouses, and those health care
14 providers that conduct certain health care transactions electronically. Third-party organizations that
15 provide a service for or on behalf of a covered entity are referred to as "business associates" when
16 the service they provide requires that the covered entity disclose PHI to them; common examples
17 of a business associate are a claims processing entity or appointment scheduling service. All
18 business associates are required to comply with HIPAA privacy protections to the same extent as
19 the covered entity for which the services are performed.

20
21 Retail health care is a term used to describe two discrete models of care: 1) walk-in clinics that
22 provide treatment from employed non-physician practitioners (e.g., CVS Minute Clinic); or 2)
23 services that connect patients with participating online clinics (e.g., Amazon Clinic). This
24 distinction is important as it has implications in deciphering responsibilities of covered entities
25 (e.g., CVS Affiliated Covered Entity, which designates itself as a single covered entity made up of
26 covered entities and health care providers owned or controlled by CVS) and business associates,
27 respectively. In order to help health care providers and organizations determine their HIPAA status,
28 the Centers for Medicare & Medicaid Services has developed a [Covered Entity Decision Tool](#).

29
30 While HIPAA has been in place since 1996, [misconceptions](#) persist regarding what is and is not a
31 covered entity or business associate, and what is or is not PHI. Fortunately, in this regard, the
32 HIPAA regulations have not changed in 10 years, since the 2013 HIPAA and Health Information
33 Technology for Economic Clinical Health Act (HITECH) Omnibus Rule. Therefore, the following
34 still hold true:

- 35
36 • A legally compliant business associate (BA) status can only be achieved by signing a BA
37 agreement (BAA) with a covered entity (CE).
- 38 • The minimum terms of each business association agreement (BAA) are mandated by
39 regulations, which have also not changed since 2013.
- 40 • The Privacy Rule provides that a BAA must require a BA to return all PHI to the CE or destroy
41 the PHI at the termination of the BAA where feasible.

42
43 Legally, the HIPAA Privacy Rule applies to covered entities and business associates. Covered
44 entities are also responsible for guaranteeing their business associates are safeguarding PHI under
45 contract. The contract between the covered entity and its business associate must be HIPAA
46 compliant. If a business associate breaches its contract, then it is up to the covered entity to correct
47 that breach or terminate the contract. In the event of a loss of PHI by a BA, a CE can be responsible
48 for their loss of data.

1 Health care data that are not created, received, maintained, or transmitted by a CE or BA are
 2 referred to as “health care adjacent data” and are not protected by the HIPAA Privacy Rule, nor
 3 subject to the safeguards of the HIPAA Security Rule. The HIPAA [Security Rule](#) requires CEs and
 4 BAs to maintain reasonable and appropriate administrative, technical, and physical safeguards for
 5 protecting electronically stored PHI (ePHI). However, health care entities that collect, use, store,
 6 and share personal health data from digital health platforms, apps, and other similar software
 7 programs (e.g., Fitbit) are not CEs or BAs and are, therefore, beyond the reach of HIPAA. These
 8 apps may be held legally accountable by federal regulators for inappropriate disclosures or data
 9 breaches by the Federal Trade Commission (FTC).

10
 11 RETAIL HEALTH CARE ORGANIZATIONS’ HIPAA STATUS

12
 13 In some cases, there is confusion regarding a retail health care company’s HIPAA status, requiring
 14 patients to read and comprehend several documents together in order to understand their rights.
 15 Determining which organizations HIPAA protections apply is a complex question, as HIPAA
 16 regulates not only the three types of covered entities (health plans, health care clearinghouses, and
 17 health care providers who transmit health information electronically in connection with a covered
 18 transaction), but also their business associates, which can be difficult for the layperson to identify.
 19 Additionally, while retail health companies often contend that they have stringent customer privacy
 20 policies, they may still require customers to sign away some data protection rights. For example,
 21 Amazon’s privacy page explains that the Clinic is not a health care provider – in other words, it is
 22 not a HIPAA covered entity. It goes on to explain that Amazon Clinic is a service provider to
 23 health care providers – thereby classifying it as a HIPAA business associate, retaining patient PHI
 24 in order to “coordinate health care services and update customer information to facilitate services
 25 from other providers.” However, the Amazon Clinic HIPAA Authorization webpage states that it is
 26 “in compliance with federal privacy laws, including HIPAA” and includes FAQs that reference its
 27 use of “HIPAA compliant technology.” The challenge is that the [Amazon Clinic HIPAA](#)
 28 [Authorization](#) needs to be read together with the intricate terms of several other Amazon legal
 29 policies, including its [Amazon Clinic Terms of Use](#), [Amazon.com Conditions of Use](#), and
 30 [Amazon.com Privacy Notice](#) in order for patients to understand all their privacy rights. While retail
 31 health companies contend that they have stringent customer privacy policies, there have been
 32 accounts of companies requiring customers to sign away some data protection rights. In May 2023,
 33 the [Washington Post](#) reported that [when enrolling for Amazon Clinic, users are required to provide](#)
 34 [consent to allow the use and disclosure of their PHI](#). The form that patients are asked to complete
 35 states that after providing consent, Amazon will be authorized to have access to the complete
 36 patient file, may re-disclose information contained in that file, and that the information disclosed
 37 will no longer be subject to HIPAA Rules.⁶ While the terms are voluntary, individuals have no
 38 option of using Amazon Clinic if they do not agree to the terms and conditions.⁷ The fundamental
 39 problem is that once patients agree to the Amazon Clinic authorization, they agree their health
 40 information may no longer be protected by HIPAA.⁸ How retail health care companies decide to
 41 manipulate data and use it may not become apparent for many years.

42
 43 CONSUMER PROTECTION & PRIVACY LAWS

44
 45 Retail health care organizations that electronically transmit standard transactions (e.g., payment,
 46 enrollment, eligibility) are covered entities subject to HIPAA. They are also subject to other
 47 consumer protection and privacy laws for non-HIPAA covered entities. Privacy rights are included
 48 in the FTC’s authority to protect consumers from deceptive or unfair business practices. The [FTC](#)
 49 [Health Breach Notification Rule](#) specifically applies to non-HIPAA covered entities who are
 50 required to notify their customers, the FTC, and, in some instances, the media if there is a breach of
 51 unsecured, individually identifiable health information.⁹

1 The State of Washington recently passed a privacy-focused law to protect PHI that falls outside
 2 HIPAA. The [My Health My Data Act](#) makes it illegal to sell or offer to sell PHI without first
 3 obtaining authorization from the consumer.¹⁰ Several other states (i.e., California, Colorado,
 4 Connecticut, Utah, and Virginia) have enacted general privacy laws with varying applicability to
 5 retail health care companies. The latter laws include various exemptions for PHI, HIPAA de-
 6 identified information, health care providers, HIPAA covered entities, HIPAA business associates,
 7 and non-profits. While all of the latter laws exempt PHI, retail health care companies may have
 8 obligations under these laws with respect to other personal information, such as website data.¹¹
 9

10 RETAIL HEALTH PRIVACY PROTECTIONS & CONSENT PRACTICES
 11

12 In a privacy notice, retail health care companies outline how HIPAA allows them to use and share
 13 PHI for treatment, payment, and health care operations. Their privacy notices also describe the
 14 circumstances where uses and disclosures of PHI do not require patient approval, including certain
 15 uses and disclosures by business associates (i.e., service providers to health care providers),
 16 designated patient caregivers, workers’ compensation claims, law enforcement, judicial or
 17 administrative proceedings, public health purposes, health oversight activities (e.g., audits),
 18 institutional review board-approved research, coroners, medical examiners and funeral directors,
 19 organ procurement organizations, correctional institutions, and military/national security activities.
 20 Retail health care companies are prohibited from disclosing PHI for purposes other than those
 21 described in their notices or for marketing purposes of any kind without written patient consent.
 22 Additionally, patients are notified that they may revoke their approval at any time, although most
 23 companies require submission of formal written notice, explaining that revocation cannot undo any
 24 use or sharing of PHI that has already happened based on previously granted permission.
 25

26 It is important to note that Amazon Clinic is not required to secure any additional waiver or
 27 “authorization” from prospective patients in order for Amazon Clinic to provide the services it
 28 promises to perform in regard to matching the patient with an available medical provider. This type
 29 of scheduling and care coordination is one aspect of “health care operations” under HIPAA, and
 30 falls within the Treatment, Payment, and Health Care Operations permissible disclosures under
 31 HIPAA, for which no patient authorization is required.* [Per Department of Health & Human
 32 Services-Office of Civil Rights \(OCR\) guidance](#), “A business associate agreement may authorize a
 33 business associate to make uses and disclosures of PHI the covered entity itself is permitted by the
 34 HIPAA Privacy Rule to make. See 45 C.F.R. § 164.504(e).” Patients are asked to sign a voluntary
 35 Amazon Clinic HIPAA authorization. The superfluous nature of Amazon’s HIPAA authorization
 36 form seems to be a tactic aimed at obtaining valuable PHI. This strategy not only allows Amazon
 37 access to use and disclose the PHI relevant to its patient matching services, it secures Amazon’s
 38 ability to collect, use, and disclose each patient’s “complete patient file” – far exceeding the
 39 amount of information needed to match a patient with a medical provider.

* See 45 C.F.R. §164.506(a) Standard: Permitted uses and disclosures. A covered entity may use or disclose protected health information for treatment, payment, or health care operations provided that such use or disclosure is consistent with other applicable requirements of this subpart. (emphasis in original). See also, “Health care operations are any of the following activities: (a) quality assessment and improvement activities, including case management and care coordination . . .” (emphasis in original) [https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html#:~:text=Health%20care%20operations%20are%20any,c\)%20conducting%20or%20arranging%20for](https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html#:~:text=Health%20care%20operations%20are%20any,c)%20conducting%20or%20arranging%20for). See finally, 45 C.F.R. §164.506 (c)(2): “A covered entity may disclose protected health information for treatment activities of a health care provider.” In the case of Amazon Clinic, Amazon discloses patient PHI to its participating providers to facilitate the patient’s treatment, in addition to care coordination.

1 The breadth of retail health care companies' coast-to-coast networks can amplify privacy concerns.
2 In December 2023, the [Senate Committee on Finance](#) found that eight of the nation's largest
3 pharmacy chains had routinely turned over customers' PHI to law enforcement agencies, even
4 without a warrant, concluding that, "these companies' privacy practices vary widely, in ways that
5 seriously impact patient privacy." None of the companies required a warrant before turning over
6 requested data, as HIPAA does not require law enforcement to obtain a warrant or judge-issued
7 subpoena before they make a lawful request for records containing PHI.

8 9 ETHICAL & COMPETITIVE CONSIDERATIONS

10
11 The investment banking industry utilizes a virtual information barrier between those who have
12 material, non-public information and those who do not, to prevent conflicts of interest, sometimes
13 referred to as an "ethical wall" or privacy wall. The legal services industry utilizes a similar
14 firewall to protect clients by restraining access to information in order to prevent conflicts of
15 interest among law firm attorneys who may have represented a now adverse party in their prior
16 legal work. Establishing a privacy wall between the health business and non-health business of
17 retail health care companies could eliminate sharing of identifiable PHI or re-identifiable PHI for
18 uses not directly related to patients' medical care.

19
20 Amazon's acquisition of One Medical is a cautionary example. The union allows Amazon to
21 collect a large cache of PHI to further cement its dominance as an online intermediary for goods
22 and services. Amazon's cross-industry reach allows it to use data to develop detailed insights about
23 individuals, without much risk of violating privacy laws. In order to protect the privacy of patients,
24 it will be important for Amazon to commit to having a privacy wall between its patient data and its
25 other areas. Amazon notes that it "will never share One Medical PHI outside of One Medical for
26 advertising or marketing purposes of other Amazon products and services without clear permission
27 from the customer."¹² However, [Amazon makes patients accept its conditions of use prior to
28 treatment, which signs away their PHI protections.](#)¹³ The combination of a vast product distributor
29 and marketer with sensitive PHI sets the stage for unfettered targeted advertising.

30
31 The implications of horizontal-vertical health care mergers, such as the one between CVS and
32 Aetna, cannot be overlooked. An [AMA evidence-based analysis](#) showed how the merger would
33 reduce competition in five key health care markets: Medicare Part D; health insurance; pharmacy
34 benefit management; retail pharmacy; and specialty pharmacy, leading to higher premiums and
35 lower-quality insurance products. Such mergers may lead to increased access to PHI, leveraging
36 data on individual biology, medical history, level of well-being, shopping habits, sleep hygiene,
37 nicotine consumption, and exercise routines to shape patients' digital health IDs. This can allow
38 health insurers to reduce their risks and, therefore, their costs by restricting access to health care
39 services for high-risk patients and vulnerable populations.

40 41 POTENTIAL FOR DATA BREACHES

42
43 On February 21, 2024, a cyberattack against UnitedHealth Group's Change Healthcare disrupted
44 operations for physicians, hospitals, insurers, and pharmacies. Change Healthcare uses Amazon
45 Web Services (AWS) to submit and process insurance claims, handling close to 14 billion
46 transactions a year. As of March 1, 2024, Change Healthcare reported that it was working with
47 Microsoft and AWS to perform an additional scan of its cloud environment. This breach highlights
48 the potential for cyberattacks to affect patient privacy in the retail health care setting.

49
50 The four most common reasons for data breaches include cyberattacks, unauthorized disclosure,
51 theft, and improper disposal of PHI.¹⁴ As retail health care companies expand their reach, the risk

1 of a data breach increases exponentially, especially if they fail to establish the technical controls,
2 training, and employee sanctions necessary to isolate retail health care business from other lines of
3 business. Legal and technical firewalls are essential in preventing retail health care data breaches
4 because they serve as the first line of defense in protecting ePHI from external threats such as
5 hacking, as well as unauthorized or unintended disclosures across business lines.

6
7 Once a covered entity knows or by reasonable diligence should have known (referred to as the
8 “date of discovery”) that a breach of PHI has occurred, the entity has an obligation to notify the
9 relevant parties “without unreasonable delay” or up to 60 calendar days following the date of
10 discovery, even if upon discovery the entity was unsure as to whether PHI had been compromised.
11 If the breach involves the unsecured PHI of more than 500 individuals, a covered entity must notify
12 a prominent media outlet serving the state or jurisdiction in which the breach occurred, in addition
13 to notifying the Department of Health & Human Services (HHS). For breaches involving fewer
14 than 500 individuals, covered entities are permitted to maintain a log of the relevant information
15 and notify HHS within 60 days after the end of the calendar year via the HHS website.
16 Additionally, covered entities may offer affected individuals free identity restoration services or
17 credit reports for a defined period of time. While such offerings are well intended, they do not
18 necessarily allow reparations commensurate with the degree of harm experienced by the affected
19 individuals.

20 21 USE OF HEALTH DATA FOR NON-CLINICAL PURPOSES

22
23 Secondary use of PHI includes activities such as analysis, research, quality and safety
24 measurement, public health, payment, physician accreditation, marketing, risk stratifying to limit
25 care to high-risk patients and vulnerable populations, and other business applications. As retail
26 health care companies continue to expand their reach, the potential for them to use PHI for non-
27 clinical purposes grows. The FTC sent a letter to Amazon in anticipation of its acquisition of One
28 Medical, reminding it of the obligation to protect sensitive health information and inquiring as to
29 how the integrated entity will use One Medical PHI for purposes beyond the provision of health
30 care. Amazon’s acquisition of One Medical was finalized in February 2023 without a regulatory
31 challenge. While the FTC could file a lawsuit to unwind the transaction in the future, experts agree
32 that if regulators had found a reason to block the deal, they already would have. Granting retail
33 health care companies enormous tranches of PHI is viewed by some as a mistake, given that
34 loopholes exist in every legal framework.

35 36 37 THE ROLE OF AUGMENTED INTELLIGENCE IN DATA PRIVACY

38
39 De-identifying PHI enables HIPAA covered entities to share health data for large-scale medical
40 research studies, policy assessments, comparative effectiveness studies, and other studies and
41 assessments without violating the privacy of patients or requiring authorizations to be obtained
42 from each patient prior to data being disclosed. Once PHI is de-identified and theoretically can no
43 longer be traced back to an individual, it is no longer protected by the HIPAA Privacy Rule.¹⁵
44 HIPAA-compliant de-identification of PHI is possible using one of two methods – [Safe Harbor or](#)
45 [Expert Determination](#). While neither method will remove all risk of re-identification of patients,
46 both can reduce risk. In essence, almost all de-identified PHI is re-identifiable.

47
48 A covered entity may assign a code or other means of record identification to allow information de-
49 identified to be re-identified by the covered entity. However, as long as the covered entity does not
50 use or disclose the code or other means of record identification for any other purpose or does not
51 disclose the mechanism for re-identification, they remain compliant with HIPAA.

1 The complexity and rise of data in health care means that augmented intelligence (AI) will
 2 increasingly be applied within the field. Several types of AI are already employed by payers, health
 3 plans, and life sciences companies. At the present time, the key categories of applications involve
 4 diagnosis and treatment recommendations, patient engagement and adherence, and administrative
 5 activities.¹⁶ Health care adjacent data, such as data collected by wearables and health care
 6 applications, are commonly transmitted to an AI-driven health care solution – for example, for the
 7 early diagnosis of a heart condition. Accordingly, there is rising concern about the ability of AI to
 8 facilitate the re-identification of PHI with relative ease. AI algorithms are sophisticated enough to
 9 “learn” new strategies from data, such as how to discern patterns in the data. Through this
 10 detection, an algorithm may be able to effect PHI re-identification. The HIPAA Privacy Rule
 11 outlines specific requirements to adhere to when de-identifying health data, but there is currently
 12 no standardized approach for using de-identified data or validating best practices. While current
 13 laws do not address the role AI might play in data privacy, regulators are continually enacting and
 14 revising their policies, such as the European Union’s General Data Protection Regulation (GDPR)
 15 and California’s Consumer Privacy Act (CCPA). Under the GDPR, there must be a legal basis for
 16 collecting personal data, while the CCPA requires that users have the ability to opt out of any
 17 personal information collection practices. At the federal level, [National Institute of Standards and](#)
 18 [Technology AI Standards](#) are currently under development, while the Government Accountability
 19 Office report, [Artificial Intelligence in Health Care](#) provides guidance for future legislation. In the
 20 interim, AI vendors and software developers are advised to follow the [Xcertia mHealth Guidelines](#),
 21 which align with many of HIPAA’s standards and are backed by the AMA, one of the founding
 22 members. The Joint Commission recently launched the [Responsible Use of Health Data](#)
 23 [Certification](#) (RUHD), a voluntary program aimed at providing health care entities with an
 24 objective evaluation of how well they maintain health data privacy best practices in their secondary
 25 use of data for endeavors such as operations improvement or AI development. The RUHD will
 26 evaluate whether an organization de-identifies data in accordance with HIPAA, whether it has
 27 established a governance structure for the use of de-identified data, and how the organization
 28 communicates with key stakeholders about the secondary use of de-identified data. The AMA has
 29 also recently created a set of [AI Principles](#) which identify and advocate for enhanced protections
 30 for de-identified data when used in conjunction with generative AI and large language models.

31
 32 **ROADBLOCKS TO PRIVACY PROTECTION**

33
 34 As HIPAA only covers CEs and BAs, concerns arise in the regulation of entities currently beyond
 35 the scope of HIPAA, such as digital health platforms, apps, and other similar software programs
 36 that collect, use, store, and share personal health data. Under federal law there is no floor – no
 37 minimum threshold at all – for an organization’s privacy policy. Thus, any health app or digital
 38 health platform can word their stated privacy policy in a weak, evasive, easy-to-comply-with
 39 manner that will sound reassuring to the consumers who choose to read it. Unfair and deceptive
 40 acts and practices affective commerce are a required basis of an FTC action. This is in stark
 41 contrast to the HIPAA Notice of Privacy Practices, which must include specific representations as
 42 to a CE’s privacy practices.

43
 44 Entities such as Amazon Clinic have taken a savvy approach by positioning themselves as BAs and
 45 thus subject to HIPAA, which reassures consumers. Amazon Clinic’s BA status appears to have
 46 been achieved by entering into a BAA with each of the medical providers (i.e., CEs) who
 47 participate with Amazon Clinic. Amazon Clinic collects data from consumers and matches them
 48 with the Clinic’s participating providers. Amazon is able to avoid most of the compliance burden
 49 and privacy protections that HIPAA requires of BAs, by requiring consumers to click through a
 50 screen whereby they effectively waive their HIPAA protections. Under HIPAA, a BA may not use
 51 or disclose PHI in a manner that would violate the Privacy Rule if done by the CE, but HIPAA

1 does allow patients to effectively waive their rights against disclosure by the CE by giving an
 2 authorization, which is [how Amazon characterizes its waiver/click-through screen](#). While
 3 amending HIPAA to provide that BAs may not get a waiver from consumers might be helpful,
 4 sophisticated companies such as Amazon would likely devise a strategy so the patient
 5 “authorization for disclosure” appears to come from the medical provider, and patient
 6 authorizations to disclose their PHI are a necessary feature of HIPAA. When patients sign up for
 7 treatment through Amazon Clinic, they also authorize all those involved (physicians, pharmacies,
 8 laboratories) to share their PHI with Amazon. Amazon then has the right to “retain, use, and
 9 disclose” PHI to facilitate services from “other providers.” It is unclear who these other providers
 10 are, leading some to believe it could include businesses looking to target patients with ads related
 11 to their condition. A substantial hurdle to privacy protection seems to be the willingness of
 12 consumers to click through screens.

13
 14 **CHALLENGING PRIVACY ROADBLOCKS**

15
 16 To ensure robust privacy protections, the Council believes that retail health care companies should
 17 be prohibited from utilizing “clickwrap” agreements, which are online agreements where the user
 18 indicates their acceptance by clicking a button or checking a box that states, “I agree.” While the
 19 purpose of a clickwrap agreement is to digitally capture acceptance of a contract, they permit
 20 patients to access a service without specific affirmative consent to data sharing. Common uses
 21 include asking website visitors to acknowledge that the website they are visiting uses cookies,
 22 installing a mobile app, or connecting to a wireless network.

23
 24 The Council also believes it is important that retail health care companies’ Terms of Use do not
 25 require data sharing for uses not directly related to patients’ medical care in order to receive care –
 26 unless required by law (e.g., reporting of infectious diseases). Operationally, this means that the
 27 Terms of Use should be distinct from the Notice of Privacy Practices, with clear indication that
 28 patients are not required to sign the latter in order to receive care. Retail health care companies
 29 should provide education on this concept to reduce patient vulnerability and achieve meaningful
 30 consent.

31
 32 There are [four types of consent](#): express consent, implied consent, opt-in consent and opt-out
 33 consent. Several retail health care companies utilize opt-out consent, which assumes user consent
 34 unless they act to withdraw it. Opt-out consent requires users to take action to indicate non-consent,
 35 placing the responsibility on users to actively protect their data. When opt-out consent is coupled
 36 with deceptive wording, it may lead patients to agree to something without meaningful consent.
 37 Meaningful consent requires a patient to be given sufficient and understandable knowledge to make
 38 a valid decision. Requiring retail health care companies to use a default opt-in consent plus plain
 39 language is essential toward protecting patients’ privacy and fostering health literacy. Once consent
 40 is given, it then becomes important to provide clear direction on how patients can withdraw
 41 consent. [Section 1798.105\(a\) of the California Consumer Privacy Act](#) grants consumers the right to
 42 request that a business delete any personal information about the consumer which the business has
 43 collected from the consumer. While the CCPA “right to be forgotten” has many exceptions that
 44 allow businesses to keep personal information, it could serve as a prototype for regulations in the
 45 retail health care arena.

46
 47 **RELEVANT AMA POLICY, ADVOCACY, & RESOURCES**

48
 49 The [AMA Privacy Principles](#), derived primarily from AMA House of Delegates policy, serve as
 50 the foundation for AMA advocacy on privacy extrinsic to HIPAA covered entities. In addition to
 51 shifting the responsibility for privacy from individuals to data holders, the principles implore that

1 individuals have the right to know whether their data will be used to develop and/or train AI
 2 algorithms and hold entities accountable toward making their de-identification processes and
 3 techniques publicly available. These Principles were developed based on an identified need to
 4 extend AMA advocacy efforts beyond protections for HIPAA covered entities to (1) provide
 5 individuals with rights and protections from discrimination; (2) shift the responsibility for privacy
 6 from individuals to data holders other than HIPAA covered entities; and (3) create principles for
 7 robust enforcement, individual rights, equity, applicability, and entity responsibility. The AMA
 8 Privacy Principles advocate for the expansion of FTC oversight to consumer data that is accessed,
 9 used, or exchanged by technology companies and vendors not classified as covered entities under
 10 HIPAA. The Principles contend that “health care data” is a subjective term and one that should be
 11 evaluated by a federal agency with broad expertise in data privacy. Accordingly, the AMA Privacy
 12 Principles’ use of the term “data” includes information that can be used to identify an individual,
 13 even if it is not descriptive on its face, such as IP addresses and advertising identifiers from mobile
 14 phones.

15
 16 While the AMA Privacy Principles recognize a role for the FTC, it is important to note why the
 17 OCR is absent from the discussion. The OCR administers and enforces HIPAA regulations with a
 18 focus on PHI, and, therefore, expanding OCR’s HIPAA legislative umbrella to include technology
 19 companies and vendors not classified as covered entities was a consideration. However, it was
 20 recognized that (1) OCR lacks the structure, resources, and expertise to regulate technology
 21 companies and vendors, who are themselves new entrants into the health care arena, and (2) an
 22 existing federal agency is better equipped to regulate health data that flows outside the traditional
 23 HIPAA covered entity arena. Furthermore, extending HIPAA protections for PHI to non-HIPAA
 24 covered technology companies and vendors could create a gap in needed privacy policies.

25
 26 Although the Office of the National Coordinator for Health Information Technology (ONC) is not
 27 mentioned in the AMA Privacy Principles, it has a role in ensuring that sensitive medical
 28 information regarding reproductive health, sexual orientation, gender identity, and substance use
 29 disorder is placed behind a firewall in the electronic health record as well as when it is requested
 30 and shared with others using national health information exchanges, such as under ONC’s Trusted
 31 Exchange Framework and Common Agreement. The [21st Century Cures Act](#) lifted limitations on
 32 the scope of ePHI, allowing information blocking regulations to go into full effect. Physicians who
 33 interfere with the access, exchange, or use of ePHI could be considered “information blockers” and
 34 subject to financial penalties, making it difficult for them to protect sensitive information.

35
 36 The AMA’s longstanding goal to support strong protections for patient privacy is reinforced by
 37 several policies, including those that:

- 38
 39 • Advocate for legislation that aligns mobile health apps and other digital health tools with the
 40 AMA Privacy Principles (Policy D-315.968);
 41 • Oppose the sale or transfer of medical history data and contact information for use in
 42 marketing or advertising (Policy D-315.973);
 43 • Engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful,
 44 and trustworthy mHealth market (Policy D-480.972);
 45 • Advocate for narrowing the definition of “health care operations” to include only those
 46 activities that are routine and critical for general business operations and that cannot be
 47 reasonably undertaken with de-identified health information (Policy H-315.975);
 48 • Support strong protections for patient privacy and, in general, require that patient medical
 49 records be kept strictly confidential unless waived by the patient in a meaningful way, de-

1 identified, or in rare instances when strong countervailing interests in public health or safety
2 justify invasions of patient privacy or breaches of confidentiality (Policy H-315.983);

- 3 • Work to ensure that computer-based patient record systems and networks, and the legislation
4 and regulations governing their use, include adequate technical and legal safeguards for
5 protecting the confidentiality, integrity, and security of patient data (Policy H-315.989); and
- 6 • Support that mHealth apps and associated devices, trackers and sensors must abide by
7 applicable laws addressing the privacy and security of patients' medical information (Policy
8 • H-480.943).

9
10 AMA policy has been developed related to the potential complications introduced by the
11 intersection of AI and patient privacy, including those that:

- 12
13 • Re-examine existing guidance relevant to the confidentiality of patient information, striving to
14 preserve the benefits of widespread use of de-identified patient data for purposes of promoting
15 quality improvement, research, and public health while mitigating the risks of re-identification
16 of such data (Policy D-315.969);
- 17 • Support efforts to promote transparency in the use of de-identified patient data and to protect
18 patient privacy by developing methods of, and technologies for, de-identification of patient
19 information that reduce the risk of re-identification of such data (Policy H-315.962); and
- 20 • Promote development of thoughtfully designed, high-quality, clinically validated health care
21 AI that safeguards patients' privacy interests and preserves the security and integrity of
22 personal information (Policy H-480.940).

23
24 The AMA has written several comment letters addressing the issue of patient privacy, including a
25 [December 2018 letter to NIST](#) which references the tenets of Policy H-315.983, noting that when
26 breaches of confidentiality are compelled by concerns for public health and safety, those breaches
27 must be as narrow in scope and content as possible, must contain the least identifiable and sensitive
28 information possible, and must be disclosed to the fewest possible to achieve the necessary end. In
29 a [February 2019 letter to the Office for Civil Rights](#), the AMA offers suggestions on a Request for
30 Information about modifying HIPAA Rules to improve coordinated care, including how the
31 regulations can be revised to promote the goals of value-based care and care coordination while
32 preserving and protecting the privacy and security of a patient's health information. In May 2019,
33 the AMA submitted patient privacy comments to several recipients, including the [Office of the](#)
34 [National Coordinator for Health Information Technology](#) and the [Centers for Medicare & Medicaid](#)
35 [Services](#), and the [FTC](#). While slightly different audiences, the message for each was similar, with a
36 focus on the AMA approach to privacy. The AMA outlined how data segmentation is critical for
37 health information exchange, regardless of where the data resides, how it is used, or with whom it
38 is exchanged. Consistent with that approach, patient consent and privacy, data provenance,
39 governance, and state and federal law compliance must be inherent in the development of
40 technology. A June 2023 letter to the [National Governors Association](#) urged that comprehensive
41 state legislative privacy proposals provide adequate protections for consumer health data,
42 especially health data obtained by apps and other devices or organizations that do not fall within
43 HIPAA or state privacy laws. In August 2023, the AMA submitted [written comments to the FTC](#)
44 regarding the Health Breach Notification Rule, noting the deficiencies in regulation of health apps.
45 A September 2023 AMA letter to [Senator Bill Cassidy](#) in response to his request for information
46 outlines the distinction between PHI and health information outside of HIPAA, and the potential
47 for harm to individuals caused by confusion between the two.

48
49 In addition to advocacy, the AMA provides members with robust resources on the issue of patient
50 privacy. The [AMA health data privacy framework](#) surveyed patient perspectives to shed light on

1 fundamental data privacy issues that can impact individuals nationwide, while the [AMA patient](#)
2 [privacy webpage](#) provides resources to ensure that patients have meaningful controls over their
3 PHI. As part of the [AMA Patient Access Playbook](#), the AMA has developed a [case for privacy by](#)
4 [design in app development](#). The 2023 [AMA Principles for Augmented Intelligence Development,](#)
5 [Deployment, and Use](#) address privacy and cybersecurity as well as establish guardrails around
6 payer use of AI in automated denials.

7
8 DISCUSSION

9
10 While HIPAA was enacted in 1996, misconceptions have muddied the waters around what is and is
11 not a covered entity or business associate, and what is or is not PHI. Given that HIPAA only
12 governs covered entities and business associates, concerns arise in the regulation of entities
13 currently beyond the scope of HIPAA, such as digital health platforms, apps, and other similar
14 software programs that collect, use, store, and share personal health data. Under federal law there is
15 no floor – no minimum threshold – for an organization’s privacy policy other than it cannot be
16 unfair or deceptive. Thus, any health app or digital health platform can word their stated privacy
17 policy in a weak, evasive, easy-to-comply-with manner that will sound reassuring to the consumers
18 who choose to read it. Furthermore, there is confusion surrounding retail health care companies’
19 HIPAA status, as they require patients to read and comprehend several documents together in order
20 to understand their rights. Determining which organizations HIPAA applies to can be difficult for
21 the layperson.

22
23 The Council therefore recommends a series of principles to address retail health care companies’
24 handling of PHI. Any health care providing entity, or one that is facilitating the referral of patients
25 for care, regardless of whether it provides the care directly, must be held to the standard of a
26 HIPAA covered entity, complete with a privacy wall between the health and non-health lines of
27 business to eliminate sharing of PHI for uses not directly related to patients’ medical care. Retail
28 health care companies should be prohibited from utilizing “clickwrap” agreements, which permit
29 patients to use a service without affirmatively consenting to the data sharing. It is also important
30 that retail health care companies’ Terms of Use do not require data sharing for uses not directly
31 related to patients’ medical care in order to receive care unless required by law. Operationally, this
32 means that the Terms of Use should be distinct from the Notice of Privacy Practices, with clear
33 indication that patients are not required to sign the latter in order to receive care. Requiring retail
34 health care companies to use a default opt-in consent plus plain language is essential toward
35 protecting patients’ privacy and fostering health literacy. Opt-in user consent requires patients to
36 acknowledge the proposed data activity, understand the purposes for collection, and agree to have
37 their data collected, processed, and stored. Once consent is given, it then becomes important to
38 provide clear direction on how patients can withdraw consent.

39
40 The Council also recommends reaffirmation of policies that advocate for legislation that aligns
41 mobile health apps and other digital health tools with the AMA Privacy Principles, supports efforts
42 to promote transparency in the use of de-identified patient data, and promotes development of
43 thoughtfully designed, high-quality, clinically validated health care AI that safeguards patients’
44 privacy interests and preserves the security and integrity of personal information.

1 RECOMMENDATIONS

2
3 The Council on Medical Service recommends that the following be adopted, and the remainder of
4 the report be filed:

- 5
6 1. That our American Medical Association (AMA) will:
- 7 (a) support regulatory guidance to establish a privacy wall between the health business and
 - 8 non-health business of retail health care companies to eliminate sharing of protected health
 - 9 information, re-identifiable patient data, or data that could be reasonably be used to re-
 - 10 identify a patient when combined with other data for uses not directly related to patients’
 - 11 medical care;
 - 12 (b) support the prohibition of Terms of Use that require data sharing for uses not directly
 - 13 related to patients’ medical care in order to receive care, while still allowing data sharing
 - 14 where required by law (e.g., infectious disease reporting);
 - 15 (c) support the separation of consents required to receive care from any consents to share
 - 16 data for non-medical care reasons, with clear indication that patients do not need to sign the
 - 17 data-sharing agreements in order to receive care;
 - 18 (d) support the prohibition of “clickwrap” contracts for use of a health care service without
 - 19 affirmative patient consent to data sharing;
 - 20 (e) support the requirement that retail health care companies must use an active opt-in
 - 21 selection for obtaining meaningful consent for data use and disclosure, otherwise the
 - 22 default should be that the patient does not consent to disclosure;
 - 23 (f) support the requirement that retail health care companies clearly indicate how patients
 - 24 can withdraw consent and request deletion of data retained by the non-health care
 - 25 providing units, which should be by a means no more onerous than providing the initial
 - 26 consent. (New HOD Policy)
- 27
- 28 2. That our AMA reaffirm Policy D-315.968, which advocates for legislation that aligns
- 29 mobile health apps and other digital health tools with the AMA Privacy Principles.
- 30 (Reaffirm HOD Policy)
- 31
- 32 3. That our AMA reaffirm Policy H-315.962, which supports efforts to promote transparency
- 33 in the use of de-identified patient data and to protect patient privacy by developing
- 34 methods of, and technologies for, de-identification of patient information that reduce the
- 35 risk of re-identification of such data. (Reaffirm HOD Policy)
- 36
- 37 4. That our AMA reaffirm Policy H-480.940, which promotes development of thoughtfully
- 38 designed, high-quality, clinically validated health care AI that safeguards patients’ privacy
- 39 interests and preserves the security and integrity of personal information. (Reaffirm HOD
- 40 Policy)
- 41
- 42 5. Rescind Policy H-315.960, as having been completed with this report. (Rescind HOD
- 43 Policy)

Fiscal Note: Less than \$500.

REFERENCES

- ¹ Lagasse, J, Healthcare Finance, “Retail Clinics Seeing Utilization Soar, Popularity Grow,” June 2023. Available at: <https://www.healthcarefinancenews.com/news/retail-clinics-seeing-utilization-soar-popularity-grow#:~:text=In%202023%2C%20there%20were%20more,account%20for%2062%25%20of%20locations>
- ² FAIR Health White Paper, FH Healthcare Indicators and FH Medical Price Index, March 26, 2024. Available at: <https://s3.amazonaws.com/media2.fairhealth.org/whitepaper/asset/FH%20Healthcare%20Indicators%20and%20FH%20Medical%20Price%20Index%202024%20-%20A%20FAIR%20Health%20White%20Paper.pdf>
- ³ Definitive Healthcare, “How Many Retail Clinics Are in the U.S.?” April 2023. Available at: <https://www.definitivehc.com/resources/healthcare-insights/retail-clinics-us#:~:text=There%20were%201%2C801%20active%20retail,states%20as%20of%20March%202023>
- ⁴ Baxter, A, HealthExec, “Patient Privacy Concerns Are Rising,” July 2022. Available at: <https://healthexec.com/topics/health-it/cybersecurity/patient-privacy-concerns-are-rising>
- ⁵ Reed, T, Axios, “Amazon Launches Drug Delivery By Drone,” October 2023. Available at: https://www.axios.com/2023/10/18/amazon-drone-drug-delivery-texas?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top
- ⁶ Hales, M, The HIPAA E-Tool, “Amazon Clinic Raises HIPAA Questions,” May 2023. Available at: <https://thehipaaetool.com/amazon-clinic-raises-hipaa-questions/#:~:text=Amazon's%20privacy%20page%20explains%20that,a%20HIPAA%20%E2%80%9Cbusiness%20associate%E2%80%9C>
- ⁷ Adler, S, The HIPAA Journal, “Senators Demand Answers on Amazon Clinic’s Uses of Customer Data,” June 2023. Available at: <https://www.hipaajournal.com/senators-demand-answers-on-amazon-clinics-uses-of-customer-data/>
- ⁸ Leonard, B, et al., Politico, “Amazon Called to Account – on Health Data,” June 2023. Available at: <https://www.politico.com/newsletters/future-pulse/2023/06/16/amazon-called-to-account-on-health-data-00102301>
- ⁹ Markus, P, Healthcare IT News, “How far will FTC expand Health Breach Notification Rule enforcement?” December 2023. Available at: <https://www.healthcareitnews.com/blog/how-far-will-ftc-expand-health-breach-notification-rule-enforcement>
- ¹⁰ Olivero, A, et al., International Association of Privacy Professionals, “Washington’s MyHealth, MyData Act,” April 2023. Available at: <https://iapp.org/resources/article/washington-my-health-my-data-act-overview/>
- ¹¹ Greene, A, Davis Wright Tremaine LLP Privacy & Security Law, “How State General Privacy Laws Apply to Healthcare Providers,” January 2023. Available at: <https://www.dwt.com/blogs/privacy--security-law-blog/2023/01/privacy-healthcare-providers-hipaa>
- ¹² McKeon, J, Health IT Security, “FTC Warns Amazon About Improper Health Data Sharing Following One Medical,” March 2023. Available at: <https://healthitsecurity.com/news/ftc-warns-amazon-about-improper-health-data-sharing-following-one-medical-acquisition>
- ¹³ Alder, S, The HIPAA Journal, “Senators Demand Answers on Amazon Clinic’s Uses of Customer Data,” June 2023. Available at: <https://www.hipaajournal.com/senators-demand-answers-on-amazon-clinics-uses-of-customer-data/>
- ¹⁴ Seh AH, Zarour M, Alenezi M, Sarkar AK, Agrawal A, Kumar R, Khan RA. Healthcare Data Breaches: Insights and Implications. Healthcare (Basel). 2020 May 13;8(2):133. doi: 10.3390/healthcare8020133. PMID: 32414183; PMCID: PMC7349636.
- ¹⁵ Cornell Law School, Legal Information Institute, “45 CFR § 164.514 - Other requirements relating to uses and disclosures of protected health information.” Available at: [https://www.law.cornell.edu/cfr/text/45/164.514#:~:text=\(a\)%20Standard%20De%20not%20individually%20identifiable%20health%20information](https://www.law.cornell.edu/cfr/text/45/164.514#:~:text=(a)%20Standard%20De%20not%20individually%20identifiable%20health%20information)
- ¹⁶ Alder, S, The HIPAA Journal, “HIPAA, Healthcare Data, and Artificial Intelligence,” December 2022. Available at: <https://www.hipaajournal.com/hipaa-healthcare-data-and-artificial-intelligence/>

**Council on Medical Service Report 7-A-24
Ensuring Privacy in Retail Health Care Settings
Policy Appendix**

Supporting Improvements to Patient Data Privacy D-315.968

Our AMA will (1) strengthen patient and physician data privacy protections by advocating for legislation that reflects the AMA's Privacy Principles with particular focus on mobile health apps and other digital health tools, in addition to non-health apps and software capable of generating patient data and (2) will work with appropriate stakeholders to oppose using any personally identifiable data to identify patients, potential patients who have yet to seek care, physicians, and any other health care providers who are providing or receiving health care that may be criminalized in a given jurisdiction.

Res. 227, A-22 Modified: Res. 230, I-22 Reaffirmation: A-23

Research Handling of De-Identified Patient Information D-315.969

The Council on Ethical and Judicial Affairs will consider re-examining existing guidance relevant to the confidentiality of patient information, striving to preserve the benefits of widespread use of de-identified patient data for purposes of promoting quality improvement, research, and public health while mitigating the risks of re-identification of such data.

BOT Rep. 16, I-21

Preventing Inappropriate Use of Patient Protected Medical Information in the Vaccination Process D-315.973

Our AMA will: (1) advocate to prohibit the use of patient/customer information collected by retail pharmacies for COVID-19 vaccination scheduling and/or the vaccine administration process for commercial marketing or future patient recruiting purposes, especially any targeting based on medical history or conditions; and (2) oppose the sale or transfer of medical history data and contact information accumulated through the scheduling or provision of government-funded vaccinations to third parties for use in marketing or advertising.

Res. 232, A-21

Guidelines for Mobile Medical Applications and Devices D-480.972

1. Our AMA will monitor market developments in mobile health (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 continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market.
3. 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. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications.
5. 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. 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. 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. 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.

[CSAPH Rep. 5, A-14](#) Appended: Res. 201, A-15 Appended: Res. 305, I-16 Modified: Res. 903, I-19

Research Handling of De-Identified Patient Information H-315.962

Our AMA supports efforts to promote transparency in the use of de-identified patient data and to protect patient privacy by developing methods of, and technologies for, de-identification of patient information that reduce the risk of re-identification of such information.

BOT Rep. 16, I-21 Reaffirmation: A-22

Police, Payer, and Government Access to Patient Health Information H-315.975

(1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define “health care operations” narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.

(2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.

(3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.

(4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.

(5) Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.

Res. 246, A-01 Reaffirmation I-01 Reaffirmation A-02 Reaffirmed: BOT Rep. 19, I-06

Reaffirmation A-07 Reaffirmed: BOT Rep. 19, A-07 Reaffirmed: BOT Rep. 22, A-17 Reaffirmed: BOT Rep. 16, I-21

Patient Privacy and Confidentiality H-315.983

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a)

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

2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

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

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

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

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

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

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

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

individual to whom the information pertains. These records should be subject to stringent security measures.

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

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

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

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

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

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

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

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

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

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

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

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

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 Reaffirmation: A-23

Confidentiality of Computerized Patient Records H-315.989

The AMA will continue its leadership in protecting the confidentiality, integrity, and security of patient-specific data; and will continue working to ensure that computer-based patient record systems and networks, and the legislation and regulations governing their use, include adequate technical and legal safeguards for protecting the confidentiality, integrity, and security of patient data.

BOT Rep. F, A-93 Reaffirmation I-99 Reaffirmed: BOT Rep. 19, I-06 Reaffirmed: BOT Rep. 19, A-07 Reaffirmed in lieu of Res. 818, I-07 Reaffirmation I-08 Reaffirmation A-10 Reaffirmed: BOT Rep. 17, A-13

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.

BOT Rep. 41, A-18

Integration of Mobile Health Applications and Devices into Practice H-480.943

1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.
2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information.
3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.
4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.
5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.
6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks
7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.
8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.

[CMS Rep. 06, I-16](#) Reaffirmation: A-17 Reaffirmation: A-23

REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (A-24)
Sustainable Payment for Community Practices
(Resolution 108-A-23)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates referred Resolution 108-A-23, which asked the American Medical Association (AMA) to assess the prevalence of insurance payments to small medical practices that are below Medicare rates and the impact of these payment levels on the ability of practices to provide care. The resolution also asked the AMA to consider the impact on small and medium-sized practices of being excluded from population health management, outcome evidence-based care, and value-based purchasing arrangements, as well as to consider model legislation to address payment rates below the cost of practicing. Council on Medical Service Report 7-I-23 was referred back to the Council to allow reconsideration of a) non-Medicare benchmarks for private payers; b) a minimum government rate, including Medicaid; and c) the impact that rates below these benchmarks have on small community practices.

Despite the current trend toward larger practices, more than half of physicians still work in small practices of 10 or fewer physicians, a percentage that has fallen continuously since 2012. While small practices have some advantages that cannot be matched by larger practices, they are not necessarily well equipped to succeed in value-based purchasing arrangements, which require financial investment and regulatory, technological, and analytic expertise. Given that the single most important factor in ensuring a sustainable level of payment for small practices is leverage, collaboration to form alliances may provide the scale needed to negotiate value-based contracts and to spread the risk across multiple practices. Strong network adequacy requirements and fair out-of-network rules are also essential for the sustainability of small practices.

While research shows that private insurance payment rates are, on average, higher than Medicare payment rates for the same medical services, it also indicates that Medicaid payment rates are substantially below Medicare payment rates. Small practices have a higher percentage of private health insurance patients than larger practices, which should benefit them. However, not all private insurance payments are reflective of the full cost of practice, the value of the care provided, or include inflation-based updates. These inadequate payment levels are exacerbated by the fact that in 2019, Medicaid fee-for-service payments for physician services were nearly 30 percent below Medicare payment levels, with an even larger differential for primary care physician services.

While AMA policy does not endorse a specific payment mechanism such as the Medicare Resource-Based Relative Value Scale (RBRVS), it does support payment at no less than 100 percent of RBRVS Medicare allowable as one option that could provide the basis for both public and private physician payment systems.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-A-24

Subject: Sustainable Payment for Community Practices
(Resolution 108-A-23)

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee A

1 At the 2023 Annual Meeting, the House of Delegates (HOD) referred Resolution 108, which was
2 sponsored by the District of Columbia Delegation. Resolution 108-A-23 asked for the American
3 Medical Association (AMA) to:

4
5 “(1) study small medical practices to assess the prevalence of insurance payments to these
6 practices that are below Medicare rates and to assess the effects of these payment levels on
7 practices’ ability to provide care, and report back by the 2024 Annual Meeting; (2) study and
8 report back on remedies for such reimbursement rates for physician practices; (3) study the
9 impact on small and medium-sized physician practices of being excluded from population
10 health management, outcome evidence-based care, and value-based purchasing arrangements;
11 and study and report back to the House of Delegates options for model legislation for states and
12 municipalities seeking to correct reimbursement rates for medical practices that are below
13 those required to meet fixed costs.”
14

15 The Council on Medical Service developed Report 7-I-23, Sustainable Payment for Community
16 Practices, which was referred to allow reconsideration of a) non-Medicare benchmarks for private
17 payers; b) a minimum government rate, including Medicaid; and c) the impact that rates below
18 these benchmarks have on small community practices.
19

20 In this report, the Council expands on the discussion included in Council Report 7-I-23 to include
21 Medicaid payment schedules and how they compare to Medicare and private insurance payment
22 rates, while acknowledging the costs of providing care to the Medicaid population as well as the
23 challenges of tying payment schedules to a Medicare benchmark. Our focus is on non-hospital
24 owned small practices, which are typically not eligible for facility fees nor possess the market
25 power inherent in larger, hospital-owned practices. We compare Medicare, Medicaid, and private
26 insurance payment rates, outline collaborative and negotiating resources available to small
27 practices, highlight essential AMA policy and resources, and present new policy recommendations.
28

29 BACKGROUND

30
31 Despite the current trend toward larger practices, more than half of physicians (51.8 percent) still
32 work in small practices of 10 or fewer physicians, a percentage that has fallen continuously from
33 61.4 percent in 2012.¹ Contributing factors to the shift include mergers and acquisitions, practice
34 closures, physician job changes, and the different practice settings chosen by younger physicians
35 compared to those of retiring physicians. The “cohort effect”² demonstrates that younger

1 physicians appear to prefer larger practices for the more predictable income and work-life balance
2 they can offer.³ They also may be hesitant to assume the business and entrepreneurial
3 responsibilities demanded by smaller practices.⁴

4
5 However, small practices have some advantages that cannot be matched by larger practices, most
6 notably patients of small practices have lower rates of preventable readmissions than those in larger
7 practices.⁵ The autonomy of small practices and preservation of the traditional patient-physician
8 relationship provide reassurance to patients that the physician is acting in their best interests. It is
9 thought that the patient-physician bond generates trust, which leads to better adherence to a
10 treatment plan.⁶ As small practices become patient-centered medical homes, their decisions can
11 control downstream costs, highlighting the importance of trusted, engaged, and financially aligned
12 physicians in value-based payment systems. Although the medical home model suggests that
13 physicians in small practices are uniquely positioned to succeed in value-based purchasing
14 arrangements, they are not necessarily well equipped to do so given the financial investment and
15 regulatory, technological, and analytic expertise necessary to enter these arrangements. In addition
16 to these inherent limitations of small practices, extrinsic factors can play a role in creating an
17 uneven playing field, including the fact that independent primary care physicians more often fill
18 gaps in care in low-income, rural, and other underserved communities.⁷

19
20 Assessing the current level of sustainability for small community practices requires appreciating
21 the current limitations of governmental authority, understanding the impact of Medicare, Medicaid,
22 and private insurance payment rates, acknowledging relevant AMA policy and advocacy, and
23 exploring the resources available for small practices that want to engage more fully in an evolving
24 value-based health care system.

25 26 FAIR LABOR STANDARDS ACT OF 1938

27
28 The Fair Labor Standards Act of 1938 (FLSA) protects workers against unfair employment
29 practices. FLSA rules specify when workers are considered “on the clock” and when they should
30 be paid overtime, along with a minimum wage. Employees are deemed either exempt or
31 nonexempt under the FLSA.

32
33 Resolution 108-A-23 postulates that the FLSA confers governmental authority to establish
34 minimum levels of payment for medical practices. However, Section 13(a)(1) of the FLSA
35 provides an exemption from both minimum wage and overtime pay for employees employed as
36 “bona fide executive, administrative, professional, and outside sales employees.” Physicians are
37 exempted from FLSA protection since they are considered “Learned Professionals,” as their
38 primary duty requires advanced knowledge, defined as work that is predominantly intellectual in
39 character and that includes work requiring the consistent exercise of discretion and judgment, in a
40 field of science or learning; and customarily acquired by a prolonged course of specialized
41 intellectual instruction.⁸ As such, the FLSA cannot provide protection for small medical practices
42 regarding minimum levels of payment.

43 44 MEDICARE PHYSICIAN PAYMENT SCHEDULE

45
46 Medicare is a federal insurance program where coverage is generally offered to individuals who are
47 65 years or older, have certain disabilities, or suffer from end-stage renal disease or amyotrophic
48 lateral sclerosis. In 1992, the federal government established a standardized Medicare Physician
49 Payment Schedule (MPPS) based on a resource-based relative value scale (RBRVS). Prior to that,
50 the federal government paid physicians using a system of “customary, prevailing, and reasonable”
51 (CPR) charges, which was based on the “usual, customary, and reasonable” system used by many

1 private insurers. The Medicare CPR system allowed for wide variation in the amount paid for the
2 same service, resulting in unfounded discrepancies in Medicare payment levels among geographic
3 service areas and physician specialties.

4
5 In an RBRVS system, payments for services are determined by the standardized resource costs
6 needed to provide them, which are then adjusted to account for differences in work, practice
7 expense, and professional liability insurance costs across national geographic service areas. The
8 RBRVS publishes relative value units (RVUs) for each service, which are then converted to a
9 payment amount using geographical practice cost indices and an annually updated Medicare
10 Conversion Factor to establish the MPPS. The AMA/Specialty Society Relative Value Scale
11 Update Committee (RUC) identifies the resources required to provide physician services, which the
12 Centers for Medicare & Medicaid Services (CMS) then considers in developing RBRVS RVUs.
13 While, historically, 90 percent or more of RUC recommendations have been accepted,⁹ CMS
14 makes all final Medicare payment decisions.

15 16 MEDICAID PAYMENT SCHEDULES

17
18 The Department of Health and Human Services describes Medicare as an insurance program,
19 whereas Medicaid is an assistance program. Medicaid is a federal and state-sponsored program that
20 assists low-income individuals with paying for their health care costs. Each state defines who is
21 eligible for Medicaid coverage, but the program generally covers individuals who have limited
22 income, including:

- 23
- 24 • Individuals 65 years or older
- 25 • Children under 19 years old
- 26 • Pregnant women
- 27 • Individuals living with a disability
- 28 • Parents or adults caring for a child
- 29 • Adults without dependent children
- 30 • Eligible immigrants
- 31

32 States have the option to charge premiums and determine cost sharing requirements for Medicaid
33 beneficiaries. While maximum out-of-pocket costs are limited, states can impose higher charges for
34 targeted groups of somewhat higher income individuals. Certain vulnerable groups, such as
35 children and pregnant women, are exempt from most out-of-pocket costs and copayments and
36 coinsurance cannot be charged for some services. The federal government funds a percentage of
37 the operating costs for each state through the federal medical assistance percentage (FMAP). The
38 FMAP varies from state to state and is inversely related to state per capita income. The matching
39 rate for a state can range from 50 percent to 83 percent. On average, the federal government
40 nominally pays 57 percent of the cost of the program.¹⁰ Medicaid payment rates are determined by
41 the state for each service in accordance with its approved Medicaid state plan.

42 43 PRIVATE INSURANCE PAYMENT SCHEDULES

44
45 For small community practices, payment schedules are typically negotiated between the payer and
46 the practice as part of a network of preferred physicians. Practices agree to these payment
47 schedules to permit inclusion in the network, since being in-network is generally more appealing to
48 patients, allows access to in-network referrals, and reduces the chance of unexpectedly low
49 payment to the practice.

1 When negotiating payment schedules, it is important that the practice is aware of its fixed and
 2 variable costs for a given service so that the long-term break-even point can be determined. The
 3 smaller the practice, the more important it is to negotiate with as much data and defined value
 4 proposition as possible, because a smaller practice has less leverage. Given that private insurance
 5 payment schedules are negotiated between two parties, they can vary by state, region, payer,
 6 specialty, and/or practice. Thus, it is likely that most small practices accept multiple different
 7 payment schedules from different payers.

8
 9 Private insurance payments are variable across physician specialties. The Urban Institute conducted
 10 an analysis of [FAIR Health professional claims](#) from March 2019 to February 2020, comparing
 11 them to the MPPS for the same time period. The analysis included 17 physician specialties and
 12 approximately 20 services per specialty, which represented about 40 percent of total professional
 13 spending. The Urban Institute found significant variation in relative prices across specialties, with
 14 commercial-to-Medicare payment ratio across all selected services for the 17 specialties averaging
 15 1.6 using an expenditure-weighted approach.¹¹

16
 17 Areas where there is greater market concentration among physicians tend to have higher payment
 18 amounts from private insurance.¹² The Health Care Cost Institute's [Health Care Cost and](#)
 19 [Utilization Report](#) found that there was substantial variation in private insurance payments across
 20 states, with average commercial prices ranging from 98 percent to 188 percent of Medicare rates.
 21 Seven states had payments that were, on average, higher than 150 percent of Medicare rates while
 22 11 states had average payments within 10 percent of Medicare. The states with the highest private
 23 insurance payments relative to Medicare tended to be in the northwest of the country and along the
 24 Great Plains.¹³

25
 26 **MEDICARE VERSUS PRIVATE INSURANCE PAYMENT RATES**

27
 28 A 2020 KFF literature review discovered that private insurance paid 143 percent of Medicare rates
 29 for physician services, on average, ranging from 118 percent to 179 percent of Medicare rates
 30 across studies.¹⁴ Estimates from a more recent Milliman white paper closely align, finding that
 31 2022 commercial payment for professional medical services to be approximately 141 percent of
 32 Medicare fee-for-service rates.¹⁵ A [2022 Congressional Budget Office report](#) identified “rapid
 33 increases in the prices that commercial insurers pay for hospitals’ and physicians’ services,”¹⁶
 34 leading to further divergence between private and public insurance payment rates, a trend that has
 35 proven consistent over time. A 2003 Office of the Inspector General review determined that of 217
 36 procedures, 119 were valued lower by Medicare than by private insurers¹⁷ and a 2017 Health Care
 37 Cost Institute report found that commercial payments for the average professional service were 122
 38 percent of what would have been paid under Medicare.¹⁸ The 2022 AMA Physician Practice
 39 Benchmark Survey found that small practices of 1 to 15 physicians have a higher percentage of
 40 private health insurance patients than larger practices (45.9 percent vs 40.9 percent).¹⁹ Since
 41 research shows that private insurance payment rates are, on average, higher than Medicare payment
 42 rates for the same health services, this may benefit small practices.

43
 44 While the Council was unable to identify a survey focused on small practice Medicare to private
 45 insurance rate ratios, anecdotal reports indicate that some small practices are seeing private insurers
 46 offer payment below 100 percent of Medicare, which may be further depressed when insurers
 47 utilize a prior year Medicare rate. A Washington, DC two-physician clinic reported receiving
 48 private insurance payment rates ranging from 16-43 percent lower than Medicare, despite
 49 becoming a Patient-Centered Medical Home and entering into a local accountable care
 50 organization (ACO). Similarly, a solo endocrinologist who left a university-affiliated practice

1 reported being disadvantaged by no longer being able to collect facility fees to generate higher
2 billing, forcing him to opt out of all insurance plans due to inadequate payment.

3 4 MEDICAID PAYMENT COMPARISON AND HEALTH EQUITY IMPLICATIONS

5
6 In 2019, Medicaid fee-for-service payments for physician services were nearly 30 percent below
7 Medicare payment levels, with an even larger differential for primary care physician services.²⁰ A
8 2017 study found that total payments for physician office visits under Medicaid averaged 62.2
9 percent of payment amounts under private insurance and 73.7 percent of those under Medicare.²¹
10 As the largest public health insurance provider in the United States, Medicaid policy has significant
11 health equity implications. Low payment rates may limit access to quality care and contribute to
12 poor health outcomes for Medicaid beneficiaries. Research has found that increasing Medicaid
13 primary care rates by \$45 per service would reduce access-to-care inequities by at least 70
14 percent.²²

15
16 While Medicaid state flexibility is intended to preserve state operational autonomy and
17 programming, it has fostered wide variability and geographic inequities, particularly between
18 Medicaid expansion states and non-expansion states,²³ further enabling health disparities.
19 Substantial dependence on state revenues has led to low payment rates that effectively limit access,
20 as it disincentivizes providing care to the often minoritized populations the program serves. As
21 small practices must absorb costs required to provide care to the Medicaid population, such as
22 compliance with regulations and addressing Social Determinants of Health toward equitable care,
23 lower payment makes it almost impossible to recover those costs. Small practices experience
24 higher burdens for translation services in regions where Medicaid patients may have limited
25 English proficiency. Small practices also have challenges in assuring adequate patient follow-up
26 due to a lack of reliable communications (e.g., lack of working phone numbers or inability to reach
27 patients during the daytime while they are working, lack of access to a computer/internet) and
28 transportation challenges.

29 30 PAYMENT BENCHMARKS

31
32 An ideal payment benchmark will reflect the cost of providing care both in the short term and long
33 term while acknowledging risk, variable expenses, an appropriate allocation of fixed costs, and
34 physician work. It is essential that the benchmark reflect the full cost of practice and the value of
35 the care provided, as well as include inflation-based updates. The benchmark should disclose
36 payment amounts and the methodology used to calculate them, as these are fundamental to
37 establishing trust between physicians and insurers and promoting sound decision making by all
38 participants in the health care system. As the Medicare RBRVS [values](#) and [methodology](#) are fully
39 transparent, a payment benchmark uncoupled from the RBRVS must be accompanied by
40 commensurate transparency in payment methodology.

41
42 A general measurement of a payment schedule is its relative payment rate compared to the MPPS
43 or “benchmarking” to Medicare. Payment schedules that are less than the MPPS are considered
44 beneficial for the payer, whereas payment schedules that match or are greater than the MPPS are
45 considered beneficial for the practice. The percentage of MPPS rates is one of the most widely
46 accepted payment benchmarks when evaluating physician payment level and comparing contracts
47 in the health care industry. It can reflect the mix of services across physicians and plans while
48 removing impacts from billed charges that can vary widely across providers and regions.
49 Additionally, Medicare RBRVS values remain the foundation for many Alternative Payment
50 Models (APMs) as they can produce more or less value by influencing how physicians spend their
51 time and the mix of services provided to patients.

1 However, there are challenges presented by tying payment to a Medicare benchmark. Some payers
2 may adopt only a portion of the Medicare RBRVS (e.g., use RVU) but utilize a lower conversion
3 factor) or use an outdated RBRVS where the RVUs are no longer reflective of current resource
4 costs. Other payers may implement time-limited or temporary arrangements or apply the RBRVS
5 to only certain specialties, leading to disruption in care or difficulties with patient referrals. Most
6 importantly, continuing to tether payment to a Medicare payment rate that has been reduced by
7 almost 10 percent in four years presents an untenable situation for small practices. After adjusting
8 for inflation, [Medicare physician payment has effectively declined 29 percent](#) from 2001 to 2024.
9

10 Some have suggested the development of a “minimum government rate” as a payment benchmark.
11 However, it is challenging to identify a rate and methodology defensible across the six major
12 government health care programs:

- 13
- 14 1) Medicare
- 15 2) Medicaid
- 16 3) The Children’s Insurance Program (CHIP)
- 17 4) The Department of Defense TRICARE and TRICARE for Life Programs
- 18 5) The Veterans Health Administration program
- 19 6) The Indian Health Service
- 20

21 While these programs collectively provide health care services to one-third of Americans, they
22 differ extensively in terms of size, scope, financing, and program design, making it unfeasible to
23 establish an equitable minimum payment rate appropriate for all. Furthermore, it would be
24 impracticable to establish a minimum payment rate in the private physician market, which is
25 currently riding a consolidation wave, transforming health insurers into much larger and more
26 powerful conglomerates. Helping small practices escape the vice grip of unfair market rates from
27 consolidated insurers begs the need for strong antitrust reform. While reference prices and price
28 floors have been used in various sectors of the economy, they appear to have a low likelihood of
29 being adopted in health care, as demonstrated by the Economic Stabilization Program of the early
30 1970s.²⁴ Programs that provide for low income and rural patient populations already struggle to
31 obtain adequate funding. As demonstrated in the [oil](#) and [agricultural](#) sectors, policymakers are not
32 likely to set a payment floor unless they are granted influence over the distribution of health care
33 prices in return.
34

35 SUSTAINABLE PAYMENT FOR SMALL COMMUNITY PRACTICES

36

37 Small practices are disproportionately affected by payment rates that fall below an ideal
38 benchmark. One of the most notable changes has been the redistribution of physicians from small
39 to large practices. The share of physicians who worked in practices that had 10 or fewer physicians
40 decreased from 61.4 percent in 2012 to 51.8 percent in 2022, with the need to better negotiate
41 favorable (higher) payment rates with payers as one of the most important motivations for private
42 practices selling to hospitals or health systems.²⁵
43

44 The term “sustainable” denotes that something is bearable and capable of being continued at a
45 certain level over a period of time. For small community practices, sustainable payment reflects the
46 full cost of practice and the value of the care provided. Additionally, it includes annual inflation-
47 based payment updates, which are essential to measure practice cost inflation and account for
48 changes in physicians' operating costs. Annual updates enable small practices to better absorb other
49 payment redistributions triggered by budget neutrality rules and performance adjustments, as well
50 as periods of high inflation and rising staffing costs; they also help physicians invest in their
51 practices and implement new strategies to provide high-value care.

1 The single most influential factor in ensuring a sustainable level of payment for small practices is
2 leverage. Strong network adequacy requirements that expect all health plans to contract with
3 sufficient numbers and types of physicians bestow bargaining power by making it difficult for
4 insurers to dismiss negotiation on an in-network payment schedule. Alternatively, when small
5 practices are able to drop onerous insurance contracts and achieve out-of-network status, their
6 leverage is amplified, most markedly when underwritten by fair out-of-network rules that require
7 out-of-network physicians be eligible to be paid at rates higher than in-network physicians would
8 otherwise receive for those services.

9
10 Physicians have been moving to larger group practices in order to gain leverage as well as access to
11 more resources to effectively implement value-based care and risk-based payment models.²⁶ In this
12 era of consolidation, there is an expectation of progression from solo or small physician practices
13 to groups and multispecialty practices and, finally, to fully integrated delivery systems that employ
14 the physicians, own the hospitals, and use a single information system. In this limited view, the
15 earlier forms of practice organization are assumed to be incapable of implementing the supporting
16 systems needed for population health (e.g., registries, electronic medical records, care management,
17 team-based care) and are therefore unable to compete in value-based payment systems. A 2011
18 report of the Massachusetts Attorney General concluded that while bearing financial risk through
19 value-based payments encourages coordinated care, it also requires significant investment to
20 develop the capacity to effectively manage risk, which is more difficult for most physicians who
21 practice in small groups and have historically been paid less than larger practices.²⁷ The report also
22 found that physicians who transitioned to larger groups received professional payment that was
23 approximately 30 percent higher, which accelerated the number of physicians leaving small
24 practices and joining larger groups.

25
26 However, small practices are able to compete if they join forces to create profitable economies of
27 scale without forfeiting the advantages of being small.²⁸ When small practices collaborate, they
28 form a network of peers to learn from and to glean deeper insights from population health models.
29 Alliances can provide the scale needed to negotiate value-based contracts and to spread the risk
30 across multiple practices, so that a handful of unavoidable hospitalizations does not destroy a single
31 practice. Collaboration allows each practice access to the necessary technologies to draw actionable
32 insights from data and regulatory and coding expertise to maximize revenue, while laying the
33 groundwork for future savings.

34
35 Independent practice associations (IPAs), if structured in compliance with antitrust laws, allow
36 contracting between independent physicians and payers and can succeed in value-based purchasing
37 arrangements if they are able to achieve results equal to more highly capitalized and tightly
38 structured large medical groups and hospital-owned practices. Traditionally, most IPAs have been
39 networks of small practices organized for the purpose of negotiating fee-for-service contracts with
40 health insurers. While small practices considering participating in an IPA should be aware of the
41 potential risks, such as underfunded capitation revenue, IPAs can act as a platform for sharing
42 resources and negotiating risk-bearing medical services agreements on behalf of participating
43 practices. Many IPAs, especially those that are clinically integrated, have already converted to an
44 ACO, or provide the infrastructure for their members to organize as one. Because many of these
45 organizations have already operated as risk-bearing provider networks, IPAs are well positioned to
46 take leading roles in developing ACOs or acting as sustaining member organizations. Even if the
47 physician organization has operated in a fee-for-service environment, an IPA can bring expertise
48 regarding contracting, analytics, and management. For example, the Greater Rochester IPA
49 ([GRIPA](#)) has over 1,500 physician members who benefit from data analytics services to stratify
50 and manage patients, as well as care management support, pharmacists, visiting home nurses, and
51 diabetes educators. GRIPA has its own ACO, which distributed 83 percent of its 2020 shared

1 savings to participants. ACOs can also benefit from participation by small practices. A 2022 study
 2 found that small practices in ACOs reduced their beneficiaries’ spending more than large practices
 3 in ACOs, thereby generating higher savings for the ACOs consisting of small practices.²⁹

4
 5 CMS structures several of its initiatives in an effort to support small practices in value-based
 6 participation, such as the [Small, Underserved, and Rural Support initiative](#), which provides free,
 7 customized technical assistance to practices with 15 or fewer physicians. Small practices can
 8 contact selected organizations in their state to receive help with choosing quality measures,
 9 strategic planning, education and outreach, and health information technology optimization. CMS
 10 also includes several reporting flexibilities and rewards, specifically targeting solo and small
 11 practices under the [Quality Payment Program’s Merit-Based Incentive Payment System](#), most
 12 notably by varying submission methods and allowing special scoring consideration. The CMS
 13 [ACO Investment Model](#) built on the experience with the Alternative Payment Model (APM) to test
 14 the use of pre-paid shared savings to encourage new ACOs to form in rural and underserved areas
 15 and to encourage current Medicare Shared Savings Program ACOs to transition to arrangements
 16 with greater financial risk. It resulted in more physicians in rural and underserved communities
 17 signing on to participate in ACOs. These new ACOs invested in better care coordination, and
 18 savings have been attributed to fewer unnecessary acute hospitalizations, fewer emergency
 19 department visits, and fewer days in skilled nursing facilities among beneficiaries. The ACO
 20 Investment Model generated \$381.5 million in net Medicare savings between 2016 and 2018.³⁰ In
 21 June 2024, CMS will launch the [Making Care Primary](#) program to allow practices to build a value-
 22 based infrastructure by “improving care management and care coordination, equipping primary
 23 care clinicians with tools to form partnerships with health care specialists, and leveraging
 24 community-based connections to address patients’ health needs as well as their health-related
 25 social needs such as housing and nutrition.” The program will offer three progressive tracks to
 26 recognize participants’ varying experience in value-based care, including one reserved for practices
 27 with no prior value-based care experience.

28
 29 **RESOURCES FOR SMALL PRACTICES**

30
 31 There has been a recent emergence of payer-sponsored arrangements, such as the one sponsored by
 32 Acuitas Health. It is a partnership between a nonprofit health plan and a large multispecialty group
 33 that offers a range of services to small practices, including billing and coding assistance, practice
 34 transformation consulting, and patient aggregation, thereby allowing practices to achieve the scale
 35 needed for value-based contracts. Through its work with Acuitas, the NYC Population Health
 36 Improvement Program was able to “answer important questions about what skills small practices
 37 need in order to succeed in the new environment and how small practices might work together to
 38 share the services necessary to develop those skills...(as well as) break new ground by presenting a
 39 financial model for the cost of shared services and probing the legal and regulatory issues raised by
 40 such arrangements.”³¹ Other private companies have created shared service infrastructures to allow
 41 small, independent practices to participate in APMs, offering low-cost shared resources in return
 42 for a portion of downstream savings.

43
 44 Regardless of the payment rates, small practices can increase profit margins if they are able to keep
 45 their costs down. Group purchasing organizations (GPOs) and physician buying groups (PBGs) can
 46 offer independent practices a chance to access lower costs by using the power of many practices to
 47 benefit all. Some GPOs do not require purchases from a given supplier yet still offer leverage with
 48 other suppliers to grant small practices reduced rates. As most community-based practices offer
 49 vaccines, PBGs can play an important role in keeping costs down. Vaccines are one of the most
 50 costly and important investments a practice makes, and PBGs can offer practices lower contract
 51 pricing and rebates from the vaccine manufacturer. Practices can save five to 25 percent on the cost

1 of supplies by joining a GPO or PBG, most of which have no fee and often allow practices to join
 2 several organizations.³²

3
 4 Small practices typically sign “evergreen” contracts with payers, which continuously renew
 5 automatically until one party terminates the agreement. A payment schedule is part of the contract
 6 and will not be updated unless one party opens the contract for negotiation. In most cases, this must
 7 be the practice since it is not usually in the payer’s best financial interest to negotiate a new
 8 contract. As such, practices need to be prepared to contact the payer multiple times in order to
 9 actually get a contract negotiated – and then come to the table with as much data and population
 10 health metrics (e.g., A1C numbers for patients with diabetes) as possible. A practice able to
 11 successfully manage complex patients will have costs within a relatively narrow range without
 12 many outliers, thereby increasing negotiating leverage. Small practices can also gain a negotiating
 13 advantage if they have extended office hours, are considered the “only show in town,” provide
 14 specialized care for an underserved patient population, have obtained quality accreditation
 15 recognition (e.g., National Committee for Quality Assurance), or can share positive patient
 16 testimonials.

17
 18 The AMA has several resources dedicated to support physicians in private practice, such as the
 19 [AMA Private Practice Simple Solutions](#) series, which are “free, open access rapid learning cycles
 20 designed to provide opportunities to implement actionable changes that can immediately increase
 21 efficiency in private practices.” Session topics range from marketing to recruitment to reducing
 22 administrative burden. The AMA Practice Management Center developed the [Evaluating and
 23 Negotiating Emerging Payment Options](#) manual to assist members who are considering
 24 transitioning to risk-based payment, while the [AMA Value Based Care Toolkit](#) is being updated for
 25 2023 to provide a step-by-step guide to designing, adopting, and optimizing the value-based care
 26 model. The 2016 adoption of AMA Policy D-160.926, which calls for the development of a guide
 27 to provide information to physicians in or considering solo and small practice on how they can
 28 align through Independent Practice Associations, Accountable Care Organizations, Physician
 29 Hospital Organizations, and other models to help them with the imminent movement to risk-based
 30 contracting and value-based care, resulted in the development of the [Joining or Aligning with a
 31 Physician-Led Integrated Health System](#) guide, which was updated in June 2020. The AMA also
 32 offers a [Private Practice Group Membership Program](#) to drive sustainability and accelerate
 33 innovation for members in private practice, as well as a [Voluntary Best Practices to Advance Data
 34 Sharing Playbook](#) to address the future of sustainable value-based payment.

35
 36 **AMA POLICY**

37
 38 The AMA’s longstanding goal to promote the sustainability of solo, small, and primary care
 39 practices is reflected in numerous AMA policies, including those that:

- 40
 41 • Call for the development of a guide to provide information to physicians in or considering
 42 solo and small practice on how they can align through IPAs, ACOs, Physician Hospital
 43 Organizations, and other models to help them with the imminent movement to risk-based
 44 contracting and value-based care (Policy D-160.926);
 45 • Advocate in Congress to ensure adequate payment for services rendered by private
 46 practicing physicians, create and maintain a reference document establishing principles for
 47 entering into and sustaining a private practice, and issue a report in collaboration with the
 48 Private Practice Physicians Section at least every two years communicating efforts to
 49 support independent medical practices (Policy D-405.988);
 50 • Support development of administrative mechanisms to assist primary care physicians in the
 51 logistics of their practices to help ensure professional satisfaction and practice

- 1 sustainability, support increased financial incentives for physicians practicing primary care,
2 especially those in rural and urban underserved areas, and advocate for public and private
3 payers to develop physician payment systems to promote primary care and specialty
4 practices in progressive, community-based models of integrated care focused on quality
5 and outcomes (Policy H-200.949);
- 6 • Reinforce the freedom of physicians to choose their method of earning a living and the
7 right of physicians to charge their patients their usual fee that is fair, irrespective of
8 insurance/coverage arrangements between the patient and the insurers (Policy H-385.926);
 - 9 • Support insurance payment rates that are established through meaningful negotiations and
10 contracts (Policy H-165.838);
 - 11 • Call for a formal, legal review of ongoing grievous behaviors of the health insurance
12 industry (Policy D-385.949);
 - 13 • Advocate for payment rates that are sufficient to cover the full cost of sustainable medical
14 practice, continue to monitor health care delivery and physician payment reform activities,
15 and provide resources to help physicians understand and participate in payment reform
16 initiatives (Policy H-390.849);
 - 17 • Seek positive inflation-adjusted annual physician payment updates that keep pace with
18 rising practice costs to ensure payment rates cover the full cost of sustainable medical
19 practice (D-390.946); and
 - 20 • Support fair out-of-network payment rules coupled with strong network adequacy
21 requirements for all physicians (H-285.904).

22
23 The AMA has policy that addresses the challenges presented by the evolving value-based health
24 care system, such as those that:

- 25
- 26 • Provide guidance and support infrastructure that allows independent physicians to join with
27 other physicians in clinically integrated networks independent of any hospital system,
28 identify financially viable prospective payment models, and develop educational
29 opportunities for physicians to learn and collaborate on best practices for such payment
30 models for physician practice, including but not limited to independent private practice
31 (Policy H-385.904);
 - 32 • Support a pluralistic approach to third-party payment methodology, promoting flexibility
33 in payment arrangements (Policy H-385.989);
 - 34 • Reaffirm the AMA's support for a neutral public policy and fair market competition among
35 alternative health care delivery and financing systems (Policy H-385.990); and
 - 36 • Emphasize the AMA's dedication to seeking payment reform, supporting independent
37 physicians in joining clinically integrated networks, and refining relative values for
38 services based on valid and reliable data (Policy H-400.972).

39
40 AMA policy does not endorse a specific payment mechanism such as Medicare RBRVS, but
41 instead, states that use of RBRVS relative values is one option that could provide the basis for both
42 public and private physician payment systems. Among the most relevant policies are those that:

- 43
- 44 • Oppose any type of national mandatory fee schedule (Policy H-385.986);
 - 45 • Support uncoupling of commercial fee schedules from Medicare conversion factors and
46 seek legislation and/or regulation to prevent insurance companies from utilizing a
47 physician payment schedule below the updated Medicare professional fee schedule (Policy
48 D-400.990); and

- Support a pluralistic approach to third-party payment methodology under fee-for-service, and do not support a preference for usual and customary or reasonable or any other specific payment methodology (Policy H-385.989).

Finally, AMA policies establish a minimum physician payment of 100 percent of the RBRVS Medicare allowable for CHIP and Medicaid (Policy H-290.976) as well as for TRICARE and any other publicly funded insurance plan (Policy H-385.921).

DISCUSSION

Research has found that small community practices are able to deliver more personalized patient care and have lower rates of preventable hospital admissions. They are able to detect potential conditions before they result in hospital admissions and accordingly play a vital role in keeping patients healthier. However, small community practices may be challenged in implementing the support systems needed for participation in population health management and value-based purchasing arrangements. As such, the Council believes that bonuses for population-based programs must be accessible to small community practices, taking into consideration the size of the populations they manage and with a specific focus on improving care and payment for children, pregnant people, and people with mental health conditions, as these groups are often disproportionately covered by Medicaid.

Small practices are typically not eligible to collect facility fees or utilize various addresses or facility types to generate higher billing for similar procedures depending on contracts and incentives, thereby creating a revenue differential with larger practices. Most importantly, small practices lack the leverage retained by larger practices, putting them at a significant disadvantage when negotiating payment schedules. The single most influential factor in ensuring a sustainable level of payment for small practices is leverage. Strong network adequacy requirements that expect all health plans to contract with sufficient numbers and types of physicians bestow bargaining power by making it difficult for insurers to dismiss negotiation on an in-network payment schedule. Alternatively, when small practices are able to drop onerous insurance contracts and achieve out-of-network status, their leverage is amplified, most markedly when underwritten by fair out-of-network rules that require out-of-network physicians be eligible to be paid at rates higher than in-network physicians would otherwise receive for those services. There are resources available to help small practices succeed, most notably in underserved markets where average private professional service payments tend to be higher than those in more competitive physician markets.³³

Resolution 108-A-23 presumes that small practices experience private insurance payment rates well below Medicare payment rates. However, research shows that private insurance payment rates are, on average, higher than Medicare payment rates for the same health care services.³⁴ While there are limitations in the available data due to inclusion of larger practices and hospital-employed physicians, variability in private insurance payment schedules means that most small practices accept multiple different payment schedules from different payers, making it difficult for them to respond to questions about payment rates with accuracy. Accordingly, the Council believes a physician survey is not likely to illuminate payment variations in small practices between private insurance and Medicare payment rates. Small practices have a higher percentage of private health insurance patients than larger practices, which should benefit them. However, not all private insurance payments are reflective of the full cost of practice, the value of the care provided, or include inflation-based updates.

1 Research also indicates that Medicaid payment rates are substantially below Medicare payment
 2 rates. As the largest public health insurance provider in the United States, Medicaid policy has
 3 significant health equity implications. Low payment rates may limit access to quality care and
 4 contribute to poor health outcomes for Medicaid beneficiaries. While Medicaid state flexibility is
 5 intended to preserve state operational autonomy and programming, it has fostered wide variability
 6 and geographic inequities, particularly between Medicaid expansion states and non-expansion
 7 states, further enabling health disparities. Substantial dependence on state revenues has led to low
 8 payment rates that effectively limit access, as it disincentivizes providing care to the often
 9 minoritized populations the program serves. As small practices must absorb costs required to
 10 provide care to the Medicaid population, such as compliance with regulations and addressing
 11 Social Determinants of Health toward equitable care, lower payment makes it almost impossible to
 12 recover those costs.

13
 14 Although AMA policy does not endorse a specific payment mechanism such as the Medicare
 15 RBRVS and opposes any type of mandatory payment schedule, it does support payment at no less
 16 than 100 percent of RBRVS Medicare allowable as one option that could provide the basis for both
 17 public and private physician payment systems. However, consideration must be given to the
 18 challenges presented by tying payment to a Medicare benchmark, which can be manipulated by
 19 payers to provide them with a financial advantage. Some payers may adopt only a portion of the
 20 Medicare RBRVS or use an outdated RBRVS where the RVUs are no longer reflective of current
 21 resource costs. Other payers may implement time-limited or temporary arrangements or apply the
 22 RBRVS to only certain specialties, leading to disruption in care or difficulties with patient
 23 referrals. Most importantly, continuing to tether payment to a Medicare payment rate that has been
 24 reduced by almost 10 percent in four years presents an untenable situation for small practices. As
 25 such, uncoupling payment schedules from a Medicare benchmark may allow for a level of payment
 26 that reflects the full cost of practice, the value of the care provided, and includes inflation-based
 27 updates, thereby sustaining small practices.

28
 29 It is unfeasible to establish an equitable minimum government payment rate defensible across the
 30 six major government health care programs. Furthermore, it would be impracticable to establish a
 31 minimum payment rate in the private physician market, which is currently riding a consolidation
 32 wave, transforming health insurers into much larger and more powerful conglomerates. The
 33 Council believes that an ideal payment benchmark will reflect the cost of providing care both in the
 34 short term and long term while acknowledging risk, variable expenses, an appropriate allocation of
 35 fixed costs, and physician work. It is essential that the benchmark reflect the full cost of practice
 36 and the value of the care provided, as well as include inflation-based updates. The benchmark
 37 should disclose payment amounts and the methodology used to calculate them, as these are
 38 fundamental to establishing trust between physicians and insurers and promoting sound decision
 39 making by all participants in the health care system.

40
 41 For small community practices, sustainable payment reflects the full cost of practice and the value
 42 of the care provided. Additionally, it includes annual inflation-based payment updates, which are
 43 essential to measure practice cost inflation and account for changes in physicians' operating costs.
 44 Annual updates enable small practices to better absorb other payment redistributions triggered by
 45 budget neutrality rules and performance adjustments, as well as periods of high inflation and rising
 46 staffing costs; they also help physicians invest in their practices and implement new strategies to
 47 provide high-value care.

1 RECOMMENDATIONS

2
3 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
4 108-A-23, and the remainder of the report be filed:

5
6 1. That our American Medical Association (AMA) support making bonuses for population-
7 based programs accessible to small community practices, taking into consideration the size
8 of the populations they manage and with a specific focus on improving care and payment
9 for children, pregnant people, and people with mental health conditions, as these groups
10 are often disproportionately covered by Medicaid. (New HOD Policy)

11
12 2. That our AMA amend Policy D-400.990 by addition and deletion, and modify the title by
13 addition and deletion, as follows:

14
15 ~~Uncoupling Commercial Fee Schedules from the Medicare Physician Payment Schedule~~
16 ~~Conversion Factors~~ D-400.990

17 Our AMA: (1) shall use every means available to convince health insurance companies and
18 managed care organizations to immediately uncouple fee schedules from ~~the Medicare~~
19 ~~Physician Payment Schedule conversion factors~~ and to maintain a ~~fair and appropriate~~
20 ~~level of payment reimbursement that is sustainable, reflects the full cost of practice, the~~
21 ~~value of the care provided, and includes an inflation-based update;~~ and (2) will seek
22 legislation and/or regulation to prevent managed care companies from utilizing a physician
23 payment schedule below the updated Medicare ~~Physician Payment professional fee~~
24 ~~Schedule~~. (Modify Current HOD Policy)

25
26 3. That our AMA amend Policy H-290.976 by addition and deletion, and modify the title by
27 addition and deletion, as follows:

28
29 ~~Enhanced SCHIP Enrollment, Outreach, and Payment Reimbursement~~ H-290.976

30 1. It is the policy of our AMA that prior to or concomitant with states' expansion of ~~State~~
31 ~~Children's Health Insurance Programs (SCHIP)~~ to adult coverage, our AMA urge all states
32 to maximize their efforts at outreach and enrollment of ~~SCHIP~~ eligible children, using all
33 available state and federal funds.

34 2. Our AMA affirms its commitment to advocating for ~~reasonable SCHIP and Medicaid~~
35 ~~payment that is sustainable, reflects the full cost of practice, the value of the care provided,~~
36 ~~and includes inflation-based updates, reimbursement for its medical providers, defined as~~
37 ~~at minimum and is no less than~~ 100 percent of RBRVS Medicare allowable. (Modify
38 Current HOD Policy)

39
40 4. That our AMA amend Policy H-385.921 by addition and deletion as follows:

41
42 ~~Health Care Access for Medicaid Patients~~ H-385.921

43 It is AMA policy that to increase and maintain access to health care for all, payment for
44 physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan
45 must be ~~sustainable, reflect the full cost of practice, the value of the care provided, and~~
46 ~~include inflation-based updates, and is no less than at minimum~~ 100 percent of ~~the~~ RBRVS
47 Medicare allowable. (Modify Current HOD Policy)

48
49 5. That our AMA reaffirm Policy D-405.988, which calls for advocacy in Congress to ensure
50 adequate payment for services rendered by private practicing physicians, creating and
51 maintaining a reference document establishing principles for entering into and sustaining a

- 1 private practice, and issuing a report in collaboration with the Private Practice Physicians
2 Section at least every two years to communicate efforts to support independent medical
3 practices. (Reaffirm HOD Policy)
4
- 5 6. That our AMA reaffirm Policy H-200.949, which supports development of administrative
6 mechanisms to assist primary care physicians in the logistics of their practices to help
7 ensure professional satisfaction and practice sustainability, support increased financial
8 incentives for physicians practicing primary care, especially those in rural and urban
9 underserved areas, and advocate for public and private payers to develop physician
10 payment systems to promote primary care and specialty practices in progressive,
11 community-based models of integrated care focused on quality and outcomes. (Reaffirm
12 HOD Policy)
13
- 14 7. That our AMA reaffirm Policy H-285.904, which supports fair out-of-network payment
15 rules coupled with strong network adequacy requirements for all physicians. (Reaffirm
16 HOD Policy)
17
- 18 8. That our AMA reaffirm Policy H-385.986, which opposes any type of national mandatory
19 fee schedule. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

- ¹ Kane, Carol, American Medical Association Policy Research Perspectives, “Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022;” Available at: <https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf>
- ² Simply Psychology, “What Is A Cohort Effect? Definitions and Examples;” Available at: <https://www.simplypsychology.org/cohort-effect-definition.html>
- ³ Dorsey ER, Jarjoura D, Rutecki GW. The influence of controllable lifestyle and sex on the specialty choices of graduating U.S. medical students, 1996-2003. *Acad Med.* 2005 Sep;80(9):791-6. doi: 10.1097/00001888-200509000-00002. PMID: 16123455. Available at: <https://pubmed.ncbi.nlm.nih.gov/16123455/>
- ⁴ Lin KY. Physicians' perceptions of autonomy across practice types: Is autonomy in solo practice a myth? *Soc Sci Med.* 2014 Jan;100:21-9. doi: 10.1016/j.socscimed.2013.10.033. Epub 2013 Nov 5. PMID: 24444835; PMCID: PMC3898537. Available at: <https://pubmed.ncbi.nlm.nih.gov/24444835/>
- ⁵ Casalino LP, Pesko MF, Ryan AM, Mendelsohn JL, Copeland KR, Ramsay PP, Sun X, Rittenhouse DR, Shortell SM. Small primary care physician practices have low rates of preventable hospital admissions. *Health Aff (Millwood).* 2014 Sep;33(9):1680-8. doi: 10.1377/hlthaff.2014.0434. Epub 2014 Aug 13. PMID: 25122562. Available at: <https://pubmed.ncbi.nlm.nih.gov/25122562/>
- ⁶ Piette JD, Heisler M, Krein S, Kerr EA. The role of patient-physician trust in moderating medication nonadherence due to cost pressures. *Arch Intern Med.* 2005;165(15):1749-1755. Available at: <https://pubmed.ncbi.nlm.nih.gov/16087823/>
- ⁷ Hostetter M, Klein S. The Commonwealth Fund Case Study, “How Independent Primary Care Clinicians Leverage Trust to Help Vulnerable Populations;” September 2020. Available at: <https://www.commonwealthfund.org/publications/case-study/2020/sep/how-independent-primary-care-clinicians-leverage-trust-help>
- ⁸ United States, Department of Labor, “Fact Sheet #17D: Exemption for Professional Employees Under the Fair Labor Standards Act (FLSA);” Available at: <https://www.dol.gov/agencies/whd/fact-sheets/17d-overtime-professional>
- ⁹ American Medical Association, “AMA/Specialty Society RVS Update Committee: An Overview of the RUC Process,” 2023. Available at: <https://amatoday.sharepoint.com/sites/teamwork/RUC/doc/ruc-update-booklet.pdf?csf=1&e=jvcBH9&cid=63350f70-c0a0-4e39-adfb-5715cde71f57>

- ¹⁰ Schneider, A, et al., The Kaiser Commission on Medicaid and the Uninsured, “Medicaid Financing,” May 2013. Available at: <https://www.kff.org/wp-content/uploads/2013/05/mrbfinancing.pdf>
- ¹¹ McMorrow, S, et al., The Urban Institute, “Commercial Health Insurance Markups over Medicare Prices for Physician Services Vary Widely by Specialty,” October 2021. Available at: <https://www.urban.org/sites/default/files/publication/104945/commercial-health-insurance-markups-over-medicare-prices-for-physician-services-vary-widely-by-specialty.pdf>
- ¹² Baker LC, Bundorf MK, Royalty AB, Levin Z. Physician Practice Competition and Prices Paid by Private Insurers for Office Visits. JAMA. 2014;312(16):1653–1662. doi:10.1001/jama.2014.10921
- ¹³ Johnson, B, et al., Health Care Cost Institute, “Comparing Commercial and Medicare Professional Service Prices,” August 2020. Available at: <https://healthcostinstitute.org/all-hcci-reports/comparing-commercial-and-medicare-professional-service-prices>
- ¹⁴ Lopez, E, et al., Kaiser Family Foundation, “How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature;” Available at: <https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/>
- ¹⁵ McBeth, A, et al., Milliman white paper, “Commercial Reimbursement Benchmarking,” November 2022. Available at: <https://www.milliman.com/en/insight/commercial-reimbursement-benchmarking#2>
- ¹⁶ Congressional Budget Office, “The Prices That Commercial Health Insurers and Medicare Pay for Hospitals’ and Physicians’ Services,” January 2022. Available at: <https://www.cbo.gov/system/files/2022-01/57422-medical-prices.pdf>
- ¹⁷ Office of Inspector General, “Comparing Medicare Physician Payments to Private Payers,” January 2003. Available at: <https://oig.hhs.gov/oei/reports/oei-06-00-00570.pdf>
- ¹⁸ Johnson, B, et al., Health Care Cost Institute, “Comparing Commercial and Medicare Professional Service Prices,” August 2020. Available at: <https://healthcostinstitute.org/all-hcci-reports/comparing-commercial-and-medicare-professional-service-prices>
- ¹⁹ Rama, Apoorva, American Medical Association, 2022 AMA Physician Practice Benchmark Survey, July 2023. Available at: <https://www.ama-assn.org/about/research/physician-practice-benchmark-survey#:~:text=2022%20Benchmark%20Survey,-Recent%20Changes%20in&text=There%20has%20been%20a%20redistribution,from%2012.2%25%20to%2018.3%25>
- ²⁰ Zuckerman S, Skopec L, Aarons J. Medicaid Physician Fees Remained Substantially Below Fees Paid By Medicare In 2019. Health Aff (Millwood). 2021 Feb;40(2):343-348. doi: 10.1377/hlthaff.2020.00611. PMID: 33523743. Available at: <https://pubmed.ncbi.nlm.nih.gov/33523743/>
- ²¹ Biener AI, Selden TM. Public And Private Payments For Physician Office Visits. Health Aff (Millwood). 2017 Dec;36(12):2160-2164. doi: 10.1377/hlthaff.2017.0749. PMID: 29200346. Available at: <https://pubmed.ncbi.nlm.nih.gov/29200346/>
- ²² Alexander, D, et al. National Bureau of Economic Research, “The Impacts of Physician Payments on Patient Access, Use, and Health,” August 2020. Available at: <https://www.nber.org/papers/w26095>
- ²³ Rubin, I, et al, Center on Budget and Policy Priorities, “Medicaid Expansion: Frequently Asked Questions,” June 2021. Available at: <https://www.cbpp.org/research/health/medicaid-expansion-frequently-asked-questions>
- ²⁴ Ozminowski RJ, Gaumer G, Coit AJ, Gabay M. Hospital wage and price controls: lessons from the Economic Stabilization Program. Health Care Financ Rev. 1994 Winter;16(2):13-43. PMID: 10142369; PMCID: PMC4193497.
- ²⁵ Kane, Carol, American Medical Association Policy Research Perspectives, “Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022;” Available at: <https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf>
- ²⁶ Muhlestein DB, Smith NJ. Physician Consolidation: Rapid Movement From Small To Large Group Practices, Health Affairs, September 2016. Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0130>
- ²⁷ Coakley, Martha, Office of the Massachusetts Attorney General, Examination of Health Care Cost Trends and Cost Drivers, June 2011. Available at: <https://www.mass.gov/doc/2011-examination-of-health-care-cost-trends-and-cost-drivers-with-appendix/download>
- ²⁸ Liaw WR, Jetty A, Petterson SM, Peterson LE, Bazemore AW. Solo and Small Practices: A Vital, Diverse Part of Primary Care. Ann Fam Med. 2016 Jan-Feb;14(1):8-15. doi: 10.1370/afm.1839. PMID: 26755778; PMCID: PMC4709150. Available at: <https://pubmed.ncbi.nlm.nih.gov/26755778/>

²⁹ Gibbons, JB, et al., The American Journal of Managed Care, “Small Practice Participation and Performance in Medicare Accountable Care Organizations,” Vol 8, Issue 3, March 2022; Available at: <https://www.ajmc.com/view/small-practice-participation-and-performance-in-medicare-accountable-care-organizations>

³⁰ Jacobs, D, et al, New England Journal of Medicine, “Expanding Accountable Care’s Reach among Medicare Beneficiaries,” July 14, 2022. Available at: <https://www.nejm.org/doi/full/10.1056/NEJMp2202991>

³¹ New York City Health Department, “The PHIP Small Practice Project Final Report,” June 2018. Available at: <https://www.nyc.gov/assets/doh/downloads/pdf/public/hip-report2018.pdf>

³² Kaplan, DA, Medical Economics Journal, “Group purchasing: Save money by aligning with other physicians,” Vol 95, Issue 21, November 2018; Available at: <https://www.medicaleconomics.com/view/group-purchasing-save-money-aligning-other-physicians>

³³ Baker LC, Bundorf MK, Royalty AB, Levin Z. Physician Practice Competition and Prices Paid by Private Insurers for Office Visits. JAMA. 2014;312(16):1653–1662. doi:10.1001/jama.2014.10921. Available at: <https://jamanetwork.com/journals/jama/fullarticle/1917436>

³⁴ Lopez, E, et al., Kaiser Family Foundation, “How Much More Than Medicare Do Private Insurers Pay? A Review of the Literature;” Available at: <https://www.kff.org/medicare/issue-brief/how-much-more-than-medicare-do-private-insurers-pay-a-review-of-the-literature/>

**Council on Medical Service Report 8-A-24
Sustainable Payment for Community Practices
Policy Appendix**

Uncoupling Commercial Fee Schedules from Medicare Conversion Factors D-400.990

Our AMA: (1) shall use every means available to convince health insurance companies and managed care organizations to immediately uncouple fee schedules from Medicare conversion factors and to maintain a fair and appropriate level of reimbursement; and (2) will seek legislation and/or regulation to prevent managed care companies from utilizing a physician payment schedule below the updated Medicare professional fee schedule.

Res. 137, A-02 Reaffirmed: CCB/CLRPD Rep. 4, A-12 Appended: Res. 103, A-13 Reaffirmation: A-19

The Preservation of the Private Practice of Medicine D-405.988

Our AMA: (1) supports preserving the value of the private practice of medicine and its benefit to patients; (2) will utilize its resources to protect and support the continued existence of solo and small group medical practice, and to protect and support the ability of these practices to provide quality care; (3) will advocate in Congress to ensure adequate payment for services rendered by private practicing physicians; (4) will work through the appropriate channels to preserve choices and opportunities, including the private practice of medicine, for new physicians whose choices and opportunities may be limited due to their significant medical education debt; (5) will work through the appropriate channels to ensure that medical students and residents during their training are educated in all of medicine's career choices, including the private practice of medicine; (6) will create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice; (7) will create and maintain a reference document establishing principles for entering into and sustaining a private practice, and encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option; and (8) will issue a report in collaboration with the Private Practice Physicians Section at least every two years communicating their efforts to support independent medical practices.

Res. 224, I-10 Appended: Res. 604, A-12 Reaffirmation I-13 Appended: Res. 735, A-14 Reaffirmed in lieu of Res. 223, I-14 Modified: Speakers Rep. 01, A-17 Reaffirmed: Res. 724, A-22 Reaffirmation: A-22 Appended: Res. 602, A-22

Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to

ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

4. Admissions and recruitment: The medical school admissions process should reflect the specific institution's mission. Those schools with missions that include primary care should consider those predictor variables among applicants that are associated with choice of these specialties.

5. Medical schools, through continued and expanded recruitment and outreach activities into secondary schools, colleges, and universities, should develop and increase the pool of applicants likely to practice primary care by seeking out those students whose profiles indicate a likelihood of practicing in primary care and underserved areas, while establishing strict guidelines to preclude discrimination.

6. Career counseling and exposure to primary care: Medical schools should provide to students career counseling related to the choice of a primary care specialty, and ensure that primary care physicians are well-represented as teachers, mentors, and role models to future physicians.

7. Financial assistance programs should be created to provide students with primary care experiences in ambulatory settings, especially in underserved areas. These could include funded preceptorships or summer work/study opportunities.

8. Curriculum: Voluntary efforts to develop and expand both undergraduate and graduate medical education programs to educate primary care physicians in increasing numbers should be continued. The establishment of appropriate administrative units for all primary care specialties should be encouraged.

9. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective. At the same time, all medical schools should be encouraged to continue to change their curriculum to put more emphasis on primary care.

10. All four years of the curriculum in every medical school should provide primary care experiences for all students, to feature increasing levels of student responsibility and use of ambulatory and community-based settings.

11. Federal funding, without coercive terms, should be available to institutions needing financial support to expand resources for both undergraduate and graduate medical education programs designed to increase the number of primary care physicians. Our AMA will advocate for public (federal and state) and private payers to a) develop enhanced funding and related incentives from all sources to provide education for medical students and resident/fellow physicians, respectively, in progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model) to enhance primary care as a career choice; b) fund and foster innovative pilot programs that change the current approaches to primary care in undergraduate and graduate medical education, especially in urban and rural underserved areas; and c) evaluate these efforts for their effectiveness in increasing the number of students choosing primary care careers and helping facilitate the elimination of geographic, racial, and other health care disparities.

12. Medical schools and teaching hospitals in underserved areas should promote medical student and resident/fellow physician rotations through local family health clinics for the underserved, with financial assistance to the clinics to compensate their teaching efforts.

13. The curriculum in primary care residency programs and training sites should be consistent with the objective of training generalist physicians. Our AMA will encourage the Accreditation Council for Graduate Medical Education to (a) support primary care residency programs, including community hospital-based programs, and (b) develop an accreditation environment and novel pathways that promote innovations in graduate medical education, using progressive, community-based models of integrated care focused on quality and outcomes (such as the patient-centered medical home and the chronic care model).

14. The visibility of primary care faculty members should be enhanced within the medical school, and positive attitudes toward primary care among all faculty members should be encouraged.

15. Support for practicing primary care physicians: Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, along with enhanced efforts to reduce administrative activities unrelated to patient care, to help ensure professional satisfaction and practice sustainability.

16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

19. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

20. Our AMA will urge urban hospitals, medical centers, state medical associations, and specialty societies to consider the expanded use of mobile health care capabilities.

21. Our AMA will encourage the Centers for Medicare & Medicaid Services to explore the use of telemedicine to improve access to and support for urban primary care practices in underserved settings.

22. Accredited continuing medical education providers should promote and establish continuing medical education courses in performing, prescribing, interpreting and reinforcing primary care services.

23. Practicing physicians in other specialties--particularly those practicing in underserved urban or rural areas--should be provided the opportunity to gain specific primary care competencies through short-term preceptorships or postgraduate fellowships offered by departments of family medicine, internal medicine, pediatrics, etc., at medical schools or teaching hospitals. In addition, part-time training should be encouraged, to allow physicians in these programs to practice concurrently, and further research into these concepts should be encouraged.

24. Our AMA supports continued funding of Public Health Service Act, Title VII, Section 747, and encourages advocacy in this regard by AMA members and the public.

25. Research: Analysis of state and federal financial assistance programs should be undertaken, to determine if these programs are having the desired workforce effects, particularly for students from disadvantaged groups and those that are underrepresented in medicine, and to gauge the impact of these programs on elimination of geographic, racial, and other health care disparities. Additional research should identify the factors that deter students and physicians from choosing and remaining in primary care disciplines. Further, our AMA should continue to monitor trends in the choice of a primary care specialty and the availability of primary care graduate medical education positions. The results of these and related research endeavors should support and further refine AMA policy to enhance primary care as a career choice.

Out-of-Network Care H-285.904

1. Our AMA adopts the following principles related to unanticipated out-of-network care:

A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.

B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.

C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.

D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

E. Patients who are seeking emergency care should be protected under the “prudent layperson” legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.

2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

3. Our AMA will advocate that any legislation addressing surprise out-of-network medical bills use an independent, non-conflicted database of commercial charges.

Res. 108, A-17 Reaffirmation: A-18 Appended: Res. 104, A-18 Reaffirmed in lieu of: Res. 225, I-18 Reaffirmation: A-19 Reaffirmed: Res. 210, A-19 Appended: Res. 211, A-19 [Reaffirmed: CMS Rep. 5, A-21](#) Modified: Res. 236, A-22

Enhanced SCHIP Enrollment, Outreach, and Reimbursement H-290.976

1. It is the policy of our AMA that prior to or concomitant with states’ expansion of State Children’s Health Insurance Programs (SCHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.

2. Our AMA affirms its commitment to advocating for reasonable SCHIP and Medicaid reimbursement for its medical providers, defined as at minimum 100 percent of RBRVS Medicare allowable.

Res. 103, I-01 Reaffirmation A-07 Reaffirmation A-11 [Reaffirmed: CMS Rep. 7, I-14](#) Reaffirmation

[A-15 Reaffirmed: CMS Rep. 3, A-15](#) Reaffirmation: A-17 Reaffirmed: CMS Rep. 02, A-19 [Reaffirmed: CMS Rep. 5, I-20](#) Reaffirmed: CMS Rep. 9, A-21 Reaffirmed: CMS Rep. 3, I-21 [Reaffirmed: CMS Rep. 1, I-22](#)

Health Care Access for Medicaid Patients H-385.921

It is AMA policy that to increase and maintain access to health care for all, payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be at minimum 100 percent of the RBRVS Medicare allowable.

Res. 103, A-07 Reaffirmed: CMS Rep. 2, I-08 Reaffirmation A-12 Reaffirmed: Res 132, A-14 Reaffirmed in lieu of Res. 808, I-14 Reaffirmation A-15 Reaffirmed in lieu of: Res. 807, I-18

National Mandatory Fee Schedule H-385.986

The AMA opposes any type of national mandatory fee schedule.

Res. 27, A-85 Reaffirmed: BOT Rep. UU, A-93 Reaffirmed CLRPD Rep. 2, I-95 Reaffirmed: CMS Rep. 7, A-05 Reaffirmed in lieu of Res. 127, A-10 Reaffirmation A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(A-24)

Introduced by: Medical Student Section

Subject: Infertility Coverage

Referred to: Reference Committee A

1 Whereas, fertility assistance and preservation are commonly used by patients diagnosed with or
2 at risk for infertility (including iatrogenic infertility due to medical interventions, such as cancer
3 treatment or hormone replacement therapy), LGBTQ+ patients, military and veteran patients,
4 and patients who desire future pregnancy at advanced reproductive age¹⁻²; and

5
6 Whereas, cost for services such as in vitro fertilization or oocyte cryopreservation ranges from
7 \$10,000 to \$13,000, not including medications, further tests, multiple cycles, and cryostorage
8 fees³⁻⁵; and

9
10 Whereas, the average cost for semen analysis by emission is around \$750, with additional costs
11 for cryostorage⁶; and

12
13 Whereas, cost due to lack of insurance coverage and need for supplemental insurance is the
14 most common barrier for patients with infertility, often leading them to end treatment⁷⁻⁸; and

15
16 Whereas, in states where employer plans cover assisted reproductive technology, the cost of in
17 vitro fertilization (IVF) is 13% of average annual disposable income compared to 52% in other
18 states, indicating that coverage regulations drastically affect affordability⁹; and

19
20 Whereas, Medicaid covers fertility drugs in only one state, covers infertility diagnostics in only a
21 few states, and does not cover other fertility assistance or preservation services¹⁰; and

22
23 Whereas, TRICARE only covers infertility care that enables “natural conception,” and the VA
24 only covers care for infertility due to service-related injuries and only if donor eggs and sperm
25 are from a couple, excluding LGBTQ+ and unmarried individuals¹⁰; and

26
27 Whereas, 25 states and DC have various regulations at least partially restricting coverage of
28 some fertility diagnostics or services in at least a portion of employer plans offered, although sex
29 and gender-based restrictions, cost-sharing, age cutoffs, marital requirements, exemptions for
30 small and large employers, and other stipulations vary widely¹⁰⁻¹⁴; and

31
32 Whereas, states with private coverage for fertility services do not experience significant
33 premium increases, with estimates ranging from 0.5-1% (\$1-5), while demonstrating 150-300%
34 greater use of fertility services compared to states without^{10,15-17}; and

35
36 Whereas, Black women may have higher infertility rates but are less likely to use fertility
37 services, and Black, Hispanic, and Asian women all experience poorly understood lower
38 success rates for fertility services, alongside many financial and logistic barriers¹⁸⁻²⁰; and

1 Whereas, women of color also report hearing comments disregarding their fertility concerns or
2 perpetuating stereotypes (that they can become pregnant easily or that they should not become
3 pregnant at all)²⁰; and
4

5 Whereas, LGBTQ+ individuals and unmarried individuals are often excluded from conditions
6 and requirements for fertility services^{10,11,21,22}; and
7

8 Whereas, unlike the IHS, other federal health programs such as the Veterans Health
9 Administration and Federal Employees Health Benefit Program, provide a spectrum of coverage
10 for infertility diagnostics and treatment²³; and

11 Whereas, the prevalence of infertility and impaired fecundity (reproductive fitness) among
12 American Indian and Alaska Native (AI/AN) persons is 7.0% and 13.2%, respectively, which is
13 greater than that of the U.S. population (6.4% and 11.0%)²⁴; and
14

15 Whereas, positive pregnancy (PP) and ongoing pregnancy/delivery (OP/D) rates are estimated
16 to be 15% and 10% per IUI cycle in the general population, respectively, but AI/AN patients
17 have marked PP/OP/D disparities (5.10% PP and 3.3% OP/D)²⁵; and
18

19 Whereas, the IHS defines Level 5 (Excluded Services) as services and procedures considered
20 purely cosmetic in nature, experimental or investigational, or with no proven medical benefit and
21 includes IVF and related services in this category, preventing IHS, Tribal, and Urban Indian
22 Health Programs from paying for this care²⁶⁻²⁸; therefore be it
23

24 RESOLVED, that our American Medical Association amend Policy H-185.990, "Infertility and
25 Fertility Preservation Insurance Coverage" by addition and deletion to read as follows;
26

27 1. Our AMA ~~encourages third party payer health insurance carriers~~
28 ~~to make available insurance benefits~~ supports federal protections
29 that ensure insurance coverage by all payers for the diagnosis and
30 treatment of recognized ~~male and female~~ infertility.

31 2. Our AMA supports payment for fertility preservation therapy
32 services by all payers when iatrogenic infertility may be caused
33 directly or indirectly by necessary medical treatments as
34 determined by a licensed physician, and will lobby for appropriate
35 federal legislation requiring payment for fertility preservation
36 therapy services by all payers when iatrogenic infertility may be
37 caused directly or indirectly by necessary medical treatments as
38 determined by a licensed physician.

39 3. Our AMA will work with interested organizations to encourage the
40 Indian Health Service to cover infertility diagnostics and treatment
41 for patients seen by or referred through an Indian Health Service,
42 Tribal, or Urban Indian Health Program. (Modify Current HOD
43 Policy); and be it further
44

45 RESOLVED, that our AMA study the feasibility of insurance coverage for fertility preservation
46 for reasons other than iatrogenic infertility (Directive to Take Action); and be it further
47

48 RESOLVED, that our AMA support the review of services defined to be experimental or
49 excluded for payment by the Indian Health Service and for the appropriate bodies to make
50 evidence-based recommendations for updated health services coverage. (New HOD Policy)

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

Received: 4/5/2024

REFERENCES

1. Benaloun E, Sermondade N, Moreau E, et al. Place de la préservation de la fertilité dans le parcours de transition des femmes transgenres [Fertility preservation for transwomen]. *Gynecol Obstet Fertil Senol*. 2021;49(6):547-552. doi:10.1016/j.gofs.2021.01.007
2. Colmorn LB, Kristensen SG, Dueholm M, Macklon KT. *Ugeskr Laeger*. 2021;183(48):V05210409.
3. Paying For Treatments. Cancer Fertility Preservation. Allianceforfertilitypreservation.org. <https://www.allianceforfertilitypreservation.org/costs/paying-for-treatments>. Published 2021. Accessed September 12, 2021.
4. Hirshfeld-Cytron J, Grobman WA, Milad MP. Fertility preservation for social indications: a cost-based decision analysis. *Fertility and Sterility*. 2012;97(3):665-670. doi:10.1016/j.fertnstert.2011.12.029
5. Jeong Perry, A., Nguyen, A. How to decide if freezing your eggs is right for you — and where to get started. www.npr.org <https://www.npr.org/2021/11/18/1056834875/egg-freezing-process-how-much-does-it-cost>. Published December 2, 2021. Accessed March 20, 2022.
6. Insogna IG, Ginsburg ES. Infertility, Inequality, and How Lack of Insurance Coverage Compromises Reproductive Autonomy. *AMA J Ethics*. 2018;20(12):E1152-E1159. Published 2018 Dec 1. doi:10.1001/amajethics.2018.1152
7. Gilbert K, Nangia AK, Dupree JM, Smith JF, Mehta A. Fertility preservation for men with testicular cancer: Is sperm cryopreservation cost effective in the era of assisted reproductive technology?. *Urol Oncol*. 2018;36(3):92.e1-92.e9. doi:10.1016/j.urolonc.2017.11.002
8. Berger R, Paul MS, Henshaw LA. Women's experience of infertility: A multi-systemic perspective. *Journal of International Women's Studies*. 2013;14(1):54-68. <https://vc.bridgew.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1651&context=jiws>
9. Mosalanejad L, Parandavar N, Abdollahifard S. Barriers to infertility treatment: an integrated study. *Glob J Health Sci*. 2013;6(1):181-191. Published 2013 Nov 25. doi:10.5539/gjhs.v6n1p181
10. Weigel, G. Coverage and Use of Fertility Services in the U.S. | KFF. <https://www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-s>. Published September 15, 2020. Accessed March 19, 2022.
11. State Laws Related to Insurance Coverage for Infertility Treatment. www.ncsl.org. <https://www.ncsl.org/research/health/insurance-coverage-for-infertility-laws.aspx>. Published March 12, 2021. Accessed March 20, 2022.
12. Insurance Coverage by State | RESOLVE: The National Infertility Association. <https://resolve.org/learn/financial-resources-for-family-building/insurance-coverage/insurance-coverage-by-state/>. Published August 27, 2021. Accessed March 20, 2022.
13. The Birth Rate is Rising Among Older Women. Got IVF Coverage? Our Thinking. www.mercer.us. <https://www.mercer.us/our-thinking/healthcare/the-birth-rate-is-rising-among-older-women-got-ivf-coverage.html>. Published May 28, 2018. Access March 20, 2022.
14. Benoit M, Chiles K, Hsieh M. The Landscape of Coverage for Fertility Preservation in Male Pediatric Patients. *Urology Practice*. 2018;5(3):198-204. doi:10.1016/j.urpr.2017.03.007
15. Jain T, Hornstein MD. Disparities in access to infertility services in a state with mandated insurance coverage. *Fertil Steril*. 2005;84(1):221-223.
16. Jain T. Socioeconomic and racial disparities among infertility patients seeking care. *Fertil Steril*. 2006;85(4):876-881.
17. Insogna I. Infertility, Inequality, and How Lack of Insurance Coverage Compromises Reproductive Autonomy. *AMA J Ethics*. 2018;20(12):E1152-1159. doi: 10.1001/amajethics.2018.1152.
18. Craig LB, Peck JD, Janitz AE. The prevalence of infertility in American Indian/Alaska Natives and other racial/ethnic groups: National Survey of Family Growth. *Paediatr Perinat Epidemiol*. 2019;33(2):119-125. doi:10.1111/ppe.12538
19. Chin HB, Howards PP, Kramer MR, Mertens AC, Spencer JB. Racial Disparities in Seeking Care for Help Getting Pregnant. *Paediatr Perinat Epidemiol*. 2015;29(5):416-425. doi:10.1111/ppe.12210
20. Ethics Committee of the American Society for Reproductive Medicine. Disparities in access to effective treatment for infertility in the United States: an Ethics Committee opinion. *Fertil Steril*. 2015;104(5):1104-1110. doi:10.1016/j.fertnstert.2015.07.1139
21. Kaufman, D. The Fight for Fertility Equality. *The New York Times*. Published July 22, 2020.
22. Ethics Committee of the American Society for Reproductive Medicine. Access to fertility treatment irrespective of marital status, sexual orientation, or gender identity: an Ethics Committee opinion. *Fertil Steril*. 2021;116(2):326-330. doi:10.1016/j.fertnstert.2021.03.034
23. U.S. Department of Veterans Affairs. In Vitro Fertilization Treatment. December 21, 2022. Accessed August 22, 2023. <https://www.va.gov/COMMUNITYCARE/programs/veterans/ivf.asp>
24. Craig LB, Peck JD, Janitz AE. The prevalence of infertility in American Indian/Alaska Natives and other racial/ethnic groups: National Survey of Family Growth. *Paediatr Perinat Epidemiol*. 2019;33(2):119-125. doi:10.1111/ppe.12538
25. Craig LB, Weedin EA, Walker WD, Janitz AE, Hansen KR, Peck JD. Racial and Ethnic Differences in Pregnancy Rates Following Intrauterine Insemination with a Focus on American Indians. *J Racial Ethn Health Disparities*. 2018;5(5):1077-1083. doi:10.1007/s40615-017-0456-8
26. Indian Health Service. Requirements: Priorities of Care. Accessed August 22, 2023. <https://www.ihs.gov/prc/eligibility/requirements-priorities-of-care>
27. Indian Health Service. Indian Health Service Medical Priority Levels. Accessed August 22, 2023. https://www.ihs.gov/sites/ihm/themes/responsive2017/display_objects/documents/pc/58619-1_Manual_Exhibit_2-3-B_IHS_MedicalPrioritiesRolesAndResponsibilities.pdf
28. Weisner M. White House to require more fertility treatment options for workforce. *Federal Times*. March 10, 2023. <https://www.federaltimes.com/fedlife/benefits/2023/03/10/white-house-to-require-more-fertility-treatment-options-for-workforce>

RELEVANT AMA POLICY

H-185.990 Infertility and Fertility Preservation Insurance Coverage

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA 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. [Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended Res. 114, A-13; Modified: Res. 809, I-14]

H-65.956 Right for Gamete Preservation Therapies

1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies. [Res. 005, A-19]

H-185.922 Right for Gamete Preservation Therapies

3. Our AMA supports insurance coverage for gamete preservation in any individual for whom a medical diagnosis or treatment modality is expected to result in the loss of fertility. [Res. 005, A-19]

H-510.984 Infertility Benefits for Veterans

1. Our AMA supports: (A) lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries; and (B) efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries; and (C) additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.
2. Our AMA encourages: (A) interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries, and (B) the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process. [CMS Rep. 01, I-16; Appended: Res. 513, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(A-24)

Introduced by: Medical Student Section

Subject: Medicaid & CHIP Benefit Improvements

Referred to: Reference Committee A

- 1 Whereas, the Centers for Medicare and Services list hearing, vision, and dental care as optional
2 benefits in Medicaid, and states vary drastically in Medicaid coverage of these services; and
3
- 4 Whereas, Medicaid is not subject to Medicare's budgetary constraints, and much of the cost of
5 improved benefits is borne by existing federal agreements for Medicaid expansion funding; and
6
- 7 Whereas, only 28 states provide varying levels of hearing coverage based on hearing loss
8 severity, 18 states offer no coverage, and some only cover devices but not services;² and
9
- 10 Whereas, of the 28 states providing some Medicaid hearing coverage, a study rated only 6 as
11 "fair" (on a scale of poor, fair, good, excellent);² and
12
- 13 Whereas, Medicaid patients are more likely to report hearing problems compared to privately
14 insured patients, and lower-income patients are twice as likely to experience more difficulty
15 using hearing aids, in part due to the cost of required support services;^{3,4} and
16
- 17 Whereas, while FDA approval of over-the-counter hearing aids is expected to greatly increase
18 access, a pair can still cost \$1,000, a prohibitive cost for many Medicaid patients;⁵⁻⁶ and
19
- 20 Whereas, only 33 states offer some Medicaid vision coverage, with 28 limiting access based on
21 severity of vision impairment, pre-existing conditions, restrictions to only eyeglasses and not
22 contacts, number of visits allowed, and approval of coverage only every 2 to 4 years;⁷ and
23
- 24 Whereas, a *JAMA Ophthalmology* study found that Medicaid patients had significantly
25 decreased odds of securing an appointment compared to privately insured patients (OR=0.41);⁸
26 and
27
- 28 Whereas, a study in *Ophthalmology* (the journal of the American Academy of Ophthalmology)
29 found that Medicaid patients are over twice as likely to not receive follow-up care after glaucoma
30 diagnosis compared to privately insured patients;⁹ and
31
- 32 Whereas, no minimum requirements for Medicaid dental coverage exist, and in 2019, only 19
33 states offered comprehensive coverage while 31 offered limited/emergency coverage;¹⁰⁻¹³ and
34
- 35 Whereas, 18% of Medicaid patients under 65 report an unmet dental need due to cost, double
36 the rate of privately insured patients;⁴ and
37
- 38 Whereas, up to 25% of non-elderly adults forgo dental care due to cost, as the average yearly
39 cost of dental care for adults under the poverty level is \$523;¹⁴⁻¹⁵ and
40

1 Whereas, adults in poverty are three times as likely to develop dental caries, and 29% of low-
2 income adults report that appearance of their teeth affects their employment chances;¹⁶⁻¹⁷ and
3

4 Whereas, Medicaid patients with dental coverage are more likely to seek dental care due to
5 reduced out-of-pocket cost and receive dental caries treatment than those without;¹⁸ and
6

7 Whereas, our 2 million dental-related emergency room visits a year cost \$2 billion;¹⁹⁻²² and
8

9 Whereas, California and Massachusetts cut Medicaid dental benefits in 2010 and subsequently
10 saw 32% and 11% increases in dental-related ER visits respectively;²³⁻²⁴ and
11

12 Whereas, California and Massachusetts restored dental benefits in 2014, and Massachusetts
13 saw a 15% reduction in dental-related ER visits afterward;²³⁻²⁴ and
14

15 Whereas, from 2012 to 2014, states that did not expand Medicaid or expanded Medicaid without
16 dental coverage saw a 27% increase in dental-related ER visits, compared to a 14% reduction
17 in states that expanded Medicaid with dental coverage;²⁵ and
18

19 Whereas, AMA advocacy on Medicaid dental coverage does not conflict with the position of the
20 American Dental Association (ADA), which is active on this issue, and amendments to existing
21 AMA policy on working with the ADA on public payer dental benefits to include Medicaid
22 ensures that the AMA would collaborate with and not conflict with the ADA in this area;²⁶ and
23

24 Whereas, to increase savings on emergency and inpatient care costs and overall costs due to
25 lost productivity, reduced employment, and disability, the benefits of Medicaid expansion can be
26 better realized via comprehensive hearing, vision, and dental coverage; therefore be it
27

28 RESOLVED, that our American Medical Association amend H-185.929 Hearing Aid Coverage
29 by addition as follows; and be it further
30

31 Hearing Aid Coverage H-185.929

- 32 1) Our American Medical Association supports public and private
33 health insurance coverage that provides all hearing-impaired
34 infants and children access to appropriate physician-led teams
35 and hearing services and devices, including digital hearing aids.
- 36 2) Our AMA supports hearing aid coverage for children that, at
37 minimum, recognizes the need for replacement of hearing aids
38 due to maturation, change in hearing ability and normal wear
39 and tear.
- 40 3) Our AMA encourages private health plans to offer optional
41 riders that allow their members to add hearing benefits to
42 existing policies to offset the costs of hearing aid purchases,
43 hearing-related exams and related services.
- 44 4) Our AMA supports coverage of hearing tests administered by a
45 physician or physician-led team as part of Medicare's Benefit.
- 46 5) Our AMA supports policies that increase access to hearing aids
47 and other technologies and services that alleviate hearing loss
48 and its consequences for the elderly.
- 49 6) Our AMA encourages increased transparency and access for
50 hearing aid technologies through itemization of audiologic
51 service costs for hearing aids.

- 1 7) Our AMA supports the availability of over-the-counter hearing
- 2 aids for the treatment of mild-to-moderate hearing loss.
- 3 8) Our AMA supports physician and patient education on the
- 4 proper role of over the counter hearing aids, including the value
- 5 of physician-led assessment of hearing loss, and when they are
- 6 appropriate for patients and when there are possible cost-
- 7 savings.
- 8 9) Our AMA encourages the United States Preventive Services
- 9 Task Force to re-evaluate its determination not to recommend
- 10 preventive hearing services and screenings in asymptomatic
- 11 adults over age 65 in consideration of new evidence connecting
- 12 hearing loss to dementia.
- 13 10) Our AMA advocates that hearing exams, hearing aids, cochlear
- 14 implants, and aural rehabilitative services be covered in all
- 15 Medicaid and CHIP programs and any new public payers.

16 (Modify Current HOD Policy)

17
18 RESOLVED, that our AMA advocate that routine comprehensive vision exams and visual aids
19 (including eyeglasses and contact lenses) be covered in all Medicaid and CHIP programs and
20 by any new public payers (Directive to Take Action); and be it further

21
22 RESOLVED, that our AMA amend H-330.872, “Medicare Coverage for Dental Services” by
23 addition and deletion as follows.

24
25 Medicare Coverage for Dental Services H-330.872
26 Our AMA supports: (1) continued opportunities to work with the
27 American Dental Association and other interested national
28 organizations to improve access to dental care for Medicare,
29 Medicaid, CHIP, and other public payer beneficiaries; and (2)
30 initiatives to expand health services research on the effectiveness
31 of expanded dental coverage in improving health and preventing
32 disease among in the Medicare, Medicaid, CHIP, and other public
33 payer beneficiaries population, the optimal dental benefit plan
34 designs to cost-effectively improve health and prevent disease ~~in~~
35 ~~the~~ among Medicare, Medicaid, CHIP, and other public payer
36 beneficiaries population, and the impact of expanded dental
37 coverage on health care costs and utilization.

38 (Modify Current HOD Policy)

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

Received: 4/19/2024

REFERENCES

1. Mandatory and Optional Medicaid Benefits. Medicaid.Gov. <https://www.medicaid.gov/medicaid/benefits/mandatory-optional-medicaid-benefits/index.html>
2. Arnold ML, Hyer K, Chisolm T. Medicaid Hearing Aid Coverage For Older Adult Beneficiaries: A State-By-State Comparison. Health Affairs. 2017;36(8):1476-1484. doi:10.1377/hlthaff.2016.1610. Accessed April 7th, 2022.
3. Willink A, Hernando MA, Steege S. Why State Medicaid Programs Should Cover Hearing Aids for Adults. JAMA Otolaryngology Head Neck Surg. 2019;145(11):999–1000. doi:10.1001/jamaoto.2019.2616. Accessed August 24, 2021.
4. Katch H, Van de Water P. Medicaid and Medicare Enrollees Need Dental, Vision, and Hearing Benefits. Center on Budget and Policy Priorities. <https://www.cbpp.org/research/health/medicaid-and-medicare-enrollees-need-dental-vision-and-hearing-benefits>. Published December 8, 2020. Accessed August 24, 2021.
5. Bennett K. Survey: Less than half of Americans have savings to cover a \$1,000 surprise expense. Bankrate. <https://www.bankrate.com/banking/savings/financial-security-january-2022/>. Published January 19, 2022. Accessed September 21, 2022.

6. Crouch, M. (2022, August 16). The FDA approves cheaper, over-the-counter hearing aids. AARP. Retrieved September 21, 2022, from <https://www.aarp.org/health/healthy-living/info-2022/fda-over-the-counter-hearing-aids.html>
7. Medicaid benefits: Eyeglasses and other visual aids. KFF. <https://www.kff.org/medicaid/state-indicator/eyeglasses/>. Published January 17, 2019. Accessed September 19, 2021.
8. Lee YH, Chen AX, Varadaraj V, et al. Comparison of Access to Eye Care Appointments Between Patients With Medicaid and Those With Private Health Care Insurance. *JAMA Ophthalmol.* 2018;136(6):622-629. doi:10.1001/jamaophthalmol.2018.0813
9. Elam AR, Andrews C, Musch DC, Lee PP, Stein JD. Large Disparities in Receipt of Glaucoma Care between Enrollees in Medicaid and Those with Commercial Health Insurance. *Ophthalmology.* 2017;124(10):1442-1448. doi:10.1016/j.ophtha.2017.05.003
10. Dental Care. Centers for Medicare and Medicaid Services. <https://www.medicare.gov/medicaid/benefits/dental-care/index.html>. Accessed April 11, 2021.
11. Medicaid adult Dental Benefits: An overview. Centers for Health Care Strategies. <https://www.chcs.org/resource/medicaid-adult-dental-benefits-overview/>. Published October 22, 2019. Accessed April 11, 2021.
12. Medicaid benefits: Dental services. Kaiser Family Foundation. <https://www.kff.org/medicaid/state-indicator/dental-services/?currentTimeframe=0&sortModel=%7B%22colId%22%3A%22Location%22%2C%22sort%22%3A%22asc%22%7D>. Published January 18, 2019. Accessed April 11, 2021.
13. State Oral Health Plans. Centers for Disease Control and Prevention. https://www.cdc.gov/oralhealth/funded_programs/oh_plans/index.htm. Published February 26, 2021. Accessed April 11, 2021.
14. Niodita G, Vujicic M. Main Barriers to Getting Needed Dental Care All Relate to Affordability. Health Policy Institute. https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0419_1.pdf?la=en Published November 2019. Accessed April 11, 2021.
15. Vujicic M, N U, BD S, et al. Dental Care Presents The Highest Level Of Financial Barriers, Compared To Other Types Of Health Care Services: *Health Affairs Journal.* Health Affairs. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0800>. Published December 1, 2016. Accessed April 11, 2021.
16. Hannah Katch, Paul N. Van de Water. Medicaid and Medicare Enrollees Need Dental, Vision, and Hearing Benefits. Center on Budget and Policy Priorities. <https://www.cbpp.org/research/health/medicaid-and-medicare-enrollees-need-dental-vision-and-hearing-benefits>. Published December 8, 2020. Accessed April 11, 2021.
17. Oral Health and Well-Being in the United States. Oral Health & Well-Being – Health Policy Institute State Fact Sheets. <https://www.ada.org/en/science-research/health-policy-institute/oral-health-and-well-being>. Accessed April 11, 2021.
18. Decker SL, Lipton BJ. Do Medicaid benefit expansions have teeth? The effect of Medicaid adult dental coverage on the use of dental services and oral health. *Journal of Health Economics.* 2015;44:212-225. doi:10.1016/j.jhealeco.2015.08.009
19. Kelekar U, Naavaal S. Dental visits and associated emergency department–charges in the United States. *The Journal of the American Dental Association.* 2019;150(4). doi:10.1016/j.adaj.2018.11.021
20. Kim P, Zhou W, McCoy S, et al. Factors Associated with Preventable Emergency Department Visits for Nontraumatic Dental Conditions in the U.S. *International Journal of Environmental Research and Public Health.* 2019;16(19): 3671. doi:10.3390/ijerph16193671
21. Akinlotan MA, Ferdinand AO. Emergency department visits for nontraumatic dental conditions: a systematic literature review. *Journal of Public Health Dentistry.* 2020;80(4):313-326. doi:10.1111/jphd.12386
22. Emergency Department Visits for Dental Conditions - A snapshot. American Dental Association Health Policy. Published 2019. https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIgraphic_0420_1.pdf?la=en. Accessed April 11, 2021.
23. Singhal A, Caplan DJ, Jones MP, et al. Eliminating Medicaid Adult Dental Coverage In California Led To Increased Dental Emergency Visits And Associated Costs. *Health Affairs.* 2015;34(5):749-756. doi:10.1377/hlthaff.2014.1358
24. Ashwini R, Young G, Garcia R, et al. Changes in Dental Benefits and Use of Emergency Departments for Nontraumatic Dental Conditions in Massachusetts. *Public Health Reports.* 2020; 135(5): 571-577. doi: 10.1177/0033354920946788
25. Elani HW, Kawachi I, Sommers BD. Changes in emergency department dental visits after Medicaid expansion. *Health Services Research.* 2020;55(3):367-374. doi:10.1111/1475-6773.13261
26. Action for Dental Health – Medicaid. American Dental Association. <https://www.ada.org/en/resources/community-initiatives/action-for-dental-health/medicaid>

RELEVANT AMA Policy

H-185.929 Hearing Aid Coverage

- 1) Our American Medical Association 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.
- 8) Our AMA supports physician and patient education on the proper role of over the counter hearing aids, including the value of physician-led assessment of hearing loss, and when they are appropriate for patients and when there are possible cost-savings.
- 9) Our AMA encourages the United States Preventive Services Task Force to re-evaluate its determination not to recommend preventive hearing services and screenings in asymptomatic adults over age 65 in consideration of new evidence connecting hearing loss to dementia. [CMS Rep. 6, I-15; Appended: Res. 124, A-19; Appended: CMS Rep. 02, A-23; Reaffirmed: CMS Rep. 02, A-23]

H-25.990 Eye Exams for the Elderly

1. Our American Medical Association encourages the development of programs and/or outreach efforts to support periodic eye examinations and access to affordable prescription eyeglasses for elderly patients.
2. Our AMA encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings. [Res. 813, I-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: CMS Rep. 02, A-23]

H-330.872 Medicare 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 beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization. [CMS Rep. 03, A-19; Reaffirmed: CMS Rep. 02, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103
(A-24)

Introduced by: Oklahoma
Subject: Medicare Advantage Plans
Referred to: Reference Committee A

1 Whereas, 52% of Medicare beneficiaries are now enrolled in Medicare Advantage (MA) plans,
2 with an anticipated growth to 70% within a years; and
3

4 Whereas, a former Center for Medicare and Medicaid Services (CMS) administrator stated
5 recently in a national publication that, "I think MA growth should be slowed or stopped, at least
6 until we end the extraordinarily high subsidies for MA plans, which are unfair to traditional
7 Medicare and burdensome to the treasury and many beneficiaries."¹; and
8

9 Whereas, it is anticipated that MA plans, in 2024 will receive \$88 billion more than what is spent
10 for the same number of patient in traditional Medicare; and
11

12 Whereas, it is anticipated that MA plans, in 2024 will receive \$88 billion more than what is spent
13 for the same number of patient in traditional Medicare; and
14

15 Whereas, the amount that an MA plan gets is adjusted for the number of codes for diagnoses
16 that a beneficiary has; and
17

18 Whereas, providers and physicians are rewarded in any MA plans for upcoming, or they receive
19 a percentage of the insurance premium the MA collects from CMS or, they are employed by the
20 MA; and
21

22 Whereas, this ends up being a transfer of funds out of the healthcare arena into the private
23 sector, which goes to profit for the MA, or for stock buybacks, or for higher compensation for the
24 MA executives, and activities that don't benefit beneficiaries; therefore be it
25

26 RESOLVED, that our American Medical Association urge the United States Congress and
27 Center for Medicare and Medicaid Services to take steps to end the upcoding for Medicare
28 Advantage plans that results in high subsidies which are unfair to traditional Medicare and
29 burdensome to the public treasury and many beneficiaries (New HOD Policy); and be it further
30

31 RESOLVED, that our AMA encourages Center for Medicare and Medicaid Services to improve
32 the attractiveness of traditional Medicare so that the option remains robust and available giving
33 beneficiaries greater traditional choices for this option and to seek better care for themselves.
34 (New HOD Policy)
35

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

Received: 4/22/2024

REFERENCES

1. <https://www.medpagetoday.com/special-reports/exclusives/108980>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(A-24)

Introduced by: Medical Student Section

Subject: Medicaid Estate Recovery Reform

Referred to: Reference Committee A

1 Whereas, 70% of Medicare beneficiaries will require long-term supports and services (LTSS),
2 but since annual LTSS costs exceeds the median Medicare beneficiary's total savings, many
3 must deplete their savings and become destitute to receive Medicaid LTSS coverage;¹⁻⁹ and
4

5 Whereas, the Social Security Act requires states to recover all Medicaid costs from patients'
6 estates after their death, but states typically only recover 0-1%, resulting in insignificant effects
7 on state budgets but disproportionate detriment to patients' inheritors;^{4,10-12} and
8

9 Whereas, because the Social Security Act does not require recovery of nonprobate assets,
10 patients with greater wealth or access to legal and financial estate planning services can evade
11 estate recovery with careful planning and modern methods of wealth transfer;^{10,13-15} and
12

13 Whereas, states disproportionately recover costs from low-income patients, exacerbating racial
14 wealth gaps and preventing intergenerational wealth;¹³ and
15

16 Whereas, Black Medicaid patients die with a median net worth of \$800, compared to white
17 Medicaid patients with \$2100, so estate recovery more rapidly depletes Black wealth;¹² and
18

19 Whereas, 25 states use 1115 waivers to capitate Medicaid LTSS coverage and may therefore
20 recover capitation payments from estates, even if a patient never received LTSS;¹⁶⁻¹⁸ and
21

22 Whereas, alternative methods to reduce LTSS costs exist, such as clinical demonstration
23 projects that improve patient outcomes while saving \$12,000 per patient annually;¹⁹ and
24

25 Whereas, California dramatically limited estate recovery by excluding patients survived by a
26 spouse and homes of modest value, and the Stop Unfair Medicaid Recoveries Act in Congress
27 would end Medicaid estate recovery altogether;²⁰⁻²¹ therefore be it
28

29 RESOLVED, that our American Medical Association oppose federal or state efforts to impose
30 liens on or seek adjustment or recovery from the estate of individuals who received long-term
31 services or supports coverage under Medicaid. (New HOD Policy)

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

Received: 4/24/2024

REFERENCES

1. Johnson RW. What is the lifetime risk of needing and receiving long-term services and supports? The Assistant Secretary for Planning and Evaluation (ASPE). April 3, 2019. Accessed August 12, 2023. <https://aspe.hhs.gov/reports/what-lifetime-risk-needing-receiving-long-term-services-supports-0#table3>.
2. Johnson RW. Who is covered by private long-term care insurance? The Urban Institute. August 2, 2016. Accessed August 12, 2023. <https://www.urban.org/research/publication/who-covered-private-long-term-care-insurance>.
3. Chidambaram P, Burns A. 10 things About Long-Term Services and Supports (LTSS). KFF. September 15, 2022. Accessed August 12, 2023. <https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/>.
4. Chidambaram P, Burns A. 10 things About Long-Term Services and Supports (LTSS). KFF. September 15, 2022. Accessed August 12, 2023. <https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/>.
5. Willink A, Kasper J, Skehan ME. Are Older Americans Getting the Long-Term Services and Supports They Need? The Commonwealth Fund. January 2019. Accessed September 16, 2023. https://www.commonwealthfund.org/sites/default/files/2019-01/Willink_are_older_americans_getting_LTSS_ib.pdf.
6. Spousal impoverishment. Medicaid.gov. Accessed August 12, 2023. <https://www.medicaid.gov/medicaid/eligibility/spousal-impoverishment/index.html>.
7. Supplemental Security Income (SSI) Disability & Medicaid coverage. Healthcare.gov. Accessed August 12, 2023. <https://www.healthcare.gov/people-with-disabilities/ssi-and-medicaid/#:~:text=In%20many%20states%2C%20SSI%20recipients,get%20SSI%20are%20still%20eligible>.
8. Musumeci M, Chidambaram P, O'Malley Watts M. Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey. KFF. June 14, 2019. Accessed August 18, 2023. <https://www.kff.org/medicaid/issue-brief/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-findings-from-a-50-state-survey/>.
9. Thach NT, Wiener JM. An Overview of Long-Term Services and Supports and Medicaid: Final Report. The Assistant Secretary for Planning and Evaluation (ASPE). August 7, 2018. Accessed August 18, 2023. <https://aspe.hhs.gov/reports/overview-long-term-services-supports-medicaid-final-report-0>.
10. Liens, Adjustments and Recoveries, and Transfers of Assets. Social Security Act §1917. Accessed August 18, 2023. https://www.ssa.gov/OP_Home/ssact/title19/1917.htm.
11. Karp N, Sabatino CP, Wood EF. Medicaid Estate Recovery: A 2004 Survey of State Programs and Practices . The AARP Public Policy Institute. June 2005. Accessed August 24, 2023. https://assets.aarp.org/rgcenter/il/2005_06_recovery.pdf.
12. Medicaid Estate Recovery: Improving Policy and Promoting Equity. MACPAC. March 2021. Accessed August 24, 2023. <https://www.macpac.gov/wp-content/uploads/2021/03/Chapter-3-Medicaid-Estate-Recovery-Improving-Policy-and-Promoting-Equity.pdf>.
13. Langbein JH. Because Property Became Contract: Understanding the American Nonprobate Revolution. SSRN. March 23, 2020. Accessed August 18, 2023. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3561181#.
14. O'Brien RC. Selective Issues in Effective Medicaid Estate Recovery Statutes. Catholic University Law Review. February 2, 2016. Accessed August 24, 2023. https://scholarship.law.edu/lawreview/vol65/iss1/7/?utm_source=scholarship.law.edu%2Fvol65%2Fiss1%2F7&utm_medium=PDF&utm_campaign=PDFCoverPages.
15. What is Estate Planning & Why it is Critical for Medicaid planning. American Council on Aging. March 6, 2023. Accessed August 24, 2023. <https://www.medicaidplanningassistance.org/estate-planning/>.
16. Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State. KFF. August 11, 2023. Accessed September 16, 2023. <https://www.kff.org/medicaid/issue-brief/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/>.
17. Coordination of Benefits & Third Party Liability in Medicaid Handbook. Medicaid.gov. 2020. Accessed August 24, 2023. <https://www.medicaid.gov/medicaid/eligibility/coordination-of-benefits-third-party-liability/index.html>.
18. True, S. Debt After Death: The Painful Blow of Medicaid Estate Recovery. US News & World Report. October 14, 2021. (Accessed September 17, 2023). <https://www.usnews.com/news/health-news/articles/2021-10-14/debt-after-death-the-painful-blow-of-medicaid-estate-recovery>
19. Szanton SL, Wolff JW, Leff B, et al. CAPABLE trial: a randomized controlled trial of nurse, occupational therapist and handyman to reduce disability among older adults: rationale and design. *Contemp Clin Trials*. 2014;38(1):102-112. doi:10.1016/j.cct.2014.03.005.
20. Seipel T. California's Seizure of Medi-Cal Patients' Assets is Limited by New Law. The Mercury News. June 27, 2016. Accessed September 16, 2023. <https://www.mercurynews.com/2016/06/27/californias-seizure-of-medi-cal-patients-assets-is-limited-by-new-law/>.
21. H.R.6698 - Stop Unfair Medicaid Recoveries Act of 2022. Congress.gov. February 10, 2022. Accessed August 24, 2023. <https://www.congress.gov/bill/117th-congress/house-bill/6698/text>.

RELEVANT AMA Policy

Policy Directions for the Financing of Long-Term Care H-280.991

Our American Medical Association believes that programs to finance long-term care should:

1. Assure access to needed services when personal resources are inadequate to finance care.
2. Protect personal autonomy and responsibility in the selection of LTC service providers.
3. Prevent impoverishment of the individual or family in the face of extended or catastrophic service costs.
4. Account for equity in order to assure affordability of long-term care for all Americans.
5. Cover needed services in a timely, coordinated manner in the least restrictive setting appropriate to the health care needs of the individual.

6. Coordinate benefits across different LTC financing program.
7. Provide coverage for the medical components of long-term care through Medicaid for all individuals with income below 100 percent of the poverty level.
8. Provide sliding scale subsidies for the purchase of LTC insurance coverage for individuals with income between 100-200 percent of the poverty level.
9. Encourage private sector LTC coverage through an asset protection program; equivalent to the amount of private LTC coverage purchased.
10. Create tax incentives to allow individuals to prospectively finance the cost of LTC coverage, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of LTC insurance premiums and expenses.
11. Authorize a tax deduction or credit to encourage family care giving. Consumer information programs should be expanded to emphasize the need for prefunding anticipated costs for LTC and to describe the coverage limitations of Medicare, Medicaid, and traditional medigap policies. State medical associations should be encouraged to seek appropriate legislation or regulation in their jurisdictions to:
 - a. provide an environment within their states that permit innovative LTC financing and delivery arrangements, and
 - b. assure that private LTC financing and delivery systems, once developed, provide the appropriate safeguards for the delivery of high quality care.

Our AMA continues to evaluate and support additional health system reform legislative initiatives that could increase states' flexibility to design and implement long-term care delivery and financing programs. Our AMA will also encourage and support the legislative and funding changes needed to enable more accurate and disaggregated collection and reporting of data on health care spending by type of service, so as to enable more informed decisions as to those social components of long-term care that should not be covered by public or private health care financing mechanisms.

2. Our AMA will work with Centers for Medicare & Medicaid Services and other relevant stakeholders to formulate appropriate medical insurance plans to provide long-term care coverage for patients with Alzheimer's and other forms of dementia. [BOT Rep. O, A-88; BOT Rep. X, I-88; Reaffirmed: CMS Rep. 3, A-94; BOT Rep. S, I-87; Reaffirmed: CMS Rep. 3-A-94; CMS Rep. 11, I-95; Reaffirmation A-04; Modified: CMS Rep. 6, I-05; Reaffirmed: BOT Rep. 32, A-09; Reaffirmation A-11; Reaffirmed: CMS Rep. 05, A-18; Appended: Res. 110, A-23; Modified: Res. 815, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(A-24)

Introduced by: Medical Student Section

Subject: Medigap Patient Protections

Referred to: Reference Committee A

1 Whereas, Medicare Supplement (Medigap) plans are used by 23% of Medicare beneficiaries
2 (14 million) to make Traditional Medicare more affordable and avoid the myriad problems with
3 Medicare Part C, including limited networks and prior authorizations¹⁻¹³; and
4

5 Whereas, when seniors enroll in Medicare Part B, they are offered a one-time 6-month
6 enrollment period for Medigap, during which they are protected by guaranteed issue and
7 community rating, preventing price discrimination based on health, age, or gender¹³⁻¹⁴; and
8

9 Whereas, after the initial 6-month Medigap enrollment period, protections for guaranteed issue
10 and community rating no longer apply, even though guaranteed issue and (modified) community
11 ratings are permanent and universal in the Affordable Care Act (ACA) marketplace¹³⁻¹⁶; and
12

13 Whereas, Medigap plans are required to be offered to all Medicare beneficiaries over 65, but not
14 to other Medicare beneficiaries under 65 on dialysis or with disabilities¹⁷⁻¹⁸; and
15

16 Whereas, several states have enacted Medigap protections for guaranteed issue, community
17 rating, and eligibility for Medicare beneficiaries under 65 and demonstrated reduced switching
18 from Traditional Medicare to Medicare Part C¹⁹⁻²⁵; and
19

20 Whereas, Congress is currently investigating deceptive tactics by private Medigap insurers,
21 presenting a timely opportunity for regulation of private health insurance companies' dubious
22 marketing tactics to steer consumers into purchasing more expensive Medigap plans,
23 representing a timely opportunity for regulatory reform^{24,26}; and
24

25 Whereas, at I-23, the AMA passed H-390.832, "Saving Traditional Medicare," "recognizing that
26 Traditional Medicare is a critical healthcare program while educating the public on the benefits
27 and threats of Medicare Part C expansion" and "acknowledg[ing] that the term "Medicare
28 Advantage" can be misleading, as it implies a superiority or enhanced value over traditional
29 Medicare, which may not accurately reflect the nature and challenges of these plans"; therefore
30 be it
31

32 RESOLVED, that our American Medical Association support annual open enrollment periods
33 and guaranteed lifetime enrollment eligibility for Medigap plans (New HOD Policy); and be it
34 further
35

36 RESOLVED, that our AMA advocate for extending modified community rating regulations to
37 Medigap supplemental insurance plans, similar to those enacted under the Affordable Care Act
38 for commercial insurance plans (Directive to Take Action); and be it further

1 RESOLVED, that our AMA support efforts to expand access to Medigap policies to all
2 individuals who qualify for Medicare benefits (New HOD Policy); and be it further

3

4 RESOLVED, that our AMA supports efforts to improve the affordability of Medigap supplemental
5 insurance for lower income Medicare beneficiaries. (New HOD Policy)

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

Received: 4/24/2024

REFERENCES

1. Ochieng N, Schwartz K, and Neuman T. How Many Physicians Have Opted-Out of the Medicare Program? KFF Medicare. October 22, 2020. Accessed March 5, 2023. <https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/>
2. Medicare Deductible, Coinsurance & Premium Rates: Calendar Year 2023 Update (2023). <https://www.cms.gov/files/document/mm12903-medicare-deductible-coinsurance-premium-rates-calendar-year-2023-update.pdf>. Accessed March 5, 2023
3. Compare Original Medicare & Medicare Advantage. Medicare.gov. <https://medicare.gov/basics/compare-original-medicare-medicare-advantage>. Published 2023. Accessed April 4, 2023.
4. Medicare insurance statistics 2022 - key data, facts, reports. Medicaresupp.org. Published January 10, 2022. Accessed August 26, 2023. <https://medicaresupp.org/medicare-insurance-statistics-2022/>
5. Medicare Advantage: A Policy Primer. The Commonwealth Fund. Published May 3, 2022. Accessed August 27, 2023. <https://www.commonwealthfund.org/publications/explainer/2022/may/medicare-advantage-policy-primer#:~:text=In%202020%2C%20the%20average%20Medigap,with%20a%20Medicare%20Advantage%20plan>
6. Peña M, Mohamed M, and Burns A. Medicaid Arrangements to Coordinate Medicare and Medicaid Dual-Eligible Individuals. KFF Medicaid. April 27, 2023. Accessed September 17, 2023. <https://www.kff.org/medicaid/issue-brief/medicaid-arrangements-to-coordinate-medicare-and-medicare-for-dual-eligible-individuals/>
7. Comparing Medigap Options. Medicare Interactive. <https://www.medicareinteractive.org/supplemental-insurance-for-original-medicare-medigaps/comparing-medigap-options>. Published 2023. Accessed April 3, 2023.
8. How are Medigap and Medicare Advantage different?. AARP Question and Answer Tool. <https://www.aarp.org/health/medicare-qa-tool/medigap-vs-advantage>. Published January 24, 2023. Accessed April 3, 2023.
9. Abelson R and Sanger-Katz M. 'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions. The New York Times. Published October 8, 2022. Accessed March 5, 2023, <https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html>
10. Martino S, Mathews M, Damberg C., et al. Rates of Disenrollment From Medicare Advantage Plans Are Higher for Racial/Ethnic Minority Beneficiaries. Medical Care. September 2021;59(9):778-784. <https://pubmed.ncbi.nlm.nih.gov/34054025>. Accessed April 2, 2023.
11. Grimm CA. Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care. HHS Office of Inspector General. Published April 2021. Accessed April 3, 2023. <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>
12. O'Brien S. There are times to consider switching or ditching your Medigap plan. What to know. CNBC. Published April 29, 2022. Accessed March 5, 2023. <https://www.cnbc.com/2022/04/29/there-are-times-it-may-make-sense-to-switch-or-ditch-your-medigap-plan.html>
13. Meyers D, Trivedi A, Mor V. Limited Medigap Consumer Protections Are Associated With Higher Reenrollment In Medicare Advantage Plans. Health Affairs. May 2019;38(5):782-787. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05428>. Accessed April 5, 2023.
14. Boccuti C, Orgera K, and Neuman T. Medigap Enrollment and Consumer Protections Vary Across States. Kaiser Family Foundation. Published July 11, 2018. Accessed March 5, 2023. <https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/>
15. Meyers DJ, Mor V, Trivedi AN. Limited Medigap Consumer Protections Are Associated With Higher Reenrollment In Medicare Advantage Plans. Health Affairs. May 2019. Accessed September 16, 2023. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05428>.
16. Improving the Health Insurance Marketplace. American Medical Association. 2015. Accessed September 16, 2023. <https://www.ama-assn.org/delivering-care/patient-support-advocacy/improving-health-insurance-marketplace>
17. Can you get Medicare supplemental insurance under 65? AARP. Accessed August 26, 2023. <https://www.aarp.org/health/medicare-qa-tool/medigap-insurance-under-65/>
18. Medigap. Center for Medicare Advocacy: Advancing Access to Medicare and Health Care. Published 2023. Accessed April 5, 2023. <https://medicareadvocacy.org/medicare-info/medigap/>
19. Malloy ML. Medigap: Background and Statistics. Congressional Research Service Informing the legislative debate since 1913. 2023. <https://crsreports.congress.gov/product/pdf/R/R47552>
20. Park. S and Coe NB. Insurance Coverage and Health Care Spending by State-Level Medigap Regulations. The American Journal of Managed Care. 2022. <https://www.ajmc.com/view/insurance-coverage-and-health-care-spending-by-state-level-medigap-regulations>
21. Norris L. Medigap eligibility rules for Americans under age 65 vary by state. Medicare Resources. 2023. <https://www.medicareresources.org/medicare-eligibility-and-enrollment/medigap-eligibility-for-americans-under-age-65-varies-by-state/>

22. Roozhehani A. Barrier to Medigap Coverage for Beneficiaries Under Age 65. Center for Medicare Advocacy Advancing Access to Medicare and Health Care. 2016. <https://medicareadvocacy.org/barriers-to-medigap-coverage-for-beneficiaries-under-age-65/#:~:text=Since%20the%20federal%20requirements%20do,disabled%20and%20ESRD%20Medicare%20beneficiaries>
23. Noris L. A guide to Medicare private coverage availability and enrollment in each state. MedicareResources.org. 2020. Accessed April 5, 2023. <https://www.medicareresources.org/enrollment-options/>
24. Abelson R. Brokers get lush trips and cash perks to sell costly Medigap plans. The New York Times. March 1, 2023. Accessed August 5, 2023. <https://www.nytimes.com/2023/03/01/health/medicare-plans-elizabeth-warren.html>.
25. Meyers DJ, Mor V, Trivedi AN. Limited Medigap Consumer Protections Are Associated With Higher Reenrollment In Medicare Advantage Plans. Health Affairs. May 2019. Accessed September 16, 2023. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2018.05428>.
26. New investigation from senator Warren uncovers insurance companies' widespread abusive marketing practices in the Medigap Market, harming seniors. U.S. Senator Elizabeth Warren of Massachusetts. March 1, 2023. Accessed August 5, 2023. <https://www.warren.senate.gov/oversight/reports/new-investigation-from-senator-warren-uncovers-insurance-companies-widespread-abusive-marketing-practices-in-the-medigap-market-harming-seniors>

RELEVANT AMA 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.

[CMS Rep. 7, A-03; Reaffirmed: CMS Rep. 6, A-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 2, I-07; Reaffirmed: BOT Rep. 7, A-09; Appended: Res. 129, A-09; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed in lieu of Res. 811, I-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed in lieu of Res. 125, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation: A-17; Reaffirmed: Res. 518, A-17; Reaffirmed: Res. 105, A-18; Reaffirmed: Joint CMS CSAPH Rep. 01, I-18; Reaffirmed: CMS Rep. 03, A-23]

Medicare Advantage Policies H-285.913

Our AMA will: 1. pursue legislation requiring that any Medicare Advantage policy sold to a Medicare patient must include a seven-day waiting period that allows for cancellation without penalty; 2. pursue legislation to require that Medicare Advantage policies carry a separate distinct page, which the patient must sign, including the statement, "THIS COVERAGE IS NOT TRADITIONAL MEDICARE. YOU HAVE CHOSEN TO CANCEL YOUR TRADITIONAL MEDICARE COVERAGE; NOT ALL PHYSICIANS, HOSPITALS AND LABORATORIES ACCEPT THIS NEW MEDICARE ADVANTAGE POLICY AND YOU MAY PERMANENTLY LOSE THE ABILITY TO PURCHASE MEDIGAP SECONDARY INSURANCE" (or

equivalent statement) and specifying the time period before they can resume their traditional Medicare coverage; and 3. petition the Centers for Medicare and Medicaid Services to implement the patient's signature page in a Medicare Advantage policy. [Res. 907, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmation: I-18]

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930

Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees. [BOT Action in response to referred for decision Res. 711, I-06; Reaffirmation A-08; Modified: CMS Rep. 01, A-19]

Ensuring Marketplace Competition and Health Plan Choice H-165.825

Our AMA will: (1) support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits; (2) oppose the sale of health insurance plans in the individual and small group markets that do not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months; and (3) support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation. [CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 01, I-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(A-24)

Introduced by: American Society for Gastrointestinal Endoscopy, American College of Gastroenterology, American Gastroenterological Association

Subject: Incorporating Surveillance Colonoscopy into the Colorectal Cancer Screening Continuum

Referred to: Reference Committee A

- 1 Whereas, in 2024, an estimated 153,000 cases of colorectal cancer (CRC) will be diagnosed in
2 the United States, and a total of 53,010 people will die from this cancer¹; and
3
4 Whereas, while CRC incidence and mortality rates have been declining because, in part, of
5 screening uptake among adults ages 50 years and older, rates have increased by 1-2 percent
6 per year since the mid-1990s in those younger than 55 years of age²; and
7
8 Whereas, when detected and treated early, the five-year survival rate for CRC is 90 percent;
9 yet, early detection occurs in less than 40 percent of CRC cases³; and
10
11 Whereas, the Affordable Care Act (ACA) requires that several CRC screening modalities,
12 including colonoscopy, be covered without patient cost-sharing for eligible individuals by non-
13 grandfathered group health plans and non-grandfathered group or individual health insurance
14 coverage; and
15
16 Whereas, the Centers for Medicare and Medicaid Services recently reported 21.3 million
17 consumers signed up for 2024 individual health insurance coverage through the Marketplaces,⁴
18 with nearly 65 percent of individuals between 18-54 years of age⁵ — the same demographic
19 experiencing increased rates of CRC; and
20
21 Whereas, the U.S. Multi-Society Task Force on Colorectal Cancer recommends that
22 asymptomatic individuals undergoing screening colonoscopy seek follow-up colonoscopy
23 exams to evaluate for new polyps at specific intervals based on the findings of the exam,
24 ranging between one to 10 years⁶; and
25
26 Whereas, Medicare considers these additional, follow-up, or surveillance, colonoscopies as
27 screening exams; and
28
29 Whereas, commercial insurers regulated by the ACA routinely treat a follow-up colonoscopy
30 exam at an interval shorter than 10 years as a “diagnostic” service rather than screening or
31 surveillance, even if a patient is asymptomatic; and
32
33 Whereas, clinical evidence indicates screening colonoscopy exams, including surveillance
34 colonoscopies, and post-polypectomy follow-up play a critical role in reducing colorectal cancer
35 incidence and death; and

1 Whereas, the U.S. Department of Health and Human Services (HHS) has the authority to issue
2 written guidance that clarifies surveillance colonoscopy after an original screening colonoscopy
3 that required polyp removal is part of the screening continuum and should therefore be covered
4 without patient cost sharing as a preventive services benefit under the ACA; and
5

6 Whereas, more than 90 national and state medical societies and patient advocacy groups have
7 asked⁷ HHS to use its existing regulatory authority make this policy clarification. And, in early
8 2024, 45 members of the U.S. House of Representatives sent a similar letter⁸ to HHS, also
9 urging the same change; therefore be it

10
11 RESOLVED, that our American Medical Association Policy H-185.960, “Support for the
12 Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans” be amended by
13 addition to read as follows:
14

- 15 1. Our AMA supports health plan coverage for the full range of colorectal cancer
16 screening tests.
17
- 18 2. Our AMA will seek to eliminate cost-sharing in all health plans for the full range of
19 colorectal cancer screening and all associated costs, including colonoscopy that
20 includes a “diagnostic” intervention (i.e. the removal of a polyp or biopsy of a mass),
21 as defined by Medicare. To further this goal, the AMA will develop a coding guide to
22 promote common understanding among health care providers, payers, health care
23 information technology vendors, and patients.
24
- 25 3. Our AMA will seek to eliminate cost-sharing in all health plans for “follow-on”
26 colonoscopies performed for colorectal cancer screening and all associated costs,
27 defined as when other alternative screening tests are found to be positive.
28
- 29 4. Our AMA will seek to classify follow-up, follow-on, or surveillance, colonoscopy after
30 an original screening colonoscopy that required polyp removal as a screening service
31 under the Affordable Care Act preventive services benefit and will seek to eliminate
32 patient cost sharing in all health plans under such circumstances.
33

34 (Modify Current HOD Policy)

Fiscal Note: TBD

Received: 4/24/2024

REFERENCES

¹ American Cancer Society. Cancer Facts & Figures 2024. Atlanta: American Cancer Society; 2024.

² Ibid.

³ American Cancer Society. <https://www.cancer.org/cancer/types/colon-rectal-cancer/detection-diagnosis-staging/detection.html>
Accessed April 9, 2024.

⁴ Centers for Medicare and Medicaid Services. <https://www.cms.gov/newsroom/press-releases/celebration-10-years-aca-marketplaces-biden-harris-administration-releases-historic-enrollment-data> Accessed April 9, 2024

⁵ Kaiser Family Foundation. <https://www.kff.org/state-category/affordable-care-act/2024-marketplace-open-enrollment-period/>
Accessed April 9, 2024

⁶ Gupta S, Lieberman D, Anderson JC, Burke CA, Dominitz JA, Kaltenbach T, Robertson DJ, Shaukat A, Syngal S, Rex DK. Recommendations for Follow-Up After Colonoscopy and Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer. *Gastrointest Endosc.* 2020 Mar;91(3):463-485.e5. doi: 10.1016/j.gie.2020.01.014. Epub 2020 Feb 7. PMID: 32044106; PMCID: PMC7389642.

⁷ Dec. 7, 2023 letter to Secretary Becerra, Acting Secretary Su and Secretary Yellen.

<https://files.constantcontact.com/11178001701/dad95981-10b9-4c83-86e3-1f0b4c741465.pdf?rdr=true>

⁸ Jan. 10, 2024 letter to Secretary Becerra.

https://debbiedingell.house.gov/uploadedfiles/dingell_improve_access_to_colonoscopy_letter.pdf

RELEVANT AMA 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.

Citation: Res. 726, I-04 Reaffirmation I-07 Reaffirmed: CMS Rep. 01, A-17 Reaffirmed: Res. 123, A-17 Appended: CMS/CSAPH Joint Rep. 01, A-18

Encourage Appropriate Colorectal Cancer Screening H-55.967

Our AMA, in conjunction with interested organizations and societies, supports educational and public awareness programs to assure that physicians actively encourage their patients to be screened for colon cancer and precursor lesions, and to improve patient awareness of appropriate guidelines, particularly within minority populations and for all high-risk groups.

CSAPH Rep. 8, A-23

Encourage Appropriate Colorectal Cancer Screening H-55.967

Our AMA, in conjunction with interested organizations and societies, supports educational and public awareness programs to assure that physicians actively encourage their patients to be screened for colon cancer and precursor lesions, and to improve patient awareness of appropriate guidelines, particularly within minority populations and for all high-risk groups.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(A-24)

Introduced by: Mississippi

Subject: Requiring Government Agencies to Contract Only with Not-For-Profit Insurance Companies

Referred to: Reference Committee A

- 1 Whereas, the medical system in the United States involves a market-like environment with a
2 charity mission; and
3
4 Whereas, for profit insurance companies have taken over much of the health care system, with
5 most of their profits directed to private entities outside of our health system; and
6
7 Whereas, many of the tactics for making a profit include strategies which complicate the
8 provision of medical care for both the patient and the physician; and
9
10 Whereas, the Dutch health care system is recognized as a successful health care system using
11 a market-type multi-payer system which utilizes not-for-profit cooperatives whose profits are
12 allocated to reserves or returned in the form of lower premiums; and
13
14 Whereas, Medicare and Medicaid, which are government owned health insurance agencies,
15 contract with insurance companies to operate aspects of the medical care delivery; therefore be
16 it
17
18 RESOLVED, that our American Medical Association advocate that government-owned health
19 agencies such as Medicare and Medicaid be required to contract only with not-for-profit
20 insurance companies or cooperatives (Directive to Take Action); and be it further
21
22 RESOLVED, that our AMA support that those not-for-profit insurance companies or
23 cooperatives receiving public revenues must allocate profits to reserves, investments in
24 improving the quality of care in the system, or returned in the form of lower premiums for
25 patients or the health agency. (New HOD Policy).
26

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

Received: 4/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(A-24)

Introduced by: Mississippi

Subject: Requiring Payments for Physician Signatures

Referred to: Reference Committee A

- 1 Whereas, insurance companies often require multiple physician signatures outside of a patient-
2 physician office, nursing home or hospital visit for bureaucratic reasons or to place hurdles to
3 obtaining testing, health services, medications, referrals, or medical equipment; and
4
5 Whereas, primary care physicians often have to sign dozens of signatures daily which are
6 outside of the clinical visit in caring for patients; and
7
8 Whereas, this duty is often a significant burden on physician time and staff time which is not
9 usually paid for; and
10
11 Whereas, physicians desire to care for their patients but often feel like these signatures are
12 deliberately placed by the insurance companies to complicate the provision of services needed;
13 and
14
15 Whereas, if insurance companies had to pay for a physician's time in signing forms, they might
16 reduce the administrative burdens currently imposed on physicians; therefore be it
17
18 RESOLVED, that our American Medical Association advocate that insurance companies be
19 required to pay a physician for any required physician signature and/or peer to peer review
20 which is requested or required outside of a patient visit. (Directive to Take Action)
21

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

Received: 4/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(A-24)

Introduced by: Association for Clinical Oncology, American Society for Radiation
Oncology

Subject: Coverage for Dental Services Medically Necessary for Cancer Care

Referred to: Reference Committee A

1 Whereas, dental services may be required prior to or after cancer treatment and such services
2 are an integral part of successful cancer treatment; and
3

4 Whereas, dental care is linked to improved outcomes in patients with cancer and improved
5 quality of life; and
6

7 Whereas, the Centers for Medicare & Medicaid Services (CMS) recently expanded coverage for
8 certain cancer treatment-related oral and dental conditions, as well as for pre-treatment exams;
9 and
10

11 Whereas, all patients, regardless of insurance coverage, deserve equal access to these
12 medically necessary treatments; therefore be it
13

14 RESOLVED, that our American Medical Association supports that oral examination and dental
15 services prior to and following the administration of radiation, chemotherapy, chimeric antigen
16 receptor (CAR) T-cell therapy and high-dose bone-modifying agents for the treatment of cancer
17 are part of medically necessary care (New HOD Policy); and be it further
18

19 RESOLVED, that our AMA will advocate that all insurers cover medically necessary oral
20 examination and dental services prior to the administration of and resulting as a complication of
21 radiation, chemotherapy and/or surgery for all cancer of the head and neck region. (Directive to
22 Take Action)
23

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

Received: 4/24/2024

REFERENCES

1. Haynes DA, Vanison CC, Gillespie MB. The impact of dental care in head and neck cancer outcomes: A systematic review and meta-analysis. *Laryngoscope*. 2022 Jan;132(1):45-52. doi: 10.1002/lary.29494. Epub 2021 Feb 26. PMID: 33635587. <https://pubmed.ncbi.nlm.nih.gov/33635587/>
2. Thanvi J, Bumb D. Impact of dental considerations on the quality of life of oral cancer patients. *Indian J Med Paediatr Oncol*. 2014 Jan;35(1):66-70. doi: 10.4103/0971-5851.133724. PMID: 25006287; PMCID: PMC4080666. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4080666/>
3. Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program, 88 FR 78818 (publication date November 16, 2023). <https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other>

RELEVANT AMA POLICY

Medicare Coverage for Dental Services H-330.872

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

Increasing Patient Access to Hearing, Dental and Vision Services D-185.972

Our AMA will: (1) promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment or dementia in later life, to physicians as well as to the public; (2) promote, and encourage other stakeholders, including public, private, and professional organizations and relevant governmental agencies, to promote the conduct and acceleration of research into specific patterns and degrees of hearing loss to determine those most linked to cognitive impairment or dementia and amenable to correction; (3) work with interested national medical specialty societies and state medical associations to encourage and promote research into hearing loss as a contributor to cognitive impairment, and to increase patient access to hearing loss identification and remediation services; and (4) work with interested national medical specialty societies and state medical associations to encourage and promote research into vision and dental health and to increase patient access to vision and dental services.

Importance of Oral Health in Patient Care D-160.925

Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians.

Definitions of “Cosmetic” and “Reconstructive” Surgery H-475.992

(1) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, including prosthodontic reconstruction (including dental implants) caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA supports that reconstructive surgery be covered by all insurers and encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(A-24)

Introduced by: American Academy of Physical Medicine and Rehabilitation, American Association of Neuromuscular & Electrodiagnostic Medicine, American Academy of Pediatrics

Subject: Coverage for Shoes and Shoe Modifications for Pediatrics Patients Who Require Lower Extremity Orthoses

Referred to: Reference Committee A

- 1 Whereas, pediatric patients with musculoskeletal and/or neuromuscular disorders frequently
2 require lower extremity orthoses to help with their mobility, maximize their function, and prevent
3 contractures; and
4
5 Whereas, an orthosis or orthotic device is defined by the International Standards Organization
6 as an externally applied device used to modify the structural and functional characteristics of the
7 neuromuscular and skeletal system; and
8
9 Whereas, shoes that work with lower extremity orthoses are an essential component of the
10 orthotic intervention; and
11
12 Whereas, one of the goals when choosing the orthoses is to optimize forces and moments
13 acting on bones, ligaments, and joints during standing and walking to allow for the most natural
14 gait; and
15
16 Whereas, the orthoses will not normalize the gait to the best potential without proper footwear;
17 and
18
19 Whereas, there are some shoe options on the market that are deep and roomy enough to
20 accommodate braces which eliminates the need for custom shoes for most patients; and
21
22 Whereas, the commercially available shoes may require external modifications, such as for leg
23 length discrepancy or plantar flexion contracture, which require foot elevation or an external
24 heel lift respectively; and
25
26 Whereas, patients with severe hypotonia, calcaneus feet, and severe crouch using solid ankle-
27 foot orthoses (AFOs) to ambulate require shoes with a stiff sole, custom rocker, and heel lever
28 to maintain consistent roll over to imitate the natural rocking motion of gait; and
29
30 Whereas, those shoe modifications are relatively inexpensive and in the skilled hands of an
31 orthotist are easy to accomplish; and
32
33 Whereas, insurance coverage for shoes to use with orthoses as well as shoe modifications is
34 limited or nonexistent; and
35
36 Whereas, this creates a burden on the patients and families and makes the providers more
37 hesitant to recommend the shoe modifications despite being medically indicated; therefore be it

- 1 RESOLVED, that our American Medical Association support coverage by all private and
2 government insurance companies for pediatric footwear suitable for use with lower extremity
3 orthoses and medically necessary shoe modifications. (New HOD Policy)
4

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

Received: 4/24/2024

REFERENCES

1. Daryabor A, Aminian G, Arazpour M, Baniasad M, Yamamoto S. The effects of ankle-foot orthoses with plantar flexion stop and plantar flexion resistance using rocker-sole shoes on stroke gait: A randomized-controlled trial. *Turk J Phys Med Rehabil.* 2021 Dec 1;67(4):449-461. doi: 10.5606/tftrd.2021.6448. PMID: 35141485; PMCID: PMC8790265.
2. Mojaver A, Arazpour M, Aminian G, Ahmadi Bani M, Bahramizadeh M, Sharifi G, Sherafatvaziri A. The effect of footwear adapted with a multi-curved rocker sole in conjunction with knee-ankle-foot orthoses on walking in poliomyelitis subjects: a pilot study. *Disabil Rehabil Assist Technol.* 2017 Oct;12(7):747-751. doi: 10.1080/17483107.2016.1260654. Epub 2016 Dec 16. PMID: 27982715.
3. Mueller M, Strube M, Allen B. Effect of six types of footwear on peak plantar pressures in patients with diabetes and transmetatarsal amputation. *Clin Biomech (Bristol, Avon).* 1997 Apr;12(3):S3. doi: 10.1016/s0268-0033(97)88308-8. PMID: 11415697.
4. Wu WL, Rosenbaum D, Su FC. The effects of rocker sole and SACH heel on kinematics in gait. *Med Eng Phys.* 2004 Oct;26(8):639-46. doi: 10.1016/j.medengphy.2004.05.003. PMID: 15471691.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(A-24)

Introduced by: Ohio

Subject: Protections for "Guarantee Issue" of Medigap Insurance and Traditional Medicare

Referred to: Reference Committee A

1 Whereas, the Federal Medicare program has 4 parts A, B, C, and D, offering hospital, medical,
2 and pharmacy benefits; and
3
4 Whereas, Part C, known as Medicare Advantage, has become popular for its offerings of zero
5 premiums and additional benefits which are not available through traditional Medicare; and
6
7 Whereas, Medicare Advantage plans have various other limitations such as narrow networks,
8 limited drug coverage, and numerous preauthorization requirements; and
9
10 Whereas, traditional Medicare often requires supplementation through Medigap or
11 Supplemental Insurance policies to cover the remaining 20% of approved expenses not covered
12 by Medicare; and
13
14 Whereas, beneficiaries who switch from Medicare Advantage to traditional Medicare face
15 significant barriers in obtaining Medigap or Supplemental Insurance, often finding themselves
16 effectively locked into their Medicare Advantage plan even if it no longer meets their healthcare
17 needs; and
18
19 Whereas, only four states—Connecticut, Massachusetts, New York, and Maine—offer
20 "guaranteed issue" protections that allow access to Medigap or Supplemental Insurance policies
21 without restrictions after the initial enrollment period for Medicare beneficiaries; therefore be it
22
23 RESOLVED, that our American Medical Association pursue all necessary legislative and
24 administrative measures to ensure that Medicare beneficiaries have the freedom to switch back
25 to Traditional Medicare and obtain Medigap insurance under federal "guaranteed issue"
26 protections. (Directive to Take Action)
27

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 4/26/2024

REFERENCES

1. <https://www.wsj.com/health/healthcare/medicare-advantage-enrollment-risks-923e7952>

RELEVANT AMA POLICY

H-285.913 Medicare Advantage Policies

Our AMA will:

1. pursue legislation requiring that any Medicare Advantage policy sold to a Medicare patient must include a seven-day waiting period that allows for cancellation without penalty;
2. pursue legislation to require that Medicare Advantage policies carry a separate distinct page, which the patient must sign, including the statement, "THIS COVERAGE IS NOT TRADITIONAL MEDICARE. YOU HAVE CHOSEN TO CANCEL YOUR TRADITIONAL MEDICARE COVERAGE; NOT ALL PHYSICIANS, HOSPITALS AND LABORATORIES ACCEPT THIS NEW MEDICARE ADVANTAGE POLICY AND YOU MAY PERMANENTLY LOSE THE ABILITY TO PURCHASE MEDIGAP SECONDARY INSURANCE" (or equivalent statement) and specifying the time period before they can resume their traditional Medicare coverage; and
3. petition the Centers for Medicare and Medicaid Services to implement the patient's signature page in a Medicare Advantage policy. [Res. 907, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmation: I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-24)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: Private and Public Insurance Coverage for Adaptive Sports Equipment
including Prostheses and Orthoses

Referred to: Reference Committee A

- 1 Whereas, adults with lifelong disabilities are more likely to have chronic disease than adults with
2 no limitations¹; and
3
- 4 Whereas, increased physical activity and exercise are associated with reduced chronic disease
5 risk and most physiologic systems in the body benefit positively from physical activity and
6 exercise by primary and secondary disease prevention²; and
7
- 8 Whereas, the Centers for Disease Control (CDC) acknowledge the benefits of exercise to
9 prevent chronic disease in patients with disability³; and
10
- 11 Whereas, the CDC recommends that adults need a weekly 150 minutes of moderate-intensity
12 physical activity and 2 days of muscle strengthening activity for chronic disease prevention⁴; and
13
- 14 Whereas, people living with disabilities, including lower limb amputations, are 16-62% less likely
15 to meet physical activity guidelines⁴; and
16
- 17 Whereas, sports are a popular means of exercise and physical activity for children, adolescents,
18 and adults in the United States; and
19
- 20 Whereas, children with disabilities are 4.5 times less likely to engage in physical activity than
21 children without disabilities; and
22
- 23 Whereas, individuals with disabilities need specialized prostheses and orthoses for physical
24 activity and recreation to improve access and equity; and
25
- 26 Whereas, organizations like So Every BODY Can Move have helped introduce bills in 13 states
27 for insurance coverage of activity specific adaptive sports and exercise equipment and bills
28 have passed in 5 states; and
29
- 30 Whereas, Medicare part B already covers durable medical equipment including ambulatory
31 assistive devices to promote safe ambulation and increased independence for people with
32 disabilities; therefore be it
33
- 34 RESOLVED, that our American Medical Association recognizes activity-specific adaptive sports
35 and exercise equipment as assistive devices that are integral to the health maintenance of
36 persons with disabilities in accordance with national exercise guidelines (New HOD Policy); and
37 be it further

1 RESOLVED, that our AMA recognizes activity-specific adaptive sports and exercise equipment,
2 such as activity-specific prostheses and orthoses, as medical devices that facilitate
3 independence and community participation (New HOD Policy); and be it further
4

5 RESOLVED, that our AMA advocate for coverage by all private and public insurance plans for
6 activity-specific adaptive sports and exercise equipment for eligible beneficiaries with disabilities
7 in order to promote health maintenance and chronic disease prevention. (Directive to Take
8 Action)
9

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 5/7/2024

REFERENCES

1. Dixon-Ibarra A, Horner-Johnson W. Disability status as an antecedent to chronic conditions: National Health Interview Survey, 2006-2012. *Prev Chronic Dis.* 2014 Jan 30;11:130251. doi: 10.5888/pcd11.130251. PMID: 24480632; PMCID: PMC3917726.
2. Anderson E, Durstine JL. Physical activity, exercise, and chronic diseases: A brief review. *Sports Med Health Sci.* 2019 Sep 10;1(1):3-10. doi: 10.1016/j.smhs.2019.08.006. PMID: 35782456; PMCID: PMC9219321.
3. Physical Activity for People with Disability, *Centers for Disease Control and Prevention (CDC)* 4 January 2022, <https://www.cdc.gov/ncbddd/disabilityandhealth/features/physical-activity-for-all.html#:~:text=Physical%20activity%20can%20also%20improve,activity%20is%20better%20than%20none>
4. How much physical activity do adults need?, *Centers for Disease Control and Prevention (CDC)* 2 June 2022, <https://www.cdc.gov/physicalactivity/basics/adults/index.htm#:~:text=Each%20week%20adults%20need%20150,Physical%20Activity%20Guidelines%20for%20Americans.&text=We%20know%20150%20minutes%20of,do%20it%20all%20at%20once>
Martin Ginis KA, van der Ploeg HP, Foster C, Lai B, McBride CB, Ng K, Pratt M, Shirazipour CH, Smith B, Vásquez PM, Heath GW. Participation of people living with disabilities in physical activity: a global perspective. *Lancet.* 2021 Jul 31;398(10298):443-455.

RELEVANT AMA POLICY

H-470.990 Promotion of Exercise Within Medicine and Society

Our AMA supports (1) education of the profession on exercise, including instruction on the role of exercise prescription in medical practice in its continuing education courses and conferences, whenever feasible and appropriate; (2) medical student instruction on the prescription of exercise; (3) physical education instruction in the school system; and (4) education of the public on the benefits of exercise, through its public relations program. [Res. 56, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation I-98; Reaffirmation A-07; Reaffirmed: BOT Rep. 21, A-12; Reaffirmed: CSAPH Rep. 1, A-22]

H-470.991 Promotion of Exercise

Our AMA: (A) supports the promotion of exercise, particularly exercise of significant cardiovascular benefit; and (B) encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest. 2. Our AMA supports National Bike to Work Day and encourages active transportation whenever possible. [Res. 83, parts 1 and 2, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 604, A-11; Reaffirmed: CSAPH Rep. 1, A-21]

H-25.995 Exercise Programs for the Elderly

The AMA recommends that physicians: (1) stress the importance of exercise for older patients and explain its physiological and psychological benefits; (2) obtain a complete medical history and perform a physical examination that includes exercise testing for quantification of cardiovascular and physical fitness as appropriate, prior to the specific exercise prescription; (3) provide appropriate follow-up of patients' exercise programs; and (4) encourage all patients to establish a lifetime commitment to an exercise program. [CSA Rep. C, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15]

H-470.952 Government to Support Community Exercise Venues

Our AMA encourages: (1) towns, cities and counties across the country to make recreational exercise more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational fitness facilities; and (2) governmental incentives such as tax breaks and grants for the development of community recreational fitness facilities. [CSAPH Rep. 1, A-22]

H-470.997 Exercise and Physical Fitness

Our AMA encourages all physicians to utilize the health potentialities of exercise for their patients as a most important part of health promotion and rehabilitation, and urges state and local medical societies to emphasize through all available channels the need for physical activity for all age groups and both sexes. The AMA encourages other organizations and agencies to join with the Association in promoting physical fitness through all appropriate means. Our AMA will study evidence of the efficacy of physical activity interventions (e.g. group fitness, personal training, or physical therapy) on behavioral activation and outcomes on depressive and anxiety symptoms. [BOT Rep. K, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 10, A-14; Modified: Res. 421, A-23]

H-90.968 Medical Care of Persons with Disabilities

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]

D-330.961 Social Security Disability Medical Benefits

Our American Medical Association 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. [Sub. Res. 101, A-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmed: CMS Rep. 01, A-23]

H-425.970 Promoting Health Awareness and Preventive Screenings in Individuals with Disabilities

Our American Medical Association will work closely with relevant stakeholders to advocate for equitable access to health promotion and preventive screenings for individuals with disabilities. [Res. 911, I-13; Reaffirmed: BOT Rep. 09, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(A-24)

Introduced by: New England
Subject: Support Prescription Medication Price Negotiation
Referred to: Reference Committee A

1 Whereas, the passage of the “Inflation reduction act” is now allowing for negotiation of 10 high
2 priced medications, and allowed for reasonable reduction of the price of insulin¹; and
3
4 Whereas, there are many more overpriced medications that our patients struggle to afford²; and
5
6 Whereas, high prices of medications lead to non-compliance, and worse clinical outcomes^{3, 4};
7 and
8
9 Whereas, medication prices in the US are far above any other country in the world, adversely
10 affecting our patient’s health⁵; and
11
12 Whereas, excessive pharmaceutical prices put a massive strain on our health care system, and
13 directly contribute to high insurance and Medicare premiums⁶; therefore be it
14
15 RESOLVED, that our American Medical Association support pharmaceutical price negotiation
16 for all prescription medications, both Medicare and private insurance (New HOD Policy); and be
17 it further
18
19 RESOLVED, that our AMA advocate for any medication price that is raised by a pharmaceutical
20 company more than the rate of inflation be immediately subject to price negotiation in the
21 following year’s negotiation schedule (Directive to Take Action); and be it further
22
23 RESOLVED, that our AMA support extending the cap on annual out of pocket prescription drug
24 spending in Medicare Part D plans to all insurance plans. (New HOD Policy)

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

Received: 5/7/2024

REFERENCES

1. <https://www.cms.gov/files/document/medicare-drug-price-negotiation-program-initial-guidance.pdf>
2. Why do your prescription drugs cost so much? <https://www.health.harvard.edu/blog/why-do-your-prescription-drugs-cost-so-much-202401183007>
3. Prescription Noncompliance due to Cost Among Adults With Disabilities in the United States, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447201/>
4. Cost-Related Medication Nonadherence and its Risk Factors among Medicare Beneficiaries Med Care. 2021 Jan; 59(1): 13-21.
5. <https://aspe.hhs.gov/sites/default/files/documents/d5541b529a379d1f908ed2f9c00a9255/aspe-cover-idr-pricing-availability.pdf>
6. Are Specialty Drug Prices Destroying Insurers and Hurting Consumers?
[Are Specialty Drug Prices Destroying Insurers and Hurting Consumers? - PMC \(nih.gov\)](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447201/)

RELEVANT AMA POLICY

Prescription Drug Prices and Medicare D-330.954

1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

Res. 211, A-04 Reaffirmation I-04 Reaffirmed in lieu of Res. 201, I-11 Appended: Res. 206, I-14
Reaffirmed: CMS Rep. 2, I-15 Appended: Res. 203, A-17 Reaffirmed: CMS Rep. 4, I-19 Reaffirmed: CMS
Rep. 3, I-20 Reaffirmed: Res. 113, I-21 Reaffirmed: CMS Rep. 4, A-22 Reaffirmed in lieu of: Res. 810, I-
22

American Medical Association House of Delegates

Resolution: 114
(A-24)

Introduced by: New York
Subject: Breast Cancer Screening/Clinical Breast Exam Coverage
Referred to: Reference Committee A

1 Whereas, Centers for Medicare and Medicaid Services, CMS, reimburses Internists and
2 Family Physicians for a single physical at the time of Medicare enrollment at the age of
3 65 with the Initial Preventive Physical Exam, IPPE; and
4
5 Whereas, CMS does not reimburse for any further annual physical exams for medicare
6 patients; and
7
8 Whereas, female patients no longer require annual cervical pap smears after the age of
9 65 if prior pap smears have been negative and they are not at higher risk for cervical
10 cancer, as is applicable for the majority of medicare female patients; and
11
12 Whereas, female patients therefore opt to no longer see their gynecologists after the
13 age of 65 as they no longer require a pap smear or have any active gynecological
14 issues; and
15
16 Whereas, these female patients need an annual or biennial clinical breast exam and this
17 should therefore be performed by their internist or family practitioner at their Annual
18 Wellness Visits (AWV) or Subsequent Annual Wellness Visits (SAWV) after their initial
19 IPPE; and
20
21 Whereas, an internist or family practitioner cannot bill for this clinical breast exam as
22 part of this AWV or SAWV visit, even though this exam is critical and a part of the
23 standard of care for breast cancer screening which includes both imaging and a clinical
24 breast exam; and
25
26 Whereas, this policy by CMS is inconsistent and gender biased since a digital rectal
27 exam for prostate cancer screening in men over 65 for Medicare patients is a covered
28 procedure at the time of their AWV or SAWV appointment with their internist or family
29 practitioner; therefore be it
30
31 RESOLVED, that our American Medical Association advocate for Medicare coverage of
32 clinical breast exams for all female and at-risk male patients during the Medicare Annual
33 Wellness Visit (AWV) and Subsequent Annual Wellness Visit (SAWV) appointments.
34 (Directive to Take Action)

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

Received: 5/8/2024

American Medical Association House of Delegates

Resolution: 115
(A-24)

Introduced by: New York
Subject: Payments by Medicare Secondary or Supplemental Plans
Referred to: Reference Committee A

- 1 Whereas, there are more than 50,000 health plans in the United States; and
2
3 Whereas, patients have paid for health insurance either as a supplemental Medicare plan or
4 through their job or union as an earned benefit prior to meeting eligibility for Medicare; and
5
6 Whereas, Medicare allowed amounts are not market based and fixed as an act of government
7 edict; secondary payer does not vary whether a Medicare participating physician is in-network
8 with the secondary payer; and
9
10 Whereas, secondary health plans and Medicare supplemental health plans engage in abusive,
11 predatory, and anticompetitive practices by tying payment as a Medicare secondary plan to
12 whether the Medicare-participating physician that provides care to Medicare patients is in-
13 network with the secondary health plan; and
14
15 Whereas, patients on Medicare are subjected to financial burdens when health plans fail to pay
16 the balance (Medicare deductible and 20% coinsurance) that rightfully belongs to a secondary
17 payer with adverse effects on their health and health equity; therefore be it
18
19 RESOLVED, that our American Medical Association advocate for legislation that would mandate
20 that all health plans cover Medicare secondary claims regardless of the provider participating in
21 the secondary health plan (Directive to Take Action); and be it further
22
23 RESOLVED, that our AMA will report on the status of this resolution and policies H-390.839 and
24 D-390.984 at the 2025 Annual Meeting. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 5/7/2024

RELEVANT AMA POLICY

Requiring Secondary and Supplemental Insurers to Medicare to Follow Medicare Payments H-390.839

Our AMA will support payment by secondary insurers of the balance of the approved Medicare payment in an amount bringing Medicare and secondary payments up to the full allowance of the secondary insurer for services covered by the secondary insurer. Res. 120, A-16

Managed Care Secondary Payers H-385.950

Our AMA:

- (1) will seek regulatory changes that require all payers of secondary Medicare insurance to reimburse the co-insurance and applicable deductible obligations of Medicare beneficiaries;
 - (2) will require that these co-insurance and deductible obligations cannot be waived contractually;
 - (3) will consider the development of draft federal legislation to require Medicare to recognize the total coinsurance and deductible amounts facing Medicare beneficiaries in instances where Medicare provides secondary insurance coverage;
 - (4) advocates that all patients covered by Medicare as their primary carrier and another health insurance plan (not a Medigap policy) as their secondary carrier should be entitled to receive payment in full from their secondary carriers for all Medicare patient deductible and copayments without regard to the amount of the Medicare payment for the service;
 - (5) advocates that all patients covered by Medicare as their primary carrier and another health insurance plan as secondary should be entitled to receive payment in full from their secondary plans for all Medicare patient deductibles and copayments without regard to any requirement that there be prior authorization by the secondary plan for medical care and treatment that is medically necessary under Medicare, by imposing limits on the amount, type or frequency of services covered, and by thereby seeking to "manage" the Medicare benefit, as if the secondary carrier were the primary carrier; and
 - (6) in its advocacy efforts, will address and seek to solve (by negotiation, regulation, or legislation) the problem wherein a secondary insurance company does not reimburse the patient for, nor pay the physician for, the remainder/balance of the allowable amount on the original claim filed with the patient's primary insurance carrier, regardless of the maximum allowed by the secondary insurance payer.]
- BOT Rep. 33, A-96 Appended: Res. 122, A-98 Reaffirmed: Res. 105, A-00 Sub. Res. 104, A-01 Reaffirmation I-01 Appended: Res. 105 and 106, A-03 Appended: Res. 821, I-11 Modified: BOT Rep. 7, A-21

Payment by Health Insurance Plans of Medicare Deductibles and Copayments D-390.984

Our AMA will: (1) seek legislation to compel all insurers paying secondary to Medicare to be required to pay the deductibles and coinsurance owed after the Medicare payment is made; and (2) seek federal legislation to require that a secondary plan not manage the primary Medicare benefit by imposing limits as if it were primary.

Res. 105 and 106, A-03 Reaffirmed: BOT Rep. 28, A-13 Modified: CCB/CLRPD Rep. 2, A-14

Reference Committee B

Report(s) of the Board of Trustees

- 09 Council on Legislation Sunset Review of 2014 House
- 11 Safe and Effective Overdose Reversal Medications in Educational Settings
- 13 Prohibiting Covenants Not-to-Compete
- 14 Physician Assistant and Nurse Practitioner Movement Between Specialties
- 15 Augmented Intelligence Development, Deployment, and Use in Health Care
- 16 Support for Mental Health Courts
- 17 Drug Policy Reform
- 18 Supporting Harm Reduction
- 19 Attorneys' Retention of Confidential Medical Records and Controlled Medical Expert's Tax Returns After Case Adjudication

Resolutions

- 201 Research Correcting Political Misinformation and Disinformation on Scope of Practice
- 202 Use of Artificial Intelligence and Advanced Technology by Third Party Payors to Deny Health Insurance Claims
- 203 Medicaid Patient Accountability
- 204 Staffing Ratios in the Emergency Department
- 205 Medical-Legal Partnerships & Legal Aid Services
- 206 Indian Health Service Youth Regional Treatment Centers
- 207 Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse
- 208 Improving Supplemental Nutrition Programs
- 209 Native American Voting Rights
- 210 Support for Physicians Pursuing Collective Bargaining and Unionization
- 211 Deceptive Hospital Badging 2.0
- 212 Advocacy Education Towards a Sustainable Medical Care System
- 213 Access to Covered Benefits with an Out of Network Ordering Physician
- 214 Support for Paid Sick Leave
- 215 American Indian and Alaska Native Language Revitalization and Elder Care
- 216 The AMA Supports H.R. 7225, the Bipartisan "Administrative Law Judges Competitive Service Restoration Act"
- 217 Protecting Access to IVF Treatment
- 218 Designation of Descendants of Enslaved Africans in America
- 219 Bundling for Maternity Care Services
- 220 Restorative Justice for the Treatment of Substance Use Disorders
- 221 Reforming Medicare Part B Drug Reimbursement to Promote Patient Affordability and Physician Practice Sustainability
- 222 Studying Avenues for Parity in Mental Health & Substance Use Coverage
- 223 Increase in Children's Hospital Graduate Medical Education Funding
- 224 Antidiscrimination Protections for LGBTQ+ Youth in Foster Care
- 225 Humanitarian Efforts to Resettle Refugees
- 226 Protecting Access to IVF Treatment
- 227 Medicare Reimbursement for Telemedicine
- 228 Waiver of Due Process Clauses
- 229 Opposition to Legalization of Psilocybin

- 230 Protecting Patients from Inappropriate Dentist and Dental Hygienist Scope of Practice Expansion
- 231 Supporting the Establishment of Rare Disease Advisory Councils
- 232 Medicare Advantage Part B Drug Coverage
- 233 Prohibiting Mandatory White Bagging
- 234 State Prescription Drug Affordability Boards - Study
- 235 Establish a Cyber-Security Relief Fund
- 236 Support of Physicians Pursuing Collective Bargaining and Unionization
- 237 Encouraging the Passage of the Preventive Health Savings Act (S.114)
- 238 AMA Supports Efforts to Fund Overdose Prevention Sites
- 239 Requiring stores that sell tobacco products to display NYS Quitline information
- 240 Expanding Visa Requirement Waivers for NY IMGs Working in Underserved Areas
- 241 Healthcare Cybersecurity Breaches
- 242 Cancer Care in Indian Health Services Facilities
- 243 Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes
- 244 Graduate Medical Education Opportunities for American Indian and Alaska Native Communities

REPORT OF THE BOARD OF TRUSTEES

B of T Report 09-A-24

Subject: Council on Legislation Sunset Review of 2014 House Policies

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

- 1 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of
2 American Medical Association (AMA) policies to ensure that our AMA’s policy database is
3 current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for
4 review and specifying the procedures to follow:
5
6 1. As the House of Delegates (HOD) adopts policies, a maximum ten-year time horizon shall
7 exist. A policy will typically sunset after 10 years unless action is taken by the HOD to retain
8 it. Any action of our AMA HOD that reaffirms or amends an existing policy position shall
9 reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.
10
11 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
12 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
13 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall
14 be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been
15 asked to review policies shall develop and submit a report to the HOD identifying policies that
16 are scheduled to sunset; (d) For each policy under review, the reviewing council can
17 recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain
18 part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each
19 recommendation that it makes to retain a policy in any fashion, the reviewing council shall
20 provide a succinct, but cogent justification; or (f) The Speakers shall determine the best way
21 for the HOD to handle the sunset reports.
22
23 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier
24 than its 10-year horizon if it is no longer relevant, has been superseded by a more current
25 policy, or has been accomplished.
26
27 4. The AMA councils and the HOD should conform to the following guidelines for sunset:
28 (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been
29 accomplished; or (c) when the policy or directive is part of an established AMA practice that is
30 transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA HOD
31 Reference Manual: Procedures, Policies and Practices.
32
33 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
34
35 6. Sunset policies will be retained in the AMA historical archives.

1 RECOMMENDATION

2

3 The Board of Trustees recommends that the House of Delegates policies that are listed in the
 4 appendix to this report be acted upon in the manner indicated and the remainder of this report be
 5 filed.

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-105.996	Impact of Pharmaceutical Advertising on Women's Health	<p>1. Our AMA urges the US Food and Drug Administration (FDA) to assure that all direct-to-consumer advertising of pharmaceuticals includes information regarding differing effects and risks between the sexes.</p> <p>2. Our AMA urges the FDA to assure that advertising of pharmaceuticals to health care professionals includes specifics outlining whether testing of drugs prescribed to both sexes has included sufficient numbers of women to assure safe use in this population and whether such testing has identified needs to modify dosages based on sex.</p> <p>(Res. 509, A-14)</p>	Retain – this policy remains relevant.
D-115.988	Medication Non-Adherence and Errors	<p>Our AMA will recommend the Centers for Medicare & Medicaid Services conduct a cost/benefit analysis and an analysis of the ability of seniors and people with disabilities to use blister packs in order to determine the feasibility of expanding coverage for timed calendar blister packs for prescription medications beyond residents of long term care facilities.</p> <p>(BOT Rep. 11, A-14)</p>	<p>Sunset this policy.</p> <p>The recommendation was communicated to the Centers for Medicare & Medicaid Services.</p>
D-120.944	Improvement of Electronic Prescription Software	<p>Our AMA will: (1) advocate for changing the national standards for controlled substance prescriptions so that prescriptions for controlled substances can be transmitted electronically directly to the pharmacy in a secure manner; and (2) work with pharmacies, vendors, and other appropriate entities to encourage the use of standards that would allow the transmission of short messages regarding</p>	<p>Retain this policy in part.</p> <p>Delete clause (1). Drug Enforcement Administration regulations allow the option of writing prescriptions for controlled substances electronically. The regulations also permit</p>

Policy Number	Title	Text	Recommendation
		<p>prescriptions so that both physicians and pharmacists could communicate directly with each other within the secure health records systems that they are already using.</p> <p>(Res. 209, A-14)</p>	<p>pharmacies to receive, dispense, and archive these electronic prescriptions.</p>
D-120.980	Regulation of Media-Based Drug Sales Without Good Faith Medical Examination	<p>Our AMA will develop and promote model federal legislation to eliminate the sale, without a legitimate prescription, of prescription drugs over the Internet, if such bills to establish national standards in this area are not forthcoming.</p> <p>(Sub. Res. 520, A-04; Reaffirmed: BOT Rep. 19, A-14)</p>	<p>Sunset this policy.</p> <p>This policy has been superseded by more recent AMA policy (H-120.956, Internet Prescribing).</p>
D-130.971	The Future of Emergency and Trauma Care	<p>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</p>	<p>Retain – this policy remains relevant.</p>

Policy Number	Title	Text	Recommendation
		<p>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.</p> <p>(BOT Rep. 14, I-06; Reaffirmation A-07; Reaffirmation A-08; BOT action in response to referred for decision Res. 204, A-11; Appended: Res. 221, I-11; Modified: CCB/CLRPD Rep. 2, A-14)</p>	
D-130.976	Implications of the November 2003 Emergency Medical Treatment and Labor Act (EMTALA) Final Rule	<p>Our AMA will: (1) ask the EMTALA Technical Advisory Group (TAG) and the Centers for Medicare and Medicaid Services (CMS) for assistance in ameliorating the differential economic and staffing burdens on certain categories of facilities, including but not limited to academic health centers, trauma centers, critical access hospitals, and safety net hospitals, which are likely to receive high volumes of patients as a result of the EMTALA regulations; (2) work with the EMTALA TAG and CMS to ensure that physicians staffing emergency departments and on-call</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>emergency services be appropriately compensated for providing EMTALA mandated services; (3) with input from all interested Federation members, coordinate an effort to educate the membership about emergency department coverage issues and the efforts to resolve them; (4) seek to require all insurers, both public and private, to pay promptly and fairly all claims for services mandated by EMTALA for all plans they offer, or face fines and penalties comparable to those imposed on providers; and (5) seek to have CMS require all states participating in Medicaid, as a condition of continued participation, establish and adequately fund state Emergency Medical Services funds which physicians providing EMTALA-mandated services may bill, and from which those physicians shall receive prompt and fair compensation.</p> <p>(CME Rep. 3, A-05; Reaffirmation A-07; Reaffirmed in lieu of Res. 605, I-08; Modified: CCB/CLRPD Rep. 2, A-14)</p>	
D-160.991	Licensure and Liability for Senior Physician Volunteers	<p>Our AMA (1) and its Senior Physician Group will inform physicians about federal and state-based charitable immunity laws that protect physicians wishing to volunteer their services in free medical clinics and other venues; and (2) will work with organizations representing free clinics to promote opportunities for physicians who wish to volunteer.</p> <p>(BOT Rep. 17, A-04; Reaffirmed: CCB/CLRPD Rep. 1, A-14)</p>	Retain – this policy remains relevant.
D-175.985	The CMS Electronic Medical Records Initiative Should Not Be Used To Detect Alleged Fraud by Physicians	<p>1. Our AMA will (A) communicate its concerns about the plan recently announced by the Centers for Medicare and Medicaid Services (CMS), in which CMS is to use data from the electronic medical record incentive program in the pursuit of fraud, waste and abuse; and (B) seek active involvement in the drafting of all program directives for CMS's electronic medical record</p>	<p>Retain this policy in part.</p> <p>Delete clauses (1) - (4) and modify clause (7). Our AMA communicated these concerns to the Centers for Medicare & Medicaid Services.</p>

Policy Number	Title	Text	Recommendation
		<p>initiative, including all directives about potential data capture and subsequent audit processes.</p> <p>2. Our AMA will lead an effort in concert with the Centers for Medicare and Medicaid Services to establish specific guidance to be utilized by entities that audit documentation generated by an electronic health record.</p> <p>3. Such guidance will provide specific protocols used by Medicare and Medicaid auditors to allege a service is not reasonable and necessary based on the generation of an electronic health record.</p> <p>4. Our AMA will inform state and specialty societies about available AMA resources to assist physicians with audits of electronic health records and prominently feature on their website information about methods, resources, and technologies related to appeals of electronic health record audits and Medicare and Medicaid overpayment recoveries as a members-only benefit.</p> <p>51. Our AMA believes that the use of time-saving features, such as cloning, templates, macros, "pull forward technology", auto-population and identical language in EMRs, by itself is not an indication of inaccurate documentation or incorrect coding.</p> <p>62. Our AMA believes that audit results that imply incorrect coding must specifically indicate which portion of the chart language either does not accurately reflect the office visit or reflects unnecessary care.</p> <p>73. Our AMA will: (1) develop guidelines in conjunction with the Centers for Medicare & Medicaid Services to provide clear and direct guidance to physicians concerning the permissible use for coding and billing of electronic health record (EHR) clinical documentation tools, such as templates, macros, cutting and pasting, and cloning; and (2) study the impact of EHR clinical documentation tools and shortcuts on</p>	

Policy Number	Title	Text	Recommendation
		<p>patient safety, quality of care and safe harbor laws.</p> <p>(Res. 212, A-10; Appended: Res. 206, I-11; Appended: Res. 715, A-13; Reaffirmed: BOT Rep. 20, A-14)</p>	
D-215.995	Specialty Hospitals and Impact on Health Care	<p>Our AMA will: (1) oppose efforts to either temporarily or permanently extend the 18-month moratorium on physician referrals to specialty hospitals in which they have an ownership interest; (2) support changes in the inpatient and outpatient Medicare prospective payment systems to eliminate the need for cross-subsidization by more accurately reflecting the relative costs of hospital care; (3) support federal legislation and/or regulations that would fix the flawed methodology for allocating Medicare and Medicaid Disproportionate Share Hospital (DSH) payments to help ensure the financial viability of safety-net hospitals so they can continue to provide adequate access to health care for indigent patients; (4) encourage physicians who contemplate formation of a specialty hospital to consider the best health interests of the community they serve. Physicians should explore the opportunities to enter into joint ventures with existing community hospitals before proceeding with the formation of a physician-owned specialty hospital; and (5) oppose the enactment of federal certificate of need (CON) legislation and support state medical associations in their advocacy efforts to repeal current CON statutes and to oppose the reinstatement of CON legislation or its expansion to physician-owned ambulatory health care facilities.</p> <p>(BOT Rep. 15, I-04; Reaffirmation A-09; Modified: CCB/CLRPD Rep. 2, A-14)</p>	Retain – this policy remains relevant.
D-255.985	Conrad 30 - J-1 Visa Waivers	<p>1. Our AMA will: (A) lobby for the reauthorization of the Conrad 30 J-1 Visa Waiver Program; (B) advocate that the J-1 Visa waiver slots be increased from 30 to 50 per state; (C) advocate for</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>expansion of the J-1 Visa Waiver Program to allow IMGs to serve on the faculty of medical schools and residency programs in geographic areas or specialties with workforce shortages; (D) publish on its website J-1 visa waiver (Conrad 30) statistics and information provided by state Conrad 30 administrators along with a frequently asked questions (FAQs) document about the Conrad 30 program; (E) advocate for solutions to expand the J-1 Visa Waiver Program 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; (F) work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad 30 administrators, IMGs, US Citizenship and Immigration Services and the State Department; and (G) continue to communicate with the Conrad 30 administrators and IMGs members to share information and best practices in order to fully utilize and expand the Conrad 30 program.</p> <p>2. Our AMA will continue to monitor legislation and provide support for improvements to the J-1 Visa Waiver program.</p> <p>3. Our AMA will continue to promote its educational or other relevant resources to IMGs participating or considering participating in J-1 Visa waiver programs.</p> <p>4. As a benefit of membership, our AMA will provide advice and information on Federation and other resources (but not legal opinions or representation), as appropriate to IMGs in matters pertaining to work-related abuses.</p> <p>5. Our AMA encourages IMGs to consult with their state medical society and consider requesting that their state society ask for assistance by the AMA</p>	

Policy Number	Title	Text	Recommendation
		<p>Litigation Center, if it meets the Litigation Center's established case selection criteria.</p> <p>(Res. 233, A-06; Appended: CME Rep. 10, A-11; Appended: Res. 303, A-11; Reaffirmation I-11; Modified: BOT Rep. 5, I-12; Appended: BOT Rep. 27, A-13; Reaffirmation A-14)</p>	
D-255.993	J-1 Visas and Waivers	<p>1. Our AMA shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program.</p> <p>2. If the USDA does not continue in its role as an interested government agency (IGA), the AMA encourage HHS to expand its J-1 visa waiver program.</p> <p>3. Our AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians' service requirements through the J-1 waiver and Conrad-30 programs with a report back at A-03.</p> <p>4. Our AMA will work towards regulation and/or legislation to allow physicians on H-1B <u>waiver</u> visas for their J-1 visa waiver, who are limited to serving in medically underserved areas, to continue to care for their patients who require hospitalization in the closest appropriate medical facility which may not be in the underserved area.</p> <p>5. Our AMA will work with state medical societies to study and report back on the feasibility of having support a national data repository of J-1 Visa Waiver statistics so that J-1 Visa Waiver unoffered positions can be transferred to states as needed to treat underserved communities and to monitor the success of this program.</p> <p>(BOT Rep. 11, I-02; Appended: Res. 324, A-11; Appended: Res. 904, I-11; Reaffirmation A-14)</p>	<p>Retain this policy in part.</p> <p>Delete clause (2) and modify clauses (3) – (5). In 2002 the USDA decided to discontinue its role as an IGA on behalf of foreign research scientists or physicians desiring a recommendation of a J-1 Visa waiver. Moreover, HHS has already expanded its J-1 visa waiver program.</p>

Policy Number	Title	Text	Recommendation
D-260.994	Point of Care Availability for Blood Glucose Testing	<p>Our AMA will work with the Food and Drug Administration and the Centers for Medicare & Medicaid Services to maintain the Clinical Laboratory Improvement Act exempt status of point-of-care glucose testing.</p> <p>(Res. 727, A-14)</p>	<p>Sunset this policy.</p> <p>Our AMA communicated support to the U.S. Food and Drug Administration and the Centers for Medicare & Medicaid services for Clinical Laboratory Improvement Amendments exempt status of point of care blood glucose testing.</p>
D-315.984	Ownership of Claims Data	<p>Our AMA will: (1) encourage physicians to include language designed to buttress rights associated with claims data ownership and access when contracting with health plan payers and other third parties; (2) continue to educate physicians on providing public and private health plan payers the "minimum necessary," as defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and regulations thereunder, protected health information necessary to achieve the purpose of a disclosure; (3) assist physicians wishing to register a complaint against health plan payers that have used claims data to form a database, or that have permitted access to or sale of the database or its contents without explicit patient and/or physician authorization, beyond the scope permitted by HIPAA with the Department of Health and Human Services Office of Civil Rights; (4) advocate to the Department of Health and Human Services, Office of the National Coordinator of Health Information Technology and/or other appropriate agencies for rules and regulations ensuring appropriate physician ownership and access rights to claims data, and appropriate protection of claims data held by various parties; and (5) continue to monitor federal and state activities impacting the exchange of physician-generated health information, including claims data.</p>	<p>Retain – this policy remains relevant.</p>

Policy Number	Title	Text	Recommendation
		(BOT Rep. 19, I-06; Modified: CCB/CLRPD Rep. 2, A-14)	
D-35.994	Scope of Practice Participants in Health Plans	<p>Our AMA Advocacy Resource Center will work at the invitation of AMA component societies to oppose legislative mandates on health care plans that may lead to inappropriate scope of practice expansion of non-physician providers.</p> <p>(Res. 923, I-04; Reaffirmed: BOT Rep. 19, A-14)</p>	Retain – this policy remains relevant.
D-375.997	Peer Reviewer Immunity	<p>Our AMA will: (1) recommend medical staffs adopt/implement staff by laws that are consistent with HCQIA and AMA policy by communicating the guidelines from AMA policy H-375.983 widely through appropriate media to the relevant organizations and institutions, including a direct mailing to all medical staff presidents in the United States, indicating that compliance is required to conform to HCQIA and related court decisions; (2) monitor legal and regulatory challenges to peer review immunity and non discoverability of peer review records/proceedings and continue to advocate for adherence to AMA policy, reporting challenges to peer review protections to the House of Delegates and produce an additional report with recommendations that will protect patients and physicians in the event of misdirected or negligent peer review at the local level while retaining peer review immunity for the process; and (3) continue to work to provide peer review protection under federal law.</p> <p>(BOT Rep.8, I-01; Reaffirmation A-05; Modified: CCB/CLRPD Rep. 2, A-14)</p>	Retain – this policy remains relevant.
D-40.995	The Implications of Health Care Personnel Delivery System	<p>Our AMA will continue to monitor the Health Care Personnel Delivery System (HCPDS) and initiate communication with the Selective Service System and other relevant governmental bodies to address questions and concerns related to the implementation of the HCPDS.</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(CME Rep. 2, I-04; Reaffirmed: CMS Rep. 1, A-14)	
D-400.984	Transparency, Participation, and Accountability in CMS' Payment Determination Process	<p>1. Our AMA will urgently advocate for the Centers for Medicare and Medicaid Services (CMS) to improve its rate-setting processes by first publishing modifications to Medicare physician fees that result from CMS' misvalued codes initiative in the Medicare Physician Fee Schedule proposed rule instead of the final rule to afford adequate time for providers, professional medical societies and other stakeholders to review and comment on such changes before they take effect.</p> <p>2. Our AMA will demand that CMS be transparent in its processes and methodologies for establishing physician work values and allow adequate opportunity for public comment on its methodologies before changes in physician work values take effect.</p> <p>(Res. 220, A-14)</p>	Retain – this policy remains relevant.
D-406.998	National Provider Identification	<p>Our AMA will work closely in consultation with the Centers for Medicare and Medicaid Services to introduce safeguards and penalties surrounding the use of National Provider Identification to protect physicians' privacy, integrity, autonomy, and ability to care for patients.</p> <p>(Res. 717, I-04; Reaffirmed: CMS Rep. 1, A-14)</p>	Retain – this policy remains relevant.
D-435.978	Loss of Medical Staff Privileges for Lack of "Tail Coverage"	<p>Our AMA will: (1) Advocate for better disclosures by professional medical liability insurance carriers to their policyholders about the continuing financial health of the carrier; and advocate that carriers create and maintain a listing of alternate professional liability insurance carriers in good financial health which can provide physicians replacement tail or other coverage if the carrier becomes insolvent; and (2) Support model medical staff bylaw language stating: "Where continuous professional liability</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>insurance coverage is a condition of medical staff membership, a temporary loss of professional liability insurance coverage (whether or not limited to "tail" coverage) is not grounds for immediate termination of medical staff membership. The Medical Executive Committee shall determine the length and other conditions of an individual waiver of the coverage requirement."</p> <p>(BOT Action in response to referred for decision Res. 537, A-04; Modified: CMS Rep. 1, A-14)</p>	
D-435.985	Use of Countersuits to Discourage Frivolous Lawsuits	<p>Our AMA will advise members of the option for countersuits against plaintiffs and attorneys who have filed frivolous lawsuits against physicians.</p> <p>(Sub. Res. 914, I-04; Reaffirmed: BOT Rep. 19, A-14)</p>	Retain – this policy remains relevant.
D-440.933	VA ACES Travel Policy	<p>Our AMA will send a letter to the Secretary of the Department of Veterans Affairs (VA) and any other appropriate entities noting that the Attendance and Cost Estimation System (ACES) system has become a barrier to VA physician attendance at medical and scientific meetings, and encourage the Secretary to adopt ACES system reforms that will allow VA employed physicians to attend medical and scientific conferences.</p> <p>(Res. 614, A-14)</p>	<p>Sunset this policy.</p> <p>Our AMA submitted a letter to the Department of Veterans Affairs advocating for ACES reforms to lower the barriers and make it easier for VA-employed physicians and researchers to attend medical and scientific conferences.</p>
D-440.934	Onerous Restrictions on Travel of Government Scientists	<p>Our AMA will pursue legislative or regulatory action to achieve <u>supports</u> easing of travel restrictions for federally-employed scientists who are attending academic or scientific conferences that are consistent with current HHS policies and procedures, to include a simplified approval process.</p> <p>(Res. 608, A-14)</p>	<p>Retain this policy in part.</p> <p>Our AMA has communicated to the federal government about easing and simplifying restrictions related to federally employed scientists attending academic and scientific conferences.</p>
D-450.959	Improvements to the Value-Based Modifier	<p>Our AMA will: (1) seek a delay in the Value-Based Modifier (VBM) penalty for smaller practices; and (2) continue to encourage selection of VBM quality</p>	<p>Sunset this policy.</p> <p>The Value-Based Modifier program was replaced by</p>

Policy Number	Title	Text	Recommendation
		<p>measures that are physician-defined, clinically meaningful, specialty-appropriate, realistic, and within reasonable control of the physician.</p> <p>(Sub. Res. 218, A-14)</p>	<p>the Merit-based Incentive Payment System (MIPS) under the Quality Payment Program.</p>
D-450.981	Protecting Patients Rights	<p>Our AMA will: (1) continue to advocate for the repeal of the flawed sustainable growth rate formula without compromising our AMA's principles for pay-for-performance; and (2) develop a media campaign and public education materials to teach patients and other stakeholders about the potential risks and liabilities of pay-for-performance programs, especially those that are not consistent with AMA policies, principles, and guidelines.</p> <p>(Modified: CCB/CLRPD Rep. 2, A-14)</p>	<p>Sunset this policy.</p> <p>The sustainable growth rate was repealed by the Medicare Access and CHIP Reauthorization Act.</p>
D-450.987	Support of Patient Safety Aspects of The Joint Commission	<p>Our AMA will continue to work with The Joint Commission on the development of standards which improve patient safety; and our AMA and The Joint Commission will then present these changes to the Centers for Medicare & Medicaid Services to effect an update of good health care policy and to delete outdated wasteful health care policy.</p> <p>(Res. 530, A-04; Modified: CMS Rep. 1, A-14)</p>	<p>Retain – this policy remains relevant.</p>
D-480.973	President's Council on Science and Technology Report	<p>Our AMA will analyze the President's Council on Science and Technology Report entitled "Better Health Care and Lower Costs: Accelerating Improvement through Systems Engineering" and respond as appropriate.</p> <p>(Res. 523, A-14)</p>	<p>Sunset this policy.</p> <p>Our AMA thoroughly analyzed the May 2014 President's Council on Science and Technology Report (PCAST) and has taken steps to implement the recommendations through testimony to an Office the National Coordinator Federal Advisory Committee, public comment on ONC's proposed 10-year health IT roadmap, and comment letters to the</p>

Policy Number	Title	Text	Recommendation
			Administration in support of the health IT framework outlined in the November 2014 Report to the President: Better Health Care and Lower Costs: Accelerating Improvement Through Systems Engineering.
D-60.968	Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth	Our AMA will work with medical societies and all clinicians to (i) work together with other child-serving sectors to ensure that new immigrant children receive timely and age-appropriate services that support their health and well-being, and (ii) secure federal, state, and other funding sources to support those services. (Res. 8, I-14)	Retain – this policy remains relevant.
D-80.997	Identify Theft	1. Our AMA will request that the Internal Revenue Service (IRS) adopt policies to ensure greater security protection for electronically filed federal income tax returns, including the universal use of PINs, or personal identification numbers. 2. Our AMA will request that the IRS and the Centers for Medicare & Medicaid Services promulgate regulations to prohibit the use of Social Security numbers (SSN) by insurers, health care vendors, state agencies other than the state taxing authority and non-financial businesses. (Res. 613, A-14)	Retain this policy in part. Delete clause 2. In 2023, the Centers for Medicare & Medicaid Services removed SSN-based health insurance claim numbers from Medicare cards and is now using Medicare Beneficiary Identifiers (MBIs) for Medicare transactions like billing, eligibility status, and claim status.
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)	Sunset this policy. This policy has been superseded by more recent AMA policy (H-110.987, Pharmaceutical Costs ; H-110.988, Controlling the Skyrocketing Costs of Generic Prescription Drugs ;

Policy Number	Title	Text	Recommendation
			H-110.997, Cost of Prescription Drugs ; H-285.965, Managed Care Cost Containment Involving Prescription Drugs ; H-110.997, Cost of Prescription Drugs).
H-120.937	Methadone Should Not Be Designated as the Sole Preferred Analgesic	Our AMA recommends that methadone should not be designated as the sole preferred analgesic by any insurance payer, whether public or private. (Res. 117, A-14)	Sunset this policy. This policy has been superseded by more recent policy (H-185.931, Workforce and Coverage for Pain Management ; D-120.932, Inappropriate Use of CDC Guidelines for Prescribing Opioids).
H-120.948	Positive Verification of Contact Lens Prescriptions	Our AMA will support positive prescription verification for contact lenses and recommend that the federal government monitor the effects of the Fairness to Contact Lens Consumers Act (FCLCA) on the accuracy of prescriptions. (Res. 225, A-04; Reaffirmed: BOT Rep. 19, A-14)	Retain – this policy remains relevant.
H-160.907	Hospital Inpatient Admission Order and Certification	Our AMA: (1) supports the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital as a condition for payment for inpatient services; and (2) believes that upon admission of any patient to a hospital for inpatient services, the admitting/attending physician should have access to appropriate information--for example the Geometric Mean Length of Stay (GMLOS)--to help the physician plan appropriately for the services that will be required to care for that particular patient; and (3) will inform the Centers for Medicare & Medicaid Services as soon as possible of the AMA's policy calling for the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital, and take appropriate action to enact this policy.	Retain this policy in part. Delete clause (3). Our AMA communicated to the Centers for Medicare & Medicaid Services the AMA's policy calling for the rescission of the requirement that a physician certify the estimated time the patient will need to remain in the hospital.

Policy Number	Title	Text	Recommendation
		(Res. 227, I-13; BOT action in response to referred for decision Res. 227, I-13; Reaffirmation A-14)	
H-175.984	Health Care Fraud and Abuse Update	<p>AMA policy is that: (1) our AMA leadership intensify efforts to urge federal policy makers to apply traditional definitions of fraud and abuse which focus on intentional acts of misconduct and activities inconsistent with accepted medical practice;</p> <p>(2) our AMA continue to work with federal law enforcement officials to improve the ability to root out intentional schemes to defraud public programs;</p> <p>(3) our AMA work with federal policymakers to balance payment integrity objectives with reasonable documentation and other administrative requirements;</p> <p>(4) our AMA develop model compliance plans and educational materials to assist physicians in conforming to the latest laws and regulations; and</p> <p>(5) our AMA continue to work in a coalition of other health care organizations to lobby for restrictions on the use of the False Claims Act.</p> <p>(BOT Rep. 25, I-97; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmed in lieu of Res. 223, A-14)</p>	Retain – this policy remains relevant.
H-185.949	Centers for Medicare and Medicaid Services Policy on Hospital Acquired Conditions - Present on Admission	<p>1. Our AMA will: (a) continue its strong opposition to non-payment for conditions outlined in the Hospital Acquired Condition -- Present on Admission (HAC-POA) policy that are not reasonably preventable through the application of evidence-based guidelines developed by appropriate medical specialty organizations based on non-biased, well-designed, prospective, randomized studies; (b) ask CMS or other appropriate bodies to monitor and evaluate practice changes made as a result of HAC-POA law, and associated outcomes, and report back on best practices; (c) educate physicians about</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>the HAC-POA law and its implications for patient care, coding requirements and payment; (d) continue its education and advocacy of CMS, Members of Congress and the public about the unintended consequences of non-payment for hospital acquired conditions that may not in fact be preventable, and that adversely affect access to and quality of care; (e) oppose the use of payment and coverage decisions of governmental and commercial health insurance entities as determinative of the standard of care for medical practice and advocate that payment decisions by any third party payer not be considered in determining standards of care for medical practice; and (f) continue to study the effect of HAC-POA penalty programs on professional liability; potential institutional demands to control or micro-manage doctors' professional decision-making; and efforts to develop evidence-based information about which events may be truly preventable as opposed to those whose frequency can be reduced by appropriate intervention. 2. Our AMA will: (a) continue its efforts to advocate against expansion of the Hospital Acquired Conditions - Present on Admission policy to physicians; (b) communicate to the Administration how burdensome the HAC-POA policy is for physicians and the Medicare program; (c) work with federal agencies to further monitor the HAC-POA program evaluation, and offer constructive input on its content and design; and (d) maintain efforts with our hospital association colleagues, such as the American Hospital Association, to monitor HAC-POA policy and its impact.</p> <p>(BOT Rep. 17, A-08; Appended: BOT Rep. 2, I-10; Modified: CCB/CLRPD Rep. 2, A-14)</p>	

Policy Number	Title	Text	Recommendation
H-185.951	Home Anti-Coagulation Monitoring	<p>1. Our AMA encourages all third party payers to extend coverage and reimbursement for home monitors and supplies for home self-monitoring of anti-coagulation for all medically appropriate conditions.</p> <p>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.</p> <p>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.</p> <p>(Res. 825, I-05; Modified and Reaffirmed: CSAPH Rep. 9, A-07; Appended: Res. 709, A-14)</p>	Retain – this policy remains relevant.
H-225.995	Duplication in Hospital Liability and Physicians' Professional Liability Insurance	<p>Our AMA believes that (1) Each physician should be free to determine whether to carry liability coverage as well as the amount of such coverage. Likewise, it is the responsibility of the hospital governing board to determine the extent to which the hospital should protect its assets by purchasing liability insurance; and (2) Regardless of the type of insurance coverage or protection plan hospitals and physicians on the organized staff have, the AMA encourages medical staffs and hospitals to work toward the establishment of effective risk management programs.</p> <p>(Res. 60, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Modified: Res. 813, I-02; Reaffirmation A-04; Modified: CMS Rep. 1, A-14)</p>	Retain – this policy remains relevant.
H-245.979	Opposition to Proposed Budget	The AMA opposes reductions in funding for WIC and Head Start and other	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
	Cuts in WIC and Head Start	<p>programs that significantly impact child and infant health and education.</p> <p>(Res. 246, I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14)</p>	
H-250.987	Duty-Free Medical Equipment and Supplies Donated to Foreign Countries	<p>Our AMA will seek, through the federal government, a process to allow for duty-free donations of medical equipment and supplies, which are intended to reach medically-underserved areas and not be used for profit, to foreign countries.</p> <p>(Res. 229, A-04; Reaffirmed: BOT Rep. 19, A-14)</p>	Retain – this policy remains relevant.
H-275.918	Pediatric Medical Orders Between States	<p>1. Our AMA supports legislation or regulation that allows physicians currently licensed and registered to practice medicine in any of the United States to duly execute conventional medical orders for their patients who are moving out of their state and into another state for use in any of the United States, for a transitional period of no more than sixty days. This would allow a child with special health care needs to attend early child care, daycare, nursery, preschool, and school safely in their new location while the family secures a new medical home, health insurance, and, when indicated, subspecialty care.</p> <p>2. Our AMA will work with interested states and specialties on legislation or regulations to allow temporary honoring of medical orders by an out-of-state physician, as long as the physician is registered and licensed to practice medicine in the United States.</p> <p>(BOT Rep. 16, A-14)</p>	Retain – this policy remains relevant.
H-330.974	Modification or Repeal of the Federal False Claims Act and Other Similar Statutes	<p>It is the policy of the AMA to expend those resources necessary to monitor situations where physicians are under investigation, to provide financial and legal assistance where it is determined these are necessary, and to lobby for modification or repeal of the Federal False Claims Act and similar federal statutes.</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		(Res. 152, A-90; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation A-01; Reaffirmed: BOT Rep. 22, A-11; Reaffirmed in lieu of Res. 223, A-14)	
H-335.980	Payment For Copying Medical Records	<p>It is the policy of the AMA to seek legislation under which Medicare will be required to reimburse physicians and hospitals for the reasonable cost of copying medical records which are required for the purpose of postpayment audit. A reasonable charge will be paid by the patient or requesting entity for each copy (in any form) of the medical record provided.</p> <p>(Res. 161, I-90; Appended by Res. 819, A-98; Reaffirmation A-08; Reaffirmed in lieu of Res. 710, A-14)</p>	<p>Sunset this policy.</p> <p>This matter is covered under Code of Medical Ethics 3.3.1, Management of Medical Records, which allows for physicians to charge a reasonable fee for the cost of transferring a record.</p>
H-35.968	Averting a Collision Course Between New Federal Law and Existing State Scope of Practice Laws	<p>1. Our AMA will: (A) work to repeal new Public Health Service Act Section 2706, so-called provider "Non-Discrimination in Health Care," as enacted in PPACA, through active direct and grassroots lobbying of and formal AMA written communications and/or comment letters to the Secretary of Health and Human Services and Congressional leaders and the chairs and ranking members of the House Ways and Means and Energy and Commerce and Senate Finance Committees; and (B) promptly initiate a specific lobbying effort and grassroots campaign to repeal the provider portion of the Patient Protection and Affordable Care Act's "Non-Discrimination in Health Care" language, including direct collaboration with other interested components of organized medicine. 2. Our AMA will: (A) create and actively pursue legislative and regulatory opportunities to <u>advocate for the repeal of the so-called "Non-discrimination in Health Care" clause in Public Health Service Act Section 2706, as enacted in the Patient Protection and Affordable Care Act;</u> and (B) lead a specific lobbying effort and grassroots campaign in cooperation with members</p>	<p>Retain this policy in part.</p> <p>Delete part 1 and modify part 2. Our AMA has advocated for repeal of section 2706 of the Affordable Care Act and has successfully advocated to the Centers for Medicare & Medicaid Services to clarify, consistent with the statutory language in the ACA and with Medicare Advantage and Medicaid policies, that section 2706 does not go beyond existing Medicare or Medicaid rules regarding the scope of practice of particular types of non-physician practitioners, nor does it require health plans and issuers to contract with particular types of non-physician practitioners or cover all types of services.</p>

Policy Number	Title	Text	Recommendation
		<p>of the federation of medicine and other interested components of organized medicine to repeal the provider portion of PPACA's "Non-Discrimination in Health Care" language.</p> <p>(Res. 220, A-10; Appended: Res. 241, A-12; Appended: BOT Rep. 8, I-12; Modified: CCB/CLRPD Rep. 2, A-14)</p>	
H-350.962	Reauthorization of the Indian Health Care Improvement Act	<p>Our AMA supports reauthorization of the Indian Health Care Improvement Act.</p> <p>(Res. 221, A-07; Modified: CCB/CLRPD Rep. 2, A-14)</p>	<p>Sunset this policy.</p> <p>The Indian Health Care Improvement Act (IHCA) was made permanent in 2010 as part of the Patient Protection and Affordable Care Act.</p>
H-355.975	Opposition to the National Practitioner Data Bank	<ol style="list-style-type: none"> 1. Our AMA communicates to legislators the fundamental unfairness of the civil judicial system as it now exists, whereby a jury, rather than a forum of similarly educated peers, determines if a physician has violated the standards of care and such results are communicated to the National Practitioner Data Bank; and impresses on our national legislators that only when a physician has been disciplined by his/her state licensing agency should his/her name appear on the National Practitioner Data Bank. 2. Our AMA affirms its support for the Federation of State Medical Boards Action Data Bank and seeks to abolish the National Practitioner Data Bank. 3. Our AMA urges HHS to retain an independent consultant to (A) evaluate the utility and effectiveness of the National Practitioner Data Bank, (B) evaluate the confidentiality and security of the reporting, processing and distribution of Data Bank information, and (C) provide the findings and recommendations to the National Practitioner Data Bank Executive Committee and the General Accounting Office. 4. Our AMA will take appropriate steps to have Congress repeal Section 4752 (f) 	<p>Retain – this policy remains relevant.</p>

Policy Number	Title	Text	Recommendation
		<p>of OBRA 1990 requiring peer review organizations and private accreditation entities to report any negative action or finding to the Data Bank.</p> <p>5. Our AMA seeks to amend the Health Care Quality Improvement Act of 1986 to allow a physician, at the time the physician notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report;</p> <p>6. Our AMA opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on his or her behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers for purposes of credentialing or reimbursement.</p> <p>7. Our AMA (A) urges HHS to work with the Federation of State Medical Boards to refine its National Practitioner Data Bank breakdown of drug violation reporting into several categories; (B) urges the HHS to analyze malpractice data gathered by the Physician Insurance Association of America and recommend to Congress that a threshold of at least \$30,000 for the reporting of malpractice payments be established as soon as possible; (C) will continue to work with HHS to allow physicians an expanded time period to verify the accuracy of information reported to the Data Bank prior to its release in response to queries; (D) will work with HHS and the Office of Management and Budget to reduce the amount of information required on the request for information disclosure form and to improve the design of the form to allow for more efficient processing of information; and (E) will continue to work with HHS to improve its mechanism to distribute revisions and clarifications of Data Bank policy and procedure.</p>	

Policy Number	Title	Text	Recommendation
		<p>8. Our AMA will review questions regarding reportability to the Data Bank and will provide periodic updates on this issue to the AMA House of Delegates.</p> <p>(CCB/CLRPD Rep. 3, A-14)</p>	
H-365.980	OSHA Regulations Pertaining to Physicians' Offices and Hospitals	<p>The AMA continues to review the data and rationale used to substantiate OSHA regulations pertaining to medical practice in physician offices and health care facilities. Where OSHA rules and regulations are found to be unnecessary or inappropriate, the AMA will work for their modification or repeal.</p> <p>(Sub. Res. 218, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14)</p>	Retain – this policy remains relevant.
H-375.972	Lack of Federal Peer Review Confidentiality Protection	<p>Our AMA will seek to vigorously pursue enactment of federal legislation to prohibit discovery of records, information, and documents obtained during the course of professional review proceedings. Our AMA will immediately work with the Administration and Congress to enact legislation that is consistent with Policy H-375.972.</p> <p>(Res. 221, I-96; Reaffirmed: BOT Rep. 13, I-00; Reaffirmation A-01; Reaffirmed: BOT Rep. 8, I-01; Reaffirmed: CMS Rep. 6, I-02; Appended: Res. 925, I-03; Reaffirmation A-05; Reaffirmed: BOT Rep. 13, I-11; Modified: CCB/CLRPD Rep. 2, A-14)</p>	<p>Sunset this policy.</p> <p>This policy is superseded by more recent AMA policy (D-375.999, Confidentiality of Physician Peer Review; H-375.962, Legal Protections for Peer Review).</p>
H-40.967	Physician Participation in Department of Defense Reserve Components	<p>1. Our AMA endorses voluntary physician participation in the military reserve components' medical programs as a means of actively aiding national defense while preserving the right of the individual physician to practice his/her profession without interruption in peace time.</p> <p>2. Our AMA supports the U.S. Department of Defense by publicizing its needs for physicians in active duty military service and in the reserve components and guard, and encourages the active support and participation of</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>physicians in active duty military service and in the reserves.</p> <p>3. Our AMA will (a) continue to work with all appropriate parties in developing and proposing a multi-faceted approach toward rejuvenation and improvement in recruitment and retention in the military reserves; (b) work to assure that retired military medical personnel become eligible for reserve status; (c) support enactment of federal laws to assist physicians in the transition from medical practice to active military service; (d) promote use of existing laws for selective service and retirement credits as models for development of practical equitable criteria to be applied; and (e) support improvements in professional utilization of military medical personnel during both active duty periods and "weekend drill."</p> <p>4. Our AMA supports the development of a statutory system of limitations on call-up, retention and recall of reservists in order to provide stability and predictability to reserve status and duty, with the basis for such a system to be defined statutorily using credits or "points" to prioritize options available to individual reservists as to call-up, retention, rotation and recall.</p> <p>(CCB/CLRPD Rep. 3, A-14)</p>	
H-406.989	Work of the Task Force on the Release of Physician Data	<p>1. Our AMA Council on Legislation will use the Release of Claims and Payment Data from Governmental Programs as a basis for draft model legislation. 2. Our AMA will create additional tools to assist physicians in dealing with the release of physician data. 3. Our AMA will continue to monitor the status of, and take appropriate action on, any legislative or regulatory opportunities regarding the appropriate release and use of physician data and its use in physician profiling programs. 4. Our AMA will monitor new and existing Web sites and programs that collect and use data on patient</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>satisfaction and take appropriate action when safeguards are not in place to ensure the validity of the results. 5. Our AMA will continue and intensify its extensive efforts to educate employers, healthcare coalitions and the public about the potential risks and liabilities of pay-for-performance and public reporting programs that are not consistent with AMA policies, principles, and guidelines. 6. Our AMA: A) opposes the public reporting of individual physician performance data collected by certification and licensure boards for purposes of MOC and MOL; and B) supports the principle that individual physician performance data collected by certification and licensure boards should only be used for the purposes of helping physicians to improve their practice and patient care, unless specifically approved by the physician.</p> <p>(BOT Rep. 18, A-09; Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10; Reaffirmed in lieu of Res. 808, I-10; Appended: Res. 327, A-11; Modified: CCB/CLRPD Rep. 2, A-14)</p>	
H-415.998	Preferred Provider Organizations	<p>The AMA: (1) opposes federal legislation that would preempt state regulation of PPOs; and (2) encourages state medical associations to support legislation that: (a) insures proper state regulation of PPOs, with particular attention to such practices as arbitrary determinations of medical necessity by carriers, "hold harmless" clauses, and predatory pricing concepts; and (b) requires independent, physician-directed peer review of the services provided by PPOs.</p> <p>(Sub. Res. 16, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14)</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
H-435.957	Uniform and Consistent Tort Reform	<p>Our AMA will not pursue federal medical liability reform legislation that would divide or diminish the voice of the House of Medicine.</p> <p>(Sub. Res. 910, I-03; Reaffirmed in lieu of Res. 216, A-04; Reaffirmed: BOT Rep. 19, A-14)</p>	Retain – this policy remains relevant.
H-435.963	Professional Liability Claims Reporting	<p>The AMA opposes the need for reporting on medical staff and other non-licensing board applications, including insurance company credentialing applications, (excepting professional liability insurance applications) any threatened, pending, or closed professional liability claims where the claim did not result in payment on behalf of that physician.</p> <p>(Sub. Res. 818, A-95; Modified: BOT Rep. 18, A-03; Reaffirmed: Res. 806, I-03; Reaffirmation A-04; Reaffirmed: BOT Rep. 19, A-14)</p>	Retain – this policy remains relevant.
H-435.968	Enterprise Liability	<p>The AMA: (1) affirms its position that effective medical liability reform based on California's MICRA model is integral to health system reform, and must be included in any comprehensive health system reform proposal that hopes to be effective in containing costs, providing access to health care services and promoting the quality and safety of health care services; (2) opposes any proposal that would mandate or impose enterprise liability concepts. Federal funding to evaluate the comparative advantages and disadvantages of enterprise liability may be best spent studying the operation, effect on liability costs and patient safety/injury prevention results of liability channeling systems that already exist and function as close analogs to the enterprise liability model (BOT Rep. I-93-53); and (3) supports strong patient safety initiatives and the investigation of alternative dispute resolution models, appropriate uses of practice parameters in medical liability litigation and other reform ideas that have the potential to decrease defensive</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		<p>medicine costs and more fairly and cost-effectively compensate persons injured in the course of receiving health care services.</p> <p>(BOT Rep. III, A-93; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: BOT Rep. 28, A-03; Reaffirmation A-04; Reaffirmed: BOT Rep. 19, A-14)</p>	
H-435.991	Professional Liability Countersuits	<p>Our AMA supports the principle that the "special injury" element required to win a malicious prosecution countersuit in some jurisdictions should be eliminated.</p> <p>(Res. 44, I-84; Reaffirmed: Sunset Report, I-98; Reaffirmed: Sub. Res. 914, I-04; Reaffirmed: BOT Rep. 19, A-14)</p>	Retain – this policy remains relevant.
H-440.876	Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients	<p>1. Our AMA: (a) opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; (b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and (c) opposes proof of citizenship as a condition of providing health care. 2. Our AMA will work with local and state medical societies to immediately, actively and publicly opposes any legislative proposals that would criminalize the provision of health care to undocumented residents.</p> <p>(Res. 920, I-06; Reaffirmed and Appended: Res. 140, A-07; Modified: CCB/CLRPD Rep. 2, A-14)</p>	<p>Retain this policy in part.</p> <p>Modify Part 2 by broadening the language and making it more consistent with Part 1.</p>
H-45.975	Proposed Change in Medical Requirements for 3rd Class Pilots' Licenses	<p>Our AMA will: (1) oppose efforts to substitute the third class medical certificate with a driver's license; and (2) write a letter encouraging the Federal Aviation Administration to retain the third class medical certification process.</p> <p>(Res. 228, A-14)</p>	<p>Sunset this policy.</p> <p>Legislation was enacted in 2016 (Public Law 114-190, the FAA Extension, Safety, and Security Act of 2016) that statutorily allows pilots of small, non-commercial planes to forgo the medical</p>

Policy Number	Title	Text	Recommendation
			<p>certification process if the pilot and aircraft meet certain prescribed conditions under an FAA program called "BasicMed." A 2020 FAA study found no difference in accident risk between flights conducted by pilots operating under BasicMed and flights conducted by pilots holding third-class medical certificates.</p>
H-478.987	<p>Compliance with Meaningful Use Requirements as a Condition of Medical Licensure</p>	<p>1. Our AMA stands on record as opposing any requirement that medical licensure be conditioned upon compliance with "Meaningful Use" requirements.</p> <p>2. Our AMA, working with state and specialty medical societies, will make efforts at all appropriate levels of government to secure the reversal of any requirements that medical licensure be conditioned upon compliance with meaningful use requirements.</p> <p>(Res. 232, A-14)</p>	<p>Sunset this policy.</p> <p>The Centers for Medicare & Medicaid Services renamed this EHR Incentive Program to the Medicare and Medicaid Promoting Interoperability Programs in April 2018. This policy has been superseded by more recent AMA policy (H-478.993, Implementing Electronic Medical Records).</p>
H-478.991	<p>Federal EMR and Electronic Prescribing Incentive Program</p>	<p>Our AMA: (1) will communicate to the federal government that the Electronic Medical Record (EMR) incentive program should be made compliant with AMA principles by removing penalties for non-compliance and by providing inflation-adjusted funds to cover all costs of implementation and maintenance of EMR systems; (2) supports the concept of electronic prescribing, as well as the offering of financial and other incentives for its adoption, but strongly discourages a funding structure that financially penalizes physicians that have not adopted such technology; and (3) will work with the Centers for Medicaid & Medicare Services and the Department of Defense to oppose programs that unfairly penalize or create disincentives, including e-prescribing limitations for physicians who provide care to military patients, and replace them with</p>	<p>Retain – this policy remains relevant.</p>

Policy Number	Title	Text	Recommendation
		<p>meaningful percentage requirements of e-prescriptions or exemptions of military patients in the percentages, where paper prescriptions are required.</p> <p>(Sub. Res. 202, A-09; Reaffirmation I-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmed in lieu of Res. 237, A-12; Reaffirmed in lieu of Res. 218, I-12; Reaffirmed in lieu of Res. 219, I-12; Reaffirmed in lieu of Res. 226, I-12; Reaffirmed in lieu of Res. 228, I-12; Reaffirmed in lieu of Res. 725, A-13; Appended: Res. 205, A-13; Reaffirmed in lieu of Res. 214, I-13; Reaffirmed in lieu of Res. 221, I-13; Reaffirmed in lieu of Res. 222, I-13; Reaffirmed in lieu of Res. 223, I-14)</p>	
H-55.991	Use of Heroin in Terminally Ill Cancer Patients With Severe Chronic Pain	<p>Our AMA remains opposed to legislation or any other action that would reschedule heroin from Schedule 1 to Schedule 2 of the Controlled Substances Act.</p> <p>(BOT Rep. TT, A-87; Reaffirmed: Sunset Report, I-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07; Modified: CCB/CLRPD Rep. 2, A-14)</p>	Retain - this policy remains relevant.
H-60.940	Partner Co-Adoption	<p>Our AMA will support legislative and other efforts to allow the adoption of a child by the non-married partner who functions as a second parent or co-parent to that child. (Res. 204, A-04)</p> <p>(Res. 204, A-04; Modified: CSAPH Rep. 1, A-14)</p>	Retain – this policy remains relevant.
H-75.998	Opposition to HHS Regulations on Contraceptive Services for Minors	<p>(1) Our AMA continues to oppose regulations that require parental notification when prescription contraceptives are provided to minors through federally funded programs, since they create a breach of confidentiality in the physician-patient relationship. (2) The Association encourages physicians to provide comparable services on a confidential basis where legally permissible.</p> <p>(Sub. Res. 65, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: BOT Rep. 28,</p>	Retain – this policy remains relevant.

Policy Number	Title	Text	Recommendation
		A-03; Reaffirmed: Res. 825, I-04; Reaffirmed: CMS Rep. 1, A-14)	
H-95.941	Restricting Prescriptions to Medicare Beneficiaries	<p>1. Our AMA will work with the Centers for Medicare & Medicaid Services and state medical societies as needed to preserve access to care and eliminate the burden of provisions in the Patient Protection and Affordable Care Act that require physicians to enroll in Medicare, Medicaid and other governmentally sponsored health insurance programs as a condition of referring, ordering or prescribing for patients enrolled in these programs.</p> <p>2. Our AMA supports federal legislation to eliminate the burden of provisions in the Patient Protection and Affordable Care Act that require physicians to enroll in Medicare, Medicaid and other governmentally sponsored health insurance programs as a condition of referring, ordering or prescribing for patients enrolled in these programs.</p> <p>(BOT Rep. 22, A-14)</p>	Retain – this policy remains relevant.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-A-24

Subject: Safe and Effective Overdose Reversal Medications in Educational Settings

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

1 INTRODUCTION

2
3 At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates
4 (HOD), Resolution 217 entitled, “Increase Access to Safe and Effective Overdose Reversal
5 Medications in Educational Settings,” was adopted. This resolution called on the AMA to:

- 6
7 • Encourage states, communities, and educational settings, to adopt legislative and
8 regulatory policies that allow schools to make safe and effective overdose reversal
9 medications naloxone readily accessible to staff and teachers to prevent opioid overdose
10 deaths in educational settings;
11 • Encourage states, communities, and educational settings to remove barriers to students
12 carrying safe and effective overdose reversal medications; and
13 • Study and report back on issues regarding student access to safe and effective overdose
14 reversal medications.
15

16 The HOD adopted the resolution, which has been codified at Policy H-95.908, “Increase Access to
17 Safe and Effective Overdose Reversal Medications in Educational Settings.” In response to the
18 third resolve of the HOD action, this report provides background information, a discussion on
19 naloxone access in schools and other educational settings, relevant AMA advocacy initiatives, and
20 other updates.

21 22 BACKGROUND

23
24 More than 2,200 adolescents (ages 10-19) died of a drug-related overdose between July 2019-
25 December 2021, with nearly 84 percent of these deaths involving illicitly manufactured fentanyl.
26 An opioid of any type was involved in more than 91 percent of deaths, according to the Centers for
27 Disease Control and Prevention (CDC).¹ Naloxone was administered only 30 percent of the time,
28 according to the CDC.² Unintentional drug overdose deaths among young people (ages 15-19)
29 continued to remain high in 2022, according to the National Institute on Drug Abuse (NIDA).³
30 Two-thirds of those who died did not have any history of prior opioid use.⁴

31
32 Naloxone was created in the 1960s and subsequently began being used in emergency departments
33 and other hospital settings.⁵ Naloxone distribution in the community became more prevalent in the
34 1990s through harm reduction organizations.⁶ Naloxone is most commonly administered via
35 intramuscular injection or intranasal spray, and user preference may vary depending on familiarity
36 with a product and how to use it.⁷ With respect to availability in schools and other educational
37 settings, the nasal spray formulation is most commonly cited in school educational resources and

1 guidelines. It is important to emphasize, however, that the AMA does not endorse any specific
2 brand or generic formulation of naloxone or other U.S. Food and Drug Administration (FDA)-
3 approved opioid overdose reversal agents. While it is beyond the scope of this report to review the
4 several decades of life-saving benefits of naloxone, it is notable that AMA policy supports
5 continued development of and access to additional medications to reverse opioid-related overdoses.
6

7 Access to naloxone in the community has increased considerably in the past decade. From
8 2012-2017, naloxone prescriptions dispensed in the United States grew from 1,061 prescriptions to
9 nearly 270,000 prescriptions.⁸ Naloxone prescriptions dispensed increased to nearly 1.7 million
10 prescriptions in 2022. Based on our strong policy, the AMA continues to urge all physicians to
11 prescribe naloxone or other overdose reversal medications to patients at risk of overdose—and to
12 friends and family of those who might be in a position to save a life from overdose. The AMA also
13 continues to encourage physicians and physician offices to educate patients about the availability of
14 naloxone and other overdose reversal agents available over the counter, from pharmacists via a
15 standing order, or reversal agents that may be available through public health agencies. The
16 National Association of Counties details multiple strategies and examples to increase state- and
17 community-level distribution of naloxone.⁹
18

19 In addition to physicians' increasing efforts in prescribing naloxone, the AMA also recognizes the
20 longstanding role that harm reduction organizations have played in saving lives from overdose.
21 Harm reduction and other community-based organizations distributed more than 3.7 million doses
22 of naloxone between 2017–2020.¹⁰ From August 2021 to July 2023, national harm reduction
23 organization, Remedy Alliance For The People, sent 1,639,542 doses of generic injectable
24 naloxone to 196 harm reduction projects in 44 US states, DC, and Puerto Rico, of which
25 206,371 doses were provided at no-cost to 138 under-resourced harm reduction projects.¹¹
26 Naloxone has saved hundreds of thousands of lives in the United States, and the Board of Trustees
27 continues to strongly support all efforts to increase access to naloxone and other opioid overdose
28 reversal agents.
29

30 DISCUSSION

31

32 Increasing access to naloxone was one of the first recommendations of the AMA Substance Use
33 and Pain Care Task Force (Task Force),¹² which was first convened in 2014 and remains a vital
34 part of ensuring that organized medicine communicates emerging issues and policies to improve
35 outcomes and save lives. The Task Force's work, including providing input on and development of
36 AMA model state legislation¹³ to increase access to naloxone, has been part of every state now
37 having broad naloxone access laws.¹⁴
38

39 AMA model legislation also includes broad authority and immunities for high schools, universities,
40 and other educational settings to possess, distribute and administer naloxone to teachers, staff, and
41 students. As a result of AMA and other organizations' advocacy, approximately 30 states authorize
42 educational settings to administer naloxone, and it varies by state regarding whether that includes
43 elementary schools, high schools, or schools of higher education.¹⁵
44

45 Multiple school districts and universities already provide naloxone and overdose prevention and
46 education opportunities. While the total number continues to grow, representative examples can be
47 found in Southwest Virginia, where nearly all schools carry naloxone,¹⁶ and the state itself has
48 amended its laws to authorize the ability for schools and school employees to carry, administer, and
49 distribute naloxone.¹⁷ All schools in the Miami-Dade public school system carry naloxone,
50 although it is most commonly held by school public safety officials.¹⁸ One student remarked that
51 she carries naloxone in her purse because, "Our friends do not know that those pills are more than

1 likely to be fake [or] have enough fentanyl in it to kill you. And that is scary. I carry Narcan in my
2 school bag. If I am going to a party, I will put it in my purse. It is just a layer of protection. You
3 wear your seatbelt not because you are going get in a car accident. It is to keep yourself safe.”
4

5 Additional examples of schools, universities and other educational settings carrying naloxone:
6

- 7 • University of Pennsylvania Perelman School of Medicine—medical students are taught
8 how to recognize signs of overdose and administer naloxone on their first day of medical
9 school.¹⁹
- 10 • University of Southern California—a group of pharmacy students found that once they
11 started a naloxone education and distribution program, demand outpaced expectations.²⁰
- 12 • Vanderbilt University—makes naloxone and other harm reduction supplies available for
13 individuals as well as at public locations throughout campus.²¹
- 14 • Akron (Ohio) School District—voted to approve naloxone availability in schools in 2017.²²
- 15 • Columbia (NY) University—students who carry naloxone have saved lives from overdose
16 in the community²³ and in schools. Naloxone education events have occurred since 2018
17 and resulted in “more than 2,500 students, faculty, staff and community members on how
18 to recognize an overdose and administer treatment.”²⁴
- 19 • University of South Carolina—naloxone is accessible at the university fitness center,
20 school pharmacy and other locations.²⁵
- 21 • Montana—authorizing naloxone distribution and use in schools has been one part of the
22 state’s naloxone efforts, which distributed more than 26,000 naloxone kits to first
23 responders, law enforcement, schools, and others.²⁶
- 24 • Texas—schools now are required to carry naloxone, which has been administered multiple
25 times to save the life of a young person, according to news reports.²⁷
26

27 This short list above of high schools, universities, and other settings is a very brief snapshot
28 showcasing the fact that school districts recognize the value of having naloxone in educational
29 settings. Given the rapid adoption of efforts to increase access to naloxone in school-based settings,
30 data on the total number of educational settings with naloxone is not currently available. The Board
31 of Trustees strongly encourages these trends to continue.
32

33 The Board of Trustees also wants to continue to dispel myths about naloxone. The Board is aware
34 of ongoing myths that naloxone may increase risky drug use behaviors. Much like debunked and
35 dangerous myths of how use of seatbelts encourages risky driving; that the presence of fire
36 hydrants encourages arson; or “that HPV vaccination increases promiscuity or increases risky
37 sexual behavior,”²⁸ the presence and availability of naloxone has consistently been found to not
38 increase use of drugs or increase risk of overdose. For example, a 2023 study found that “Naloxone
39 access laws and pharmacy naloxone distribution were more consistently associated with decreases
40 rather than increases in lifetime heroin and [injection drug use] among adolescents.”²⁹ The study
41 authors make clear that “Our findings therefore do not support concerns that naloxone access
42 promotes high-risk adolescent substance use behaviors.” A smaller study of heroin users found “no
43 evidence of compensatory drug use following naloxone/overdose training.”³⁰ And a report from
44 2010 looking at multiple myths cited multiple studies disproving the link between naloxone
45 availability and increased drug use.³¹ The Board of Trustees further emphasizes that while the
46 Board does not support illicit drug use, it unequivocally supports efforts to save lives from
47 unintentional drug-related overdose, including dispelling myths and supporting widespread
48 availability of naloxone and other opioid overdose reversal agents. The limitations of naloxone,
49 however, should be recognized. NIDA advises that “People with physical dependence on opioids
50 may have withdrawal symptoms within minutes after they are given naloxone. Withdrawal

1 symptoms might include headaches, changes in blood pressure, rapid heart rate, sweating, nausea,
2 vomiting, and tremors.”³² NIDA aptly points out, however, that “The risk of death for someone
3 overdosing on opioids is worse than the risk of having a bad reaction to naloxone.” The Board of
4 Trustees agrees that death is a greater harm than withdrawal symptoms.

5
6 As noted in the 2023 AMA Overdose Epidemic Report, overdose and death related to illicitly
7 manufactured fentanyl, methamphetamine and cocaine increase; and xylazine and other toxic
8 synthetic adulterants present new challenges. Naloxone does not reverse an overdose related to
9 methamphetamine, cocaine or other toxic substances. Naloxone also does not work to counteract
10 overdose related to alcohol, benzodiazepines or xylazine, which may increase the sedative effects
11 of opioids, making the antagonist effects of naloxone appear not as rapid or sustaining.³³
12 Polysubstance use, moreover, may be intentional or unintentional as illicit substances may contain
13 multiple toxic adulterants, including illicitly manufactured fentanyl.³⁴ The CDC, SAMHSA, NIDA
14 and many other leading public health organizations, including the AMA, continue to counsel that in
15 addition to immediately calling 911, it is still advised to administer naloxone because it is likely an
16 opioid is present, and naloxone will not harm an individual. The Board of Trustees agrees and
17 further points out that if an individual’s overdose is related to multiple substances, administering
18 naloxone could help reduce respiratory depression. Again, the benefits of naloxone outweigh the
19 limitations.

20
21 The presence of fentanyl in the nation’s illicit drug supply also has raised the question of whether
22 additional doses of naloxone are necessary, greater dose strengths, or different opioid overdose
23 reversal medication (OORM) work more effectively than another. According to SAMHSA, the
24 evidence shows that:

- 25
- 26 • Giving more than one dose of naloxone and using higher dose products may not be
27 necessary when responding to a known fentanyl overdose.
 - 28 • An overdose may appear to need additional doses if other sedating drugs are present in the
29 person’s body, such as alcohol, benzodiazepines, or xylazine; however, rapidly giving
30 more naloxone or using a stronger, more concentrated OORM will not necessarily speed
31 up the reversal process.
- 32

33 In fact, SAMHSA reports that “Multiple studies have found that despite the presence of fentanyl,
34 more doses were not associated with improved outcomes.”³⁵ The Board of Trustees further
35 emphasizes that there are multiple OORM that have been approved by the FDA. The AMA does
36 not take a position on which OORM is more effective than another and—for the purposes of this
37 report—encourages states, communities, and educational settings, to adopt legislative and
38 regulatory policies that allow schools to make safe and effective overdose reversal medications
39 such as naloxone readily accessible to staff and teachers to prevent opioid overdose deaths in
40 educational settings. The Board of Trustees further encourages states, communities, and
41 educational settings to remove barriers to students carrying safe and effective overdose reversal
42 medications. The Board of Trustees wants to make clear that even when naloxone or other OORM
43 saves a life from overdose, it is essential to seek immediate medical attention.

44 AMA POLICY

45
46
47 The two most relevant AMA policies covering the areas of this report are (1) “Increasing
48 Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications”
49 (Policy H-95.932); and (2) “Prevention of Drug-Related Overdose” (Policy D-95.987).
50 Adoption of H-95.932 has helped the AMA to support a broad array of naloxone access initiatives
51 for nearly a decade. As identified in H-95.932, these initiatives include:

1
2 ...legislative, regulatory, and national advocacy efforts to increase access to
3 affordable naloxone and other safe and effective overdose reversal medications,
4 including but not limited to collaborative practice agreements with pharmacists and
5 standing orders for pharmacies and, where permitted by law, community-based
6 organizations, law enforcement agencies, correctional settings, schools, and other
7 locations that do not restrict the route of administration for naloxone and other safe
8 and effective overdose reversal medications delivery.
9

10 Moreover, in accordance with AMA policy, specifically “Increasing Availability of Naloxone and
11 Other Safe and Effective Overdose Reversal Medications” (Policy H-95.932), AMA advocacy has
12 helped states enact broad liability protections “for physicians and other healthcare professionals
13 and others who are authorized to prescribe, dispense and/or administer naloxone and other safe and
14 effective overdose reversal medications pursuant to state law.” As part of our advocacy to support
15 broad access, in accordance with AMA policy entitled, “Increasing Availability of Naloxone and
16 Other Safe and Effective Overdose Reversal Medications” (Policy H-95.932), AMA continues “to
17 encourage individuals who are authorized to administer naloxone and other safe and effective
18 overdose reversal medications to receive appropriate education to enable them to do so
19 effectively.”
20

21 As noted briefly above, existing AMA policy entitled, “Increasing Availability of Naloxone and
22 Other Safe and Effective Overdose Reversal Medications” (Policy H-95.932), also allows for broad
23 support for “the widespread implementation of easily accessible naloxone and other safe and
24 effective overdose reversal medications rescue stations,” as well as “access to and use
25 of naloxone and other safe and effective overdose reversal medications in all public spaces
26 regardless of whether the individual holds a prescription.” This includes public schools and other
27 educational settings.
28

29 Given the broad nature of our existing AMA policy, which is amply reflected in the positive
30 developments to implement these policies throughout the United States, the Board of Trustees
31 concludes that AMA policy is sufficient and that additional new policy is not necessary. This report
32 also accomplishes the task set to the Board of Trustees to study and report back on issues regarding
33 student access to safe and effective overdose reversal medications.
34

35 RECOMMENDATIONS

36

37 The Board of Trustees recommends that the following be adopted, and that the remainder of the
38 report be filed:
39

- 40 1. Existing American Medical Association (AMA) policy entitled, “Increasing Availability of
41 Naloxone and Other Safe and Effective Overdose Reversal Medications” (Policy H-
42 95.932), be reaffirmed, and (Reaffirm HOD Policy)
43
- 44 2. The third resolve of Policy H-95.908, “Increase Access to Safe and Effective Overdose
45 Reversal Medications in Educational Settings” be rescinded and that the policy be updated
46 as noted. (Modify Current HOD Policy)

47 1. Our AMA will encourage states, communities, and educational settings to adopt
48 legislative and regulatory policies that allow schools to make safe and effective overdose
49 reversal medications readily accessible to staff and teachers to prevent opioid overdose
50 deaths in educational settings.

- 1 2. Our AMA will encourage states, communities, and educational settings to remove
- 2 barriers to students carrying safe and effective overdose reversal medications.
- 3 ~~3. Our AMA will study and report back on issues regarding student access to safe and~~
- 4 ~~effective overdose reversal medications.~~

Fiscal Note: Less than \$500.

REFERENCES

- ¹ Tanz LJ, Dinwiddie AT, Mattson CL, O'Donnell J, Davis NL. Drug Overdose Deaths Among Persons Aged 10–19 Years — United States, July 2019–December 2021. *MMWR Morb Mortal Wkly Rep* 2022;71:1576–1582. DOI: <http://dx.doi.org/10.15585/mmwr.mm7150a2>
- ² Tanz LJ, Dinwiddie AT, Mattson CL, O'Donnell J, Davis NL. Drug Overdose Deaths Among Persons Aged 10–19 Years — United States, July 2019–December 2021. *MMWR Morb Mortal Wkly Rep* 2022;71:1576–1582. DOI: <http://dx.doi.org/10.15585/mmwr.mm7150a2>
- ³ Unintentional Drug Overdose Death Rates Among US Youth Aged 15-19. National Institute on Drug Use. December 13, 2023. Available at <https://nida.nih.gov/research-topics/trends-statistics/infographics/unintentional-drug-overdose-death-rates-among-us-youth-aged-15-19>
- ⁴ Tanz LJ, Dinwiddie AT, Mattson CL, O'Donnell J, Davis NL. Drug Overdose Deaths Among Persons Aged 10–19 Years — United States, July 2019–December 2021. *MMWR Morb Mortal Wkly Rep* 2022;71:1576–1582. DOI: <http://dx.doi.org/10.15585/mmwr.mm7150a2>
- ⁵ Campbell ND. Naloxone as a technology of solidarity: history of opioid overdose prevention. *CMAJ*. 2019 Aug 26;191(34):E945-E946. doi: 10.1503/cmaj.190257. PMID: 31451527; PMCID: PMC6710079. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6710079/>
- ⁶ The history of naloxone access in the United States. Remedy Alliance for the People. <https://remedyallianceftp.org/pages/history>
- ⁷ Marks, K.R., Oyler, D.R., Strickland, J.C. *et al.* Bystander preference for naloxone products: a field experiment. *Harm Reduct J* 20, 171 (2023). <https://doi.org/10.1186/s12954-023-00904-9>.
- ⁸ IQVIA Xponent limited to retail pharmacy dispensed prescriptions. Denition: USC 78312 Opioid Reversal Agents (naloxone). State-by-state data available at <https://end-overdose-epidemic.org/wp-content/uploads/2023/11/AMA-2023-overdose-report-IQVIA-data-naloxone-FINAL.pdf>
- ⁹ Naloxone to Reverse Opioid Overdose. National Association of Counties. July 17, 2023. Available at <https://www.naco.org/resource/osc-naloxone>
- ¹⁰ “Recommendations for Federal Partners and Health Departments Navigating Naloxone Supply.” NASTAD. July 2021. Available at <https://nastad.org/resources/recommendations-federal-partners-and-health-departments-navigating-naloxone-supply>
- ¹¹ Alliance For The People, R., Wheeler, E., Doe Simkins, M., & Dasgupta, N. (2023). Remedy Alliance For The People Annual Report 2023. <https://doi.org/10.17615/ymxe-6x08>
- ¹² The first set of recommendations were issued in 2015 and revised at several intervals. See, for example, the 2017 update here: <https://end-overdose-epidemic.org/wp-content/uploads/2020/06/AMA-Task-Force-to-Reduce-Opioid-Abuse-Overview-updated-June-2017.pdf>
- ¹³ The AMA Board of Trustees first approved model state legislation recommend by the AMA Council on Legislation in 2013. The model bill has been amended multiple times since then to strengthen access to naloxone and other forms of opioid-overdose reversal agents. In addition to the protections for school personnel, the model bill provides for liability protections to health care professionals prescribing naloxone as well as authorizing third-party prescriptions and standing orders to allow persons without a prescription to obtain naloxone from a pharmacy. It also includes broad Good Samaritan protections that provide extensive protections for civil and criminal penalties, including parole violations. Medical societies interested in broadening their state laws should contact the AMA Advocacy Resource Center.
- ¹⁴ Legal Interventions to Reduce Overdose Mortality: Naloxone Access Laws. The Network for Public Health Law. As of August 1, 2023. Available at <https://www.networkforphl.org/wp-content/uploads/2023/11/Naloxone-Access-Laws-50-State-Survey-2023.pdf>
- ¹⁵ See, for a general discussion of examples of state laws, “States Split on Whether to Stock Overdose Drugs in Schools.” *Governing*. KFF Health News. Oct. 6, 2023. Available at <https://www.governing.com/health/states-split-on-whether-to-stock-overdose-drugs-in-schools>
- ¹⁶ ‘List of Southwest Virginia schools that carry Narcan/Naloxone.’ WDBJ. February 15, 2024. Available at <https://www.wdbj7.com/2024/02/15/list-southwest-virginia-schools-that-carry-narcan-naloxone/>.
- ¹⁷ See, § 54.1-3408. Professional use by practitioners. <https://law.lis.virginia.gov/vacode/title54.1/chapter34/section54.1-3408/>
- ¹⁸ “All Miami-Dade public schools now stock overdose reversal drugs.” WLRN. November 3, 2023. Available at <https://www.wlrn.org/education/2023-11-03/miami-schools-naloxone-narcan-overdose-reversal-drugs>

- ¹⁹ “Narcan bootcamp, then the white coat.” University of Penn Medicine News. December 8, 2023. <https://www.pennmedicine.org/news/publications-and-special-projects/penn-medicine-magazine/fall-winter-2023/first-year-medical-students-learn-lifesaving-skills-on-day-one>
- ²⁰ Brown M, Tran C, Dadiomov D. Lowering barriers to naloxone access through a student-led harm reduction program. *J Am Pharm Assoc* (2003). 2023 Jan-Feb;63(1):349-355. doi: 10.1016/j.japh.2022.10.030. Epub 2022 Nov 4. PMID: 36443177.
- ²¹ Vanderbilt Recovery Support provides resources for campus community. October 11, 2023. <https://news.vanderbilt.edu/2023/10/11/vanderbilt-recovery-support-provides-resources-for-campus-community/>
- ²² Naloxone in Schools Policy Brief. Ohio Department of Health. September 30, 2020. Available at https://takecharge.ohio.gov/static/healthcare-professionals-toolkit/naloxone-resource-information/naloxone-in-schools_policy-brief.pdf
- ²³ Opioid Avengers: Columbia Students Save Four Lives With Naloxone. Carla Cantor. Columbia News. February 21, 2020. Available at <https://news.columbia.edu/news/opioid-overdose-students-save-lives-naloxone>
- ²⁴ Opioid Avengers: Columbia Students Save Four Lives With Naloxone. Carla Cantor. Columbia News. February 21, 2020. Available at <https://news.columbia.edu/news/opioid-overdose-students-save-lives-naloxone>
- ²⁵ “USC offers Narcan at fitness center, makes emergency resource more accessible.” The Daily Gamecock. September 4, 2023. Available at <https://www.dailygamecock.com/article/2023/09/usc-offers-narcan-at-fitness-center-makes-emergency-resource-more-accessible-news-bassett>
- ²⁶ Opioid Education and Naloxone Distribution Program. Montana Department of Public Health and Human Services. June 20, 2023. <https://content.govdelivery.com/accounts/MTDPHHS/bulletins/360ffbf>
- ²⁷ “Texas now requires your kid’s school to have Narcan: Here’s how it works.” November 9, 2023. <https://www.click2houston.com/news/local/2023/11/09/texas-now-requires-your-kids-school-to-have-narcan-heres-how-it-works/>
- ²⁸ Taumberger N, Joura EA, Arbyn M, Kyrgiou M, Sehoul J, Gultekin M. Myths and fake messages about human papillomavirus (HPV) vaccination: answers from the ESGO Prevention Committee. *Int J Gynecol Cancer*. 2022 Jul 12;32(10):1316–20. doi: 10.1136/ijgc-2022-003685. Epub ahead of print. PMID: 35820716; PMCID: PMC9554067.
- ²⁹ Emilie Bruzelius, Magdalena Cerdá, Corey S. Davis, Victoria Jent, Katherine Wheeler-Martin, Christine M. Mauro, Stephen Crystal, Katherine M. Keyes, Hillary Samples, Deborah S. Hasin, Silvia S. Martins, Naloxone expansion is not associated with increases in adolescent heroin use and injection drug use: Evidence from 44 US states, *International Journal of Drug Policy*, Volume 114, 2023, 103980, ISSN 0955-3959, <https://doi.org/10.1016/j.drugpo.2023.103980>. <https://www.sciencedirect.com/science/article/pii/S0955395923000294>
- ³⁰ Jones JD, Campbell A, Metz VE, Comer SD. No evidence of compensatory drug use risk behavior among heroin users after receiving take-home naloxone. *Addict Behav*. 2017 Aug;71:104-106. doi: 10.1016/j.addbeh.2017.03.008. Epub 2017 Mar 9. PMID: 28325710; PMCID: PMC5449215.
- ³¹ Bazazi AR, Zaller ND, Fu JJ, Rich JD. Preventing opiate overdose deaths: examining objections to take-home naloxone. *J Health Care Poor Underserved*. 2010 Nov;21(4):1108-13. doi: 10.1353/hpu.2010.0935. PMID: 21099064; PMCID: PMC3008773.
- ³² NIDA. 2022, January 11. Naloxone DrugFacts. Retrieved from https://nida.nih.gov/publications/drugfacts/naloxone_on_March_14_2024.
- ³³ Substance Abuse and Mental Health Services Administration. SAMHSA Overdose Prevention and Response Toolkit. Publication No. PEP23-03-00-001. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2023. Available at <https://store.samhsa.gov/sites/default/files/overdose-prevention-response-kit-pep23-03-00-001.pdf>
- ³⁴ Polysubstance Use Facts. National Center for Injury Control and Prevention, Division of Drug Overdose Prevention. U.S. Centers for Disease Control and Prevention. Page last reviewed February 23, 2022. Available at <https://www.cdc.gov/stopoverdose/polysubstance-use/index.html>
- ³⁵ Substance Abuse and Mental Health Services Administration. SAMHSA Overdose Prevention and Response Toolkit. Publication No. PEP23-03-00-001. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2023. Available at <https://store.samhsa.gov/sites/default/files/overdose-prevention-response-kit-pep23-03-00-001.pdf>

REPORT 13 OF THE BOARD OF TRUSTEES (A-24)
Prohibiting Covenants Not-to-Compete (Resolution 237-A-23, Resolve 3)
Reference Committee B

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Resolution 237 entitled, “Prohibiting Covenants Not-to-Compete in Physician Contracts.” Resolution 237 was introduced by California, American Academy of Family Physicians, American Association of Neurological Surgeons, American College of Surgeons, Congress of Neurological Surgeons, and The Society of Thoracic Surgeons.

Resolve 3 of Resolution 237 (Resolve 3) directs that our AMA study and report back on current physician employment contract terms and trends with recommendations to address balancing legitimate business interests of physician employers while also protecting physician employment mobility and advancement, competition, and patient access to care – such recommendations to include the appropriate regulation or restriction of (1) covenants not to compete in physician contracts with independent physician groups that include time, scope, and geographic restrictions; and (2) de facto non-compete restrictions that allow employers to recoup recruiting incentives upon contract termination.

The term “non-compete” in the report refers to an agreement between an employer and an employed physician that prohibits the physician from working within a certain geographic area and for a period of time after the physician’s employment ends.

This report discusses physicians’ recurring concerns about the effect that non-competes have on both physicians and patients. The report also highlights the reasons why an independent physician group may think it necessary to use a reasonable non-compete to protect legitimate business interests (LBIs).

As directed by Resolve 3, this report describes many ways that non-competes can be regulated, restricted, or modified to achieve the purposes of Resolve 3. The report ends with a recommendation that would be new HOD policy. The recommendation calls on the AMA to continue assisting interested state medical associations in developing fair and reasonable strategies regarding restrictive covenants between physician employers and physician employees including regularly updating the AMA’s state restrictive covenant legislative template.

Following the instructions of the HOD, this report addresses only Resolve 3. As such, this report does not consider non-competes generally, nor does it adjust any AMA policy positions regarding the pros and cons of non-competes as they may exist between physician practices and physician employees.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-A-24

Subject: Prohibiting Covenants Not-to-Compete
(Resolution 237-A-23, Resolve 3)

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

1 INTRODUCTION

2
3 At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates
4 (HOD) adopted Resolution 237 entitled, “Prohibiting Covenants Not-to-Compete in Physician
5 Contracts.” Resolution 237 was introduced by California, American Academy of Family
6 Physicians, American Association of Neurological Surgeons, American College of Surgeons,
7 Congress of Neurological Surgeons, and The Society of Thoracic Surgeons. Resolution 237 stated
8 the following:
9

10 RESOLVED, That our American Medical Association support policies,
11 regulations, and legislation that prohibits covenants not-to-compete for all
12 physicians in clinical practice who hold employment contracts with for-profit or
13 non-profit hospital, hospital system, or staffing company employers (New HOD
14 Policy); and be it further
15

16 RESOLVED, That our AMA oppose the use of restrictive covenants not-to-
17 compete as a contingency of employment for any physician-in-training, regardless
18 of the ACGME accreditation status of the residency/fellowship training program
19 (New HOD Policy); and be it further
20

21 RESOLVED, That our AMA study and report back on current physician
22 employment contract terms and trends with recommendations to address balancing
23 legitimate business interests of physician employers while also protecting
24 physician employment mobility and advancement, competition, and patient access
25 to care - such recommendations to include the appropriate regulation or restriction
26 of 1) Covenants not to compete in physician contracts with independent physician
27 groups that include time, scope, and geographic restrictions; and 2) De facto non-
28 compete restrictions that allow employers to recoup recruiting incentives upon
29 contract termination. (Directive to Take Action)
30

31 As directed by the HOD, this report addresses only Resolve 3 of Resolution 237 (Resolve 3). As
32 such, this report does not consider non-competes generally, nor does it adjust any AMA policy
33 positions regarding the pros and cons of non-competes as they may exist between physician
34 practices and physician employees.
35

36 In this report, “non-compete” is defined as “a contractual term between a physician employer, e.g.,
37 a hospital, and a physician employee that prohibits the employee from working within a certain

1 geographic area and period of time after the physician’s employment ends.” For example, a
2 restrictive covenant may prohibit the physician from practicing medicine within 10 miles of the
3 location where he or she treated patients for two years after employment has ended.

4
5 BACKGROUND

6
7 Adoption of Resolution 237 made a significant change to the AMA’s policy on non-compete
8 clauses (a/k/a covenants not-to-compete or non-competes). Prior to Resolution 237, the AMA was
9 primarily guided by *Ethical Opinion 11.2.3.1, Restrictive Covenants (Ethical Opinion 11.2.3.1)*,
10 which states that physicians should not enter into unreasonable non-competes.¹

11
12 Pursuant to Resolution 237, AMA policy now requires the AMA to “support policies, regulations,
13 and legislation that prohibits covenants not-to-compete for all physicians in clinical practice who
14 hold employment contracts with for-profit or non-profit hospital, hospital system, or staffing
15 company employers.” Resolution 237 does not supplant *Ethical Opinion 11.2.3.1*, which opposes
16 the use of unreasonable physician non-competes. Thus, while Resolution 237 prohibits covenants
17 not-to-compete for all physicians in clinical practice who hold employment contracts with for-
18 profit or non-profit hospital, hospital system, or staffing company employers, *Ethical Opinion*
19 *11.2.3.1* applies in other contexts, and thus opposes the use of unreasonable non-competes between
20 physician employers and physician employees.

21
22 Resolve 3 appears to recognize the negative impact that non-competes – even those used by
23 physician employers – may have on physicians and patients. Specifically, Resolve 3 asks the AMA
24 to make recommendations concerning the appropriate regulation or restriction of non-competes in
25 physician contracts with independent physician groups that include time, scope, and geographic
26 restrictions. What follows is a brief discussion regarding how non-competes may harm patients and
27 physicians.

28
29 *Non-competes Harm Patients*

30
31 Enforcement of non-competes often harms patients by ending patient-physician relationships, e.g.,
32 if a non-compete forces a physician out of a community or otherwise makes the physician
33 geographically inaccessible to patients. Patients may be particularly at risk when the non-compete
34 severs long-standing patient-physician relationships where the physician has been taking care of
35 patients with chronic illnesses. Similarly, a non-compete can thwart a patient’s choice of physician.

36
37 Non-competes may hinder patients’ ability to timely access care. For example, depending on the
38 geographic area, there may be a few physicians, general practitioners, or specialists available to
39 serve the patient population. Even if several physicians practice in the community, forcing a
40 physician to leave the area may reduce the number of available physicians. Although a replacement
41 physician may ultimately be recruited to the area, recruitment can be a lengthy process. In the
42 meantime, the absence of the physician subject to the non-compete may frustrate timely patient
43 access to physician services – assuming the community’s remaining physicians have the capacity to
44 take on new patients.

45
46 Non-competes may also harm patients by compromising physician autonomy. For example, most
47 physician employment agreements allow the employer (and the physician) to end the agreement at
48 any time, so long as the other party is given advance notice. (This is typically referred to as
49 “without cause” termination). A physician who knows that an employer can end their employment
50 at any time, which will in turn trigger a non-compete, may be very reluctant to engage in patient
51 advocacy, and speak up about matters negatively affecting patient care, clinical decision-making,

1 etc.

2
3 *Non-competes Harm Physicians*
4

5 Non-competes can also harm employed physicians by locking them into untenable working
6 conditions or responsibilities that are detrimental to physicians' mental and/or physical health,
7 thereby contributing to the physician burnout epidemic. A physician who is practicing medicine in
8 demoralizing working conditions may feel an urgent need to find a job with a better working
9 environment and where the employer listens to its physicians' concerns and fosters a workplace
10 that is more conducive to the practice of medicine. If a competing employer in the community
11 offers the physician such an opportunity, a non-compete would bar the physician from accepting
12 the new position. The physician might solve this issue if he or she were willing to work for an
13 employer outside the non-compete's geographic restrictions. Doing so, however, could not only
14 force the physician to leave the area, but require the physician to uproot his or her family from a
15 community where the family has established significant roots. As a practical matter, working
16 outside of the non-compete's geographic restriction may then be completely out of the question.
17 Thus, the physician will simply have no option but to stay in a demoralizing employment situation
18 that continues to put the physician's mental and physical health at risk and increasingly subjects the
19 physician to burnout.
20

21 Based on all of the above, we understand that employed physicians have a strong case for wanting
22 the AMA to adopt policy calling for a complete ban on non-competes. However, while Resolve 3
23 requires the AMA to support a ban on non-competes in employment contracts with for-profit or
24 non-profit hospitals, hospital systems, or staffing company employers, Resolve 3 does not call on
25 the AMA to do the same with respect to non-competes between independent physician groups and
26 their physicians. Rather, Resolve 3 asks the AMA to study and report back with recommendations
27 to address balancing legitimate business interests (LBIs) of physician employers while also
28 protecting physician employment mobility and advancement, competition, and patient access to
29 care. Thus Resolve 3 appears to recognize that physician employers may feel the need to use
30 reasonable non-competes to protect LBIs. The next paragraph discusses those interests.
31

32 *Employer's Reasons for Requiring Restrictive Covenants*
33

34 Physician employers may feel that reasonable non-competes are essential to protect LBIs, which
35 may take several forms. For example, an independent physician group may train the physician,
36 make referral sources and contacts available to the physician, give the physician access to patients
37 and patient lists, market the physician in the community, and provide the physician with
38 proprietary practice information to help the physician build up his or her practice. Physician
39 employers may want to use non-competes to prohibit a physician from leaving and then opening up
40 their own practice "down the hall," in the same building, or even across the street – after receiving
41 the benefit of information, training, patient contacts, and other resources provided by the
42 independent physician group. Non-competes may give the physician employer the freedom and
43 security to invest significant resources in the employed physician's success, without the employer
44 having to worry that the physician will later leave after the physician has developed a significant
45 patient base, taking those patients with him or her.
46

47 DISCUSSION
48

49 There are two recent, major developments or trends relating to physician employment contract
50 terms relating to the potential balancing of the physician employer and their employed physicians
51 and patient access. These developments are: (1) the Federal Trade Commission's (FTC) proposed

1 rule on non-competes and (2) the ongoing enactment of state legislation dealing with non-
 2 competes. Because the FTC’s proposed rule bans physician non-competes, except with respect to
 3 501(c)(3) organizations under the U.S. Internal Revenue Code (which includes at least some
 4 hospitals and health systems), the proposed rule is not a source of recommendations about how
 5 physician contracting, regulation, or restrictions to non-competes might modify non-competes
 6 themselves to achieve the balance described in Resolve 3. The proposed rule does not prohibit the
 7 use of reasonable confidentiality provisions to protect trade secrets and other confidential
 8 information or repayment agreements. These types of provisions might, if taken together, be a
 9 possible means of achieving the kind of balance described by Resolve 3.

10
 11 *Recommendations Concerning Possible Modifications to Traditional Non-competes*

12
 13 State legislatures continue to consider bills that address non-competes, and most states have
 14 enacted statutes that are applicable to non-competes between physician employers and physician
 15 employees. These laws, as well as court decisions, provide the basis of how non-competes between
 16 physician employers and physician employees might be regulated. In states where one or more of
 17 these laws do not apply, the following recommendations could also be considered in contract
 18 negotiations between physician employers and their employees as a means of trying to achieve the
 19 balance described in Resolve 3.

- 20
 21 • **Bases of termination.** Rather than having the non-compete apply regardless of the reason for
 22 employment termination, the non-compete might be modified so that it is enforceable only if:
 23 (1) the physician terminated his or her employment without cause; (2) the physician’s license
 24 to practice medicine, or prescribe or dispense controlled substances, is currently revoked; or (3)
 25 the physician is currently excluded from participating in Medicare, Medicaid, or any other
 26 governmental program providing compensation for services rendered to patients.
 27
- 28 • **Duration.** A non-compete could be drafted so that it has a short duration. It is not unusual for
 29 physician non-competes to last two years. But, following the direction of several state laws, the
 30 duration could be reduced to one year, or even six months. For example, Connecticut limits the
 31 duration of a physician non-compete to no more than one year.² In a frequently cited Arizona
 32 Supreme Court case, the court affirmed a lower court’s ruling that six months, rather than three
 33 years, was sufficient to protect the legitimate business interests of a physician practice with
 34 respect to competition from a formerly employed pulmonologist.³
 35
- 36 • **Scope of services.** A non-compete should apply only to services that the employed physician
 37 provided to the physician employer, and not, for example, broadly restrict the physician from
 38 “practicing medicine.” For example, a Louisiana court ruled that a non-compete was too broad
 39 because it prohibited the physician employee from engaging in the practice of medicine, rather
 40 than being limited to the pain management services that he provided.⁴ On the other hand, the
 41 Illinois Supreme Court upheld a ruling holding that a non-compete prohibiting a physician
 42 from practicing medicine was not too broad.⁵
 43
- 44 • **Working for competitors.** A non-compete could be structured so that it prohibits the departing
 45 physician from working for a competitor, rather than prohibiting the physician from working
 46 for any employer in the relevant geographic area.⁶
 47
- 48 • **Tying the geographic scope of the non-compete to a single location.** A non-compete should
 49 be written so that it is tied to the specific location where the physician provided the majority of
 50 his or her services, sometimes referred to in state law as the “primary practice site.” A non-

1 compete should not include any geographic area where the physician employer has offices—
2 since the employer may have several offices in a state or states.⁷

- 3
- 4 • **Reasonable buy-out provision.** A non-compete could be drafted so that the departing
5 physician could buy his or her way out of the non-compete.⁸ The amount of the buyout should
6 be reasonable based on a predetermined formula to eliminate ambiguity concerning how the
7 buyout amount will be calculated. However, in some cases, even if there is no dispute
8 concerning the buyout’s reasonableness, a departing physician may not be able to buy his or
9 her way out of a non-compete because the amount of the buyout is more than the physician can
10 pay.
 - 11
 - 12 • **Carve out for specific types of patients.** Some state statutes that do permit the use of non-
13 competes allow the departing physician to continue to see patients with specific types of
14 conditions. For example, the Texas statute permits the physician to still treat patients with an
15 acute illness.⁹ The Colorado statute may also serve as an example here. Although the Colorado
16 law prohibits non-competes in physician employment agreements, it does permit punitive
17 damages related to competition. However, punitive damages are not recoverable if the formerly
18 employed physician is treating a patient with a rare disorder.¹⁰

19

20 *Use of Contractual Provisions that are not Non-competes*

21

22 There are other kinds of post-employment restrictions that may represent other ways of attempting
23 to achieve the balance described in Resolve 3. A physician employer may, however, be concerned
24 that these alternatives do not sufficiently protect its LBI. This section describes some of these other
25 options, which may be used in combination with one another.

26

27 Trade Secrets

28

29 A contract clause obligating the departing physician not to disclose the employer’s trade secrets is
30 one way that the physician employer could protect its LBI. All states have laws protecting trade
31 secrets and most states have adopted the Uniform Trade Secrets Act¹¹ (UTSA) in various forms.
32 The UTSA defines “trade secret” as information, including a formula, pattern, compilation,
33 program, device, method, technique, or process, that: (1) derives independent economic value,
34 actual or potential, from not being generally known to, and not being readily ascertainable by
35 proper means by, other persons who can obtain economic value from its disclosure or use and
36 (2) is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.

37

38 The UTSA includes a civil cause of action for trade secret misappropriation, which refers to
39 disclosure or use of a trade secret by a former employee without express or implied consent.
40 Moreover, the courts have held that trade secrets include patient lists, medical records, and
41 superbills containing patient addresses, medical diagnoses and treatment codes, and patient
42 insurance information.¹² AMA policy states, however, that billing records and associated medical
43 records should not be treated as proprietary or as trade secrets.¹³

44

45 Confidentiality Clauses

46

47 Physician employers may also use confidentiality agreements to protect legitimate business
48 interests. Confidential information includes, but is not limited to, trade secrets. Some state laws
49 define “confidential information.” For example, the Georgia non-compete statute defines
50 “confidential information” in part to mean data and information:

1 Relating to the business of the employer, regardless of whether the data or
2 information constitutes a trade secret...disclosed to the employee, that has value to
3 the employer; is not generally known to the employer's competitors; competitors
4 of the employer; and includes trade secrets, methods of operation, names of
5 customers, price lists, financial information and projections, route books, personnel
6 data, and similar information...¹⁴
7

8 The employer should require that, upon termination of the physician's employment, that the
9 departing physician promptly return any confidential information in the physician's possession or
10 control to the physician employer, including but not limited to, information on electronic devices.
11 Further, the physician employer should consider requiring the employee to agree to a provision
12 prohibiting a physician from taking any property, patient lists, or records of the employer with him
13 or her upon the termination or expiration of the employment agreement.¹⁵
14

15 Protecting Trade Secrets and Confidential Information Through Non-disclosure Agreements

16

17 A physician employer can take steps to protect both confidential and trade secrets information by
18 requiring the employee to sign a non-disclosure agreement (NDA) that applies after the physician
19 leaves the employer. An NDA needs to be (1) clear about the information that is protected and (2)
20 specifically tailored to protect that information. Courts may refuse to enforce NDAs that are too
21 broad, e.g., they apply to information that is not considered to be confidential.
22

23 In some circumstances an NDA may be so broad that it can function as a de facto non-compete.
24 One example of an NDA functioning as a de facto non-compete is found in *Brown v. TGS Mgmt.*
25 *Co., LLC*. In this case, "confidential information" included any information that was "usable in" or
26 "relates to" the securities industry. A California court refused to enforce the NDA because it
27 defined confidential information "so broadly as to prevent [the employee] from ever working again
28 in securities trading" and thus, operated as a de facto non-compete. As a result, the court concluded
29 that it could not be enforced under California law.¹⁶
30

31 While NDAs do not restrict the mobility of physician employees as much as non-competes,
32 physician employers may be concerned that an NDA is not sufficient to protect its trade secrets and
33 other confidential information. It may be challenging for the physician employer to detect a breach
34 of an NDA in comparison with a non-compete. Further, there can be significant litigation
35 concerning just what damage the breach has caused the employer. Issues with detection and
36 establishing damage amounts are likely to make enforcement of NDAs more expensive than
37 enforcement of non-competes. However, in lieu of having to prove damage amounts, the physician
38 employer might, to the extent permitted by state law, be able to include in the employment contract
39 a clause entitling the employer to liquidated damages if the physician breaches an NDA, although
40 the amount of liquidated damages could itself be subject to litigation.
41

42 Non-solicitation Agreements

43

44 Most states that prohibit non-competes do not disallow the use of non-solicitation agreements
45 (NSA). For example, the Minnesota non-compete statute does not prohibit an NDA, an agreement
46 designed to protect trade secrets or confidential information, an NSA, or an agreement restricting
47 the ability to use client or contact lists or solicit customers of the employer.¹⁷ NSAs can apply to
48 the physician employer's patients, employees, or both. An NSA should, however, entitle the
49 physician to notify patients whom they have seen and who wish to continue care with them of their
50 new location and be advised they may sign a records release to have their records transferred to
51 their physician of choice.

1 As in the case of NDA, it is likely that an employer will find it more difficult, and thus more
2 expensive, to detect the breach of an NSA and prove damages, as opposed to a non-compete.
3 Proving a breach of an NSA may be particularly challenging because employees may want to work
4 for, and patients may decide to continue their relationship with, the departing physician on their
5 own initiative without any solicitation from the physician. Again, as in the case of breach of an
6 NDA, the physician employer might, to the extent permitted by state law, include a liquidated
7 damages provision in its employment agreement with the physician to remedy a breach of an NSA,
8 which, as noted above, may also be the subject of litigation.

9 10 Repayment Agreements

11
12 Using a repayment agreement can be another way to attempt to achieve the balance described in
13 Resolve 3. The main concern here most likely has to do with what costs are covered by the
14 agreement. Fortunately, some state non-compete statutes address this issue. For example, the New
15 Mexico non-compete law, which bans non-competes in physician employee contracts, states that
16 during an initial employment period of less than three years, the physician employer can require
17 the departing physician to repay all or a portion of: (1) a loan; (2) relocation expenses; (3) a
18 signing bonus or other remuneration to induce the health care practitioner to relocate or establish a
19 health care practice in a specified geographic area; or (4) recruiting, education, and training
20 expenses.¹⁸ The West Virginia non-compete statute, on the other hand, states that a physician
21 employer may require an employed physician to repay all or a portion of: (1) a loan; (2) location
22 expenses; (3) a signing bonus; (4) remuneration to induce the physician to relocate or establish a
23 physician practice in a specific geographic area; or (5) recruiting, education, and training expenses.
24 (The West Virginia statute does permit the use of physician non-competes lasting no more than
25 one year). Unlike the New Mexico statute, the repayment obligation appears to have no time
26 limit.¹⁹

27
28 A physician employer must take care that the repayment agreement is fair and is not inflated by
29 costs that do not reflect actual financial benefits conferred on the employed physician. Notably, the
30 FTC's proposed non-compete rule states that a repayment agreement may function as a de facto
31 non-compete if the repayment obligation is not reasonably related to the costs the employer
32 incurred for training the worker.²⁰ The abuse of repayment agreements has come under fire from
33 other quarters as a means of preventing employees from leaving their jobs through debt, and are
34 being used as a work-around in states where non-competes are banned.²¹ If a physician employer is
35 considering how to structure a repayment agreement and what types of costs ought to be covered,
36 the cost categories listed in the New Mexico and the West Virginia laws may be useful guides,
37 keeping in mind that the cost amounts must also be reasonable.

38 39 *AMA Educational and Advocacy Resources*

40
41 The AMA has many educational and advocacy resources concerning non-competes. For example,
42 the Advocacy Resource Center (ARC) has, pursuant to prior AMA policy, developed a
43 comprehensive analysis of all state non-compete laws that apply to physicians entitled "Legislative
44 Template: Covenants not-to-Compete in Physician Contracts." Those interested in this advocacy
45 resource may obtain it by contacting the ARC at [https://www.ama-assn.org/system/files/rc-](https://www.ama-assn.org/system/files/rc-legislative-template.pdf)
46 [legislative-template.pdf](https://www.ama-assn.org/system/files/rc-legislative-template.pdf). The AMA Career Planning Resource webpage also has a wealth of
47 information discussing physician employment issues, which includes information and tips regarding
48 restrictive covenants. The AMA Career Planning Resource webpage may be accessed at
49 [https://www.ama-assn.org/residents-students/career-planning-resource/understanding-employment-](https://www.ama-assn.org/residents-students/career-planning-resource/understanding-employment-contracts)
50 [contracts](https://www.ama-assn.org/residents-students/career-planning-resource/understanding-employment-contracts).

1 RELEVANT AMA POLICY

2
3 The following AMA policy is relevant to this Board Report:

4
5 • **Code of Medical Ethics 11.2.3.1 Restrictive Covenants**

6
7 Competition among physicians is ethically justifiable when it is based on such factors as
8 quality of services, skill, experience, conveniences offered to patients, fees, or credit terms.

9
10 Covenants-not-to-compete restrict competition, can disrupt continuity of care, and may limit
11 access to care.

12
13 Physicians should not enter into covenants that:

14
15 (a) Unreasonably restrict the right of a physician to practice medicine for a specified period of
16 time or in a specified geographic area on termination of a contractual relationship; and

17
18 (b) Do not make reasonable accommodation for patients' choice of physician.

19
20 Physicians in training should not be asked to sign covenants not to compete as a condition of
21 entry into any residency or fellowship program.

22
23 AMA Principles of Medical Ethics: III, IV, VI, VII

24
25 • **Restrictive Covenants of Large Health Care Systems D-383.978**

26
27 Our AMA, through its Organized Medical Staff Section, will educate medical students,
28 physicians-in-training, and physicians entering into employment contracts with large health
29 care system employers on the dangers of aggressive restrictive covenants, including but not
30 limited to the impact on patient choice and access to care.

31
32 • **Restrictive Covenants in Physician Contracts H-383.987**

33
34 Our AMA will provide guidance, consultation, and model legislation concerning the
35 application of restrictive covenants to physicians upon request of state medical associations and
36 national medical specialty societies.

37
38 • **Prohibiting Covenants Not-To-Compete in Physician Contracts H-265.988**

39
40 (1) Our American Medical Association support policies, regulations, and legislation that
41 prohibits covenants not-to-compete for all physicians in clinical practice who hold employment
42 contracts with for-profit or non-profit hospital, hospital system, or staffing company
43 employers.

44
45 (2) Our AMA will oppose the use of restrictive covenants not-to-compete as a contingency of
46 employment for any physician-in-training, regardless of the ACGME accreditation status of the
47 residency/fellowship training program.

48
49 (3) Our AMA will study and report back on current physician employment contract terms and
50 trends with recommendations to address balancing legitimate business interests of physician

1 employers while also protecting physician employment mobility and advancement,
2 competition, and patient access to care - such recommendations to include the appropriate
3 regulation or restriction of a) Covenants not to compete in physician contracts with
4 independent physician groups that include time, scope, and geographic restrictions; and b) De
5 facto non-compete restrictions that allow employers to recoup recruiting incentives upon
6 contract termination.

7
8 • **Covenants Not to Compete D-265.988**
9

10 Our AMA will create a state restrictive covenant legislative template to assist state medical
11 associations, national medical specialty societies and physician members as they navigate the
12 intricacies of restrictive covenant policy at the state level.

13
14 **RECOMMENDATIONS**
15

16 The Board of Trustees recommends that the following policy be adopted, and the remainder of the
17 report be filed:

- 18
19 1. That the American Medical Association (AMA) continue to assist interested state
20 medical associations in developing fair and reasonable strategies regarding restrictive
21 covenants between physician employers and physician employees including regularly
22 updating the AMA's state restrictive covenant legislative template. (New HOD Policy)

Fiscal Note: Less than \$500

REFERENCES

- ¹ See <https://policysearch.ama-assn.org/policyfinder/detail/%2211.2.3.1%20Restrictive%20Covenants%22?uri=%2FAMADoc%2FEthics.xml-E-11.2.3.1.xml>
- ² Conn. Gen. Stat. § 20-14p
- ³ *Valley Medical Specialists v. Farber*, 982 P.2d 1277, 1281 (Ariz. 1999)
- ⁴ *Paradigm Health Sys., L.L.C. v. Faust*, 218 So. 3d 1068, 1071 (La.App. 1 Cir. 2017)
- ⁵ *Mohanty v. St. John Heart Clinic, S.C.*, 225 Ill. 2d 52, 77 (2006)
- ⁶ See e.g., NV Rev Stat § 613.195(6)(a) and (b)
- ⁷ See e.g., Conn. Gen. Stat. section 20-14p and W. Va. Code § 47-11E-2
- ⁸ For statutory examples, see IN Code § 25-22.5-5.5 and TX Bus & Com Code § 15.50
- ⁹ Tex. Bus. & Com. Code § 15.50
- ¹⁰ C.R.S. 8-2-113
- ¹¹ See <https://www.uniformlaws.org/committees/community-home/librarydocuments?communitykey=3a2538fb-e030-4e2d-a9e2-90373dc05792&LibraryFolderKey=&DefaultView=&5a583082-7c67-452b-9777-e4bdf7e1c729=eyJsaWJ5YXJ5ZXU50cnkiOiI3NDkwMWU4OS0zMmFkLTRjOGItODk3Yi1jYWE2ZjA4N2U4ZWmifQ%3D%3D>
- ¹² See e.g., *Total Care Physicians, P.A. v. O'Hara*, 798 A.2d 1043, 1054 (Del. Super. Ct. 2001)
- ¹³ Physician Access to Their Medical and Billing Records D-315.971
- ¹⁴ O.C.G.A. § 13-8-51
- ¹⁵ See e.g., W.Va. Code § 47-11E-3
- ¹⁶ *Brown v. TGS Mgmt. Co., LLC*, 57 Cal. App. 5th 303, 306, 319 (Cal. Ct. App. 2020); FTC Proposed Non-compete Rule, 88 F.R. 3482, 3509 (January 19, 2023) <https://www.govinfo.gov/content/pkg/FR-2023-01-19/pdf/2023-00414.pdf>
- ¹⁷ Minn. Stat. § 181.988
- ¹⁸ N.M. Stat. Ann. § 24-11-3
- ¹⁹ W.Va. Code § 47-11E-3
- ²⁰ FTC Proposed Non-compete Rule, 88 F.R. 3482, 3535 (January 19, 2023) <https://www.govinfo.gov/content/pkg/FR-2023-01-19/pdf/2023-00414.pdf>
- ²¹ See e.g., Harris, Jonathan, The New Non-compete: The Training Repayment Agreement Provision (TRAP) as a Scheme to Retain Workers through Debt (November 9, 2022). Northwestern University Law Review Of Note, Nov. 9, 2022, Loyola Law School, Los Angeles Legal Studies Research Paper No. 2022-15, Available at SSRN: <https://ssrn.com/abstract=4273728>

EXECUTIVE SUMMARY

While physicians receive extensive training in a chosen specialty during their medical residency, nurse practitioners and physician assistants do not specialize in a comparable way. Both nurse practitioners and physician assistants must graduate from an accredited program and pass a certification examination for licensure in most states. While didactic education and clinical training differs between the two professions, the education of both nurse practitioners and physician assistants is broadly focused, especially compared to that of a physician. Any focus on a specific specialty in formal training is limited. While some nurse practitioners and physician assistants may “specialize” by gaining certifications in a certain area, these additional certifications are earned by acquiring experience “on-the-job,” are optional upon completion of their formal training, and are separate from the initial certifications typically attained upon graduation.

Nurse practitioner programs do prepare students to provide care to a particular population as determined by the population focus selected by the students. Students choose one of six population foci—for example, family/individual, pediatrics, or psychiatric/mental health—to emphasize in their training. The chosen population focus typically determines the certification a nurse practitioner attains following graduation. As such, nurse practitioner programs vary based on the nurse practitioner’s chosen population foci and the primary certification they plan to attain. Importantly, however, the education around the population focus does not rise to the level of specialty training. Specialty training represents a “much more focused area of preparation and practice than does the APRN role/population focus level.”¹¹

On the other hand, physician assistant programs intentionally train physician assistants as “generalists,” not specialists. The physician assistant curriculum is largely the same for all physician assistant students. However, physician assistants can obtain Certificates of Added Qualifications (CAQs) post-graduation in certain specialties such as cardiovascular and thoracic surgery or emergency medicine. These CAQs are optional and require physician assistants to acquire work hours in the relevant specialty. Of note, CAQs are separate from the PA-C certification, which is the single certification offered to physician assistants who have graduated from an accredited program and passed the Physician Assistant National Certifying Examination.

A nurse practitioner or physician assistant’s certification is not always aligned with the specialty or setting in which they practice during their career. In fact, both can move between specialties throughout their career often with little to no additional education or training. Available data shows that an increasing number of nurse practitioners and physician assistants are practicing in specialties outside of primary care. However, there is no publicly available data on how often nurse practitioners change specialties and very little such data on physician assistants. Nevertheless, the flexibility to move between specialties is often touted as a “selling point” for prospective students.

This Board Report provides a summary of the underlying education and training of nurse practitioners and physician assistants, as well as an overview of initial certifications and optional specialty certifications available to each profession. The report also examines existing workforce studies and data on specialties and practice settings of nurse practitioners and physician assistants and the alignment of such to the certification of the respective nurse practitioner or physician assistant.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-A-24

Subject: Physician Assistant and Nurse Practitioner Movement Between Specialties

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

1 INTRODUCTION

2

3 At the 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates
4 (HOD) adopted Resolution 239 entitled, “Physician Assistant and Nurse Practitioner Movement
5 Between Specialties.” This resolution asked the AMA to study the movement of nonphysician
6 health care professionals between specialties.

7

8 *Procedural History*

9

10 Resolution 239 was introduced by the Arizona delegation and asked:

11

12 That our American Medical Association Board of Trustees study and report back
13 at the 2023 Interim meeting on the economic impact to primary care and other
14 lower tier income medical specialties of specialty switching by Advanced
15 Practice Providers (Directive to Take Action); and

16

17 That our AMA Board of Trustees study and report back at the 2023 Interim
18 meeting about possible options on how APP’s can best be obligated to stay in a
19 specialty tract that is tied to the specialty area of their supervising physician in
20 much the same way their supervisory physicians are tied to their own specialty,
21 with an intent for the study to look at how the house of medicine can create
22 functional barriers that begin to make specialty switching by Advanced Practice
23 Providers appropriately demanding. (Directive to Take Action)

24

25 Similar in intent, Resolution 262 was introduced by the Private Practice Physicians Section and
26 asked:

27

28 That our American Medical Association create a national task force that will
29 make recommendations for the best process for advanced practice providers
30 (APPs) to develop specialty designations or an associated apprenticeship process
31 that is parallel to the specialties of the physicians that supervise them (Directive
32 to Take Action);

33

34 That our American Medical Association study and report back at Interim 2023 on
35 the economic impact to medical practices of specialty switching by advanced
36 practice providers (Directive to Take Action); and

1 That our American Medical Association study and report back at the 2023
2 Interim Meeting about possible options on how advanced practice providers can
3 best be obligated to stay in a specialty tract (Directive to Take Action).
4

5 Testimony on both of these Resolutions was limited. The Reference Committee heard that the
6 AMA does not have the authority or purview over post-graduate clinical training requirements of
7 nonphysicians and that the AMA has extensive resources detailing the education and training of
8 nurse practitioners and physician assistants. However, the Reference Committee also heard
9 testimony indicating that a growing number of nonphysicians are moving between specialties, and
10 that this is a concern for physicians.
11

12 Seeking to meet the underlying concerns raised in Resolutions 239 and 262, the Reference
13 Committee recommended that Resolution 239 be adopted with an amendment, and that the
14 amended Resolution 239 be adopted in lieu of Resolution 262. The HOD agreed and ultimately
15 adopted amended Resolution 239, which reads as follows:
16

17 That our American Medical Association study the movement of nonphysician
18 health care professionals such as physician assistants and nurse practitioners
19 between specialties.
20

21 This Board of Trustees Report aims to address this directive. It examines the educational
22 preparation of nurse practitioners and physician assistants and evaluates their ability to move
23 between specialties.
24

25 BACKGROUND

26

27 The implications of specialty switching by nurse practitioners and physician assistants are best
28 understood when one considers the underlying education, training, and certification of each
29 profession.
30

31 *Nurse Practitioner Education and Training*

32

33 Nurse practitioners are one type of Advanced Practice Registered Nurse (APRN). While the focus
34 of this board report is on nurse practitioner and physician assistant certification, the foundational
35 documents for nurse practitioner education include APRNs in four types of “roles:” nurse
36 practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse
37 anesthetists (CRNAs). Each type of APRN has its own accreditation and certifying bodies. For
38 example, CRNA programs are accredited by the Council on Accreditation of Nurse Anesthesia
39 Education Programs (COA) and CRNAs can obtain certification from the National Board of
40 Certification and Recertification for Nurse Anesthetists (NBCRNA). By contrast, the Commission
41 on Collegiate Nursing Education (CCNE) and the Accreditation Commission for Education in
42 Nursing (ACEN) both accredit nurse practitioner programs, and nurse practitioners may be
43 certified by one of several different certifying bodies.
44

45 APRN education and training is based on foundational documents that were drafted and agreed to
46 by leaders in the nursing profession:
47

- 48 • Two American Association of Colleges of Nursing (AACN) “Essentials” documents: *The*
49 *Essentials of Master’s Education in Nursing (2011)* and *The Essentials of Doctoral*
50 *Education for Advanced Nursing Practice (2006)* (together, the *AACN Essentials*).

- 1 • The National Task Force on Quality Nurse Practitioner Education’s *2016 Criteria for*
2 *Evaluation of Nurse Practitioner Programs (NTF Standards)*.
- 3 • The Consensus Model for APRN Regulation: Licensure, Accreditation, Certification &
4 Education (APRN Consensus Model).

5
6 Taken together, these documents provide the framework for the curriculum and accreditation of
7 nurse practitioner graduate education programs.

8
9 What is referred to as the “APRN Consensus Model” also provides a model for APRN regulation
10 and certification. The APRN Consensus Model is the basis for the four distinct roles of APRNs and
11 the six-population foci that are foundational to APRN education and training:

- 12
- 13 • Family/individual across the lifespan;
- 14 • Adult-gerontology;
- 15 • Pediatrics;
- 16 • Neonatal;
- 17 • Women’s health/gender-related; and
- 18 • Psychiatric/mental health.

19
20 A nurse practitioner’s specific educational experience will depend on their chosen population
21 focus, and so will their certification. The APRN Consensus Model states that, “[e]ducation,
22 certification, and licensure of an individual must be congruent in terms of role and population
23 foci.”ⁱⁱ As such, distinct certifications—which are generally required for licensure—were created
24 for each population focus, and in some cases for primary care as distinct from acute care. Each
25 certification is aligned with a different educational track. In short, it is expected that a nurse
26 practitioner’s education and training will be based on the certification they plan to attain after
27 graduation. Consequentially, nurse practitioner programs vary slightly based on the nurse
28 practitioner’s chosen population foci and the certification they plan to attain. Each certification has
29 a somewhat different educational pathway, but all nurse practitioners must meet the same core
30 academic requirements. The APRN Consensus Model provides the required “APRN core” courses
31 included in the curriculum for all nurse practitioners (and all APRNs):

- 32
- 33 • Physiology/pathophysiology;
- 34 • Health assessment; and
- 35 • Pharmacology.ⁱⁱⁱ

36
37 Specialty training, by contrast, represents a “much more focused area of preparation and practice
38 than does the APRN role/population focus level.”^{iv}

39
40 Across all population foci, nurse practitioner clinical training requirements are largely not
41 standardized, in sharp contrast to physician clerkships and residencies. Nurse practitioners only
42 undergo 500-750 hours of clinical training. This results in evident experience gaps. For example,
43 even though some of the nurse practitioner certifications broadly span patient populations,
44 including across the lifespan from children to geriatric patients, studies on nurse practitioner
45 education have documented that family nurse practitioners (FNPs) often receive minimal training
46 across patient populations.

47
48 Notably, a study in the *Journal of Nursing Regulation* surveyed recent FNP graduates on how often
49 they performed basic tasks like prescribing medications, obtaining a health history, ordering

1 diagnostic tests, and developing differential diagnoses during their entire training.^v The survey also
2 examined these tasks across patient populations, providing a window into how the FNP education
3 and training prepares students for practice. The results were shocking. For example, only
4 61.5 percent of FNPs reported they prescribed medications to an adult patient more than 10 times,
5 15 percent said they only prescribed medications to an adult patient one to two times.^{vi} The
6 numbers were even lower for pediatric and geriatric patients. Only 44.6 percent and 56.3 percent of
7 FNP students surveyed said they prescribed medications more than 10 times to a pediatric patient
8 and geriatric patient respectively, with 5.5 percent and 4.0 percent of FNP students indicating they
9 *never* prescribed medications to pediatric or geriatric patients respectively during their clinical
10 training.^{vii} This study demonstrates the lack of standardization in nurse practitioner training
11 programs. Yet, FNPs often practice across patient populations and increasingly in specialties
12 outside primary care.

13

14 *Nurse Practitioner Certification*

15

16 For initial certification of nurse practitioners, two major certifying bodies exist: the American
17 Academy of Nurse Practitioners Certification Board (AANPCB) and the American Nurses
18 Credentialing Center (ANCC).^{viii} Each certifying body administers their own examination and
19 offers their own certifications. Both AANPCB and ANCC require nurse practitioners to renew their
20 certification every five years. Most states require certification for licensure as a nurse practitioner,
21 and certification exams are generally aligned with population foci.

22

23 The AANPCB offers three initial certifications: Family Nurse Practitioner (FNP), Adult-
24 Gerontology Primary Care Nurse Practitioner (A-GNP), and Psychiatric Mental Health Nurse
25 Practitioner (PMHNP).^{ix} AANPCB's FNP examination is an online examination with 150 multiple
26 choice questions, which must be completed in three-hours. In 2021 the pass rate was 84 percent.
27 AANPCB has retired a couple of certifications, including the Adult Nurse Practitioner (retired in
28 2017) and Gerontology Nurse Practitioner (retired in 2012). Nurse practitioners who obtained these
29 retired certifications can maintain the credential as long as they continue to renew their certification
30 by completing the required clinical practice hours and continuing education.

31

32 ANCC offers four certifications for nurse practitioners: Family Nurse Practitioner (FNP-BC),
33 Adult-Gerontology Primary Care Nurse Practitioner (AGPCNP-BC), Adult-Gerontology Acute
34 Care Nurse Practitioner (AGACNP-BC), and Psychiatric Mental Health Nurse Practitioner
35 (PMHNP-BC). ANCC's FNP-BC certifying examination includes 150-200 questions that vary in
36 format from multiple choice, drop and drag, and multiple response. The average pass rate in
37 2021 was 87 percent. ANCC also offers certifications for registered nurses, as well as micro-
38 credentials in certain sub-specialties. ANCC has also retired several certifications, including Acute
39 Care Nurse Practitioner, Adult Nurse Practitioner, Adult-Psychiatric Mental Health Nurse
40 Practitioner, Emergency Nurse Practitioner, Gerontological Nurse Practitioner, Pediatric Primary
41 Care Nurse Practitioner, and School Nurse Practitioner. Like the retired certifications offered by
42 AANPCB, nurse practitioners may renew these ANCC retired certifications to maintain their
43 credential.^x

	American Academy of Nurse Practitioners Certification Board (AANPCB)	American Nurses Credentialing Center (ANCC)
Current certifications	Family Nurse Practitioner (FNP) Adult-Gerontology Primary Care Nurse Practitioner (A-GNP) Psychiatric Mental Health Nurse Practitioner (PMHNP)	Family Nurse Practitioner (FNP-BC) Adult-Gerontology Primary Care Nurse Practitioner (AGPCNP-BC) Adult-Gerontology Acute Care Nurse Practitioner (AGACNP-BC) Psychiatric Mental Health Nurse Practitioner (PMHNP-BC)
Retired certifications	Adult NP (retired) Gerontology NP (retired)	Acute Care NP (retired) Adult NP (retired) Adult-Psychiatric Mental Health NP (retired) Emergency NP (retired) Gerontological NP (retired) Pediatric Primary Care NP (retired) School NP (retired)

1 While AANPCB and ANCC are the largest certifying bodies for nurse practitioners, other smaller
 2 certification bodies exist, including the American Association of Critical-Care Nurses (AACN),
 3 National Certification Corporation (NCC), Pediatric Certification Board (PNCB), Certification
 4 Board for Urological Nurses & Associates (CBUNA), and Hospice & Palliative Credentialing
 5 Center (HPCC).

6

7 *Nurse Practitioner Specialties*

8

9 Under the APRN Consensus Model, advanced practice registered nurses are licensed at the level of
 10 the population focus—not at the specialty level.^{xi} Advanced practice registered nurses cannot be
 11 licensed solely within a specialty area.^{xii} Regarding specialties, the APRN Consensus Model notes
 12 that specialties are optional but must be congruent with and build on the individual’s established
 13 role and population foci.

14

15 Nurse practitioners may pursue optional certification in various specialties/subspecialties after
 16 initial certification in their role and population focus. An array of certifying boards issue
 17 “specialty” certifications for nurse practitioners—typically these certifications are based on hours
 18 of practice experience in a specialty and passage of an exam. Customarily, the certifying boards are
 19 specific to nursing and specific to a single specialty. For example, the Orthopaedic Nurses
 20 Certification Board certifies nurse practitioners in the orthopaedic specialty (ONP-C) and the
 21 Dermatology Nurses Association certifies dermatology nurse practitioners (DCNPs). However,
 22 AANPCB offers an Emergency Nurse Practitioner (ENP) certification for certified FNPs with
 23 specialty education and practice in emergency care.

24

25 Note that specialty certification is generally not required for practice within a given specialty—
 26 indeed, work within a specific specialty is required to earn specialty certification.

27

28 *Nurse Practitioner Workforce*

29

30 Nurse practitioners are not required to practice within the specialty in which they are certified, and
 31 so there is great misalignment between nurse practitioner certification and the setting or specialty
 32 in which they practice. The APRN Consensus Model attempts to align the nurse practitioner
 33 curriculum with the certification a nurse practitioner can attain after graduation, however, a nurse

1 practitioner’s certification is not always congruent with the specialty or setting in which the nurse
 2 practitioner practices during their career. Myriad data sources confirm this misalignment. For
 3 example, the American Association of Nurse Practitioners (AANP) claims that 88 percent of nurse
 4 practitioners are certified in primary care, but also reports that only 70.3 percent of nurse
 5 practitioners deliver primary care. The most recent Health Resources and Services Administration
 6 (HRSA) workforce data suggests a greater disparity, reflecting that only 24 percent of nurse
 7 practitioners deliver primary care.^{xiii}

8
 9 HRSA’s findings are consistent with several state-level workforce studies, including the following:

- 10
 11 • A study from the Oregon Center for Nursing examined the number of nurse practitioners
 12 practicing in primary compared to specialty care in Oregon. Looking at practice setting and
 13 area of practice, data from the survey revealed that only one-third of nurse practitioners
 14 practice in primary care and about 22 percent provided a combination of primary and
 15 specialty care. Of those nurse practitioners providing both primary and specialty care,
 16 about 62 percent spent less than half of their time focusing on primary care.^{xiv} The study
 17 found that the gap between nurse practitioners providing primary care versus specialty care
 18 is widening over time, with a greater number of nurse practitioners providing specialty care
 19 and fewer nurse practitioners providing primary care. It concluded that certification alone
 20 is not enough to determine one’s area of practice.
- 21 • Adding to this body of evidence is *A Profile of New York State Nurse Practitioners, 2017*,
 22 a workforce report in which only about *one-third* of actively practicing nurse practitioners
 23 were considered primary care nurse practitioners based on their specialty certification and
 24 practice setting, even though a vast majority of nurse practitioners in the state report a
 25 primary care specialty certification. To indicate, 87 percent of nurse practitioners reported
 26 a certification in primary care (36.8 percent in family health, 23.2 percent in adult health,
 27 8.1 percent in pediatrics).^{xv}
- 28 • A *2023 South Dakota Workforce Study* had similar findings.^{xvi} Based on data gathered
 29 from nurse license renewal applications, including nurses who renewed their license,
 30 reactivated an inactive license, or reinstated a lapsed license, 80.9 percent indicated they
 31 were licensed and certified as family nurse practitioners yet only 24.9 percent identified
 32 “family health” as their primary area of specialty, 5.1 percent chose “primary care”, and
 33 6 percent chose adult health.^{xvii} Other notable specialties selected include “other”
 34 (11.6 percent), psychiatric/mental health/substance abuse (8.2 percent), acute/critical care
 35 (7.3 percent), cardiology (4.2 percent), and emergency/trauma (3.5 percent).^{xviii}

36
 37 Studies also elucidate lack of congruence between nurse practitioners’ certification and their
 38 practice in acute care settings.^{xix} As noted earlier, some certifications distinguish between primary
 39 and acute care—and this distinction is ostensibly reflected in the nurse practitioner’s educational
 40 track. Yet, many nurse practitioners are certified in primary care work in an acute care practice
 41 specialty or setting.

42
 43 A study published in *Nursing Outlook* using data from HRSA’s 2018 National Sample Survey of
 44 Registered Nurses found that among nurse practitioners working in acute care settings, only
 45 44.5 percent held a certification in acute care, while 55.5 percent held only a primary care
 46 certification (13.7 percent held both acute care and primary care certifications). Notably, only about
 47 half of nurse practitioners working in acute care reported that they feel prepared to be an
 48 independent practitioner.^{xx}

1 Below are findings by clinical specialty area in which the respondents worked:

	Acute Care Certified (N = 8,256)	Primary Care Certified (N = 10,297)
Total	44.5%	55.5%
Clinical Specialty		
General medical surgical	27.5%	37.6%
Critical care	23.5%	25.3%
Chronic Care	30.0%	10.6%
Neurological	6.4%	7.0%
Oncology	5.0%	9.2%
Other	7.6%	10.3%

*from Nursing Outlook $p < .01$

2 These findings were consistent with other studies examining the misalignment between nurse
 3 practitioners’ credentials and their practice setting. For example, using data from the AANP
 4 National Nurse Practitioner Sample Survey, researchers found that of the 366 nurse practitioners
 5 who responded they were a hospitalist caring for adult patients (i.e., in an acute care setting),
 6 74.7 percent were certified in primary care—with a full 75 percent indicating “on-the-job training”
 7 as their qualification to be a nurse practitioner hospitalist.^{xxi}

8
 9 Similarly, while emergency departments are for acute-life or limb threatening emergencies and
 10 providing care to critically ill patients, most nurse practitioners working in emergency departments
 11 are certified as an FNP. In fact, while there is a separate specialty certification for emergency nurse
 12 practitioners (ENPs), only FNPs are eligible for such certification—not acute care nurse
 13 practitioners, even though emergency departments are acute care settings. Moreover, 90 percent of
 14 nurse practitioners practicing in emergency departments do not have the ENP additional specialty
 15 certification.^{xxii}

16
 17 Altogether, education and certification are not determinative of where a nurse practitioner will
 18 practice—workforce studies show that nurse practitioners commonly practice in clinical settings or
 19 specialties that are misaligned with, their education, training, and credentials.

20
 21 *Specialty Switching by Nurse Practitioners*
 22

23 Nurse practitioners may switch specialties throughout their career with few limitations, with the
 24 primary limitation being that, per the APRN Consensus Model, a nurse practitioner’s specialty
 25 must align with the population focus of the nurse practitioner’s training, as well as their
 26 certification. For some nurse practitioners this provides broad latitude in mid-career changes. For
 27 example, FNPs are trained to provide primary care across the lifespan and so would qualify for a
 28 broad range of specialties. By contrast, an adult-gerontology primary care nurse practitioner (AG-
 29 PCNP) might be more limited. For example, an AG-PCNP would likely have to complete
 30 additional training to care for children, or to care for adult or geriatric patients outside primary
 31 care.^{xxiii}

32
 33 *Physician Assistant Education and Training*
 34

35 Physician assistant programs are accredited by the Accreditation Review Commission on
 36 Education for the Physician Assistant (ARC-PA) and are two-to-three years in length. Physician

1 assistant programs provide a generalist education rather than focus on a particular specialty.^{xxiv} Per
2 the standards, program curriculum must include, “applied medical, behavioral and social sciences;
3 patient assessment and clinical medicine; *supervised clinical practice*; and health policy and
4 professional practice issues.”^{xxv} Upon completion of the program graduates are awarded a master’s
5 degree and become eligible to sit for the physician assistant certification examination.

6 7 *Physician Assistant Certification*

8
9 A single body certifies physician assistants: the National Commission on Certification of Physician
10 Assistants (NCCPA). Certification is available to physician assistants who graduate from an ARC-
11 PA accredited program and pass the Physician Assistant National Certifying Examination.
12 Physician assistants are eligible to take the examination up to six-years after graduation and those
13 who pass are awarded the PA-C credential. To maintain certification, physician assistants must
14 complete a minimum number of hours of continuing medical education (CME) and pass the
15 Physician Assistant National Recertifying Examination (PANRE) every 10 years. Most states
16 require completion of a minimum number of hours of CME, current certification by NCCPA, or
17 both as a condition of licensure or for licensure renewal.

18
19 The single certification for physician assistants is consistent with the approach for physician
20 assistant education and training—to provide a generalist education without a focus on specialty.
21 This is evident in both the didactic curriculum and clinical training of physician assistants. For
22 example, the 2,000 hours of clinical practice required of physician assistants includes rotations in
23 various specialties, including emergency medicine, obstetrics and gynecology, psychiatry, family
24 medicine, and internal medicine. Standards also include requirements that these clinical rotations
25 must include specific types of encounters. For example, physician assistant students must treat
26 patients requiring chronic, acute, emergent, and preventive care and must also provide care in a
27 variety of settings, including the emergency department, outpatient, and inpatient facilities. There
28 is no path for specialized focus in the physician assistant educational program.

29
30 In addition to the PA-C certification, NCCPA also offers optional specialty Certificates of Added
31 Qualification (CAQs) to physician assistants in 10 specialties, including:

- 32
33
- 34 • Cardiovascular & Thoracic Surgery;
 - 35 • Dermatology;
 - 36 • Emergency Medicine;
 - 37 • Hospital Medicine;
 - 38 • Nephrology;
 - 39 • Obstetrics and Gynecology;
 - 40 • Orthopaedic Surgery;
 - 41 • Palliative Medicine and Hospice Care;
 - 42 • Pediatrics; and
 - 43 • Psychiatry.^{xxvi}

44 A physician assistant who has acquired a CAQ is considered “board certified.” The specific
45 requirements vary by specialty but generally require the following: (1) completion of specialty-
46 specific CME, (2) attestation that the physician assistant has completed a certain number of hours
47 of experience in the specialty, (3) attestation that the physician assistant has the knowledge and
48 skills relevant to practice in the specialty, including the knowledge and skills to perform the
49 procedures relevant to the specialty, and/or that the physician assistant understands how and when

1 the knowledge and skills should be applied for appropriate patient management or how and when
2 the procedures should be performed, and (4) achieve a passing score on a specialty examination
3 (online or in person).

4
5 CAQs often rely heavily on attestations and may not actually require the physician assistant to
6 complete relevant procedures. Consider as an example the requirements to attain a CAQ in
7 emergency medicine:

- 8
- 9 • Self-attest to completing 75 credits of Category 1 CME focused on emergency medicine;
10 25 of which must be earned within two-years of the date of the application for the specialty
11 examination and the remaining earned within six years before this date.
 - 12 • Complete a comprehensive emergency medicine course that reflects the guidelines set forth
13 in the most current version of Model of the Clinical Practice of Emergency Medicine, and
14 complete the following courses:
 - 15 ○ Pediatric Advanced Life Support or Advanced Pediatric Life Support
 - 16 ○ Advanced Trauma Life Support
 - 17 ○ Airway course
 - 18 • Self-attest to completing 3,000 hours of experience working as a physician assistant in
19 emergency medicine within at least six-years.
 - 20 • Obtain attestation from a physician, lead/senior physician assistant, or physician/physician
21 assistant post graduate program director who works in emergency medicine and is familiar
22 with the physician assistant's practice and experience. The attestation must affirm that the
23 physician assistant, "*has performed* the procedures and patient management relevant to the
24 practice setting and/or *understands* how and when the procedures *should* be
25 performed...the PA may not have experience with each procedure, but he or she must be
26 knowledgeable of the basics of the procedures, in what situation the procedures should be
27 done, and the associated management of patients."^{xxvii}
 - 28 • Pass an examination which consists of 120 multiple choice questions, which can be taken
29 at a test center or online.
- 30

31 CAQs are wholly optional for physician assistants and are generally not required for physician
32 assistants to practice. Indeed, before earning and in order to earn a CAQ in the first instance, a
33 physician assistant must practice in a chosen specialty.

34 *Physician Assistant Workforce*

35
36
37 According to the NCCPA 2022 statistical profile of board-certified physician assistants, only 23.1
38 percent of physician assistants work in primary care, which includes "family medicine/general
39 practice, internal medicine general, and pediatrics general." When asked to identify their primary
40 area of practice, the most physician assistants reported working in the five specialties:

- 41
- 42 • Surgical subspecialties (18.6 percent);
 - 43 • Family medicine/general practice (17.1 percent);
 - 44 • Emergency medicine (11.2 percent);
 - 45 • Other (10.6 percent; *note that the most frequent responses include: urgent care,
46 interventional radiology, sleep medicine, aesthetics, trauma surgery, wound care, and
47 transplant surgery); and
 - 48 • Internal medicine subspecialties (9.9 percent).

1 Most physician assistants practice in hospital settings (41.7 percent) with office-based private
2 practice a close second (37.1 percent). Urgent care (5.6 percent) and federal government
3 facility/hospital/unit (4.7 percent) are a distant fourth and fifth.

4
5 While most physician assistants hold one clinical position (84.9 percent), 11.3 percent of physician
6 assistants hold two or more clinical positions, with emergency medicine (25.6 percent) being the
7 most common secondary specialty area of these physician assistants.

8 9 *Specialty Switching by Physician Assistants*

10
11 Since physician assistants are trained as “generalists,” they face very few barriers to specialty
12 switching. Indeed, more than half have changed specialties at least once during their career with
13 over 20 percent indicating they have changed specialties two to three times.^{xxviii} This can be done
14 without any additional education, formal training, or certification.

15 16 AMA POLICY

17
18 The AMA has extensive policy supporting physician-led team-based care, including policy on
19 appropriate physician supervision of nurse practitioners and physician assistants:

- 20
21
- 22 • Policy H-160.949, “Practicing Medicine by Non-Physicians;”
 - 23 • Policy H-160-906, “Models /Guidelines for Medical Health Care Teams;”
 - 24 • Policy H-160.950, “Guidelines for Integrated Practice of Physician and Nurse
25 Practitioner;”
 - 26 • Policy H-360.987, “Principles Guiding AMA Policy Regarding Supervision of Medical
27 Care Delivered by Advanced Practice Nurses in Integrated Practice;”
 - 28 • Policy H-35.989, “Physician Assistants;” and
 - 29 • Policy D-35.985 “Support for Physician Led, Team Based Care.”

30 The AMA also has policy directing our AMA to educate the public on the difference in the
31 education and training of physicians and non-physicians. Specifically:

- 32
- 33 • Policy H-160.949, “Practicing Medicine by Non-Physicians;”
 - 34 • Policy H-450.955, “Education of the General Public on the Role of Physician and Non-
35 Physician Health Care Providers;” and
 - 36 • Policy H-275.943, “Public Education about Physician Qualifications.”

37 38 DISCUSSION

39
40 The nurse practitioner and physician assistant professions both began with an emphasis on
41 providing primary care to patients to help address the primary care workforce shortages. Over time,
42 however, both nurse practitioners and physician assistants are increasingly choosing to practice in
43 specialties instead of primary care and may switch specialties multiple times during their career.
44 The idea of specialty switching by nurse practitioners and physician assistants is not a new
45 phenomenon and such flexibility in specialization is often touted by both professions as a positive
46 attribute to prospective students.

47
48 The underlying education and clinical training of both nurse practitioners and physician assistants
49 is founded upon a generalist approach. With limited exceptions, there is no focus on specialty care.

1 While state licensure requires graduation from an accredited program and certification by a
2 designated body, physician assistant certification and most nurse practitioner certifications are
3 extremely broad, allowing wide latitude in the patient population, specialty or setting in which they
4 can practice.

5
6 Moreover, there are little-to-no guardrails limiting the specialties in which nurse practitioners and
7 physician assistants may work. In fact, many studies show a misalignment between nurse
8 practitioner education, training, and certification and the specialty or setting in which they practice,
9 such that some nurse practitioners find themselves in the position of caring for a patient population
10 or level of acuity in which they have received no formal education or training. For both
11 professions, on-the-job training post-graduation is a common means to gain the requisite
12 knowledge in the specialty and practice setting in which they practice. This reinforces the
13 importance of physician-led team-based care.

14
15 While studies demonstrate the increased number of nurse practitioners and physician assistants
16 practicing in specialties as opposed to primary care, there is no publicly available data on specialty
17 switching by nurse practitioners. There are also no studies on the impact of specialty switching on
18 the cost and quality of care provided by nurse practitioners and physician assistants. Moreover,
19 there are no studies on the additional workload placed on physicians and other health care
20 professionals who must provide on-the-job training to nurse practitioners or physician assistants
21 who have switched specialties and/or are practicing in a specialty in which they have no formal
22 education, training, or certification. Moreover, there are no studies looking at the impact of
23 specialty switching in these professions on physician burnout, nor are there studies that look at the
24 impact on physician's time away from providing direct patient care. These gaps in literature are
25 ripe for analysis, particularly by those conducting research on the health care workforce. State
26 nursing and medical boards could also capture this information as part of a survey conducted at the
27 time of licensure renewals by nurse practitioners and physician assistants.

28 29 RECOMMENDATIONS

30
31 The Board of Trustees recommends that the following policy be adopted, and the remainder of the
32 report be filed:

- 33
34 1. That the American Medical Association (AMA) support workforce research, including
35 surveys by state medical and nursing boards, that specifically focus on gathering
36 information on nurse practitioners and physician assistants practicing in specialty care,
37 their certification(s), alignment of their certification to their specialty, and whether they
38 have switched specialties during their career. (New HOD Policy)
- 39 2. That the AMA support research that evaluates the impact of specialty switching by nurse
40 practitioners and physician assistants on the cost and quality of patient care. (New HOD
41 Policy)
- 42 3. That the AMA encourage hospitals and other health care entities employing nurse
43 practitioners to ensure that the nurse practitioner's certification aligns with the specialty in
44 which they will practice. (New HOD Policy)
- 45 4. That the AMA continue educating policymakers and lawmakers on the education, training,
46 and certification of nurse practitioners and physician assistants, including the concept of
47 specialty switching. (New HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

- ⁱ Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education (July 7, 2008) pg. 12.
- ⁱⁱ *Id.* at 6.
- ⁱⁱⁱ *Id.* at 11.
- ^{iv} *Id.* at 12.
- ^v McNelis AM, Dreifuerst T, Beebe S, et al. Types, Frequency, and Depth of Direct Patient Care Experiences of Family Nurse Practitioner Students in the United States, *Journal of Nursing Regulation*, 2021; 12(1), 19-27.
- ^{vi} *Id.* at 25.
- ^{vii} *Id.*
- ^{viii} Other certifying bodies include: the American Association of Critical-Care Nurses (offers certification to RNs and APRNs),
- ^{ix} PMHNP is a new certification which will be available from AANPCB in January 2024.
- ^x <https://www.nursingworld.org/certification/aprn-consensus-model/> (last visited on Jan. 23, 2024).
- ^{xi} *Supra* note 1 at 13.
- ^{xii} *Id.* at 6
- ^{xiii} Health Resources and Services Administration. (2018). NCHWA Nursing Workforce Dashboard based on data form the 2018 National Sample Survey of Registered Nurses, which include Nurse Practitioners. <https://data.hrsa.gov/topics/health-workforce/nursing-workforce-dashboards>
- ^{xiv} Oregon Center for Nursing. Primary Care Workforce Crisis Looming in Oregon: Nurse Practitioners Vital to Filling the Gap, But Not Enough to Go Around. Portland, OR, Oregon Center for Nursing. 2020.
- ^{xv} Martiniano R, Wang S, Moore J. A Profile of New York State Nurse Practitioners, 2017. Center for Health Workforce Studies, School of Public Health, SUNY Albany. Oct. 2017.
- ^{xvi} South Dakota Center for Nursing Workforce. South Dakota Nursing Workforce: 2023 Supply and Employment Characteristics. April 8, 2023.
- ^{xvii} *Id.*
- ^{xviii} *Id.*
- ^{xix} Hoyt A, O'Reilly-Jacob M, & Souris-Kraemer M. (2022, May/June). Certification alignment of nurse practitioners in acute care. *Nursing Outlook*, 70(3), 417-428.
- ^{xx} *Id.*
- ^{xxi} Kaplan L, Klein T. Characteristics and perceptions of the US nurse practitioner hospitalist workforce. *Journal of the American Association of Nurse Practitioners* 33(12):p 1173-1179, December 2021.
- ^{xxii} Lavin RP, Veenema TG, Sasnett L, Schneider-Firestone S, et al. Analysis of Nurse Practitioners' Educational Preparation, Credentialing, and Scope of Practice in U.S. Emergency Departments, *Journal of Nursing Regulation*, Jan. 2022.
- ^{xxiii} Type of Nurse Practitioner Specialties, <https://www.nursingworld.org/practice-policy/workforce/what-is-nursing/types-of-nurse-practitioner-specialties/>. accessed Feb. 19, 2024.
- ^{xxiv} Dunker A, Krofah E, Isasi F. The Role of Physician Assistants in Health Care Delivery (Washington, D.C.: National Governor's Association Center for Best Practices, September 22, 2014).
- ^{xxv} ARC-PA *Accreditation Standards for Physician Assistant Education*, Fifth Edition, Effective Sept. 1, 2020.
- ^{xxvi} NCCPA. Specialty Certificates of Added Qualifications (CAQs). <https://www.nccpa.net/specialty-certificates/>
- ^{xxvii} *Id.* <https://www.nccpa.net/specialty-certificates/#emergency-medicine>
- ^{xxviii} NCCPA Statistical Profile of Board Certified PAs, Annual Report. 2022, p. 38.

REPORT 15 OF THE BOARD OF TRUSTEES (A-24)
Augmented Intelligence Development, Deployment, and Use in Health Care
(Resolution 247-A-23) (Resolution 206-I-23)
(Reference Committee B)

EXECUTIVE SUMMARY

At the June 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted policy [H-480-935](#), “Assessing the Potentially Dangerous Intersection Between AI and Misinformation.” This policy calls on the AMA to “study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24.” This policy reflects the intense interest and activity in augmented intelligence (AI) prompted by the arrival of OpenAI’s ChatGPT and other LLMs/generative AI.

Additionally, at the November 2023 Interim Meeting, the AMA HOD referred Resolution 206-I-23, “The Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of Practice.” Resolution 206-I-23 asked, “that our American Medical Association encourage physicians to educate our patients, the public, and policymakers about the benefits and risks of facing LLMs including GPTs for advice on health policy, information on health care issues influencing the legislative and regulatory process, and for information on scope of practice that may influence decisions by patients and policymakers.”

Generative AI is a type of AI that can recognize, summarize, translate, predict, and generate text and other content based on knowledge gained from large datasets. There has been increasing discussion about clinical applications of generative AI, including use as clinical decision support to provide differential diagnoses, early detection and intervention, and to assist in treatment planning. Generative AI tools are also being developed to assist with administrative functions, such as generating office notes, responding to documentation requests, and generating patient messages. While generative AI tools show tremendous promise to make a significant contribution to health care, there are a number of risks and limitations to consider when using these tools in a clinical setting or for direct patient care.

As the number of AI-enabled health care tools and systems continues to grow, these technologies must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, and transparent. With a lagging effort towards adoption of national governance policies or oversight of AI, it is critical that the AMA and the physician community engage in the development of policies to help inform patient and physician education, help guide development of these tools in a way that best meets both patient and physician needs, and advocate for governance policies to help ensure that risks arising from AI are mitigated to the greatest extent possible.

This report highlights the AMA’s recognition of the issues raised at both the A-23 and I-23 HOD meetings, introduces and explains major themes of the report’s recommendations, and provides background information on the evolution of AI policy in health care and the direction that policy appears to be headed.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-A-24

Subject: Augmented Intelligence Development, Deployment, and Use in Health Care
(Res. 247-A-23) Assessing the Potentially Dangerous Intersection Between AI
and Misinformation
(Res. 206-I-23) The Influence of Large Language Models (LLMs) on Health
Policy Formation and Scope of Practice

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

1 INTRODUCTION

2
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4 (HOD) adopted policy [H-480-935](#), “Assessing the Potentially Dangerous Intersection Between AI
5 and Misinformation.” This policy calls on the AMA to “study and develop recommendations on
6 the benefits and unforeseen consequences to the medical profession of large language models
7 (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-
8 generated medical advice or content, and that our AMA propose appropriate state and federal
9 regulations with a report back at A-24.” This policy reflects the intense interest and activity in
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11 LLMs/generative AI.

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13 Additionally, at the 2023 Interim Meeting, the AMA HOD referred Resolution 206-I-23, “The
14 Influence of Large Language Models (LLMs) on Health Policy Formation and Scope of
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16 physicians to educate our patients, the public, and policymakers about the benefits and risks of
17 facing LLMs including GPTs for advice on health policy, information on health care issues
18 influencing the legislative and regulatory process, and for information on scope of practice that
19 may influence decisions by patients and policymakers.”

20
21 Testimony on Resolution 206-I-23 highlighted the importance of physician understanding of
22 LLMs and the ability to weigh the benefits and risks of these tools as the excitement and
23 eagerness to implement them in everyday practice increases. Testimony emphasized that our
24 AMA is currently in the process of fulfilling the directive in Policy H-480-935 (adopted at A-23)
25 that directs our AMA to study and develop recommendations on the benefits and unforeseen
26 consequences to the medical profession of LLMs, such as GPTs, and other augmented
27 intelligence-generated medical advice or content. The HOD referred Resolution 206 so that the
28 issues raised in this resolution could be considered along with the issues in Policy H-480.935.

29
30 BACKGROUND

31
32 The issue of AI first presented itself as an area of potential interest to AMA physicians and
33 medical students that necessitated creation of AMA policy in 2018. At that time, physicians and
34 medical students primarily considered AI-enabled technologies within the context of medical

1 device and clinical decision support (CDS), although administrative applications of AI began to
2 grow exponentially and started to gain traction in the hospital, health system, and insurer space.
3 Since the development of the AMA’s foundational AI policy in 2018 and subsequent policy on
4 coverage and payment for AI in 2019, the number of AI-enabled medical devices approved by the
5 U.S. Food and Drug Administration (FDA) has grown to nearly 700. In 2022, the concept of
6 “generative AI” and what it can do became better understood to the public. Generative AI is a
7 broad term used to describe any type of artificial intelligence that can be used to create new text,
8 images, video, audio, code, or synthetic data. Generative AI and LLMs have rapidly transformed
9 the use cases and policy considerations for AI within health care, necessitating updated AMA
10 policy that reflects the rapidly evolving state of the technologies.

11
12 AMA policy adopted in [2018](#) and [2019](#) enabled the AMA to be a strong advocate on behalf of
13 patients and physicians and has been the bedrock of AMA’s advocacy on AI in the form of
14 lobbying key congressional committees, participating in expert panel discussions, creating
15 educational resources, and working with our Federation colleagues at the federal and state levels.
16 However, as AI has rapidly developed beyond AI-enabled medical devices and into
17 LLMs/generative AI, new policy and guidance are needed to ensure that they are designed,
18 developed, and deployed in a manner that is ethical, equitable, responsible, and transparent.

19
20 As an initial step, in November 2023, the AMA Board of Trustees approved a set of [advocacy](#)
21 [principles](#) developed by the Council on Legislation (COL) that serve as the framework of this
22 Board report. The main topics addressed in the principles include AI oversight, disclosure
23 requirements, liability, data privacy and security, and payor use of AI. In addition to the COL,
24 these principles have been vetted among multiple AMA business units, and AMA staff has
25 worked with several medical specialty societies that have an expertise in AI and has received
26 additional guidance and input from outside experts that have further refined these principles.
27 These principles build upon and are supplemental to the AMA’s existing AI policy, especially
28 Policy [H-480.940](#), “Augmented Intelligence in Health Care,” Policy [H-480.939](#), “Augmented
29 Intelligence in Health Care,” and Policy [D-480.956](#), “Use of Augmented Intelligence for Prior
30 Authorization,” as well as the [AMA’s Privacy Principles](#). The Board recommends adoption of
31 these principles as AMA policy to guide our AMA’s advocacy and educational efforts on
32 LLM/generative AI issues.

33
34 This report highlights the AMA’s recognition of the issues raised at both the A-23 and I-23 HOD
35 meetings, introduces and explains major themes of the report’s recommendations, and provides
36 background information on the evolution of AI policy in health care and the direction that policy
37 appears to be headed.

38 39 CURRENT STATUS OF OVERSIGHT OF AUGMENTED INTELLIGENCE-ENABLED 40 TECHNOLOGIES

41
42 There is currently no whole-of-government strategy for oversight and regulation of AI. The U.S.
43 Department of Health and Human Services (HHS) did establish an AI Office in March 2021 and
44 developed a general strategy to promote the use of trustworthy AI, but has not produced a
45 department-wide plan for the oversight of AI. While many other federal departments and agencies
46 also have some authority to regulate health care AI, many regulatory gaps exist. To address the
47 lack of a national strategy and national governance policies directing the development and
48 deployment of AI, the federal government has largely defaulted to public “agreements”
49 representing promises by large AI developers and technology companies to be good actors in
50 their development of AI-enabled technologies.

1 In December 2023, the Biden Administration released a reasonably comprehensive [executive](#)
2 [order](#) on the “Safe, Secure, and Trustworthy Development and Use of Artificial Intelligence.”
3 While the executive order does not create new statutory or regulatory requirements, it does serve
4 to direct federal departments and agencies to take action to provide guidance, complete studies,
5 identify opportunities, etc. on AI across several sectors, including HHS. The AMA was pleased to
6 see close alignment between the executive order’s direction and AMA principles. However,
7 executive orders do not represent binding policy, so the regulatory status quo remains unchanged
8 at present.

9
10 The Biden Administration had also previously released a “[Blueprint for an AI Bill of Rights](#)”
11 setting forth five principles that should guide the design, use, and deployment of AI. Those
12 include recommendations for creating safe and effective systems; algorithmic discrimination
13 protections; data privacy; notice and explanation; and human alternatives, considerations, and
14 fallback. Like executive orders, this blueprint does not create new or binding policy and it does
15 not appear there have been new efforts by federal departments and agencies to take action to
16 ensure that AI aligns with these principles.

17
18 There have been few, but notable, additional actions by federal agencies that may serve to impact
19 patient and physician interaction with AI-enabled technologies. In 2022, the Centers for Medicare
20 & Medicaid Services (CMS) and HHS Office for Civil Rights (OCR) introduced a sweeping
21 liability proposal within its Section 1557 Non-Discrimination in Health Programs and Activities
22 proposed rule. The proposal, if finalized, would create liability for physicians if they “rely” on a
23 clinical algorithm that results in discriminatory harm to a patient. In the proposal, “clinical
24 algorithm” is defined to include AI. The AMA submitted detailed [comments](#) opposing this
25 section of the proposed rule. CMS and OCR have yet to finalize the rule.

26
27 In addition, the Office of the National Coordinator for Health Information Technology (ONC)
28 proposed and finalized, with some modifications, policies that will require electronic health record
29 (EHR) technology developers to make certain information about AI used in EHRs available to
30 physicians and other users. ONC refers to these AI tools as Predictive Decision Support
31 Interventions (Predictive DSI). Starting in 2025, EHR developers that supply Predictive DSIs as
32 part of the developer’s EHR offering must disclose specific attributes and inform users if patient
33 demographic, social determinants of health, or health assessment data are used in the Predictive
34 DSI. EHRs will be subject to regulatory requirements regarding the design, development,
35 training, and evaluation of Predictive DSIs along with mandated risk management practices.
36 ONC’s stated goal is to ensure that physicians understand how these tools work, how data are
37 used, the potential for bias, and any known limitations.

38 39 FDA APPROVED AI-ENABLED MEDICAL DEVICES

40
41 The FDA continues to rapidly approve AI-enabled medical devices. While FDA approval and
42 clearance of algorithmic-based devices dates back to 1995, clearance and approval of these
43 devices has rapidly accelerated in the last several years. As of October 2023, 692 devices that
44 FDA classifies as Artificial Intelligence/Machine Learning (AI/ML) devices have been approved
45 for marketing. The overwhelming number of these devices are classified as radiology devices and
46 this category of devices has seen the steadiest increases in the number of applications for FDA
47 approval. However, the number of applications is increasing in several specialties, including
48 cardiology, neurology, hematology, gastroenterology, urology, anesthesiology, otolaryngology,
49 ophthalmology, and pathology. A significant number of cleared or approved devices are
50 considered diagnostic in nature and many currently support screening or triage functions.

1 In 2017, the FDA announced that they were evaluating a potentially new regulatory approach
2 towards Software as a Medical Device, which would include AI/ML technologies. The so-called
3 Pre-Certification program, or “Pre-Cert,” progressed to an initial pilot program involving nine
4 manufacturer applicants. The program proposed to pre-certify manufacturers of software-based
5 medical devices. Devices developed by pre-certified manufacturers would be subject to varying
6 levels of FDA review based on risk to patients, including potentially being exempt from review if
7 the risk is low. However, the Pre-Cert program has been tabled and the pilot dismantled for the
8 time being, leaving FDA to utilize traditional review pathways for AI-enabled medical devices. In
9 the absence of new regulatory strategies tailored to SaMD and AI/ML, FDA has issued some
10 proposed guidance for developers of these devices but has not yet moved forward with additional
11 guidance for important, physician-facing topics, such as transparency and labeling requirements.
12 While transparency was listed as one of five major FDA priorities in this area, the Agency does
13 not have current plans to move forward on additional guidance at this time. This leaves a critical
14 gap in the oversight of AI-enabled medical devices.

15 *Data Privacy and Cybersecurity Considerations in Health Care AI*

16
17
18 The integration of AI into health care signifies a transformative era, greatly enhancing patient
19 care and operational efficiency. However, this advancement also introduces considerable
20 challenges, particularly in data privacy and cybersecurity. As health care facilities, technology
21 vendors, clinicians, and users increasingly adopt AI, it is vital to focus on protecting patient and
22 user data and securing AI systems against cyber threats. Handling vast amounts of sensitive data
23 raises critical questions about privacy and security. Survey data has shown that 9 out of 10
24 patients believe privacy is a right and nearly 75 percent of people are concerned about protecting
25 the privacy of their health data.ⁱ Addressing these concerns necessitates a multifaceted approach
26 that includes advanced data privacy techniques, data use transparency, robust cybersecurity
27 strategies, and compliance with regulatory standards.

28
29 Ensuring the protection of patient data in the context of AI requires sophisticated privacy
30 techniques. Key methods such as anonymization and pseudonymization can remove or replace
31 personal identifiers in data sets and significantly reduce the risk of re-identification. Additionally,
32 implementing a robust data management system empowers patients by providing clear ways to
33 grant, deny, or revoke consent for the use of their data, enhancing patient trust and ensuring
34 compliance with global data protection regulations such as the General Data Protection
35 Regulation and the Health Insurance Portability and Accountability Act (HIPAA). Moreover, the
36 collection of data should be kept to a minimum. By collecting only the data necessary for the
37 intended purpose, AI systems can mitigate the risks associated with data breaches and misuse.

38
39 Cybersecurity plays a crucial role in health care, especially in the context of the increasing
40 digitalization of medical records, patient data, and health care services. The health care sector is a
41 prime target for cyber-attacks due to the sensitivity and value of the data it handles, including
42 personal health information (PHI), financial data, and intellectual property related to medical
43 research. The integration of technology in health care has undoubtedly brought significant
44 benefits such as improved patient care, streamlined operations, and enhanced data analytics.
45 However, it also introduces vulnerabilities. These include potential unauthorized access, data
46 breaches, and disruptions to health care services, which can have dire consequences for patient
47 privacy and safety. In 2017, 83 percent of surveyed physicians had already experienced a
48 cyberattack and 85 percent stated that they want to share electronic PHI but were concerned about
49 the data security necessary to protect it.ⁱⁱ This risk is amplified by the recent increased use of
50 interconnected devices and systems, such as EHRs, telemedicine platforms, and mobile health
51 applications.

1 The attack on Change Healthcare in February 2024 is a stark reminder of the critical importance
2 of cybersecurity in health care. Change Healthcare, a division of UnitedHealth Group, was struck
3 by a ransomware attack that significantly disrupted the largest health care payment and operations
4 system in the United States. This incident led to widespread disruptions, affecting thousands of
5 medical practices, hospitals, pharmacies, and others. The attack was attributed to ransomware.
6 Despite efforts to recover from this attack, the impact on health care operations was profound,
7 including the disruption of claims processing, payments, and electronic prescriptions leading to
8 financial strain on physicians and delays in patient care. The health care sector's reliance on
9 interconnected digital systems for patient records, billing, and payments, means that the impact of
10 a cyberattack can be both immediate and widespread, affecting patient care and operational
11 continuity.

12
13 The implications of cybersecurity in health care AI are multifaceted. AI in health care,
14 encompassing machine learning algorithms, predictive analytics, and robotic process automation,
15 hold immense potential for diagnostic accuracy, personalized medicine, and operational
16 efficiency. However, the deployment of AI in health care settings creates unique cybersecurity
17 challenges. AI systems require large datasets to train and operate effectively, increasing the risk
18 of large-scale data breaches. Additionally, the complexity of AI algorithms can make them
19 opaque and vulnerable to manipulation, such as adversarial attacks that can lead to misdiagnoses
20 or inappropriate treatment recommendations. AI-driven health care solutions often rely on
21 continuous data exchange across networks, escalating the risk of cyber-attacks that can
22 compromise both the integrity and availability of critical health care services.

23
24 Model stealing attack represents a significant cybersecurity threat in the realm of AI, where a
25 malicious actor systematically queries an AI system to understand its behavior and subsequently
26 replicates its functionality. This form of intellectual property theft is particularly alarming due to
27 the substantial resources and time required to develop sophisticated AI models. An example of
28 this issue involves a health care organization that has invested heavily in an AI model designed to
29 predict patient health outcomes based on a wide range of variables. If a malicious entity were to
30 engage in model stealing by extensively querying this predictive model, it could essentially
31 duplicate the original model's predictive capabilities along with capitalizing on sensitive health
32 care information and physicians, users, or the entity's intellectual property. Absent strong
33 protections against input manipulation and malicious attacks, AI can become a new conduit for
34 bad actors to compromise health care organizations and harm patients. This not only undermines
35 the original investment but also poses a direct threat to the competitive advantage of the
36 innovating organization.

37
38 Moreover, the risk extends beyond intellectual property theft to encompass serious privacy
39 concerns. This is exemplified by incidents where generative AI models, trained on vast datasets,
40 inadvertently reveal sensitive information contained within their training data in response to
41 certain prompts. In the health care sector, where models are often trained on highly sensitive
42 patient data, including personally identifiable information, the unauthorized extraction of this data
43 can lead to significant breaches of patient confidentiality. The dual threat of intellectual property
44 theft and data privacy breaches underscores the critical need for robust cybersecurity measures in
45 safeguarding AI models, particularly those developed and utilized within the health care industry,
46 to maintain the integrity of both their intellectual property and the confidentiality of the sensitive
47 data they handle.

48
49 While there are new federal policies to increase data transparency when AI is used in conjunction
50 with health information technology, such as those issued by ONC, these new policies only cover

1 the certified EHR developer and stop short of holding AI developers accountable for robust data
2 governance or data security and privacy practices.ⁱⁱⁱ

3 4 GENERATIVE AI

5
6 The broad introduction of generative AI into the public sphere in 2022 saw a paradigm shift in
7 how physicians contemplated AI. Open-source LLM Chat GPT presented a new, easily accessible
8 AI-enabled technology with significant capabilities to generate new content and provide readily
9 available access to information from a huge number of sources. Generative AI tools have
10 significant potential to relieve physician administrative burdens by helping to address actions
11 such as in-box management, patient messages and prior authorization requests. They also show
12 promise in providing clinical decision support. These generative AI tools, however, can also pose
13 significant risk, particularly for clinical applications. They are largely unregulated, as there is no
14 current regulatory structure for generative AI clinical decision support tools unless they meet the
15 definition of a medical device regulated by the FDA. The U.S. Federal Trade Commission (FTC)
16 has limited authority to regulate data privacy issues that may be associated with generative AI
17 tools. The FTC can also regulate activities considered to be an unfair, deceptive, or abusive
18 business practice and can enforce laws for consumer protection. CMS has some authority to
19 regulate use of AI by entities receiving funds from Medicare and Medicaid, including use by
20 Medicare Advantage plans. OCR has some additional authorities to regulate data privacy and
21 nondiscrimination. CMS and OCR have already put forth a very concerning proposal regarding
22 physician liability for clinical algorithms, which the AMA has vigorously opposed.

23
24 While some federal agencies may have oversight and authorities to regulate some aspects of AI,
25 there are many regulatory gaps. These regulatory gaps are particularly significant when
26 considering generative AI, as tools like ChatGPT and others currently fall well outside the
27 definition of a regulated medical device. While generative AI use for clinical applications is
28 relatively limited right now, it is expected to grow and patients and physicians will need
29 assurances that it is providing safe, correct, non-discriminatory answers to the full extent possible,
30 whether through regulation or generally accepted standards for design, development, and
31 deployment.

32 33 USE OF AI BY PAYORS

34
35 There have been numerous reports recently regarding the use of what has been termed
36 “automated decision-making tools” by payors to process claims. However, numerous reports
37 regarding the use of these tools show a growing tendency toward inappropriate denials of care or
38 other limitations on coverage. Reporting by ProPublica claims that tools used by Cigna denied
39 300,000 claims in two months, with claims receiving an average of 1.2 seconds of review.^{iv} Two
40 class action lawsuits were filed during 2023, charging both United Health Care and Humana with
41 inappropriate claims denials resulting from use of the nHPredict AI model, a product of United
42 Health Care subsidiary NaviHealth. Plaintiffs in those suits claim the AI model wrongfully denied
43 care to elderly and disabled patients enrolled in Medicare Advantage (MA) plans with both
44 companies. Plaintiffs also claim that payors used the model despite knowing that 90 percent of
45 the tool’s denials were faulty.

46
47 There is growing concern among patients and physicians about what they perceive as increasing
48 and inappropriate denials of care resulting from the use of these automated decision-making tools.
49 In his recent Executive Order on AI, President Biden addressed this issue as an area of concern,
50 directing the HHS to identify guidance and resources for the use of predictive and generative AI

1 in many areas, including benefits administration, stating that it must take into account
2 considerations such as appropriate human oversight of the application of the output from AI.

3
4 There are currently no statutory and only limited regulatory requirements addressing the use of AI
5 and other automated decision-making tools by payors. States are beginning to look more closely
6 at this issue given the significant negative reporting in recent months and are a likely place for
7 near-term action on this issue. Congress has also shown increasing concern and has convened
8 hearings for testimony on the issue; however, there has been no further Congressional action or
9 legislation to pursue further limitations on use of these algorithms. Additionally, CMS has not
10 taken broad regulatory action to limit the use of these algorithms by entities administering
11 Medicare and Medicaid benefits.

12 13 AMA POLICY

14
15 The AMA has existing policies, [H-480.940](#) and [H-480.939](#) both titled “Augmented Intelligence in
16 Health Care,” which stem from a 2018 and 2019 Board report and cover an array of areas related
17 to the consequences and benefits of AI use in the physician’s practice. In pertinent part to this
18 discussion, AMA Policy H-480.940 seeks to “promote development of thoughtfully designed,
19 high-quality, clinically validated health care AI, encourage education for patients, physicians,
20 medical students, other health care professionals, and health administrators to promote greater
21 understanding of the promise and limitations of health care AI, and explore the legal implications
22 of health care AI, such as issues of liability or intellectual property, and advocate for appropriate
23 professional and governmental oversight for safe, effective, and equitable use of and access to
24 health care AI.” This policy reflects not only the significance of attribution on the part of the
25 developer, but furthermore emphasizes that physicians and other end users also play a role in
26 understanding the technology and the risks involved with its use.

27
28 AMA Policy H.480.939 also addresses key aspects of accountability and liability by stating that
29 “oversight and regulation of health care AI systems must be based on risk of harm and benefit
30 accounting for a host of factors, including but not limited to: intended and reasonably expected
31 use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods;
32 level of automation; transparency; and, conditions of deployment.” Furthermore, this policy
33 asserts that “liability and incentives should be aligned so that the individual(s) or entity(ies) best
34 positioned to know the AI system risks and best positioned to avert or mitigate harm do so
35 through design, development, validation, and implementation. Specifically, developers of
36 autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best
37 position to manage issues of liability arising directly from system failure or misdiagnosis and
38 must accept this liability with measures such as maintaining appropriate medical liability
39 insurance and in their agreements with users.”

40
41 AMA Policy [D-480.956](#) supports “greater regulatory oversight of the use of augmented
42 intelligence for review of patient claims and prior authorization requests, including whether
43 insurers are using a thorough and fair process that: (1) is based on accurate and up-to-date clinical
44 criteria derived from national medical specialty society guidelines and peer reviewed clinical
45 literature; (2) includes reviews by doctors and other health care professionals who are not
46 incentivized to deny care and with expertise for the service under review; and (3) requires such
47 reviews include human examination of patient records prior to a care denial.”

1 DISCUSSION

2
3 As the number of AI-enabled health care tools and systems continues to grow, these technologies
4 must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, and
5 transparent. With a lagging effort towards adoption of national governance policies or oversight
6 of AI, it is critical that the physician community engage in development of policies to help drive
7 advocacy, inform patient and physician education, and guide engagement with these new
8 technologies. It is also important that the physician community help guide development of these
9 tools in a way that best meets both patient and physician needs, and help define their own
10 organization's risk tolerance, particularly where AI impacts direct patient care. AI has significant
11 potential to advance clinical care, reduce administrative burdens, and improve clinician well-
12 being. This may only be accomplished by ensuring that physicians engage only with AI that
13 satisfies rigorous, clearly defined standards to meet the goals of the quadruple aim:^v advance
14 health equity, prioritize patient safety, and limit risks to both patients and physicians.

15
16 *Oversight of Health Care Augmented Intelligence*

17
18 There is currently no national policy or governance structure in place to guide the development
19 and adoption of non-device AI. As discussed above, the FDA regulates AI-enabled medical
20 devices, but many types of AI-enabled technologies fall outside the scope of FDA oversight^{vi}.
21 This potentially includes AI that may have clinical applications, such as some generative AI
22 technologies serving clinical decision support functions. While the FTC and OCR have oversight
23 over some aspects of AI, their authorities are limited and not adequate to ensure appropriate
24 development and deployment of AI generally, and specifically in the health care space. Likewise,
25 ONC's enforcement is limited and focused on EHR developers' use and integration of AI within
26 their federally certified EHRs. While this is a major first step in requiring AI transparency, it is
27 still the EHR developer that is regulated with few requirements on the AI developer itself.
28 Encouragement of a whole-of-government approach to implement governance policies will help
29 to ensure that risks to consumers and patients arising from AI are mitigated to the greatest extent
30 possible.

31
32 In addition to the government, health care institutions, practices, and professional societies share
33 some responsibility for appropriate oversight and governance of AI-enabled systems and
34 technologies. Beyond government oversight or regulation, purchasers and users of these
35 technologies should have appropriate and sufficient policies in place to ensure they are acting in
36 accordance with the current standard of care. Similarly, clinical experts are best positioned to
37 determine whether AI applications are high quality, appropriate, and whether the AI tools are
38 valid from a clinical perspective. Clinical experts can best validate the clinical knowledge,
39 clinical pathways, and standards of care used in the design of AI-enabled tools and can monitor
40 the technology for clinical validity as it evolves over time.

41
42 *Transparency in Use of Augmented Intelligence-Enabled Systems and Technologies*

43
44 As implementation of AI-enabled tools and systems increases, it is essential that use of AI in
45 health care be transparent to both patients and physicians. Transparency requirements should be
46 tailored in a way that best suits the needs of the end users. Care must be taken to preserve the
47 integrity of data sets used in health care such that individual choice and data privacy are balanced
48 with preserving algorithms that remain as pristine as possible to avoid exacerbating health care
49 inequities. Disclosure should contribute to patient and physician knowledge without increasing
50 administrative burden. When AI is utilized in health care decision-making, that use should be
51 disclosed and documented to limit risks to, and mitigate inequities for, both patients and

1 physicians, and to allow each to understand how decisions impacting patient care or access to
2 care are made. While transparency does not necessarily ensure AI-enabled tools are accurate,
3 secure, or fair, it is difficult to establish trust if certain characteristics are hidden.
4

5 Heightened attention to transparency and additional transparency requirements serve several
6 purposes. They help to both ensure that the best possible decisions are made about a patient's
7 health care and help patients and physicians identify critical decision points and possible points of
8 error. They can also serve as mechanisms to help shield physicians from liability so that potential
9 issues related to use of AI-enabled technologies can be isolated and accountability apportioned
10 appropriately.
11

12 There are currently few federal requirements for transparency regarding AI. The FDA requires
13 product labeling to provide certain information to physicians and other users, but requirements for
14 device labeling are generally considered to be less stringent and have more leeway than drug
15 product labeling. While FDA has stated that transparency is a key priority for the agency to
16 address, they have not taken any additional action to update the labeling requirements for AI-
17 enabled medical devices or put into place additional transparency requirements for AI-enabled
18 devices. As discussed above, ONC also has new transparency requirements applicable to the use
19 of AI within EHRs; however, again, those requirements are limited to AI within an EHR or other
20 applications integrated and made available through the EHR. They will not apply to AI-enabled
21 tools accessible through the Internet, cellular phones, etc. It is clear that there is an urgent need
22 for additional federal action to ensure AI transparency.
23

24 *Required Disclosures by Health Care Augmented Intelligence-Enabled Systems and Technologies* 25

26 Along with significant opportunity to improve patient care, all new technologies in health care
27 will likely present certain risks and limitations that physicians must carefully navigate during the
28 early stages of clinical implementation of these new systems and tools. AI-enabled tools are no
29 different and are perhaps more challenging than other advances as they present novel and
30 complex questions and risks. To best mitigate these risks, it is critical that physicians understand
31 AI-driven technologies and have access to certain information about the AI tool or system being
32 considered, including how it was trained and validated, so that they can assess the quality,
33 performance, equity, and utility of the tool to the best of their ability. This information may also
34 establish a set of baseline metrics for comparing AI tools. Transparency and explainability
35 regarding the design, development, and deployment processes should be mandated by law where
36 feasible, including potential sources of inequity in problem formulation, inputs, and
37 implementation. Additionally, sufficient detail should be disclosed to allow physicians to
38 determine whether a given AI-enabled tool would reasonably apply to the individual patient they
39 are treating.
40

41 Physicians should be aware and understand that, where they utilize AI-enabled tools and systems
42 without transparency provided by the AI developer, their risks of liability for reliance on that AI
43 will likely increase. The need for full transparency is greatest where AI-enabled systems have
44 greater impact on direct patient care, such as by AI-enabled medical devices, clinical decision
45 support, and interaction with AI-driven chatbots. Transparency needs may be somewhat lower
46 where AI is utilized for primarily administrative, practice-management functions.
47 While some of this information may be provided in labeling for FDA cleared and approved
48 medical devices, the labeling requirements for such devices have not been specifically tailored to
49 clearly convey information about these new types of devices. Updated guidance for FDA-
50 regulated medical devices is needed to provide this critical information. Congress should consider
51 actions to ensure appropriate authorities exist to require appropriate information to be provided to

1 users of AI so that they can best evaluate the technology to determine reported performance,
2 intended use, intended population, and appropriateness for the task. Developers and vendors
3 should consider voluntarily providing this information about their products, and physicians and
4 other purchasers should consider this information when selecting the AI tools they use.

5 6 *Generative AI*

7
8 Generative AI is a type of AI that can recognize, summarize, translate, predict, and generate text
9 and other content based on knowledge gained from large datasets. Generative AI tools are finding
10 an increasing number of uses in health care, including assistance with administrative functions,
11 such as generating office notes, responding to documentation requests, and generating patient
12 messages. Additionally, there has been increasing discussion about clinical applications of
13 generative AI, including use as clinical decision support to provide differential diagnoses, early
14 detection and intervention, and to assist in treatment planning. While generative AI tools show
15 tremendous promise to make a significant contribution to health care, there are a number of risks
16 and limitations to consider when using these tools in a clinical setting or for direct patient care.
17 These risks are especially important to consider for clinical applications that may impact clinical
18 decision-making and treatment planning where risks to patients are higher.

19
20 Given that there are no regulations or generally accepted standards or frameworks to govern the
21 design, development, and deployment of generative AI, consideration and mitigation of the
22 significant risks is paramount. To manage risk, health care organizations should develop and
23 adopt appropriate policies that anticipate and minimize negative impacts. Physicians who consider
24 utilizing a generative AI-based tool in their practice should ensure that all practice staff are
25 educated on the risks and limitations, including patient privacy concerns, and should have
26 appropriate governance policies in place for its use prior to adoption. Also, as raised in
27 Resolution 206-I-23, physicians should be encouraged to educate their patients about the benefits
28 and risks of using AI-based tools, such as LLMs, for information about health care conditions,
29 treatment options, or the type of health care professionals who have the education, training, and
30 qualifications to treat a particular condition. Patients and physicians should be aware that chatbots
31 powered by LLMs/generative AI could provide inaccurate, misleading, or unreliable information
32 and recommendations. This principle is incorporated in the recommendations in this report and
33 current AMA Policy [H-480.940](#), “Augmented Intelligence in Health Care.”

34 35 *Liability*

36
37 The question of physician liability for use of AI-enabled technologies presents novel and complex
38 legal questions and poses risks to the successful clinical integration of AI-enabled technologies. It
39 is also one of the most serious concerns for physicians when considering integration of AI into
40 their practice. Concerns also arise for employed physicians who feel they may have no choice but
41 to utilize the AI, should hospitals or health systems mandate its use or utilize an EHR system that
42 incorporates AI-based applications as standard.

43
44 The challenge for physicians regarding questions of liability for use of AI is that there is not yet
45 any clear legal standard for determining liability. While there are clear standards for general
46 medical malpractice and for medical device liability, AI presents novel and potentially complex
47 legal questions. When AI has suggested a diagnosis, the question of how appropriate it is for a
48 physician to rely on that result is yet to be determined and will likely continue to evolve as AI
49 improves. Ultimately the “standard of care” will help guide physician liability. It is expected that,
50 as it improves over time, AI will be incorporated into what is likely to be specialty-specific
51 standards of care. However, until that occurs, AI-transparency is of critical importance and

1 physicians will need to be diligent in ensuring that they engage with AI tools where performance
2 has been validated in their practice setting.

3
4 As AI continues to evolve, there may ultimately be questions regarding liability when physicians
5 fail to use AI and rely only on their professional judgment. Again, this question may ultimately
6 turn on what evolves to be considered the standard of care.

7
8 It should be noted that, when using AI, physicians will still be subject to general legal theories
9 regarding medical liability. Negligent selection of an AI tool, including using tools outside their
10 intended use or intended population, or choosing a tool where there is no evidence of clinical
11 validation, could be decisions that expose a physician to a liability claim.

12 13 *Data Privacy and Augmented Intelligence*

14
15 Data privacy is highly relevant to AI development, implementation, and use. The AMA is deeply
16 invested in ensuring individual patient rights and protections from discrimination remain intact,
17 that these assurances are guaranteed, and that the responsibility rests with the data holders. AI
18 development, training, and use requires assembling large collections of health data. AI machine
19 learning is data hungry; it requires massive amounts of data to function properly. Increasingly,
20 more electronic health records are interoperable across the health care system and, therefore, are
21 accessible by AI trained or deployed in medical settings. AI developers may enter into legal
22 arrangements (e.g., business associate agreements) that bring them under the Health Insurance
23 Portability and Accountability Act (HIPAA) Privacy and Security Rules. While some uses of AI
24 in health care, such as research, are not allowed by HIPAA absent patient authorization, the
25 applicability of other HIPAA privacy protections to AI use is not as clear and HIPAA cannot
26 protect patients from the “black box” nature of AI which makes the use of data opaque. AI system
27 outputs may also include inferences that reveal personal data or previously confidential details
28 about individuals. This can result in a lack of accountability and trust and exacerbate data privacy
29 concerns. Often, AI developers and implementers are themselves unaware of exactly how their
30 products use information to make recommendations.

31
32 It is unlikely that physicians or patients will have any clear insight into a generative AI tool’s
33 conformance to state or federal data privacy laws. LLMs are trained on data scraped from the web
34 and other digital sources, including one well-documented instance where HIPAA privacy
35 protections were violated.^{vii} Few, if any, controls are available to help users protect the data they
36 voluntarily enter in a chatbot query. For instance, there are often no mechanisms in place for
37 users to request data deletion or ensure that their inputs are not stored or used for future model
38 training. While tools designed for medical use should align with HIPAA, many “HIPAA-
39 compliant” generative tools rely on antiquated notions of deidentification, i.e., stripping data of
40 personal information. With today’s advances in computing power, data can easily be reidentified.
41 Rather than aiming to make LLMs compliant with HIPAA, all health care AI-powered generative
42 tools should be designed from the ground up with data privacy in mind.

43
44 [The AMA’s Privacy Principles](#) were designed to provide individuals with rights and protections
45 and shift the responsibility for privacy to third-party data holders. While the Principles are
46 broadly applicable to all AI developers, e.g., entities should only collect the minimum amount of
47 information needed for a particular purpose, the unique nature of LLMs and generative AI
48 warrant special emphasis on entity responsibility and user education.

1 *Augmented Intelligence Cybersecurity*

2
3 Data privacy relies on strong data security measures. There is growing concern that cyber
4 criminals will use AI to attack health care organizations. AI poses new threats to health IT
5 operations. AI-operated ransomware and AI-operated malware can be targeted to infiltrate health
6 IT systems and automatically exploit vulnerabilities. Attackers using ChatGPT can craft
7 convincing or authentic emails and use phishing techniques that entice people to click on links—
8 giving them access to the entire electronic health record system.

9
10 AI is particularly sensitive to the quality of data. Data poisoning is the introduction of “bad” data
11 into an AI training set, affecting the model’s output. AI requires large sets of data to build logic
12 and patterns used in clinical decision-making. Protecting this source data is critical. Threat actors
13 could also introduce input data that compromises the overall function of the AI tool. Failure to
14 secure and validate these inputs, and corresponding data, can contaminate AI models—resulting
15 in patient harm.

16
17 Because stringent privacy protections and higher data quality standards might slow model
18 development, there could be a tendency to forgo essential data privacy and security precautions.
19 However, strengthening AI systems against cybersecurity threats is crucial to their reliability,
20 resiliency, and safety.

21
22 *Payor Use of Augmented Intelligence in Automated Decision-Making*

23
24 Payors and health plans are increasingly using AI and algorithm-based decision-making in an
25 automated fashion to determine coverage limits, make claim determinations, and engage in
26 benefit design. Payors should leverage automated decision-making systems that improve or
27 enhance efficiencies in coverage and payment automation, facilitate administrative simplification,
28 and reduce workflow burdens. While the use of these systems can create efficiencies such as
29 speeding up prior authorization and cutting down on paperwork, there is concern these systems
30 are not being designed or supervised effectively—creating access barriers for patients and
31 limiting essential benefits.

32
33 Increasingly, evidence indicates that payors are using automated decision-making systems to
34 deny care more rapidly, often with little or no human review. This manifests in the form of
35 increased denials, stricter coverage limitations, and constrained benefit offerings. For example, a
36 payor allowed an automated system to cut off insurance payments for Medicare Advantage
37 patients struggling to recover from severe diseases, forcing them to forgo care or pay out of
38 pocket. In some instances, payors instantly reject claims on medical grounds without opening or
39 reviewing the patient’s medical record. There is also a lack of transparency in the development of
40 automated decision-making systems. Rather than payors making determinations based on
41 individualized patient care needs, reports show that decisions are based on algorithms developed
42 using average or “similar patients” pulled from a database. Models that rely on generalized,
43 historical data can also perpetuate biases leading to discriminatory practices or less inclusive
44 coverage.^{viii,ix,x,xi}

45
46 While AI can be used inappropriately by payors with severe detrimental outcomes to patients, it
47 can also serve to reduce administrative burdens on physicians, providing the ability to more easily
48 submit prior authorization and documentation requests in standardized forms that require less
49 physician and staff time. Given the significant burden placed on physicians and administrative
50 staff by prior authorization requests, AI could provide much needed relief and help to increase
51 professional satisfaction among health care professionals. With clear guidelines, AI-enabled

1 decision-making systems may also be appropriate for use in some lower-risk, less complex care
2 decisions.

3
4 While payor use of AI in well-defined situations with clear guidelines has the potential to reduce
5 burdens and benefit physician practices, new regulatory or legislative action is necessary to
6 ensure that automated decision-making systems do not reduce needed care, nor systematically
7 withhold care from specific groups. Steps should be taken to ensure that these systems do not
8 override clinical judgment. Patients and physicians should be informed and empowered to
9 question a payor's automated decision-making. There should be stronger regulatory oversight,
10 transparency, and audits when payors use these systems for coverage, claim determinations, and
11 benefit design. [See Policy [D-480.956](#), "Use of Augmented Intelligence for Prior Authorization;"
12 Policy [H-320.939](#), "Prior Authorization and Utilization Management Reform"]

13 14 CONCLUSION

15
16 As the number of AI-enabled health care tools and systems continue to grow, these technologies
17 must be designed, developed, and deployed in a manner that is ethical, equitable, responsible, and
18 transparent. In line with AMA Policy [H-480-935](#) and Resolution 206-I-23, this report highlights
19 some of the potential benefits and risks to the medical profession and patients of LLMs (e.g.,
20 GPTs) and other AI-generated medical decision-making tools, and recommends adoption of
21 policy to help inform patient and physician education and guide engagement with this new
22 technology, as well as position the AMA to advocate for governance policies that help to ensure
23 that risks arising from AI are mitigated to the greatest extent possible.

24 25 RECOMMENDATION

26
27 The Board of Trustees recommends that the following be adopted in lieu of Resolution 206-I-23
28 and that the remainder of the report be filed:

29 30 **AUGMENTED INTELLIGENCE DEVELOPMENT, DEPLOYMENT, AND USE IN** 31 **HEALTH CARE**

32 33 General Governance

- 34
- 35 • Health care AI must be designed, developed, and deployed in a manner which is ethical,
36 equitable, responsible, and transparent.
 - 37 • Use of AI in health care delivery requires clear national governance policies to regulate
38 its adoption and utilization, ensuring patient safety, and mitigating inequities.
39 Development of national governance policies should include interdepartmental and
40 interagency collaboration.
 - 41 • Compliance with national governance policies is necessary to develop AI in an ethical
42 and responsible manner to ensure patient safety, quality, and continued access to care.
43 Voluntary agreements or voluntary compliance is not sufficient.
 - 44 • Health care AI requires a risk-based approach where the level of scrutiny, validation, and
45 oversight should be proportionate to the potential overall of disparate harm and
46 consequences the AI system might introduce. [See also Augmented Intelligence in Health
47 Care [H-480.939](#) at (1)]
 - 48 • Clinical decisions influenced by AI must be made with specified human intervention
49 points during the decision-making process. As the potential for patient harm increases,
50 the point in time when a physician should utilize their clinical judgment to interpret or act
51 on an AI recommendation should occur earlier in the care plan.

- 1 • Health care practices and institutions should not utilize AI systems or technologies that
2 introduce overall or disparate risk that is beyond their capabilities to mitigate.
3 Implementation and utilization of AI should avoid exacerbating clinician burden and
4 should be designed and deployed in harmony with the clinical workflow.
- 5 • Medical specialty societies, clinical experts, and informaticists are best positioned and
6 should identify the most appropriate uses of AI-enabled technologies relevant to their
7 clinical expertise and set the standards for AI use in their specific domain. [See
8 Augmented Intelligence in Health Care [H-480.940](#) at (2)]
9

10 When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and 11 Technologies 12

- 13 • When AI is used in a manner which directly impacts patient care, access to care, or
14 medical decision making, that use of AI should be disclosed and documented to both
15 physicians and/or patients in a culturally and linguistically appropriate manner. The
16 opportunity for a patient or their caregiver to request additional review from a licensed
17 clinician should be made available upon request.
- 18 • When AI is used in a manner which directly impacts patient care, access to care, medical
19 decision making, or the medical record, that use of AI should be documented in the
20 medical record.
- 21 • AI tools or systems cannot augment, create, or otherwise generate records,
22 communications, or other content on behalf of a physician without that physician's
23 consent and final review.
- 24 • When health care content is generated by generative AI, including by large language
25 models, it should be clearly disclosed within the content that was generated by an AI-
26 enabled technology.
- 27 • When AI or other algorithmic-based systems or programs are utilized in ways that impact
28 patient access to care, such as by payors to make claims determinations or set coverage
29 limitations, use of those systems or programs must be disclosed to impacted parties.
- 30 • The use of AI-enabled technologies by hospitals, health systems, physician practices, or
31 other entities, where patients engage directly with AI should be clearly disclosed to
32 patients at the beginning of the encounter or interaction with the AI-enabled technology.
33

34 What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled 35 Systems and Technologies 36

- 37 • When AI-enabled systems and technologies are utilized in health care, the following
38 information should be disclosed by the AI developer to allow the purchaser and/or user
39 (physician) to appropriately evaluate the system or technology prior to purchase or
40 utilization:
 - 41 ○ Regulatory approval status
 - 42 ○ Applicable consensus standards and clinical guidelines utilized in design,
43 development, deployment, and continued use of the technology
 - 44 ○ Clear description of problem formulation and intended use accompanied by clear
45 and detailed instructions for use
 - 46 ○ Intended population and intended practice setting
 - 47 ○ Clear description of any limitations or risks for use, including possible disparate
48 impact
 - 49 ○ Description of how impacted populations were engaged during the AI lifecycle
 - 50 ○ Detailed information regarding data used to train the model:
 - 51 ■ Data provenance

- 1 ▪ Data size and completeness
- 2 ▪ Data timeframes
- 3 ▪ Data diversity
- 4 ▪ Data labeling accuracy
- 5 ○ Validation Data/Information and evidence of:
- 6 ▪ Clinical expert validation in intended population and practice setting and
- 7 intended clinical outcomes
- 8 ▪ Constraint to evidence-based outcomes and mitigation of “hallucination”
- 9 or other output error
- 10 ▪ Algorithmic validation
- 11 ▪ External validation processes for ongoing evaluation of the model
- 12 performance, e.g., accounting for AI model drift and degradation
- 13 ▪ Comprehensiveness of data and steps taken to mitigate biased outcomes
- 14 ▪ Other relevant performance characteristics, including but not limited to
- 15 performance characteristics at peer institutions/similar practice settings
- 16 ▪ Post-market surveillance activities aimed at ensuring continued safety,
- 17 performance, and equity
- 18 ○ Data Use Policy
- 19 ▪ Privacy
- 20 ▪ Security
- 21 ▪ Special considerations for protected populations or groups put at
- 22 increased risk
- 23 ○ Information regarding maintenance of the algorithm, including any use of active
- 24 patient data for ongoing training
- 25 ○ Disclosures regarding the composition of design and development team,
- 26 including diversity and conflicts of interest, and points of physician involvement
- 27 and review
- 28
- 29 • Purchasers and/or users (physicians) should carefully consider whether or not to engage
- 30 with AI-enabled health care technologies if this information is not disclosed by the
- 31 developer. As the risk of AI being incorrect increases risks to patients (such as with
- 32 clinical applications of AI that impact medical decision making), disclosure of this
- 33 information becomes increasingly important. [See also Augmented Intelligence in Health
- 34 Care [H-480.939](#)]
- 35

36 Generative Augmented Intelligence

- 37
- 38 • Generative AI should: (a) only be used where appropriate policies are in place within the
- 39 practice or other health care organization to govern its use and help mitigate associated
- 40 risks; and (b) follow applicable state and federal laws and regulations (e.g., HIPAA-
- 41 compliant Business Associate Agreement).
- 42 • Appropriate governance policies should be developed by health care organizations and
- 43 account for and mitigate risks of:
- 44 ○ Incorrect or falsified responses; lack of ability to readily verify the accuracy of
- 45 responses or the sources used to generate the response
- 46 ○ Training data set limitations that could result in responses that are out of date or
- 47 otherwise incomplete or inaccurate for all patients or specific populations
- 48 ○ Lack of regulatory or clinical oversight to ensure performance of the tool
- 49 ○ Bias, discrimination, promotion of stereotypes, and disparate impacts on access
- 50 or outcomes
- 51 ○ Data privacy

- 1 ○ Cybersecurity
- 2 ○ Physician liability associated with the use of generative AI tools
- 3 • Health care organizations should work with their AI and other health information
- 4 technology (health IT) system developers to implement rigorous data validation and
- 5 verification protocols to ensure that only accurate, comprehensive, and bias managed
- 6 datasets inform generative AI models, thereby safeguarding equitable patient care and
- 7 medical outcomes. [See Augmented Intelligence in Health Care [H-480.940](#) at (3)(d)]
- 8 • Use of generative AI should incorporate physician and staff education about the
- 9 appropriate use, risks, and benefits of engaging with generative AI. Additionally,
- 10 physicians should engage with generative AI tools only when adequate information
- 11 regarding the product is provided to physicians and other users by the developers of those
- 12 tools.
- 13 • Clinicians should be aware of the risks of patients engaging with generative AI products
- 14 that produce inaccurate or harmful medical information (e.g., patients asking chatbots
- 15 about symptoms) and should be prepared to counsel patients on the limitations of AI-
- 16 driven medical advice.
- 17 • Governance policies should prohibit the use of confidential, regulated, or proprietary
- 18 information as prompts for generative AI to generate content.
- 19 • Data and prompts contributed by users should primarily be used by developers to
- 20 improve the user experience and AI tool quality and not simply increase the AI tool's
- 21 market value or revenue generating potential.
- 22

23 Physician Liability for Use of Augmented Intelligence-Enabled Technologies

- 24
- 25 • Current AMA policy states that liability and incentives should be aligned so that the
- 26 individual(s) or entity(ies) best positioned to know the AI system risks and best
- 27 positioned to avert or mitigate harm do so through design, development, validation, and
- 28 implementation. [See Augmented Intelligence in Health Care [H-480.939](#)]
- 29 ○ Where a mandated use of AI systems prevents mitigation of risk and harm, the
- 30 individual or entity issuing the mandate must be assigned all applicable liability.
- 31 ○ Developers of autonomous AI systems with clinical applications (screening,
- 32 diagnosis, treatment) are in the best position to manage issues of liability arising
- 33 directly from system failure or misdiagnosis and must accept this liability with
- 34 measures such as maintaining appropriate medical liability insurance and in their
- 35 agreements with users.
- 36 ○ Health care AI systems that are subject to non-disclosure agreements concerning
- 37 flaws, malfunctions, or patient harm (referred to as gag clauses) must not be
- 38 covered or paid and the party initiating or enforcing the gag clause assumes
- 39 liability for any harm.
- 40 • When physicians do not know or have reason to know that there are concerns about the
- 41 quality and safety of an AI-enabled technology, they should not be held liable for the
- 42 performance of the technology in question.
- 43

44 Data Privacy and Augmented Intelligence

- 45
- 46 • Entity Responsibility:
- 47 ○ Entities should make information available about the intended use of generative
- 48 AI in health care and identify the purpose of its use. Individuals should know
- 49 how their data will be used or reused, and the potential risks and benefits.

- 1 ○ Individuals should have the right to opt-out, update, or forget use of their data in
2 generative AI tools. These rights should encompass AI training data and
3 disclosure to other users of the tool.
- 4 ○ Generative AI tools should not reverse engineer, reconstruct, or reidentify an
5 individual’s originally identifiable data or use identifiable data for nonpermitted
6 uses, e.g., when data are permitted to conduct quality and safety evaluations.
7 Preventive measures should include both legal frameworks and data model
8 protections, e.g., secure enclaves, federated learning, and differential privacy.
9
- 10 • User Education:
 - 11 ○ Users should be provided with training specifically on generative AI. Education
12 should address:
 - 13 ▪ legal, ethical, and equity considerations;
 - 14 ▪ risks such as data breaches and re-identification;
 - 15 ▪ potential pitfalls of inputting sensitive and personal data; and
 - 16 ▪ the importance of transparency with patients regarding the use of
17 generative AI and their data.

18 [See [H-480.940](#), Augmented Intelligence in Health Care, at (4) and (5)]

20 Augmented Intelligence Cybersecurity

- 22 • AI systems must have strong protections against input manipulation and malicious
23 attacks.
- 24 • Entities developing or deploying health care AI should regularly monitor for anomalies or
25 performance deviations, comparing AI outputs against known and normal behavior.
- 26 • Independent of an entity’s legal responsibility to notify a health care provider or
27 organization of a data breach, that entity should also act diligently in identifying and
28 notifying the individuals themselves of breaches that impact their personal information.
- 29 • Users should be provided education on AI cybersecurity fundamentals, including specific
30 cybersecurity risks that AI systems can face, evolving tactics of AI cyber attackers, and
31 the user’s role in mitigating threats and reporting suspicious AI behavior or outputs.
32

33 Payor Use of Augmented Intelligence and Automated Decision-Making Systems

- 35 • Use of automated decision-making systems that determine coverage limits, make claim
36 determinations, and engage in benefit design should be publicly reported, based on easily
37 accessible evidence-based clinical guidelines (as opposed to proprietary payor criteria),
38 and disclosed to both patients and their physician in a way that is easy to understand.
- 39 • Payors should only use automated decision-making systems to improve or enhance
40 efficiencies in coverage and payment automation, facilitate administrative simplification,
41 and reduce workflow burdens. Automated decision-making systems should never create
42 or exacerbate overall or disparate access barriers to needed benefits by increasing denials,
43 coverage limitations, or limiting benefit offerings. Use of automated decision-making
44 systems should not replace the individualized assessment of a patient’s specific medical
45 and social circumstances and payors’ use of such systems should allow for flexibility to
46 override automated decisions. Payors should always make determinations based on
47 particular patient care needs and not base decisions on algorithms developed on “similar”
48 or “like” patients.
- 49 • Payors using automated decision-making systems should disclose information about any
50 algorithm training and reference data, including where data were sourced and attributes
51 about individuals contained within the training data set (e.g., age, race, gender). Payors

- 1 should provide clear evidence that their systems do not discriminate, increase inequities,
2 and that protections are in place to mitigate bias.
- 3 • Payors using automated decision-making systems should identify and cite peer-reviewed
4 studies assessing the system’s accuracy measured against the outcomes of patients and
5 the validity of the system’s predictions.
 - 6 • Any automated decision-making system recommendation that indicates limitations or
7 denials of care, at both the initial review and appeal levels, should be automatically
8 referred for review to a physician (a) possessing a current and valid non-restricted license
9 to practice medicine in the state in which the proposed services would be provided if
10 authorized and (b) be of the same specialty as the physician who typically manages the
11 medical condition or disease or provides the health care service involved in the request
12 prior to issuance of any final determination. Prior to issuing an adverse determination, the
13 treating physician must have the opportunity to discuss the medical necessity of the care
14 directly with the physician who will be responsible for determining if the care is
15 authorized.
 - 16 • Individuals impacted by a payor’s automated decision-making system, including patients
17 and their physicians, must have access to all relevant information (including the coverage
18 criteria, results that led to the coverage determination, and clinical guidelines used).
 - 19 • Payors using automated decision-making systems should be required to engage in regular
20 system audits to ensure use of the system is not increasing overall or disparate claims
21 denials or coverage limitations, or otherwise decreasing access to care. Payors using
22 automated decision-making systems should make statistics regarding systems’ approval,
23 denial, and appeal rates available on their website (or another publicly available website)
24 in a readily accessible format with patient population demographics to report and
25 contextualize equity implications of automated decisions. Insurance regulators should
26 consider requiring reporting of payor use of automated decision-making systems so that
27 they can be monitored for negative and disparate impacts on access to care. Payor use of
28 automated decision-making systems must conform to all relevant state and federal laws.
29 (New HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

ⁱ <https://www.ama-assn.org/system/files/ama-patient-data-privacy-survey-results.pdf>.

ⁱⁱ <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/government/advocacy/medical-cybersecurity-findings.pdf>.

ⁱⁱⁱ https://www.healthit.gov/sites/default/files/page/2024-01/DSI_HTI1%20Final%20Rule%20Presentation_508.pdf.

^{iv} <https://www.propublica.org/article/cigna-health-insurance-denials-pxdx-congress-investigation#:~:text=The%20letter%20follows%20an%20investigation.PXDX%20system%2C%20spending%20an%20average.>

^v 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.

^{vi} For example, the 21st Century Cures Act includes several exemptions to FDA’s oversight, such as software intended for administrative support of a health care facility, maintaining or encouraging a healthy lifestyle (and is unrelated to the diagnosis, cure, mitigation, prevention, or treatment of a disease or condition), is intended to be used as electronic patient records, is intended for transferring, storing, converting formats, or displaying data or results, and otherwise does not meet the definition of a medical device under the Federal Food, Drug, and Cosmetic Act.

^{vii} Feathers, T., et al. “Facebook is receiving sensitive medical information from hospital websites. The Markup. June 16, 2022.” <https://themarkup.org/pixel-hunt/2022/06/16/facebook-is-receiving-sensitive-medical-information-from-hospital-websites>.

^{viii} Obermeyer, Ziad, et al. “Dissecting racial bias in an algorithm used to manage the health of populations.” *Science* 366.6464 (2019): 447-453. <https://www.science.org/doi/10.1126/science.aax2342>.

^{ix} Ross, C., Herman, B. (2023) “Medicare Advantage Plans’ Use of Artificial Intelligence Leads to More Denials.” <https://www.statnews.com/2023/03/13/medicare-advantage-plans-denial-artificial-intelligence/> (Accessed September 14, 2023).

^x Rucker, P., Miller, M., Armstrong, D. (2023). “Cigna and Its Algorithm Deny Some Claims for Genetic Testing, ProPublica Finds.” <https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims> (Accessed September 14, 2023).

^{xi} Ross, C., Herman, B. (2023). “Medicare Advantage Algorithms Lead to Coverage Denials, With Big Implications for Patients.” <https://www.statnews.com/2023/07/11/medicare-advantage-algorithm-navihealth-unitedhealth-insurance-coverage/> (Accessed September 14, 2023).

REPORT OF THE BOARD OF TRUSTEES

B of T Report 16-A-24

Subject: Support for Mental Health Courts

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

1 INTRODUCTION

2
3 At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates
4 (HOD), Resolution 202 entitled, “Support for Mental Health Courts,” was introduced by the
5 Medical Student Section and called on the AMA to amend existing policy – Policy H-100.955
6 entitled, “Support for Drug Courts” – as follows:

7
8 Our AMA: (1) supports the establishment and use of mental health drug courts,
9 including drug courts and sobriety courts, as an effective method of intervention within
10 a comprehensive system of community-based supports and services for individuals
11 with mental illness involved in the justice system ~~addictive disease who are convicted~~
12 ~~of nonviolent crimes~~; (2) encourages legislators to establish mental health drug courts
13 at the state and local level in the United States; and (3) encourages mental health drug
14 courts to rely upon evidence-based models of care for those who the judge or court
15 determine would benefit from intervention rather than incarceration.

16
17 There was robust discussion of this resolution, including widespread support for increasing access
18 to evidence-based care for individuals with a mental illness or substance use disorder (SUD) who
19 were involved with the justice system. Multiple questions were raised, however, regarding terms
20 of art that may be in use in legal settings compared to medical settings; the potential of unintended
21 consequences; and the different uses of such courts. Ultimately, the HOD referred this resolution
22 to the Board of Trustees for study. In response, this report provides background information;
23 discusses the different courts; presents AMA policy; and makes recommendations.

24
25 BACKGROUND

26
27 There are more than 4,000 courts in the United States that provide some measure of alternative to
28 incarceration when there is evidence of a mental illness, SUD, or other health condition impacting
29 an individual and/or family.¹ There are at least 39 states with a diversion program that addresses
30 substance use, and at least 24 that directly address mental health and illness needs.² A fact sheet
31 from the Obama Administration noted that, “Since 1989, drug courts have been established or are
32 being planned in all 50 States, the District of Columbia, the Northern Mariana Islands, Puerto Rico,
33 Guam, and in nearly 90 Tribal locations.”³ The AMA has long been a supporter of these programs.⁴

34
35 These programs go by many names, including “treatment court,” “adult drug court,” “DWI court,”
36 “family treatment court,” “juvenile treatment court,” “tribal healing to wellness court,” or “veterans
37 treatment court.” Other names used to describe programs that seek alternatives to incarceration are
38 “opioid intervention court,” “opiate treatment court,” “heroin court,” “treatment pathway

1 program,” “overdose avoidance and recovery program,” and “heroin overdose prevention and
2 education initiative.”⁵ The U.S. Department of Justice (DOJ) broadly describes these programs as
3 “pretrial diversion programs” to which the U.S. Attorney has discretion to “divert” if there are
4 “substance abuse or mental health challenges.”⁶

5
6 Given the many different types of programs that are designed to provide mental health or SUD
7 services as an alternative to incarceration, for the purposes of this report, any program that
8 addresses substance use or mental health in a justice-involved or justice-related setting or program
9 will be denoted as a “diversion program.” A recent issue brief from the National Conference of
10 State Legislatures (NCSL)⁷ further explains that “Pretrial diversion programs are post-arrest
11 interventions that occur at some point prior to final entry of judgment. Programs can take place
12 before charges are filed, before first appearance or before adjudication.”

13
14 Public health and public justice and law enforcement officials generally agree on the considerable
15 need to treat mental illness and SUDs. Data reported by the U.S. Substance Abuse and Mental
16 Health Services Administration (SAMHSA) show much greater prevalence of mental illness and
17 SUDs in jails and prisons compared to the general population. It is estimated that:⁸

- 18
- 19 • 18 percent of the general population has a mental illness; 44 percent of those in jail and
20 37 percent of those in prison have a mental illness;
- 21 • 11 percent of 18–25-year-olds, and 6 percent of those over 25 years old have a SUD; and
- 22 • 63 percent of people in jail and 58 percent in prison have a SUD.

23
24 In terms of sheer numbers, “1.2 million individuals living with mental illness sit in jail and prison
25 each year.”⁹ Making matters more challenging, more than 60 percent of individuals with a history
26 of mental illness do not receive treatment while incarcerated, and more than 50 percent of
27 individuals receiving medication for mental health conditions stop taking them upon being
28 incarcerated.¹⁰ The National Institutes on Drug Abuse says that estimates for SUD prevalence in
29 jails and prisons have been as high as 65 percent.¹¹

30 31 DISCUSSION

32 33 *Are Diversion Programs an Effective Method of Intervention for Individuals with Mental Illness or* 34 *Substance Use Disorder Involved with the Justice System?*

35
36 The first issue to address is whether diversion programs are an effective method of intervention for
37 individuals with a mental illness or SUD involved with the justice system. If so, what elements of a
38 diversion program demonstrate efficacy? For the purposes of this report, at least two metrics for
39 “efficacy” can be viewed as to whether individuals receive and continue to engage in treatment, as
40 well as whether they become re-incarcerated. While it is beyond the scope of this report to evaluate
41 the 4,000+ programs in existence in the United States, there are innumerable examples of programs
42 reporting that individuals enrolled in diversion programs not only start and continue treatment but
43 are also less likely to return to jail or prison or be re-arrested. Proponents of diversion programs
44 cite multiple economic and other benefits, including that they can connect hundreds of thousands of
45 individuals to medications for opioid use disorder (OUD).

46
47 A sample of meta-analyses also show general positivity, but identify challenges that come with
48 evaluating such programs:

- 1 • A 2012 meta-analysis found that adult drug courts are effective “in reducing
2 recidivism...[and] The evidence assessing DWI courts’ effectiveness is very promising but
3 more experimental evaluations are needed. Juvenile drug courts typically produce small
4 reductions in recidivism.”¹²
- 5 • A 2013 meta-review broadly found benefits of juvenile justice diversion programs.¹³
- 6 • A 2016 review of juvenile justice programs found, “There is no evidence that juvenile drug
7 courts are more or less effective than traditional court processing in terms of reducing
8 juveniles’ recidivism and drug use, but there is also no evidence of harm. The quality of
9 the body of evidence is very low, however, so we have little confidence in these null
10 findings.”¹⁴
- 11 • A 2016 guide from the National Drug Court Institute cited multiple studies showing that,
12 “Use of all three [MOUD] medications is associated with significantly reduced use of
13 unauthorized opioids among probationers, parolees, and other persons with opioid use
14 disorders involved in the criminal justice system.”¹⁵
- 15 • A 2017 review of mental health courts (MHC) found that, “Overall, a small effect of MHC
16 participation on recidivism was noted, compared with traditional criminal processing.
17 Findings suggest the need for research to identify additional sources of variability in the
18 effectiveness of MHCs.”¹⁶
- 19 • A 2019 systematic review of drug courts found that, “Treatment accessed via community-
20 based diversion is effective at reducing drug use in Class A drug-using offenders. Evidence
21 of a reduction in offending amongst this group as a result of diversion is uncertain. Poor
22 methodological quality and data largely limited to US methamphetamine users limits
23 available evidence.”¹⁷
- 24 • A 2020 literature review of mental health courts found that, while research generally
25 supports MHCs’ positive effects to reduce recidivism, there are inconsistencies with
26 overall study designs, data collection, lack of adequate controls and other methodological
27 faults.¹⁸
- 28 • Another 2020 meta-analysis found that, “diversion programs for low-level drug offenders
29 are likely to be cost-effective, generating savings in the criminal justice system while only
30 moderately increasing healthcare costs. Such programs can reduce incarceration and its
31 associated costs and avert overdose deaths and improve quality of life for PWID [people
32 who inject drugs], PWUD [people who use drugs], and the broader population (through
33 reduced HIV and HCV transmission).”¹⁹

34
35 Considering individual programs reporting broad benefits²⁰ and meta-analyses showing benefits as
36 well as raising questions about how broad those benefits might be, it seems prudent to call for
37 additional research as well as mechanisms to identify best practices. For example, some programs
38 to treat OUD might prohibit use of medications for opioid use disorder (MOUD) or rely on non-
39 evidence-based approaches. The Board of Trustees notes, however, that what works in one
40 jurisdiction may not work in another—and given the evidence that points to the overall benefits and
41 lack of harm, we believe that the AMA should continue to support these programs. To guide
42 programs, we highlight that professional medical organizations have published multiple guidelines
43 and treatment considerations for diversion programs and care for individuals involved with the
44 justice system, including the American Society of Addiction Medicine,²¹ American Psychiatric
45 Association,²² and Providers Clinical Support System.²³

46
47 There are many potential elements of “a comprehensive system of community-based supports and
48 services.” This includes benefits provided by “wraparound services,” such as community-based
49 interagency cooperation, care coordination, child and/or family teams, unified plans of care,
50 evidence-based systems of care, and other areas.²⁴ Additional guidance can be found in recent

1 SAMHSA grants for diversion programs in three jurisdictions.²⁵ These grants identify multiple
2 types of services that may be useful in a diversion program, including motivational interviewing;
3 crisis intervention training; psychiatric/psychosocial rehabilitation; dialectical behavior therapy;
4 community-based treatment; case management; comprehensive psychiatric services, including
5 psychotherapy and supportive counseling; substance use and detoxification treatment; housing and
6 employment support, including skills training; screening, assessment, referral, and treatment to
7 individuals at risk of entering the criminal justice system; and links between individuals and other
8 community resources. While not all diversion programs will have all these elements, the Board of
9 Trustees believes that the AMA should support development of diversion programs that include
10 broad-based community support that include these types of resources.

11
12 *Should Diversion Programs be Available to Both Nonviolent and Violent Offenders?*

13
14 The second issue is whether diversion programs should be available to both nonviolent and violent
15 offenders. It is first important to distinguish that *access to a diversion program* is related to—but
16 different from than *access to evidence-based treatment* for a mental illness or SUD within the
17 justice system. In 2022, the DOJ issued guidance making it clear that the Americans with
18 Disabilities Act (ADA) protects individuals with an OUD to continue treatment for an OUD while
19 incarcerated, including protecting continuity of care with MOUD.²⁶ The AMA has advocated in
20 multiple legal, legislative, and other forums that individuals involved with the justice system have a
21 medical—and constitutional right—to continue OUD while incarcerated. This advocacy is
22 highlighted in seminal cases: *Smith v. Aroostook County*²⁷ and *Pesce v. Coppinger*.²⁸ By extension,
23 an individual also likely has statutory and constitutional rights to MOUD—or other evidence-based
24 care—in a diversion program, but as the DOJ points out, there may be nuances if “the individual is
25 currently engaged in illegal drug use.”²⁹ The National Institute on Drug Abuse (NIDA) explains
26 that:

27
28 The chronic nature of addiction means that for some people relapse, or a return to
29 drug use after an attempt to stop, can be part of the process, but newer treatments
30 are designed to help with relapse prevention. Relapse rates for drug use are similar
31 to rates for other chronic medical illnesses. If people stop following their medical
32 treatment plan, they are likely to relapse.³⁰

33
34 The Board of Trustees believes that AMA support for individuals being able to stay in treatment
35 even if they engaged in illegal drug use is a natural extension of existing AMA policy to not punish
36 people because they have a SUD.

37
38 With respect to whether diversion programs should be available to non-violent and violent
39 offenders, given the evidence showing benefits of these programs—even if limited in some cases—
40 the AMA should continue to support access to evidence-based care, including MOUD, for non-
41 violent offenders. Notably, no change in policy is needed to meet this result. Whether to support
42 and advocate for diversion programs to be available to individuals charged or convicted of violent
43 offenses, however, raises multiple issues.

44
45 The first issue is whether those charged or convicted of a violent offense are legally eligible for a
46 diversion program. The U.S. Government Accountability Office (GAO) reports that, “adult drug
47 courts funded by DOJ grants are prohibited by law from using grant funding to include individuals
48 with prior or current violent offenses in their programs.”³¹ The GAO pointed out, however, that, “a
49 few adult drug courts told us that they admit violent offenders, by ensuring that they do not use
50 federal funding to serve these clients.” The GAO, which interviewed representatives from 44 adult
51 drug courts from a mix of rural, suburban, urban, and tribal adult drug courts, highlighted that some

1 violent offenders and those convicted of drug-related crimes would benefit from drug court
2 services. State law also commonly excludes individuals charged or convicted of a violent offense—
3 or having been convicted within a certain time period in the past.

4
5 The National Association of Drug Court Professionals counsels that, “Evidence does not support
6 blanket disqualification from treatment court for persons with a history of violent crimes. Instead,
7 persons charged with offenses involving violence, or who have a history of such offenses, should
8 be evaluated on a case-by-case basis to determine if they can be safely supervised in treatment
9 court.”³² The Board of Trustees agrees. Just as AMA policy does not discriminate against an
10 individual’s right to receive treatment based on external factors, the AMA should not discriminate
11 against access to evidence-based care for SUD and mental illness based on carceral status or
12 judicial supervision. As noted above, the provision of evidence-based care for mental illness and
13 SUDs has strong constitutional protections. And as discussed below, current AMA policy strongly
14 supports evidence-based care for individuals with a mental illness or SUD in jails and prisons.

15
16 Saying that the AMA should not oppose participation in a diversion program does not mean,
17 however, that there should not be comprehensive considerations about which individuals would
18 benefit most from participation in a diversion program. Such considerations, moreover, should
19 include whether an individual’s participation constitutes a threat to public safety. Thankfully, there
20 are robust eligibility criteria to help judicial and health care professionals make those
21 determinations. This guidance can help ensure “equitable access, services, and outcomes for all
22 sociodemographic and sociocultural groups,” including “guidance for treatment courts to monitor
23 and rectify unwarranted cultural disparities.”³³ The eligibility guidance, moreover, can help
24 diversion programs remove inappropriate restrictions and exclusions, ensure evidence-based care,
25 connect individuals to complementary services, as well as avoid conflicts of interest. And just as
26 important, the Board of Trustees agrees that:

27
28 All persons meeting evidence-based eligibility criteria for treatment court receive
29 the same opportunity to participate and succeed in the program regardless of their
30 sociodemographic characteristics or sociocultural identity, including but not
31 limited to their race, ethnicity, sex, gender identity, sexual orientation, age,
32 socioeconomic status, national origin, native language, religion, cultural practices,
33 and physical, medical, or other conditions.³⁴

34 35 AMA POLICY

36
37 A bedrock of AMA advocacy is found in Policy H-430-987, “Medications for Opioid Use Disorder
38 in Correctional Facilities,” which provides, “Our AMA endorses: (a) the medical treatment model
39 of employing medications for opioid use disorder (OUD) as the standard of care for persons with
40 OUD who are incarcerated.” This policy also calls for the AMA to advocate for

41
42 . . . legislation, standards, policies, and funding that require correctional facilities
43 to increase access to evidence-based treatment of OUD, including initiation and
44 continuation of medications for OUD, in conjunction with psychosocial treatment
45 when desired by the person with OUD, in correctional facilities within the United
46 States and that this apply to all individuals who are incarcerated, including
47 individuals who are pregnant, postpartum, or parenting.

1 The Board of Trustees recommends that diversion programs be held to the same standards.

2
3 The AMA also supports “veterans courts” as “a method of intervention for veterans who commit
4 criminal offenses that may be related to a neurological or psychiatric disorder.” (Policy H-510-979,
5 “Support for Veterans Courts”). If AMA policy supports broad access to veterans’ courts as a
6 matter of policy, the Board of Trustees does not see any reason why such policy should not also
7 apply to other types of diversion programs. Similarly, AMA policy calling to support “justice
8 reinvestment initiatives ... and assessing individuals for substance use disorders and mental health
9 issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and
10 treatment programs,” does not distinguish between nonviolent and violent offenses.
11 (Policy H-94-931, “AMA Support for Justice Reinvestment Initiatives”).
12

13 Finally, AMA Ethics Policy recognizes that, “Although convicted criminals have fewer rights and
14 protections than other citizens, being convicted of a crime does not deprive an offender of all
15 protections under the law.” (Policy E-9.7.2, “Court-Initiated Medical Treatment in Criminal
16 Cases”). This policy also counsels for physicians to, “Treat patients based on sound medical
17 diagnoses, not court-defined behaviors. While a court has the authority to identify criminal
18 behavior, a court does not have the ability to make a medical diagnosis or to determine the type of
19 treatment that will be administered.” (Policy E-9.7.2, “Court-Initiated Medical Treatment in
20 Criminal Cases”). Thus, while the justice system may have guidance about which individuals are
21 eligible for a diversion program, the physician’s role is not to raise barriers to such care.
22

23 RECOMMENDATIONS

24
25 The Board of Trustees recommends that existing policy – Policy H-100.955, entitled, “Support for
26 Drug Courts” – be amended by addition and deletion in lieu of Resolution 202 as follows:
27

28 Support for Diversion Programs, Including Drug Courts, Mental Health Courts, Veterans 29 Courts, Sobriety Courts, and Similar Programs

30
31 Our AMA:

32
33 (1) supports the establishment and use of diversion and treatment programs ~~drug~~
34 ~~courts, including drug courts, mental health courts, veterans courts, sobriety courts,~~
35 and other types of similar programs, as an effective method of intervention within a
36 comprehensive system of community-based supports and services for individuals
37 with a mental illness or substance use disorder involved in the justice system
38 ~~addictive disease who are convicted of nonviolent crimes;~~

39 (2) encourages legislators and court systems to establish diversion and treatment
40 programs ~~drug courts~~ at the state and local level in the United States; ~~and~~

41 (3) encourages diversion and treatment programs ~~drug courts~~ to rely upon evidence-based
42 models of care, including medications for opioid use disorder, for those who the judge or
43 court determine would benefit from intervention, including treatment, rather than
44 incarceration; and

45 (4) supports individuals enrolled in diversion or treatment programs not be removed from a
46 program solely because of evidence showing that an individual used illegal drugs while
47 enrolled. (Modify HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

- ¹ All Rise, formerly known as the National Association of Drug Court Professionals. <https://allrise.org/about/treatment-courts/>
- ² Pretrial Diversion. National Conference of State Legislatures. September 2017. Available at <https://www.ncsl.org/civil-and-criminal-justice/pretrial-diversion>
- ³ Drug Courts: A Smart Approach to Criminal Justice. Office of National Drug Control Policy. May 2011. Available at https://obamawhitehouse.archives.gov/sites/default/files/ondcp/Fact_Sheets/drug_courts_fact_sheet_5-31-11.pdf
- ⁴ See, for example, letter from AMA Executive Vice President and CEO, James L. Madara, MD, to the National Governors Association, American Medical Association comments on “Reducing Prescription Drug Abuse: Lessons Learned, from an NGA Policy Academy.” December 17, 2013. Available at <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fnga-recommendations-lessons-learned.pdf>
- ⁵ Lucas, David; Arnold, Aaron. Center for Court Innovation. July 2019. Available at https://www.cossup.org/Content/Documents/Articles/Court_Responses_To_The_Opioid_Epidemic_Happening_Now.pdf
- ⁶ “Pretrial Diversion Program.” Justice Manual. Title 9. U.S. Department of Justice. Updated February 2023. Available at <https://www.justice.gov/jm/jm-9-22000-pretrial-diversion-program>
- ⁷ The Legislative Primer Series for Front-End Justice: Deflection and Diversion. National Conference of State Legislatures. August 2023. Available at <https://documents.ncsl.org/wwwncsl/Criminal-Justice/Deflection-Diversion-f02.pdf>
- ⁸ About Criminal and Juvenile Justice. U.S. Substance Abuse and Mental Health Services Administration. Last Updated March 2, 2022. Available at <https://www.samhsa.gov/criminal-juvenile-justice>
- ⁹ Access to Mental Health Care and Incarceration. Mental Health America. Available at <https://www.mhanational.org/issues/access-mental-health-care-and-incarceration> Last accessed February 23, 2024
- ¹⁰ Mental Health Treatment While Incarcerated. National Alliance on Mental Illness. Available at <https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-Treatment-While-Incarcerated>
- ¹¹ Criminal Justice Drug Facts. National Institutes on Drug Abuse. Last updated June 2020. Available at <https://nida.nih.gov/publications/drugfacts/criminal-justice>
- ¹² Ojmarh Mitchell, David B. Wilson, Amy Eggers, Doris L. MacKenzie, Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and non-traditional drug courts, Journal of Criminal Justice, Volume 40, Issue 1, 2012, Pages 60-71, <https://doi.org/10.1016/j.jcrimjus.2011.11.009>. <https://www.sciencedirect.com/science/article/pii/S0047235211001255>
- ¹³ The Effect of Youth Diversion Programs on Recidivism. A Meta-Analytic Review. Criminal Justice and Behavior. Vol. 40. No. 5. May 2013. Available at http://users.soc.umn.edu/~uggen/Wilson_CJB_13.pdf
- ¹⁴ Meta-Analysis of Research on the Effectiveness of Juvenile Drug Courts. Emily E. Tanner-Smith, PhD Mark W. Lipsey, PhD. David B. Wilson, PhD. Peabody Research Institute at Vanderbilt University. Available at <https://www.ojp.gov/pdffiles1/ojdp/grants/250439.pdf>
- ¹⁵ Drug Court Practitioner Fact Sheet. Medication-Assisted Treatment for Opioid Use Disorders in Drug Courts. National Drug Court Institute. August 2016. Vol. XI, No. 2. Available at https://allrise.org/wp-content/uploads/2022/07/mat_fact_sheet-1.pdf
- ¹⁶ Lowder EM, Rade CB, Desmarais SL. Effectiveness of Mental Health Courts in Reducing Recidivism: A Meta-Analysis. Psychiatr Serv. 2018 Jan 1;69(1):15-22. doi: 10.1176/appi.ps.201700107. Epub 2017 Aug 15. PMID: 28806894.
- ¹⁷ Hayhurst, K. P., Leitner, M., Davies, L., Millar, T., Jones, A., Flentje, R., Hickman, M., Fazel, S., Mayet, S., King, C., Senior, J., Lennox, C., Gold, R., Buck, D., & Shaw, J. (2019). The effectiveness of diversion programmes for offenders using Class A drugs: A systematic review and meta-analysis. Drugs: Education, Prevention & Policy, 26(2), 113–124. <https://doi.org/10.1080/09687637.2017.1398715>
- ¹⁸ Otto, H. D. (2020). A review of literature on mental health court goals, effectiveness, and future implications. Illinois Criminal Justice Information Authority.

¹⁹ Bernard CL, Rao IJ, Robison KK, Brandeau ML. Health outcomes and cost-effectiveness of diversion programs for low-level drug offenders: A model-based analysis. *PLoS Med.* 2020 Oct 13;17(10):e1003239. doi: 10.1371/journal.pmed.1003239. PMID: 33048929; PMCID: PMC7553283.

²⁰ For example, a study supported by the U.S. Department of Justice, National Institute of Justice evaluating the Multnomah County Drug Court in Oregon showed that participating offenders were rearrested less frequently than offenders going through traditional court. Drug court participants cost local taxpayers \$5,071 less on average over a 30-month period than those processed through traditional court. Overall, the drug courts saved Multnomah County more than \$1.5 million per year or approximately \$5,000 on average for each of the program participants in the study.

²¹ Drug Court Resources. American Society of Addiction Medicine. Available at <https://www.asam.org/quality-care/clinical-guidelines/clinical-resources/drug-court-resources>

²² Examining Mental Health Courts. American Psychiatric Association. Available at <https://www.psychiatry.org/news-room/apa-blogs/examining-mental-health-courts>

²³ Drug Court/Treatment Court. Providers Clinical Support System. Available at <https://pcssnow.org/topics/drug-court-treatment-court/>

²⁴ “Wraparound Process.” Literature review. Washington, D.C. Office of Juvenile Justice and Delinquency Prevention. https://www.ojjdp.gov/mpg/litreviews/Wraparound_Process.pdf Last updated April 2014.

²⁵ Law Enforcement and Behavioral Health Partnerships for Early Diversion. U.S. Substance Abuse and Mental Health Services Administration. Last Updated January 30, 2024. Available at <https://www.samhsa.gov/criminal-juvenile-justice/grants-grantees/early-diversion>

²⁶ The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery. U.S. Department of Justice. Civil Rights Division. April 5, 2022. Available at https://archive.ada.gov/opioid_guidance.pdf

²⁷ See, generally, *Smith v. Aroostook County*. ACLU of Maine. <https://www.aclumaine.org/en/cases/smith-v-arostook-county>

²⁸ See, generally, *Pesce v. Coppinger*. ACLU of Massachusetts. <https://www.aclum.org/en/cases/pesce-v-coppinger>

²⁹ The Americans with Disabilities Act and the Opioid Crisis: Combating Discrimination Against People in Treatment or Recovery. U.S. Department of Justice. Civil Rights Division. April 5, 2022. Available at https://archive.ada.gov/opioid_guidance.pdf

³⁰ NIDA. 2023, September 25. Treatment and Recovery. Retrieved from <https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery-on-February-24-2024>.

³¹ Factors Related to Eligibility and Acceptance of Offers to Participate in DOJ Funded Adult Drug Courts. U.S. Government Accountability Office. February 2023. Available at <https://www.gao.gov/assets/gao-23-105272.pdf>

³² “Adult Treatment Court Best Practice Standards.” All Rise. 2023. https://allrise.org/wp-content/uploads/2023/12/All-Rise-Adult-Treatment-Court-Best-Practice-Standards-2nd-Ed.-I-VI_final.pdf

³³ “Adult Treatment Court Best Practice Standards.” All Rise. 2023. https://allrise.org/wp-content/uploads/2023/12/All-Rise-Adult-Treatment-Court-Best-Practice-Standards-2nd-Ed.-I-VI_final.pdf

³⁴ “Adult Treatment Court Best Practice Standards.” All Rise. 2023. https://allrise.org/wp-content/uploads/2023/12/All-Rise-Adult-Treatment-Court-Best-Practice-Standards-2nd-Ed.-I-VI_final.pdf

REPORT OF THE BOARD OF TRUSTEES

B of T Report 17-A-24

Subject: Drug Policy Reform

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

1 INTRODUCTION

2
3 At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD),
4 Resolution 203 entitled, “Drug Policy Reform,” was introduced by the Medical Student Section and
5 called on the AMA to:

- 6
7 • Advocate for federal and state reclassification of drug possession offenses as civil
8 infractions and the corresponding reduction of sentences and penalties for individuals
9 currently incarcerated, monitored, or penalized for previous drug-related felonies;
- 10 • Support federal and state efforts to expunge criminal records for drug possession
11 upon completion of a sentence or penalty at no cost to the individual; and
- 12 • Support federal and state efforts to eliminate incarceration-based penalties for
13 persons under parole, probation, pre-trial, or other criminal supervision for drug
14 possession.

15
16 Ultimately, Resolution 203 was referred to the Board of Trustees for study. Some of the primary reasons
17 for referral included the need for more background information on criminal penalties for drug possession;
18 the need to review the role of expungement for those convicted of drug-related crimes for drug
19 possession; and the need to identify the AMA’s unique role concerning other issues relating to drug
20 possession. This report also provides background information; discusses relevant policy and public health
21 considerations; presents AMA policy; and makes recommendations.

22 23 BACKGROUND

24
25 The National Center for Drug Abuse Statistics (NCDAS) reports that, “1.16 million Americans are
26 arrested annually for drug related offenses” and that, “227,655 Americans are arrested annually for the
27 possession of heroin, cocaine, and derivative products.” At the same time, NCDAS reports that, “40,446
28 Americans are arrested annually for the possession of synthetic drugs.”¹ A 2022 report from the Pew
29 Charitable Trusts found that between 2009-2019, “87 percent [of] drug arrests were for possession; the
30 rest were for sale or manufacturing.”² In the federal prison system, more than 44 percent of individuals
31 were incarcerated because of a drug-related offense.³

32
33 Incarceration rates for drug-related offenses, however, are decreasing. While the figures vary by state,
34 between 2009-2019, “The prison population in the 39 states with available data dropped by approximately
35 117,000 individuals from 2009 to 2019. The decrease in the number of people in prison for drug offenses
36 accounted for 61% of this total decline. Similarly, prison admissions fell by more than 131,000 from
37 2009 to 2019, with the drop in drug-related admissions accounting for 38 percent of the total.”⁴
38 There are significant racial disparities for those incarcerated for a drug-related offense. While use and
39 dependence rates between groups only vary by 1-2 percent, Black people are far more likely to be arrested

1 and incarcerated.⁵ These disparities have existed for decades,⁶ and they unfortunately continue. Research
2 from 2000 showed that Black individuals made up more than 60 percent of those sent to state prisons for
3 a drug-related offense⁷. The same study reported that, “Nationwide, black men are sent to state prison on
4 drug charges at 13 times the rate of white men.” More recent data show that, “prison admissions for Black
5 individuals for drug offenses decreased by 59 percent between 2009 and 2019, accounting for a quarter
6 (26 percent) of the total drop in admissions over that span.”⁸ Despite these decreases, disparities remain.
7 According to the Pew Charitable Trusts, “Black people made up 28 percent of admissions and 36 percent
8 of the population in prison for drug convictions in 2019, which are two and three times, respectively, their
9 share of the general population.”

10
11 The data also show differences in the prison population when race and gender are both considered.
12 Between 2009-2019, there was a “4 percent increase in admissions of White individuals for drug
13 offenses...[and] a 32 percent increase in the number of White females entering prison with drug
14 convictions. By comparison, admissions for drug offenses fell 71 percent for Black females and 4 percent
15 for White males.”⁹

16
17 Regarding youth-related drug offenses, between 2011-2020, there were an estimated 42,280 juvenile
18 arrests.¹⁰ Juvenile arrests for drug offenses decreased 72 percent between 2016-2020.¹¹ According to the
19 U.S. Office of Juvenile Justice and Delinquency Prevention, “the peak year for juvenile drug abuse
20 violation arrest rates was 1997 ... [and] overall from 1980 to 2020, the drug abuse violation arrest rate for
21 youth ages 15-17 decreased 64 percent , compared with a 21 percent decrease for young adults ages
22 18-20 and a 7 percent increase for young adults ages 21-24.”¹²

23 24 *Civil Infractions, Misdemeanors, and Felonies*

25
26 It is beyond the scope of this report to go into extensive detail about the wide variability and extensive
27 nuances in federal or state criminal codes concerning drug possession.¹³ A brief overview, however, may
28 be useful to underscore that the AMA’s unique role for this report is to focus on public health rather than
29 criminal law.

30
31 In general, a misdemeanor means any crime that does not amount to a felony.¹⁴ Misdemeanors generally
32 are those criminal offenses that carry punishments by incarceration of a year or less.¹⁵ A felony typically
33 denotes a crime more serious than a misdemeanor that subjects an individual to incarceration.¹⁶
34 Punishments for a felony typically are incarceration for periods of one year or more.¹⁷ An “infraction” can
35 have different meanings depending on the state, but it generally refers to a criminal act that is less serious
36 and carries less severe penalties than a misdemeanor, such a speeding ticket or parking meter violation.¹⁸
37 Criminal codes also distinguish “simple possession”¹⁹ from possession with intent to sell or distribute.²⁰

38
39 To prove a statutory crime, it is required to show both that an individual committed a criminal act, and in
40 so doing, acted with the state of mind requisite to constitute the crime in question.²¹ For simple drug
41 possession, the prosecutor must prove, generally, that the illicit substance was knowingly and/or
42 intentionally in the accused individual’s possession. Simple possession crimes differ from those with
43 intent to sell, manufacture or deliver in that simple possession typically is limited to personal use or
44 control whereas the crime of possession with intent to sell, manufacture or deliver requires proving both
45 possession/control of an illicit substance and that the individual had the intent to sell, manufacture or
46 deliver the substance. To prove intent to sell, manufacture or deliver, additional facts would be required,
47 which could come from undercover law enforcement or other witness testimony, exchange of money,
48 possession of manufacturing equipment, video surveillance, customer lists or other factual elements that
49 show more than just an intent limited to personal use or control.

50 There are a limited number of states that have decriminalized certain drug-related offenses. In 2020,
51 Oregon voters passed Ballot Measure 110, which among other things, effectively decriminalized
52 possession of certain amounts of Schedule I Controlled Substances, including cocaine, heroin, psilocybin,

1 and methamphetamine. Possession of amounts greater than the law authorized, as well as possession for
2 non-prescribed Schedule II-IV Controlled Substances, would subject an individual to a “Class E”
3 violation. Violators would be subject to a fine or agree to undertake a screening in lieu of a fine.²² Since
4 the measure went into effect, more than 7,600 individuals have received a Class E violation with
5 methamphetamine (55 percent) and Schedule II Controlled Substances (26 percent) the top reasons for
6 violations.²³ In response to multiple factors, including considerable public concern about reported
7 increases in public drug use, mortality and crime, the Oregon Legislature effectively ended
8 decriminalization of illegal drugs for personal use with passage of House Bill 4002, which the governor
9 said she will sign.²⁴ HB 4002 passed with wide, bipartisan margins in both the Oregon House and
10 Senate.²⁵

11
12 Additional state actions have occurred regarding psychedelics and other substances. For example,
13 legislative efforts surrounding Schedule I psychedelics are increasing. More than two dozen states have
14 considered or enacted measures to further study psychedelics, regulate their use, and establish pilot
15 treatment programs. For example, certain psychedelics were decriminalized in Washington, D.C. in
16 2021²⁶ and Colorado in 2022.²⁷ In 2021, drug possession was decriminalized in Washington state as a
17 result of a state supreme court decision in *State v. Blake*, which found the state’s drug possession statute
18 unconstitutional because it lacked an intent requirement.²⁸ The Washington Legislature re-criminalized
19 drug possession (as a misdemeanor) several months later in a special session.²⁹ The Washington law also
20 included provisions for diversion programs as an alternative to incarceration. The 2024 state legislative
21 sessions are actively considering many similar proposals.³⁰

22 23 *Expungement*

24
25 The Board of Trustees explained in [Board of Trustees Report 17-A-22](#) that it is important to recognize
26 that expungement, destruction, and sealing are legal processes.³¹ An expungement process may involve
27 multiple steps where the result is to remove a record of arrest and/or conviction from the official state or
28 federal record. The idea is that post-expungement, the record never existed. While an expungement may
29 “erase” a record, “sealing” hides the record from public view. More specifically, when “sealed,” the
30 record can be accessed under certain circumstances.³² Finally, “destruction” of a record generally means
31 to physically destroy it. When a record is “destroyed,” there is no record remaining whatsoever.³³ It is
32 important to note that specific definitions may vary by state.

33
34 Under federal law, the record of a conviction for drug possession may be able to be expunged depending
35 on the circumstances. An individual must qualify for expungement and undertake the process to formally
36 seek expungement. There are different requirements for those 21 years of age and older and those
37 younger than 21. The record of the underlying expungement also offers protection against future adverse
38 use, but it is retained by the U.S. Department of Justice.³⁴

39
40 At the state level, eligibility, and procedures for expungement of drug possession crimes vary
41 considerably.³⁵ State laws often are non-specific to controlled substances. In other words, eligibility and
42 procedures would be dependent on multiple factors, including whether a drug possession crime was a
43 misdemeanor or felony, and whether there were additional circumstances, including whether there were
44 other crimes committed and whether they were violent or nonviolent. Other states have waiting periods
45 after a sentence has been served, but these also are dependent on other factors that may be present,
46 including whether the drug possession crime was a first offense. States typically have different processes
47 and qualifications for minors.³⁶ In contrast, 24 states have specific procedures when the state has
48 decriminalized cannabis for medical and/or adult use.³⁷

1 DISCUSSION

2
3 *Reclassification of Drug Possession Offenses as Civil Infractions*
4

5 Proponents of decriminalizing drug possession cite multiple potential benefits, including saving money
6 from incarceration, focusing resources on treatment and social services, and other benefits such as
7 reducing the stigma surrounding drug use and having a substance use disorder.³⁸ Being incarcerated does
8 not often lead to treatment for a substance use disorder. The Pew Charitable Trusts reported data showing
9 that “1.1 million people with past-year illicit drug dependence or misuse reported being arrested and
10 booked in the past year...[but] 1 in 13—85,199—reported receiving drug treatment while in jail or prison.
11 Further, the drug- or alcohol-related mortality rate in jails increased from 9 in 100,000 in 2009 to 26 in
12 100,000 in 2019.”³⁹ Proponents also point to collateral consequences of having a criminal record for drug
13 possession, including denial of public benefits, losing custody of children, loss of voting rights, inability
14 to secure loans or financial aid, to name a few negative effects.⁴⁰ A meta-analysis of drug
15 decriminalization policies in 2020 focused on “evaluating effects of drug decriminalization or legal
16 regulation on drug availability, use or related health and social harms globally.”⁴¹ The analysis concluded
17 there was “a need for a broadening of the metrics used to assess the impacts of drug decriminalization and
18 legal regulation.”
19

20 Except for cannabis, there are few tangible examples in the United States on which to evaluate the
21 potential public health and collateral benefits of reclassifying drug possession offenses as civil infractions.
22 The Board of Trustees notes that our AMA Council on Science and Public Health has issued two previous
23 reports detailing the continued public health dangers associated with cannabis. Oregon, Colorado, and
24 Washington, D.C. are the only states to specifically decriminalize illicit substances, while multiple others
25 have enacted measures to direct law enforcement to treat possession of, for example, certain psychedelics,
26 as a “low priority.”⁴² In Oregon, the language of Ballot Measure 110 based part of its argument on the
27 premise that, “People suffering from addiction are more effectively treated with health care services than
28 with criminal punishments. A health care approach includes a health assessment to figure out the needs of
29 people who are suffering from addiction, and it includes connecting them to the services they need.” The
30 reality of Ballot Measure 110’s effects, however, demonstrate widespread challenges with connecting
31 individuals to screening, treatment, or recovery.
32

33 Three main studies of the effects of Oregon Ballot Measure 110 show that it generally failed to reduce
34 overdose-related fatality, and that it did not connect individuals to screening, treatment, or recovery. One
35 study found that Ballot Measure 110 “caused 182 additional unintentional drug overdose deaths to occur
36 in Oregon in 2021. This represents a 23 percent increase over the number of unintentional drug overdose
37 deaths predicted if Oregon had not decriminalized drugs.”⁴³ A separate study, however, found that there
38 was no significant change in death rates.⁴⁴ Perhaps most concerning is that Ballot Measure 110’s promise
39 of increased connections to treatment and increased access to evidence-based care has not been realized.
40 A state audit of Ballot Measure 110 discussed the widespread hopes for the ballot measure to improve
41 access to care for substance use disorders, reduce health inequities, and other laudable goals. The reality,
42 unfortunately, has been hampered by widespread challenges, including inefficient “program governance,”
43 “silos and fragmentation in the delivery of mental health and substance use disorder treatment,” poor
44 “stakeholder collaboration,” poor data collection and reporting structures, and a lack of coordination
45 between public health, public safety, and other agencies.⁴⁵
46

47 The Board of Trustees understands that the original intent of Oregon Ballot Measure 110 included an
48 effort to increase access to treatment, but there is a clear lack of evidence demonstrating public health
49 benefits or increases in access to evidence-based mental health or substance use disorder services in the
50 state. The available research, furthermore, does not clearly demonstrate tangible benefits on a wider scale.
51 The Board of Trustees observes that drug-related overdoses in Oregon have increased from 1,147 deaths
52 reported for the 12-month period between October 2020 and October 2021 to 1,683 deaths reported for

1 the 12-month period between October 2022 and October 2023.⁴⁶ The Board of Trustees believes that it is
2 premature to recommend decriminalizing drug possession offenses as a public health benefit in the
3 absence of evidence demonstrating public health benefits.

4
5 *Expungement of Criminal Records for Drug Possession upon Completion of a Sentence*

6
7 As noted above, there are ongoing collateral consequences experienced by individuals convicted of drug
8 possession (or other) crimes. The Board of Trustees emphasized these consequences as part of Board of
9 Trustees Report 17-A-22, “Expungement, Destruction, And Sealing Of Criminal Records For Legal
10 Offenses Related To Cannabis Use Or Possession.” That report recommended support for expungement
11 of cannabis-related offenses when those offenses were no longer illegal (because of newly enacted state
12 laws). As the Board stated in BOT Report 17-A-22,

13
14 Even if a record is expunged or sealed, however, that may not address collateral
15 consequences of the arrest or conviction, e.g., potential professional licensing sanctions,
16 adverse employment actions, and qualification for government benefits, including loans
17 and housing. These collateral consequences can also suppress the local tax base by
18 locking people into unemployment or lower paying jobs and increase taxpayer costs due
19 to increasing likelihood of further involvement in the criminal legal system.⁴⁷

20
21 The Board of Trustees supports reducing barriers to address these social determinants of health, including
22 supporting federal and state efforts to expunge criminal records for drug possession upon completion of a
23 sentence or penalty. Given that individuals released from jail or prison may have limited financial means,
24 we also support that the expungement process consider an individual’s financial hardship.

25
26 *Incarceration-based Penalties for Persons under Parole, Probation, Pre-trial, or other Criminal*
27 *Supervision for Drug Possession.*

28
29 As with different state laws and policies concerning what constitutes a drug possession felony or
30 misdemeanor, there is likely even greater state variation in what constitutes a violation of parole,
31 probation, pre-trial, or other supervisory agreement with an individual charged or convicted of drug
32 possession. While drug possession while on parole might trigger an automatic revocation in some
33 jurisdictions, in others there would be discretion. This is why some commentators argue for the “need to
34 critically examine the revocation process for probationers and parolees who transgress the terms and
35 conditions of their community supervision.”⁴⁸ Other commentators cite drug use or drug possession as a
36 common reason for parole, probation or other supervisory violations.⁴⁹ The Board of Trustees notes that
37 AMA advocacy and policy focus primarily on helping ensure individuals involved with the justice system
38 have access to evidence-based care. We certainly encourage discretion by court officers but do not believe
39 that the AMA has the unique expertise or experience to make categorical determinations about judicial
40 discretion.

41
42 Your Board – in a separate board report under consideration at this meeting, Board of Trustees Report 16
43 – explains why diversion programs should not automatically exclude individuals because they may have
44 previously used illicit substances. Similarly, we argue that individuals should not be removed from a
45 diversion program solely because they used an illicit substance. The National Institute of Drug Abuse
46 explains that “The chronic nature of addiction means that for some people relapse, or a return to drug use
47 after an attempt to stop, can be part of the process, but newer treatments are designed to help with relapse
48 prevention. Relapse rates for drug use are similar to rates for other chronic medical illnesses. If people
49 stop following their medical treatment plan, they are likely to relapse.”⁵⁰ AMA support for individuals
50 being able to continue parole or probation even if they engaged in illegal drug use is a natural extension
51 of AMA policy to not punish people because they have a substance use disorder.

1 AMA POLICY

2
3 AMA policy includes “support [for] legislation that promotes the use of non-financial release options for
4 individuals charged with nonviolent crimes.” (Policy H-80-993, “Ending Money Bail to Decrease Burden
5 on Lower Income Communities”). AMA policy also supports a broad range of elements for individuals
6 who are incarcerated, including, “...(a) linkage of those incarcerated to community clinics upon release in
7 order to accelerate access to comprehensive health care, including mental health and substance use
8 disorder services, and improve health outcomes among this vulnerable patient population, as well as
9 adequate funding; (b) the collaboration of correctional health workers and community health care
10 providers for those transitioning from a correctional institution to the community; (c) the provision of
11 longitudinal care from state supported social workers, to perform foundational check-ins that not only
12 assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration
13 with community-based organizations and integrated models of care that support formerly incarcerated
14 people with regard to their health care, safety, and social determinant of health needs, including
15 employment, education, and housing.” (Policy H-430-986, “Health Care While Incarcerated”). Whether
16 these elements could be achieved through decriminalization of drug possession crimes is not clear,
17 however, which is why your Board supports additional research to inform future decision making.

18
19 AMA policy also supports “automatic expungement, sealing, and similar efforts regarding an arrest or
20 conviction for a cannabis-related offense for use or possession that would be legal or decriminalized
21 under subsequent state legalization or decriminalization of adult use or medicinal cannabis.”
22 (Policy H-95.910, “Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses
23 Related to Cannabis Use or Possession”). AMA’s cannabis-related expungement policy also extends to
24 protections for minors and for “ending conditions such as parole, probation, or other court-required
25 supervision because of a cannabis-related offense for use or possession that would be legal or
26 decriminalized under subsequent state legalization or decriminalization of adult use or medicinal
27 cannabis.” (Policy H-430.986, “Health Care While Incarcerated”). Finally, AMA policy also calls for
28 “fairness in the expungement and sealing of records.” (Policy H-60.916, “Youth Incarceration in Adult
29 Facilities”). These policies highlight issues of fairness with respect to expungement as well as support for
30 the principle that drug use or possession—by itself—should not be a cause for additional criminal
31 penalty.

32
33 RECOMMENDATIONS

34
35 The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution
36 203 and the remainder of the report be filed:

- 37
38 1. That the American Medical Association (AMA) will continue to monitor the legal and public
39 health effects of state and federal policies to reclassify criminal offenses for drug possession for
40 personal use; (New HOD Policy)
- 41 2. That the AMA will support federal and state efforts to expunge, at no cost to the individual,
42 criminal records for drug possession for personal use upon completion of a sentence or penalty;
43 (New HOD Policy) and
- 44 3. That the AMA support programs that provide comprehensive substance use disorder treatment
45 and social support to people who use or possess illicit drugs for personal use as an alternative to
46 incarceration-based penalties for persons under parole, probation, pre-trial, or other civic,
47 criminal, or judicial supervision. (New HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

- ¹ Drug Related Crime Statistics. National Center for Drug Abuse Statistics. Updated 2024. Available at <https://drugabusestatistics.org/drug-related-crime-statistics/>
- ² Drug Arrests Stayed High Even as Imprisonment Fell From 2009 to 2019. Pew Charitable Trusts. February 2022. Available at <https://www.pewtrusts.org/-/media/assets/2022/02/drug-arrests-stayed-high-even-as-imprisonment-fell-from-2009-to-2019.pdf>
- ³ Offenses. Federal Bureau of Prisons. Data updated weekly. Accessed February 29, 2024. https://www.bop.gov/about/statistics/statistics_inmate_offenses.jsp
- ⁴ Drug Arrests Stayed High Even as Imprisonment Fell From 2009 to 2019. Pew Charitable Trusts. February 2022. Available at <https://www.pewtrusts.org/-/media/assets/2022/02/drug-arrests-stayed-high-even-as-imprisonment-fell-from-2009-to-2019.pdf>
- ⁵ Ojmarrh Mitchell & Michael S. Caudy (2015) Examining Racial Disparities in Drug Arrests, Justice Quarterly, 32:2, 288-313, DOI: 10.1080/07418825.2012.761721
- ⁶ Langan, Patrick A. The Racial Disparity in U.S. Drug Arrests. Bureau of Justice Statistics. October 1, 1995. <https://bjs.ojp.gov/content/pub/pdf/r dusda.pdf>
- ⁷ Punishment and Prejudice: Racial Disparities in the War on Drugs. Human Rights Watch. <https://www.hrw.org/legacy/campaigns/drugs/war/key-facts.htm>
- ⁸ Drug Arrests Stayed High Even as Imprisonment Fell From 2009 to 2019. Pew Charitable Trusts. February 2022. Available at <https://www.pewtrusts.org/-/media/assets/2022/02/drug-arrests-stayed-high-even-as-imprisonment-fell-from-2009-to-2019.pdf>
- ⁹ Drug Arrests Stayed High Even as Imprisonment Fell From 2009 to 2019. Pew Charitable Trusts. February 2022. Available at <https://www.pewtrusts.org/-/media/assets/2022/02/drug-arrests-stayed-high-even-as-imprisonment-fell-from-2009-to-2019.pdf>
- ¹⁰ OJJDP Statistical Briefing Book. Online. Available: <https://ojjdp.ojp.gov/statistical-briefing-book/crime/faqs/QA05101>. Released on 7/8/2022.
- ¹¹ OJJDP Statistical Briefing Book. Online. Available: <https://ojjdp.ojp.gov/statistical-briefing-book/crime/faqs/QA05101>. Released on 7/8/2022.
- ¹² OJJDP Statistical Briefing Book. Online. Available: <https://ojjdp.ojp.gov/statistical-briefing-book/crime/faqs/qa5308>. Released on July 08, 2022.
- ¹³ Drug Possession Laws: 50-State Survey. Justia. Last reviewed September 2023. Available at <https://www.justia.com/criminal/offenses/drug-crimes/drug-possession-laws-50-state-survey/>
- ¹⁴ Misdemeanor. Definition & Legal Meaning. The Law Dictionary. <https://thelawdictionary.org/misdemeanor/>
- ¹⁵ What Happens in a Misdemeanor Case. U.S. Attorneys Office. Northern District of Illinois. <https://www.justice.gov/usao-ndil/programs/vwa-misdemeanor> Updated July 24, 2015.
- ¹⁶ Felony. Definition & Legal Meaning. The Law Dictionary. <https://thelawdictionary.org/felony/>
- ¹⁷ What Happens in a Felony Case. U.S. Attorneys Office. Northern District of Illinois. <https://www.justice.gov/usao-ndil/programs/vwa-felony> Last Updated July 24, 2015.
- ¹⁸ Infraction. Legal Information Institute. Cornell Law School. <https://www.law.cornell.edu/wex/infraction>
- ¹⁹ 21 U.S.C. § 844 - Penalties for simple possession. <https://www.govinfo.gov/content/pkg/USCODE-2011-title21/pdf/USCODE-2011-title21-chap13-subchapI-partD-sec844.pdf>
- ²⁰ See, for example, Code of Virginia § 18.2-248. Manufacturing, selling, giving, distributing, or possessing with intent to manufacture, sell, give, or distribute a controlled substance or an imitation controlled substance prohibited; penalties. Available at <https://law.lis.virginia.gov/vacode/title18.2/chapter7/section18.2-248/>
- ²¹ See, generally, “criminal law.” Legal Information Institute. Cornell Law School. Available at https://www.law.cornell.edu/wex/criminal_law
- ²² See, Oregon Judicial Department. ORS 153.062. Class E violation proceedings. Available at https://oregon.public.law/statutes/ors_153.062
- ²³ Class E Violations Through 1/31/2024. Oregon Judicial Department. Available at <https://www.courts.oregon.gov/about/Documents/BM110Statistics.pdf>
- ²⁴ “Oregon Senate votes to end drug decriminalization.” Oregon Public Broadcasting, March 4, 2024. Available at <https://www.opb.org/article/2024/03/04/oregon-senate-votes-to-end-drug-decriminalization/>
- ²⁵ Oregon Legislative Information. Oregon State Legislature. HB 4002 Enrolled. 2024 Regular Session. Available at <https://olis.oregonlegislature.gov/liz/2024R1/Measures/Overview/HB4002>
- ²⁶ “Magic Mushrooms Are Decriminalized in DC as of Today. Ayahuasca, too.” The Washingtonian. March 15, 2021. Available at <https://www.washingtonian.com/2021/03/15/magic-mushrooms-are-decriminalized-in-dc-as-of-today/>

- ²⁷ “Colorado Voted to Decriminalize ‘Magic Mushrooms’—What Happens Next?” University of Colorado. November 15, 2022. Available at <https://news.cuanschutz.edu/medicine/colorado-magic-mushrooms-psilocybin>
- ²⁸ *State v. Blake*, 197 Wn.2d 170, 481 P.3d 521 (2021)
- ²⁹ “Washington governor signs new law keeping drug possession illegal.” CNN. May 17, 2023. Available at <https://www.cnn.com/2023/05/17/us/washington-drug-possession-law/index.html>
- ³⁰ Siegel JS, Daily JE, Perry DA, Nicol GE. Psychedelic Drug Legislative Reform and Legalization in the US. *JAMA Psychiatry*. 2023 Jan 1;80(1):77-83. doi: 10.1001/jamapsychiatry.2022.4101. PMID: 36477830; PMCID: PMC10069558.
- ³¹ “Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession.” Board of Trustees Report 17-A-22. Pages 87-91. Available at <https://www.ama-assn.org/system/files/a22-bot-reports.pdf>
- ³² “Restoration of Rights.” National Association of Criminal Defense Lawyers. “Expungement results in deletion of any record that an arrest or criminal conviction ever occurred. A sealed record is removed from general review; the record still exists and can be reviewed under limited circumstances.” Last accessed February 14, 2022. Available at <https://nacdl.org/Landing/RestorationofRightsandStatusAfterConviction>
- ³³ “What is expungement?” American Bar Association. November 20, 2018. Available at https://www.americanbar.org/groups/public_education/publications/teaching-legal-docs/what-is-expungement/
- ³⁴ 18 U.S.C. § 3607. Special probation and expungement procedures for drug possessors. Available at <https://www.govinfo.gov/app/details/USCODE-2022-title18/USCODE-2022-title18-partII-chap229-subchapA-sec3607>
- ³⁵ Record Clearing by Offense. National Conference of State Legislatures. Updated August 14, 2020. Available at <https://www.ncsl.org/civil-and-criminal-justice/record-clearing-by-offense>
- ³⁶ Automatic Expungement of Juvenile Records. National Conference of State Legislatures. Updated January 4, 2024. Available at <https://www.ncsl.org/civil-and-criminal-justice/automatic-expungement-of-juvenile-records>
- ³⁷ “50-State Comparison: Marijuana: Marijuana Legalization, Decriminalization, Expungement, and Clemency.” Restoration of Rights Project. Updated January 2023. Available at <https://ccresourcecenter.org/state-restoration-profiles/50-state-comparison-marijuana-legalization-expungement/>
- ³⁸ “Decriminalize Drugs, Invest in Health Services.” Drug Policy Alliance. Available at <https://drugpolicy.org/issue/decriminalize-drugs-invest-in-health-services/>
- ³⁹ Drug Arrests Stayed High Even as Imprisonment Fell From 2009 to 2019. Pew Charitable Trusts. February 2022. Available at <https://www.pewtrusts.org/-/media/assets/2022/02/drug-arrests-stayed-high-even-as-imprisonment-fell-from-2009-to-2019.pdf>
- ⁴⁰ “Fifty Years Ago Today, president Nixon Declared the War on Drugs.” Vera Institute on Justice. June 17, 2021. Available at <https://www.vera.org/news/fifty-years-ago-today-president-nixon-declared-the-war-on-drugs>
- ⁴¹ Scheim AI, Maghsoudi N, Marshall Z, Churchill S, Ziegler C, Werb D. Impact evaluations of drug decriminalisation and legal regulation on drug use, health and social harms: a systematic review. *BMJ Open*. 2020 Sep 21;10(9):e035148. doi: 10.1136/bmjopen-2019-035148. PMID: 32958480; PMCID: PMC7507857.
- ⁴² Psychedelic Legalization & Decriminalization Tracker. Psychedelic Alpha. Last Updated November 29, 2023. Available at <https://psychedelicalpha.com/data/psychedelic-laws>
- ⁴³ Noah Spencer, Does drug decriminalization increase unintentional drug overdose deaths?: Early evidence from Oregon Measure 110 ? *Journal of Health Economics*, Volume 91, 2023, 102798, ISSN 0167-6296, <https://doi.org/10.1016/j.jhealeco.2023.102798>. (<https://www.sciencedirect.com/science/article/pii/S0167629623000759>)
- ⁴⁴ Joshi S, Rivera BD, Cerdá M, et al. One-Year Association of Drug Possession Law Change With Fatal Drug Overdose in Oregon and Washington. *JAMA Psychiatry*. 2023;80(12):1277–1283. doi:10.1001/jamapsychiatry.2023.3416
- ⁴⁵ Too Early to Tell: The Challenging Implementation of Measure 110 Has Increased Risks, but the Effectiveness of the Program Has Yet to Be Determined. Oregon Health Authority. January 2023. Available at <https://sos.oregon.gov/audits/Documents/2023-03.pdf>
- ⁴⁶ Ahmad FB, Cisewski JA, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2024. Last accessed March 13, 2024.
- ⁴⁷ “Expungement, Destruction, And Sealing Of Criminal Records For Legal Offenses Related To Cannabis Use Or Possession.” Board of Trustees Report 17-A-22.
- ⁴⁸ “Probation and Parole Officers and Discretionary Decision-Making: Responses to Technical and Criminal Violations.” Federal Probation. Volume 71, Number 1. Available at https://www.uscourts.gov/sites/default/files/71_1_2_0.pdf

⁴⁹ “Revoked: How Probation and Parole Feed Mass Incarceration in the United States.” Human Rights Watch. July 31, 2020. Available at <https://www.hrw.org/report/2020/07/31/revoked/how-probation-and-parole-feed-mass-incarceration-united-states>

⁵⁰ NIDA. 2023, September 25. Treatment and Recovery. Retrieved from <https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery-on-February-24>, 2024.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 18-A-24

Subject: Supporting Harm Reduction

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

1 INTRODUCTION

2
3 At the June 2023 Annual Meeting, the American Medical Association (AMA) House of Delegates
4 (HOD), Resolution 204 entitled, “Supporting Harm Reduction,” was introduced by the Medical Student
5 Section and called on the AMA to:

- 6
7 • Advocate for the removal of buprenorphine from the misdemeanor crime of
8 possession of a narcotic;
9 • Support any efforts to decriminalize the possession of non-prescribed
10 buprenorphine; and
11 • Amend the 4th and 6th resolves of Policy D-95.987 by addition and deletion to
12 read as follows:

13 4. Our AMA will advocate for and encourage state and county medical
14 societies to advocate for harm reduction policies that provide civil and
15 criminal immunity for the possession, distribution, and use of “drug
16 paraphernalia” designed for harm reduction from drug use, including but
17 not limited to drug contamination testing, safer smoking, and injection
18 drug preparation, use and disposal supplies.

19
20 6. Our AMA will advocate for ~~supports efforts to~~ increased access to and
21 decriminalization of fentanyl test strip, and other drug checking supplies,
22 and safer smoking kits for purposes of harm reduction.

23
24 The HOD discussed the strong evidence base supporting buprenorphine as a treatment for opioid use
25 disorder (OUD), the uncertainty surrounding the facts of buprenorphine “diversion,” and the significant
26 concerns about the meaning and practice of “safer smoking.” Ultimately, the HOD referred the resolution
27 to the Board of Trustees for study. In response, this board report provides background information;
28 discusses the different issues raised by the resolution; presents AMA policy; and makes policy
29 recommendations.

30
31 BACKGROUND

32
33 *Buprenorphine*

34
35 Buprenorphine is a Schedule III Controlled Substance that the U.S. Drug Enforcement Administration
36 (DEA) defines as a narcotic for purposes of drug scheduling.¹ The U.S. Food and Drug Administration
37 (FDA) first approved buprenorphine-containing products in 2002 for the treatment of OUD.

1 Buprenorphine for OUD may be prescribed as a “mono-product,” and some manufacturers combine it
2 with naloxone (“combination product”) to treat OUD. It may be available as a tablet, sublingual film,
3 transdermal film, or injection.
4

5 There is widespread evidence that supports buprenorphine as an evidence-based medication to treat
6 OUD.² Researchers and clinicians commonly promote statements such as, “opioid agonist therapy (OAT)
7 with methadone or buprenorphine is the gold-standard treatment for OUD.”³ The U.S. Substance Abuse
8 and Mental Health Services Administration (SAMHSA) provides multiple resources about
9 buprenorphine, including clinical and safety information, treating pregnant and postpartum individuals,
10 potential for misuse, and safety considerations.⁴ Because of its evidence-base, AMA advocacy has for
11 years called for removing all barriers to buprenorphine for the treatment of OUD—including prior
12 authorization reforms,⁵ the x-waiver,⁶ telehealth restrictions,⁷ and dosage caps.⁸
13

14 While prescriptions dispensed for medications to treat opioid use disorder (MOUD) have marginally
15 increased in the past five years from 14.54 million to 16.05 million,⁹ there remain millions of Americans
16 who misuse illicit substances, prescription opioids and/or have untreated substance use disorder.¹⁰ More
17 than 78 million illicit fentanyl-containing pills and 12,000 pounds of fentanyl powder were seized by the
18 U.S. Drug Enforcement Administration (DEA) in 2023.¹¹ The U.S. Centers for Disease Control and
19 Prevention (CDC) advise that, “Powdered fentanyl looks just like many other drugs. It is commonly
20 mixed with drugs like heroin, cocaine, and methamphetamine and made into pills that are made to
21 resemble other prescription opioids.”¹²
22

23 *“Safer Smoking”* 24

25 As a threshold matter, and discussed briefly below, the AMA does not support the concept of “safer
26 smoking.” The issue of “safer smoking” in relation to the nation’s drug-related overdose and death
27 epidemic, however, is a harm reduction concept that seeks to reduce the spread of infectious disease as
28 well as support changes to injection drug use. The types of safer smoking supplies are often, “specific for
29 each type of drug used, but generally includes a heat resistant pipe or foil, protective mouthpiece, tamp,
30 screen, and lip protectant, all of which reduce heat-related injuries and infection risk.”¹³ In addition to
31 reducing injection drug use, proponents of safer smoking supplies also point to, “Smoking supplies
32 distributed by harm reduction programs [that] are clean and safer than improvised items like aluminum
33 cans, plastic tubes, steel wool, and light bulbs that can break easily or release toxic fumes.”¹⁴ These
34 supplies are typically considered illicit drug paraphernalia, and “Nearly all states penalize the possession
35 and distribution of glass pipes and other devices used for smoking or inhaling illegal drugs.”¹⁵
36

37 In addition to state law prohibitions against safer smoking supplies, federal law defines a wide variety of
38 materials as illegal drug paraphernalia, including,
39

- 40 (1) metal, wooden, acrylic, glass, stone, plastic, or ceramic pipes with or without screens,
- 41 permanent screens, hashish heads, or punctured metal bowls; (2) water pipes; (3)
- 42 carburetion tubes and devices; (4) smoking and carburetion masks; (5) roach clips:
- 43 meaning objects used to hold burning material, such as a marijuana cigarette, that has
- 44 become too small or too short to be held in the hand; (6) miniature spoons with level
- 45 capacities of one-tenth cubic centimeter or less; (7) chamber pipes; (8) carburetor pipes;
- 46 (9) electric pipes; (10) air-driven pipes; (11) chillums; (12) bongs; (13) ice pipes or
- 47 chillers; (14) wired cigarette papers; or (15) cocaine freebase kits.¹⁶
48

49 Every state—except Alaska—has a drug paraphernalia law.¹⁷ While state laws vary considerably, one
50 distinction is that needles and syringes may still be considered drug paraphernalia, but they are allowed

1 for personal use in most states. Penalties for individuals convicted of possession or use of other drug
2 paraphernalia can range from misdemeanors to felonies.¹⁸

3 4 DISCUSSION

5 6 *Decriminalization of Non-prescribed Possession and Use of Buprenorphine*

7
8 While penalties vary, possession of non-prescribed buprenorphine—like other non-prescribed controlled
9 substances—is generally considered a violation of state and/or federal law and can subject an individual
10 to monetary penalties and/or imprisonment depending on the circumstances.¹⁹ One of the key questions
11 for this board report, however, is whether the benefits of using non-prescribed buprenorphine in certain
12 circumstances outweigh the risks. The National Institute on Drug Abuse (NIDA) reports that, “most data
13 suggest that the majority of buprenorphine and methadone misuse (use without a prescription) is for the
14 purpose of controlling withdrawal and cravings for other opioids and not to get high.”²⁰ NIDA also points
15 out low rates of diversion risk, illicit use, and emergency department visits related to buprenorphine.
16 Research comparing buprenorphine-involved deaths compared to opioid-involved deaths during the
17 COVID-19 pandemic found that, “actions to facilitate access to buprenorphine-based treatment for opioid
18 use disorder during the COVID-19 pandemic were not associated with an increased proportion of
19 overdose deaths involving buprenorphine; efforts are needed to expand more equitable and culturally
20 competent access to and provision of buprenorphine-based treatment.”²¹ The AMA has argued that
21 individuals’ lack of access to buprenorphine is due to multiple factors, including stigma, and inadequate
22 networks of addiction medicine physicians, psychiatrists, primary care and other physicians willing to
23 prescribe buprenorphine. Access to buprenorphine is particularly problematic for racial and ethnic
24 minorities.²² The AMA and the AMA Substance Use and Pain Care Task Force has long urged that all
25 efforts be taken to increase access to buprenorphine and other medications for opioid use disorder
26 (MOUD). Decriminalization, however, is an issue of first impression for the AMA.

27
28 Decriminalization of possession of non-prescribed buprenorphine for personal use already is occurring in
29 the United States. Vermont became the first state in 2021 to specifically decriminalize possession of
30 224 milligrams of non-prescribed buprenorphine for personal use.²³ Initially enacted as a two-year pilot,
31 after positive reviews that the bill helped increase access to buprenorphine among people who use drugs
32 (PWUD) and also increase access to other forms of treatment, the Vermont Legislature made the
33 exemption permanent in 2023.²⁴ Rhode Island also decriminalized buprenorphine in 2021 by amending its
34 criminal code.²⁵ Another state example is when Oregon, in 2020, effectively decriminalized a wide range
35 of drugs for personal use, including Schedule III Controlled Substances.²⁶ It is not clear whether this has
36 increased access to buprenorphine in Oregon, but a report from the Oregon Judicial Department did not
37 cite “buprenorphine” for any of the new “Class E” violations.²⁷

38
39 Multiple studies have found the mortality risk of buprenorphine is low. This includes retrospective
40 mortality reviews showing how buprenorphine-involved mortality was commonly part of polysubstance
41 use.²⁸ In a study of Medicare beneficiaries, “Buprenorphine treatment after nonfatal opioid-involved
42 overdose was associated with a 62% reduction in the risk of opioid-involved overdose death.”²⁹ A review
43 of COVID-19-era opioid-involved overdose deaths found that “buprenorphine was involved in
44 2.6 percent of opioid-involved overdose deaths during July 2019 to June 2021”—a rate that “did not
45 increase” even as rates of overdose overall increased.³⁰ Commentators suggest that while there are some
46 risks to using non-prescribed buprenorphine, there are many benefits, including overcoming barriers that,
47 “extend across socioeconomic, bureaucratic, and stigmatizing lines and include unemployment, insurance
48 status, buprenorphine waiting lists, and most importantly, knowledge and physical access to providers
49 who can and want to prescribe buprenorphine.”³¹ The Board of Trustees acknowledges that use of
50 nonprescribed buprenorphine carries risks, but views the available evidence as mitigating in support of

1 doing all that is necessary to reduce health inequities and save lives from an opioid-related overdose,
2 including decriminalizing the personal possession and use of nonprescribed buprenorphine.

3
4 *“Safer Smoking” as a Harm Reduction Measure*

5
6 The AMA has supported a broad range of what are generally considered “harm reduction” measures. This
7 includes support for laws and other policies encouraging prescribing, distribution, and use of naloxone
8 and other opioid-overdose reversal agents. The AMA also supports broad Good Samaritan protections to
9 provide civil and criminal protections for individuals at the scene of an overdose event. The AMA further
10 supports the same protections for individuals who overdose. AMA policy also supports harm reduction
11 centers (also called overdose prevention sites), as well as the ability for syringe services programs (SSPs)
12 to provide sterile needles and syringes to help stem the spread of blood borne infectious disease. While
13 there will always be detractors and stigma, these harm reduction measures have been well-studied and
14 have been shown to help reduce mortality and improve health outcomes. It is beyond the scope of this
15 report to detail all the research for these measures, but it is important to highlight that each (to different
16 degrees) has largely overcome stigma in the medical community. The Board of Trustees acknowledges
17 that stigma remains a considerable barrier for SSPs and harm reduction centers.

18
19 Injection drug use continues to be a major public health issue. A Centers for Disease Control and
20 Prevention (CDC) study found that nearly 3.7 million people in the United States injected drugs in
21 2018—a 5-fold increase from 2011.³² The study also found that more than 42 percent of overdose deaths
22 were from injections. Another CDC report found that, “During 2013–2017, reported methamphetamine,
23 injection drug, and heroin use increased substantially among women and heterosexual men with [primary
24 and secondary] syphilis.”³³ Injection drug use may also result in the spread of skin and groin infections,
25 Hepatitis C, bacterial endocarditis, osteomyelitis, and other preventable health conditions.³⁴ Prevention of
26 the spread of blood-borne infectious disease is one of many reasons the AMA strongly supports broad
27 access to sterile needle and SSPs.

28
29 AMA support for SSPs, however, has been based on the strong evidence-base for SSPs. We raise the
30 question, therefore, whether the evidence supports increased use of safer smoking supplies (as defined
31 above), including decriminalization of such supplies. A 2023 descriptive review of 550 PWUDs found
32 that there was limited access but high interest in obtaining safer smoking supplies for heroin, crack
33 cocaine, and methamphetamine.³⁵ The authors were clear about the study limitations but highlighted other
34 research suggesting that obtaining safer smoking supplies could reduce injection drug use. A recently
35 published meta-review of global practices reported that, “Ten studies found that when people who use
36 drugs were provided with safer smoking materials, they engaged in fewer risky drug use behaviors (e.g.,
37 pipe sharing, using broken pipes) and showed improved health outcomes.”³⁶ The authors concluded that,
38 “safer smoking practices are essential forms of harm reduction,” but that “Additional research is also
39 needed to evaluate the efficacy of and access to safer smoking services, particularly in the U.S. and other
40 similar countries, where such practices are being implemented but have not been empirically studied in
41 the literature.” We agree that more research is necessary.

42
43 It is also important to emphasize that additional research into the potential benefits of any harm reduction
44 measure in no way condones or supports the use of illicit drugs or other substances whether through
45 injection, inhalation, or other routes of administration. The Board of Trustees notes that while reductions
46 in injection drug use should be considered positive, it is deeply concerning that it may be accompanied by
47 increases in smoking illicit fentanyl.³⁷ We agree with comments from addiction psychiatrists such as, “I
48 do not know that we are at a place where we can say, ‘Hey, maybe you should smoke it instead,’” and “It
49 would be hard for me to feel confident in recommending that to somebody.”³⁸ Further, it must be stressed
50 that there is no such thing as “safer smoking” of fentanyl, cannabis, tobacco or illicit substances, and also
51 stressed that smoking fentanyl carries significant risks, including overdose and death.³⁹ Similarly, the

1 Board of Trustees believes that while there may be some evidence showing reduced harms associated
2 with smoking fentanyl and certain safer smoking supplies as compared to injection use, there is a clear
3 need for much more research before the AMA spends its resources and puts its public health and science
4 credibility on the line.

5
6 *Decriminalization of Fentanyl Test Strips*
7

8 This resolution also calls for the AMA to support the decriminalization of fentanyl test strips. It is critical
9 to note that this ask is redundant as AMA policy already effectively accomplishes this. Specifically, our
10 policy states that, “Our AMA will: advocate for the removal of fentanyl test strips (FTS) and other testing
11 strips, devices or testing equipment used in identifying or analyzing whether a substance contains fentanyl
12 or other adulterants from the legal definition of drug paraphernalia.” (Policy D-95.987, “Prevention of
13 Drug-Related Overdose”) The AMA has advocated for this at the state and federal levels⁴⁰ and
14 encourages all medical societies to support legislation to implement this important policy. In this regard,
15 we appreciate the opportunity to highlight AMA advocacy and conclude that existing policy (and
16 subsequent advocacy measures) already meet the intent and purpose of the resolution.
17

18 **AMA POLICY**
19

20 Extending AMA policy to support decriminalization of non-prescribed buprenorphine for personal use
21 would become part of a broad and growing policy base supporting increased access to buprenorphine and
22 other MOUD. Policies in this family include:
23

- 24 • Policy H-420.970, “Treatment Versus Criminalization - Physician Role in Drug Addiction During
25 Pregnancy;”
- 26 • Policy H-95.956, “Harm Reduction Through Addiction Treatment;”
- 27 • Policy H-430.987, “Medications for Opioid Use Disorder in Correctional Facilities;”
- 28 • Policy H-290.962, “Medicaid Substance Use Disorder Coverage;”
- 29 • Policy H-320.941, “Eliminate Fail First Policy in Addiction Treatment;”
- 30 • Policy H-95.944, “Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy;”
- 31 • Policy D-95.955, “Improving Access to Post-Acute Medical Care for Patients with Substance Use
32 Disorder (SUD);” and
- 33 • Policy D-95.972, “Expanding Access to Buprenorphine for the Treatment of Opioid Use
34 Disorder.”
35

36 It bears repeating that the Board of Trustees strongly supports the provision of MOUD to occur within a
37 medically supervised and physician-led environment. We also recognize that given the innumerable
38 barriers to such care, combined with the clear benefits of increasing access to buprenorphine, calling for
39 decriminalization of non-prescribed buprenorphine for personal use is necessary to help reduce harms,
40 including overdose and death.
41

42 AMA policy already supports efforts to increase access to a broad range of harm reduction initiatives:
43

44 Our AMA will advocate for and encourage state and county medical societies to advocate
45 for harm reduction policies that provide civil and criminal immunity for the possession,
46 distribution, and use of “drug paraphernalia” designed for harm reduction from drug use,
47 including but not limited to drug contamination testing and injection drug preparation,
48 use, and disposal supplies. (Policy D-95.987, “Prevention of Drug-Related Overdose”)
49

50 It is reasonable to conclude, therefore, that this policy helps inform AMA support for SSPs, public

1 availability of sharps disposal units, and other areas. For example, AMA support for SSPs can be found
2 here:

3
4 . . . encourages the extensive application of needle and syringe exchange and distribution
5 programs and the modification of restrictive laws and regulations concerning the sale and
6 possession of needles and syringes to maximize the availability of sterile syringes and
7 needles, while ensuring continued reimbursement for medically necessary needles and
8 syringes. strongly supports the ability of physicians to prescribe syringes and needles to
9 patients who inject drugs in conjunction with addiction counseling to help prevent the
10 transmission of contagious diseases. (Policy H-95.954, “The Reduction of Medical and
11 Public Health Consequences of Drug Use”)
12

13 Finally, as discussed above, the evidence base for SSPs has been demonstrated. In contrast, the evidence
14 base in support of safer smoking supplies has not. The Board, therefore, urges increased research as it
15 relates to the latter.
16

17 RECOMMENDATIONS

18

19 The Board of Trustees recommends that the following new policy be adopted in lieu of Resolution 204,
20 and that the remainder of the report be filed.
21

- 22 1. That the American Medical Association (AMA) support efforts to decriminalize the possession
23 of non-prescribed buprenorphine for personal use by individuals who lack access to a physician
24 for the treatment of opioid use disorder; (New HOD Policy)
- 25 2. That the AMA oppose the concept, promotion, or practice of “safe smoking” with respect to
26 inhalation of tobacco, cannabis or any illicit substance; (New HOD Policy)
- 27 3. That the AMA encourage additional study whether “safer smoking supplies” may be a potential
28 harm reduction measure to reduce harms from the nation’s overdose and death epidemic; and
29 (New HOD Policy)
- 30 4. That the AMA reaffirm Policy D-95.987, “Prevention of Drug-Related Overdose.” (Reaffirm
31 AMA Policy)

Fiscal Note: Less than \$500.

REFERENCES

- ¹ Controlled Substances—Alphabetical Order. U.S. Drug Enforcement Administration. Available at https://www.deadiversion.usdoj.gov/schedules/orangebook/c_cs_alpha.pdf
- ² Medications to Treat Opioid Use Disorder Research Report. NIDA. December 2, 2021. Available at <https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/overview>
- ³ Hagedorn H, Kenny M, Gordon AJ, Ackland PE, Noorbaloochi S, Yu W, Harris AHS. Advancing pharmacological treatments for opioid use disorder (ADaPT-ODU): protocol for testing a novel strategy to improve implementation of medication-assisted treatment for veterans with opioid use disorders in low-performing facilities. *Addict Sci Clin Pract.* 2018 Dec 13;13(1):25. doi: 10.1186/s13722-018-0127-z. PMID: 30545409; PMCID: PMC6293521. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6293521/>
- ⁴ Buprenorphine. U.S. Substance Abuse and Mental Health Services Administration. Last Updated January 30, 2024. <https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/buprenorphine>
- ⁵ “Removing prior authorization for MAT results in more patient care.” American Medical Association. February 5, 2020. Available at <https://www.ama-assn.org/practice-management/prior-authorization/removing-prior-authorization-mat-results-more-patient-care>
- ⁶ “AMA statement on HHS decision to remove barriers for opioid treatment.” Patrice A. Harris, MD, MA. January 14, 2021. Available at <https://www.ama-assn.org/press-center/press-releases/ama-statement-hhs-decision-remove-barriers-opioid-treatment>
- ⁷ “Why DEA’s latest move on telehealth could be a lifesaver.” American Medical Association. November 1, 2023. Available at <https://www.ama-assn.org/practice-management/digital/why-dea-s-latest-move-telehealth-could-be-lifesaver>
- ⁸ “Add flexibility on buprenorphine Rx for opioid use disorder.” American Medical Association. January 31, 2024. Available at <https://www.ama-assn.org/delivering-care/overdose-epidemic/add-flexibility-buprenorphine-rx-opioid-use-disorder>
- ⁹ Total dispensed prescriptions to treat opioid use disorder. IQVIA Xponent limited to retail pharmacy dispensed prescriptions; USC 78340 (drug dependency), which includes molecules buprenorphine (except where indicated for pain management in USC 02200), buprenorphine/naloxone, naltrexone. Available at <https://end-overdose-epidemic.org/wp-content/uploads/2023/11/AMA-2023-overdose-report-IQVIA-data-buprenorphine-FINAL.pdf>
- ¹⁰ SAMHSA Announces National Survey on Drug Use and Health (NSDUH) Results Detailing Mental Illness and Substance Use Levels in 2021. U.S. Substance Use and Mental Health Services Administration. January 4, 2023. Available at <https://www.hhs.gov/about/news/2023/01/04/samhsa-announces-national-survey-drug-use-health-results-detailing-mental-illness-substance-use-levels-2021.html>
- ¹¹ One Pill Can Kill. U.S. Drug Enforcement Administration. Available at <https://www.dea.gov/onepill>
- ¹² Fentanyl Facts. U.S. Centers for Disease Control and Prevention. Last Reviewed: September 6, 2023. Available at <https://www.cdc.gov/stopoverdose/fentanyl/index.html>
- ¹³ Reid MC, Oliphant-Wells T, Moreno C, Ketchum J, Fitzpatrick T, McMahan VM, Glick SN. High levels of interest in access to free safer smoking equipment to reduce injection frequency among people who inject drugs in Seattle, Washington. *Drug Alcohol Depend Rep.* 2023 May 2;7:100163. doi: 10.1016/j.dadr.2023.100163. PMID: 37214756; PMCID: PMC10193167.
- ¹⁴ Singh S, Banta-Green C, Kingston S. Distribution of Safer Drug Smoking Supplies as a Public Health Strategy. Seattle, WA: Addictions, Drug & Alcohol Institute, University of Washington, January 2022. <https://adai.uw.edu/SaferSmoking-Brief-2022>
- ¹⁵ Corey S. Davis, J.D., M.S.P.H., and Derek H. Carr, J.D. Repealing State Drug-Paraphernalia Laws — The Need for Federal Leadership. October 13, 2022. *N Engl J Med* 2022; 387:1344-1346. DOI: 10.1056/NEJMp2207866.
- ¹⁶ 21 U.S.C. 863 - Drug paraphernalia. <https://www.govinfo.gov/content/pkg/USCODE-2022-title21/pdf/USCODE-2022-title21-chap13-subchapl-partD-sec863.pdf>
- ¹⁷ Drug Paraphernalia: Summary of State Laws. Legislative Analysis and Public Policy Association. April 2022. Available at <https://legislativeanalysis.org/wp-content/uploads/2022/09/Drug-Paraphernalia-Summary-of-State-Laws-FINAL.pdf>
- ¹⁸ Drug Paraphernalia: Summary of State Laws. Legislative Analysis and Public Policy Association. April 2022. Available at <https://legislativeanalysis.org/wp-content/uploads/2022/09/Drug-Paraphernalia-Summary-of-State-Laws-FINAL.pdf>

- ¹⁹ See, for example, 21 U.S.C. §844. Penalties for simple possession. Available at <https://www.govinfo.gov/content/pkg/USCODE-2011-title21/html/USCODE-2011-title21-chap13-subchapI-partD-sec844.htm>
- ²⁰ NIDA. 2021, April 13. What is the treatment need versus the diversion risk for opioid use disorder treatment?. Retrieved from <https://nida.nih.gov/publications/research-reports/medications-to-treat-opioid-addiction/what-treatment-need-versus-diversion-risk-opioid-use-disorder-treatment> on 2024, February 28
- ²¹ Tanz LJ, Jones CM, Davis NL, et al. Trends and Characteristics of Buprenorphine-Involved Overdose Deaths Prior to and During the COVID-19 Pandemic. *JAMA Netw Open*. 2023;6(1):e2251856. doi:10.1001/jamanetworkopen.2022.51856
- ²² Dong H, Stringfellow EJ, Russell WA, Jalali MS. Racial and Ethnic Disparities in Buprenorphine Treatment Duration in the US. *JAMA Psychiatry*. 2023;80(1):93–95. doi:10.1001/jamapsychiatry.2022.3673
- ²³ “Vermont becomes first state to legalize possession of buprenorphine.” VT Digger. June 3, 2021. Available at <https://vtdigger.org/2021/06/03/vermont-becomes-first-state-to-legalize-limited-possession-of-buprenorphine/>
- ²⁴ House Bill 222. An Act relating to reducing overdoses. Enacted May 25, 2023. Available at <https://legislature.vermont.gov/Documents/2024/Docs/ACTS/ACT022/ACT022%20As%20Enacted.pdf>
- ²⁵ S. 0065 Substitute A. Uniform Controlled Substances Act. Enacted July 7, 2021. Available at <http://webserver.rilin.state.ri.us/BillText/BillText21/SenateText21/S0065A.pdf>
- ²⁶ Ballot Measure 110. Secretary of State. Oregon. Available at <https://sos.oregon.gov/admin/Documents/irr/2020/044text.pdf>
- ²⁷ Percent of Class E Violation Offenses by Substance. Oregon Judicial Department. January 31, 2024. Available at <https://www.courts.oregon.gov/about/Documents/BM110Statistics.pdf>
- ²⁸ Del Pozo B, Atkins D, Andraka-Christou B, Wightman R, Clark MH, Huynh P, Ray B. Buprenorphine involvement in opioid overdose deaths: A retrospective analysis of postmortem toxicology in Marion County, Indiana, 2015-2021. *Drug Alcohol Depend Rep*. 2023 Mar;6:100131. doi: 10.1016/j.dadr.2023.100131. Epub 2023 Jan 4. PMID: 36777895; PMCID: PMC9910498.
- ²⁹ Samples, et al. Buprenorphine After Nonfatal Opioid Overdose: Reduced Mortality Risk in Medicare Disability Beneficiaries. *American Journal of Preventive Medicine*. March 10, 2023. DOI: <https://doi.org/10.1016/j.amepre.2023.01.037>
- ³⁰ Tanz LJ, Jones CM, Davis NL, et al. Trends and Characteristics of Buprenorphine-Involved Overdose Deaths Prior to and During the COVID-19 Pandemic. *JAMA Netw Open*. 2023;6(1):e2251856. doi:10.1001/jamanetworkopen.2022.51856
- ³¹ Messinger et al. Against Our Instincts: Decriminalization of Buprenorphine. *Journal of the American Board of Family Medicine*. March-April 2022. Vol. 35 No. 2. Available at <https://www.jabfm.org/content/jabfp/35/2/394.full.pdf>
- ³² Bradley H, Hall EW, Asher A, Furukawa NW, Jones CM, Shealey J, Buchacz K, Handanagic S, Crepaz N, Rosenberg ES. Estimated Number of People Who Inject Drugs in the United States. *Clin Infect Dis*. 2023 Jan 6;76(1):96-102. doi: 10.1093/cid/ciac543. PMID: 35791261; PMCID: PMC10202436.
- ³³ Kidd SE, Grey JA, Torrone EA, Weinstock HS. Increased Methamphetamine, Injection Drug, and Heroin Use Among Women and Heterosexual Men with Primary and Secondary Syphilis — United States, 2013–2017. *MMWR Morb Mortal Wkly Rep* 2019;68:144–148. <https://www.cdc.gov/mmwr/volumes/68/wr/mm6806a4.htm>
- ³⁴ Cornford C, Close H. The physical health of people who inject drugs: complexities, challenges, and continuity. *Br J Gen Pract*. 2016 Jun;66(647):286-7. doi: 10.3399/bjgp16X685333. PMID: 27231287; PMCID: PMC4871283.
- ³⁵ Reid MC, Oliphant-Wells T, Moreno C, Ketchum J, Fitzpatrick T, McMahan VM, Glick SN. High levels of interest in access to free safer smoking equipment to reduce injection frequency among people who inject drugs in Seattle, Washington. *Drug Alcohol Depend Rep*. 2023 May 2;7:100163. doi: 10.1016/j.dadr.2023.100163. PMID: 37214756; PMCID: PMC10193167.
- ³⁶ Tapper A, Ahern C, Graveline-Long Z, Newberger NG, Hughto JMW. The utilization and delivery of safer smoking practices and services: a narrative synthesis of the literature. *Harm Reduct J*. 2023 Oct 27;20(1):160. doi: 10.1186/s12954-023-00875-x. PMID: 37891658; PMCID: PMC10612300.
- ³⁷ Kral AH, Lambdin BH, Browne EN, Wenger LD, Bluthenthal RN, Zibbell JE, Davidson PJ. Transition from injecting opioids to smoking fentanyl in San Francisco, California. *Drug Alcohol Depend*. 2021 Oct 1;227:109003. doi: 10.1016/j.drugalcdep.2021.109003. Epub 2021 Aug 27. PMID: 34482046; PMCID: PMC10790652.
- ³⁸ “Once feared, illicit fentanyl is now a drug of choice for many opioid users.” NBC News. August 7, 2022. Available at <https://www.nbcnews.com/health/health-news/feared-illicit-fentanyl-now-drug-choice-many-opioids-users-rcna40418>

³⁹ Can You Smoke Fentanyl? Effects of Smoking & Inhaling, Bicycle Health. October 15, 2023.

<https://www.bicyclehealth.com/opioid-education/fentanyl/smoking-inhaling-dangers>

⁴⁰ See, for example, AMA letters available at <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-7-9-Letter-to-LaBelle-re-ONDCP-2022-Strategy-v2.pdf>, <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Ffcts.zip%2FAMA-letter-supporting-NE-LB1325-FINAL.pdf>, and <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2Fltrf.zip%2F2023-1-25-Letter-Supporting-SD-Drug-Testing-Eq-Final.pdf>

REPORT OF THE BOARD OF TRUSTEES

B of T Report 19-A-24

Subject: Attorneys’ Retention of Confidential Medical Records and Controlled Medical Expert’s Tax Returns After Case Adjudication (Resolution 240-A-23)

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee B

1 INTRODUCTION

2
3 Resolution 240-A-23, introduced by the Illinois State Medical Society, consisted of the following
4 proposals:

5
6 RESOLVED, That our American Medical Association advocate that attorney requests for
7 controlled medical expert personal tax returns should be limited to 1099-MISC forms
8 (miscellaneous income) and that entire personal tax returns (including spouse’s) should not be
9 forced by the court to be disclosed (Directive to Take Action); and be it further

10
11 RESOLVED, That our AMA advocate through legislative or other relevant means the proper
12 destruction by attorneys of medical records (as suggested by *Haage v. Zavala*, 2021 IL
13 125918)¹ and medical expert’s personal tax returns within sixty days of the close of the case.
14 (Directive to Take Action).

15
16 FIRST RESOLVED

17
18 In cases requiring physicians as medical expert witnesses, their testimony is critical to the
19 resolution of the case. They provide an invaluable service. At the same time, it is the right of the
20 opposing party’s attorney to request discovery that allows the attorney to cross-examine the witness
21 to show potential bias. *See United States v. Abel*, 469 U.S. 45, 49-52 (1984). This discovery often
22 involves the expert’s financial history. Still, discovery must be balanced with the expert’s privacy
23 rights and the burden imposed. *See Grant v. Rancour*, 157 N.E.3d 1083, 1094-95 (Ill. 2020).
24 (“[W]hile cross-examination is permissible to show bias, partisanship, or financial interest, there is
25 a point at which such inquiries trample on the legitimate bounds of cross-examination and unduly
26 harass or unnecessarily invade the privacy of the witness.”).

27
28 There is no general rule or universal leaning that courts take when it comes to an expert’s personal
29 tax returns. Personal tax returns may be relevant to show an expert’s potential biases – how often
30 they have testified, how much they have earned for that testimony, what sources are paying for that
31 testimony, etc. Courts decide whether personal tax returns should be allowable discovery on a case-

¹ The form of citation quoted in the First Resolved refers to an Illinois-specific publication, one that might not be available to those outside of Illinois. For ease of reference and accessibility, the Board will use the citation of the case as published in the North Eastern Reporter, a widely available publication. The citation is *Haage v. Zavala*, 183 N.E.3d 830 (Ill. 2021).

1 by-case basis, depending on the specific facts of the case. *See, e.g., Olson v. State Farm Fire &*
2 *Cas. Co.*, No. C14-0786RSM, 2015 WL 753501, at *3 (W.D. Wash. Feb. 23, 2015) (“there is no
3 need for the expert to have to produce his or her tax returns, if the party seeking the discovery has
4 accurate information regarding the percentage of income earned as an expert”); *but see Noffke v.*
5 *Perez*, 178 P.3d 1141, 1150 (Alaska 2008) (“trial court determined that the income tax returns were
6 relevant and that production of the returns would help clarify any stake the witness might have in
7 the outcome of the case”). As with most discovery disputes, the resolution is within the court’s
8 discretion. “Courts must use their discretion to oversee the process and ensure that it is fair to both
9 sides.” *Grant*, 157 N.E.3d at 1095.

10
11 With this background, the Board agrees that seeking a medical expert’s entire personal income tax
12 returns is, in most instances, overly broad and unnecessarily invades the expert’s privacy. The
13 Board also agrees that limiting personal tax return discovery of a medical expert to miscellaneous
14 income (1099-MISC forms) strikes a reasonable balance between allowing the probing for
15 potential bias and protecting the expert’s privacy and burdens. Miscellaneous income discovery
16 would encompass the income that is received from serving as an expert, and the source of that
17 income. In most cases, this should shed sufficient light on potential bias.

18
19 This position is also in line with current AMA policy, which states, “(c) The AMA supports the
20 right to cross examine physician expert witnesses on the following issues: (i) the amount of
21 compensation received for the expert’s consultation and testimony; (ii) the frequency of the
22 physician’s expert witness activities; (iii) the proportion of the physician’s professional time
23 devoted to and income derived from such activities; and (iv) the frequency with which he or she
24 testified for either plaintiffs or defendants.” *Expert Witness Testimony*, H-265.994.

25
26 On the other hand, the Board believes the phrase “and that entire personal tax returns (including
27 spouse’s) should not be forced by the court to be disclosed” should be removed from the First
28 Resolved. It would be an overreach for the AMA to tell courts how to use their discretion in
29 managing discovery, which as discussed, varies on a case-by-case basis. In any event, the first part
30 of the Resolved makes this latter part largely unnecessary. Advocating for the limitation of tax
31 return discovery to miscellaneous income means that the discovery of entire personal tax returns is
32 generally unnecessary and inappropriate. Along those lines, we suggest that the word “usually” be
33 inserted between “should” and “be.”

34
35 As such, the Board believes the First Resolved should be rewritten as follows:

36
37 RESOLVED, That our American Medical Association advocate that attorneys’ discovery
38 requests for the personal tax returns of a medical expert for the opposing party should usually
39 be limited to 1099-MISC forms (miscellaneous income).

40
41 SECOND RESOLVED

42
43 The Second Resolved likely lumps together two different categories of documents: 1) client
44 medical records, and 2) tax returns of medical experts. The first category is personal health
45 information (“PHI”), likely protected under the Health Insurance Portability and Accountability
46 Act of 1996 (“HIPAA”). The second category is financial information that has nothing to do with
47 HIPAA. Yet the Second Resolved advocates for the destruction of both types of documents within
48 60 days of the conclusion of a case, using *Haage v. Zavala*, 183 N.E.3d 830 (Ill. 2021) as an
49 example.

50

1 In *Haage*, a personal injury matter, the trial court issued HIPAA qualified protective orders
2 (“QPOs”) expressly requiring the destruction of PHI within 60 days after the conclusion of the
3 litigation. The insurance company objected to the QPOs, arguing that the orders prevented insurers
4 from performing functions related to fraud detection and deterrence. The appellate court disagreed
5 and enforced the QPOs, finding that no law or regulations required the insurance company to use or
6 disclose plaintiffs’ PHI after the conclusion of the litigation. *See Haage*, 183 N.E.3d at 853.

7
8 Thus, *Haage* may be relevant to the return or destruction of PHI under a HIPAA QPO, but it is
9 irrelevant to the return or destruction of an expert’s tax return information. Thus, the Second
10 Resolved does not need to mention *Haage*.

11
12 Regarding the return of client records, the American Bar Association’s (“ABA”) Rules of
13 Professional Conduct state: “Upon termination of representation, a lawyer shall take steps to the
14 extent reasonably practicable to protect a client’s interests, such as . . . surrendering papers and
15 property to which the client is entitled[.] The lawyer may retain papers relating to the client to the
16 extent permitted by other law.” ABA Rule 1.6(d). The ABA rules do not address exactly *when*
17 attorneys are to return or destroy their client’s records.

18
19 As a general matter, the Board agrees with the intent of the Second Resolved – that certain
20 documents contain clients’ or experts’ sensitive and confidential information, and it is logical that
21 those individuals do not want that sensitive information used or available for longer than absolutely
22 necessary. Sixty days after the conclusion of litigation also seems like a reasonable time period for
23 the return or destruction of those documents. At the same time, the Board notes that reaching this
24 goal will likely be an uphill battle, as it would likely entail specific changes to the ABA’s Model
25 Rules of Professional Conduct, and could require changes to state and federal laws. Nonetheless,
26 advocating for this goal seems like a worthwhile effort.

27
28 As such, the Board believes the Second Resolved should be rewritten as follows:

29
30 RESOLVED, That our AMA support through legislative or other relevant means the proper
31 return or destruction of client medical records and medical expert’s personal tax returns by
32 attorneys within sixty days of the conclusion of the litigation.

33
34 RECOMMENDATION

35
36 The Board of Trustees recommends that the following be adopted in lieu of Resolution 240-A-23
37 and the remainder of this report be filed:

- 38
39 1. That our American Medical Association advocate that attorneys’ discovery requests for the
40 personal tax returns of a medical expert for the opposing party should usually be limited to
41 1099-MISC forms (miscellaneous income) (New HOD Policy); and
42
43 2. RESOLVED, That our AMA support through legislative or other relevant means the
44 proper return or destruction of client medical records and medical expert’s personal tax
45 returns by attorneys within sixty days of the conclusion of the litigation (New HOD
46 Policy).

Fiscal Note: TBD

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(A-24)

Introduced by: American Academy of Ophthalmology

Subject: Research Correcting Political Misinformation and Disinformation on Scope of Practice

Referred to: Reference Committee B

Whereas, state and federal policymakers are regularly exposed to political misinformation and disinformation about the benefits and safety of scope of practice expansion from non-physician practitioners; and

Whereas, members of our American Medical Association spend valuable time and resources attempting to counter this political misinformation and disinformation with varying success; and

Whereas, recent research has explored various psychological and communication strategies to correct political misinformation and disinformation^{1,2,3,4,5,6}; and

Whereas, there may be differences between strategies that work to correct political misinformation and disinformation in different contexts, amongst different audiences, and on different issues; and

Whereas, members of our AMA may lack information about these strategies and how they might apply to correcting political misinformation and disinformation on scope of practice; therefore be it

RESOLVED, that our American Medical Association perform a comprehensive literature review on current research on correcting political misinformation and disinformation and conduct field research on ways to correct political misinformation and disinformation amongst policymakers as it pertains to scope of practice (Directive to Take Action); and be it further

RESOLVED, that our AMA Board of Trustees report its findings and recommendations by the I-24 meeting to the HOD on correcting political misinformation and disinformation and that our AMA incorporate these findings to the extent possible into our AMA's advocacy efforts on scope of practice. (Directive to Take Action)

Fiscal Note: \$330,526: Perform comprehensive literature review on current research on correcting political misinformation and disinformation. Conduct field research through focus groups and surveys on ways to correct political misinformation and disinformation.

Received: 4/8/2024

References

1. Berinsky, Adam J., *Political Rumors: Why We Accept Misinformation and How to Fight It*, Princeton University Press, 2023
2. Traberg, C. S., Roozenbeek, J., & van der Linden, S. (2022). Psychological Inoculation against Misinformation: Current Evidence and Future Directions. *The ANNALS of the American Academy of Political and Social Science*, 700(1), 136-151. <https://doi.org/10.1177/00027162221087936>
3. Sangalang, Angeline, Yotam Ophir, and Joseph N. Cappella. "The potential for narrative correctives to combat misinformation." *Journal of communication* 69, no. 3 (2019): 298-319.
4. Walter, Nathan, and Sheila T. Murphy. "How to unring the bell: A meta-analytic approach to correction of misinformation." *Communication monographs* 85, no. 3 (2018): 423-441.
5. Swire, Briony, and Ullrich Ecker. "ELEVEN Misinformation and Its Correction: Cognitive Mechanisms and Recommendations for Mass Communication." In *Misinformation and mass audiences*, pp. 195-211. University of Texas Press, 2018.
6. Chan, Man-pui Sally, Christopher R. Jones, Kathleen Hall Jamieson, and Dolores Albarracín. "Debunking: A meta-analysis of the psychological efficacy of messages countering misinformation." *Psychological science* 28, no. 11 (2017): 1531-1546.

Relevant AMA Policy

G-640.050 Preserving the AMA's Grassroots Legislative and Political Mission

Our AMA will ensure that all Washington activities, including lobbying, political education, grassroots communications and membership activities be staffed and funded so that all reasonable legislative missions and requests by AMA members and constituent organizations for political action and training can be met in a timely and effective manner. (Res. 619, A-00; Reaffirmed: BOT Rep. 6, A-10; CCB/CLRPD Rep. 3, A-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22)

G-620.021 Communications and Collaboration with the Federation

Our AMA: (1) when confronted with attempts by non-physicians to expand scope of practice via state legislation, shall work at the invitation of its component societies to develop strategies to most effectively promote and protect the best interest of our patients; (2) shall continue to work with national medical specialty societies to assist them in working with and coordinating activities with state medical associations and that the AMA, when requested by either a state medical association or a national specialty society, provide a mechanism to attempt to resolve any dispute between such organizations; (3) shall become actively involved in lobbying and/or communicating with state officials at the request of the state medical associations. (4) Prior to placing targeted advertising, our AMA will contact the relevant state medical associations and/or specialty societies for the purpose of enhancing communication about AMA's planned activities. (CCB/CLRPD Rep. 3, A-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22)

2.3.4 Political Communications

Physicians enjoy the rights and privileges of free speech shared by all Americans. It is laudable for physicians to run for political office; to lobby for political positions, parties, or candidates; and in every other way to exercise the full scope of their political rights as citizens. Physicians may exercise these rights individually or through involvement with professional societies and political action committees or other organizations.

When physicians wish to express their personal political views to a patient or a patient's family, the physician must be sensitive to the imbalance of power in the patient- physician relationship, as well as to the patient's vulnerability and desire for privacy. Physicians should refrain from initiating political conversations during the clinical encounter.

Physicians must not allow differences with the patient or family about political matters to interfere with the delivery of professional care.

When expressing political views to a patient or a patient's family, physicians should:

- (a) Judge both the intrusiveness of the discussion and the patient's level of comfort before initiating such a discussion.
 - (b) Discuss political matters only in contexts where conversation with the patient or family about social, civic, or recreational matters is acceptable.
 - (c) Refrain from conversation about political matters when the patient or family is emotionally pressured by significant medical circumstances.
 - (d) Work towards and advocate for the reform and proper administration of laws related to health care.
- Physicians should stay well informed of current political questions regarding needed and proposed reforms.

(e) Stay well informed about needed or proposed policies concerning health care access and quality, medical research, and promoting public health so as to be able to advocate for patients' needs. (AMA Principles of Medical Ethics: I,VII, Issued 2016)

H-160.947 Physician Assistants and Nurse Practitioners

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician. BOT Rep. 6, A-95Reaffirmed: Res 240 and Reaffirmation A-00Reaffirmed: (Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13; Reaffirmed: Res. 206, I-22; Reaffirmed: CMS Rep. 09, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(A-24)

Introduced by: American Association of Clinical Urologists

Subject: Use of Artificial Intelligence and Advanced Technology by Third Party Payors
to Deny Health Insurance Claims

Referred to: Reference Committee B

- 1 Whereas, insurers use of Artificial Intelligence (AI) and advanced technology to analyze Health
2 Insurance Claims is very frequent; and
3
- 4 Whereas, Humana, Cigna and UnitedHealthcare are facing class actions from consumers and
5 their estates for allegedly deploying advanced technology to deny claims; and
6
- 7 Whereas, health plans use of AI or algorithm software managed by firms such as naviHealth
8 and CareCentrix assist in coverage decisions; and
9
- 10 Whereas, insurers are using AI and algorithms to improve their bottom line under the guise of
11 delivering better service to their policy holders; and
12
- 13 Whereas, doctors, diagnostic companies and others are not able to deliver appropriate medical
14 care when insurance coverage is arbitrarily denied; and
- 15 Whereas, President Biden signed an executive order to establish AI standards in October 2023
16 which includes the responsible use of AI in Healthcare. This also requires the Department of
17 Health and Human Services (HHS) to set up a safety program to take in reports of harm or
18 unsafe health practices involving AI; and
- 19 Whereas, the HHS office of the National Coordinator for Health Information Technology issued
20 a rule in December 2023 requiring more transparency around AI; and
- 21 Whereas, the Center for Medicare and Medicaid Services (CMS) finalized rules requiring
22 Medicare Advantage Plans in 2024 to ensure they are making medical necessity determinations
23 based on the circumstances of a specific individual rather than an algorithm or software that
24 does not account for individual circumstances. Additionally, coverage denials based on medical
25 necessity determinations must be reviewed by a physician or other health care professional;
26 therefore be it
- 27 **RESOLVED**, that our American Medical Association adopt as policy that Commercial third-party
28 payors, Medicare, Medicaid, Workers Compensation, Medicare Advantage and other health
29 plans ensure they are making medical necessity determinations based on the circumstances of
30 the specific patient rather than by using an algorithm, software, or Artificial Intelligence (AI) that
31 does not account for an individual's circumstances (New HOD Policy); and be it further

- 1 RESOLVED, that our AMA adopt as policy that coverage denials based on a medical necessity
- 2 determination must be reviewed by a physician in the same specialty or by another appropriate
- 3 health care professional for non-physician health care providers. (New HOD Policy)

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

Received: 3/11/2024

REFERENCES

1. Lopez I., Pugh T. "AI Lawsuits Against Insurers Signal Wave of Health Litigation", news.bloomberglaw.com, Feb 1, 2024, 5:05 AM EST.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(A-24)

Introduced by: Florida

Subject: Medicaid Patient Accountability

Referred to: Reference Committee B

- 1 Whereas, most Medicaid managed care plans assign patients who do not select their own
2 primary care physician (PCP) randomly to a physician of the plan's choosing; and
3
4 Whereas, despite their best efforts, physicians at times are unable to persuade these Medicaid
5 patients to come into the office for wellness visits, immunization updates, or their childhood
6 check-up visit; and
7
8 Whereas, parents in many states have the ability to opt out of vaccines and other treatments for
9 pediatric patients through state approved religious or medical exemptions; and
10
11 Whereas, physicians are responsible for their assigned patients completing visits to record
12 Healthcare Effectiveness Data and Information Set (HEDIS) measures; and
13
14 Whereas, physicians may be given bonuses/incentives or be penalized based on their HEDIS
15 star rating score; therefore be it
16
17 RESOLVED, that our American Medical Association advocate that physicians' Healthcare
18 Effectiveness Data and Information Set and other quality scores and ratings not be affected by
19 non-compliant patients or patients whose parents exercise state exemptions from
20 recommended treatment. (Directive to Take Action)

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

Received: 4/3/2024

Relevant AMA Policy

Retroactive Assignment of Patients by Managed Care Entities H-285.947

Our AMA opposes the practice of "retroactive or late assignment" of patients by managed care entities, noting that "retroactive or last assignment" includes: (a) the practice of failing to require enrollees in a capitated plan to select a responsible physician(s) at the time of enrollment; (b) the practice of failing to inform the responsible physician(s) of the enrollment of the patient and the assignment of responsibility until the patient has sought care; and (c) the practice of failing to pay the responsible physician the capitated rate until after the patient has sought care.

Sub. Res. 719, A-97Reaffirmation I-01Modified: CMS Rep. 7, A-11Reaffirmation: A-19

Physician Payment Reform H-390.849

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

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

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

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes (including functional improvements, if appropriate), quality and risk-adjustment measures only if measures are scientifically valid, reliable, and consistent with national medical specialty society- developed clinical guidelines/standards.

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

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

Policy Timeline

CMS Rep. 6, A-09Reaffirmation A-10Appended: Res. 829, I-10Appended: CMS Rep. 1, A-11Appended: CMS Rep. 4, A-11Reaffirmed in lieu of Res. 119, A-12

Reaffirmed in lieu of Res. 122, A-12Modified: CMS Rep. 6, A-13Reaffirmation I-15Reaffirmation: A-16Reaffirmed in lieu of: Res. 712, A-17

Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17 Reaffirmation: A-19

Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19 Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19

Reaffirmed: Res. 212, I-21 Reaffirmed: Res. 240, A-22 Reaffirmation: A-22 Modified: CMS Rep. 04, A-23
Reaffirmed: Res. 214, A-23 Reaffirmation: A-23

Work of the Task Force on the Release of Physician Data H-406.991

Principles for the Public Release and Accurate Use of Physician Data

The AMA encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care services. The AMA supports this use of physician data when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all patients and is used to provide accurate physician performance assessments in concert with the following Principles:

1. Patient Privacy Safeguards

- All entities involved in the collection, use and release of claims data comply with the HIPAA Privacy and Security Rules (H-315.972, H-315.973, H-315.983, H-315.984, H-315.989, H-450.947).
- Disclosures made without patient authorization are generally limited to claims data, as that is generally the only information necessary to accomplish the intended purpose of the task (H-315.973, H-315.975, H-315.983).

2. Data Accuracy and Security Safeguards

- Effective safeguards are established to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data (H-406.996, H-450.947, H-450.961).
- Reliable administrative, technical, and physical safeguards provide security to prevent the unauthorized use or disclosure of patient or physician-specific health care data and physician profiles (H-406.996, H-450.947, H-450.961).
- Physician-specific medical practice data, and all analyses, proceedings, records and minutes from quality review activities are not subject to discovery or admittance into evidence in any judicial or administrative proceeding without the physician's consent (H-406.996, H-450.947, H-450.961).

3. Transparency Requirements

- When data are collected and analyzed for the purpose of creating physician profiles, the methodologies used to create the profiles and report the results are developed in conjunction with relevant physician organizations and practicing physicians and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure (H-315.973, H-406.993, H-406.994, H-406.998, H-450.947, H-450.961).
- The limitations of the data sources used to create physician profiles are clearly identified and acknowledged in terms understandable to consumers (H-406.994, H-450.947).
- The capabilities and limitations of the methodologies and reporting systems applied to the data to profile and rank physicians are publicly revealed in understandable terms to consumers (H-315.973, H-406.994, H-406.997, H-450.947, H-450.961).
- Case-matched, risk-adjusted resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients (H-285.931).

4. Review and Appeal Requirements

- Physicians are provided with an adequate and timely opportunity to review, respond and appeal the results derived from the analysis of physician-specific medical practice data to ensure accuracy prior to their use, publication or release (H-315.973, H-406.996, H-406.998, H-450.941, H-450.947, H-450.961).
- When the physician and the rater cannot reach agreement, physician comments are appended to the report at the physician's request (H-450.947).

5. Physician Profiling Requirements

- The data and methodologies used in profiling physicians, including the use of representative and statistically valid sample sizes, statistically valid risk-adjustment methodologies and statistically valid attribution rules produce verifiably accurate results that reflect the quality and cost of care provided by the physicians (H-406.994, H-406.997, H-450.947, H-450.961).
- Data reporting programs only use accurate and balanced data sources to create physician profiles and do not use these profiles to create tiered or narrow network programs that are used to steer patients towards certain physicians primarily on cost of care factors (H-450.951).

- When a single set of claims data includes a sample of patients that are skewed or not representative of the physicians' entire patient population, multiple sources of claims data are used.
- Physician efficiency of care ratings use physician data for services, procedures, tests and prescriptions that are based on physicians' patient utilization of resources so that the focus is on comparative physicians' patient utilization and not on the actual charges for services.
- Physician-profiling programs may rank individual physician members of a medical group but do not use those individual rankings for placement in a network or for reimbursement purposes.

6. Quality Measurement Requirements

- The data are used to profile physicians based on quality of care provided - never on utilization of resources alone -- and the degree to which profiling is based on utilization of resources is clearly identified (H-450.947).
- Data are measured against evidence-based quality of care measures, created by physicians across appropriate specialties, such as the Physician Consortium for Performance Improvement. (H-406.994, H-406.998, H-450.947, H-450.961).
- These evidence-based measures are endorsed by the National Quality Forum (NQF) and/or the AQA and HQA, when available. When unavailable, scientifically valid measures developed in conjunction with appropriate medical specialty societies and practicing physicians are used to evaluate the data.

7. Patient Satisfaction Measurement Requirements

- Until the relationship between patient satisfaction and other outcomes is better understood, data collected on patient satisfaction is best used by physicians to better meet patient needs particularly as they relate to favorable patient outcomes and other criteria of high quality care (H-450.982).
- Because of the difficulty in determining whether responses to patient satisfaction surveys are a result of the performance of a physician or physician office, or the result of the demands or restrictions of health insurers or other factors out of the control of the physician, the use of patient satisfaction data is not appropriate for incentive or tiering mechanisms.
- As in physician profiling programs, it is important that programs that publicly rate physicians on patient satisfaction notify physicians of their rating and provide a chance for the physician to appeal that rating prior to its publication.

Policy Timeline

BOT Rep. 18, A-09Reaffirmation A-10Reaffirmed: BOT action in response to referred for decision Res. 709, A-10, Res. 710, A-10, Res. 711, A-10 and BOT Rep. 17, A-10

Reaffirmation I-10Reaffirmed in lieu of Res. 808, I-10Reaffirmed in lieu of Res. 824, I-10Reaffirmation A-11Reaffirmed: BOT Rep. 17, A-13Reaffirmed: Res. 806, I-13

Reaffirmation: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(A-24)

Introduced by: Florida
Subject: Staffing Ratios in the Emergency Department
Referred to: Reference Committee B

1 Whereas, the Emergency Department is the medical safety net for the nation and provides care
2 to vulnerable patients who may not otherwise have access to primary or specialty medical care;
3 and

4
5 Whereas, in many states, physicians are the only health professionals authorized to practice
6 medicine in the Emergency Department without limitation; and

7
8 Whereas, every patient presenting to an Emergency Department should be under the direct,
9 real-time care of a licensed physician, including the on-site and real-time supervision of non-
10 physician practitioners (NPPs); and

11
12 Whereas, state laws vary on the number of nurse practitioners and physician assistants that a
13 physician can supervise, with some states having no limits at all; and

14
15 Whereas, a 2022 NBER paper using data from the VA shows that nurse practitioners working
16 without supervision in the Emergency Department resulted in increased lengths of stay,
17 increased costs, increased 30-day re-admissions, and increased mortality rates among the
18 higher acuity patients. Nursing literature also supports that NPs should not be working
19 unsupervised in the ED; and

20
21 Whereas, in an increasing number of states, most Emergency Physicians are employed by
22 corporate staffing groups with private equity backing seeking to maximize profit through
23 understaffing physicians and replacing them with non-physician practitioners (NPPs); and

24
25 Whereas, the staffing ratio of NPPs to physicians at any given time in the Emergency
26 Department determines whether a physician has time to adequately supervise and see the
27 patients being cared for by the NPPs; therefore be it

28
29 RESOLVED, that our American Medical Association seek federal legislation or regulation
30 prohibiting staffing ratios that do not allow for proper supervision of NPPs in the Emergency
31 Department (Directive to Take Action); and be it further

32
33 RESOLVED, that our AMA seek federal legislation or regulation that would require all
34 Emergency Departments to be staffed 24-7 by a qualified physician. (Directive to Take Action)

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

Received: 4/9/2024

References:

1. Chan, D. and Chen, Y. The Productivity of Professions: Evidence from the Emergency Department, National Bureau of Economic Research, Working Paper 30608, Oct 2022. <https://www.nber.org/papers/w30608>
2. Proffitt Lavin, R PhD FNP-BC FAAN, et al. Analysis of Nurse Practitioners' Educational Preparation, Credentialing, and Scope of Practice in U.S. Emergency Departments. Journal of Nursing Regulation, Vol 12, Issue 4, P50-62, Jan 01, 2022. [https://www.journalofnursingregulation.com/article/S2155-8256\(22\)00010-2/fulltext](https://www.journalofnursingregulation.com/article/S2155-8256(22)00010-2/fulltext)
3. Updated Position Statement on Non-Physician Practitioners. AAEM - American Academy of Emergency Medicine. Accessed April 12, 2023. <https://www.aaem.org/resources/statements/position/updated-advanced-practice-providers>
4. American Academy of Emergency Medicine (AAEM) paper on guidelines for safe patients per hour and NPP supervision limits...in process

Relevant AMA Policy

Promoting Supervision of Emergency Care Services in Emergency Departments by Physicians D-35.976

Our AMA will advocate for the establishment and enforcement of legislation and/or regulations that ensure only physicians supervise the provision of emergency care services in an emergency department. [Res. 218, A-23]

Principles for Strengthening the Physician-Hospital Relationship H-225.957

The following twelve principles are AMA policy:

PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, and working continuously to improve patient care and outcomes, with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.
2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.
3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.
4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.
5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.
6. The organized medical staff has inherent rights of self governance, which include but are not limited to:

- a) Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.
- b) Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.
- c) Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.
- d) Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.
- e) Establishing within the medical staff bylaws: 1) the qualifications for holding office, 2) the procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee, and 3) the qualifications for election and/or appointment to committees, department and other leadership positions.
- f) Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.
- g) Retaining and being represented by legal counsel at the option and expense of the organized medical staff.
- h) Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.
- i) Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.
- j) The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.
- k) Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.
- l) Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.
- m) Enforcing the organized medical staff bylaws, regulations and policies and procedures.
- n) Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.

7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.
8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.
9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.
10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.
11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.
12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body. [Res. 828, I-07 Reaffirmed in lieu of Res. 730, A-09 Modified: Res. 820, I-09 Reaffirmed: Res. 725, A-10 Reaffirmation A-12 Reaffirmed: CMS Rep. 6, I-13 Reaffirmed: CMS Rep. 5, A-21]

Supervision and Proctoring by Facility Medical Staff H-375.967

Our AMA advocates that the conduct of medical staff supervision be included in medical staff bylaws and be guided by the following principles:

- (1) Physicians serving as medical staff supervisors should be indemnified at the facility's expense from malpractice claims and other litigation arising out of the supervision function.
- (2) Physicians being supervised should be indemnified at the facility's expense for any damages that might occur as a result of implementing interventions recommended by medical staff supervisors.
- (3) AMA principles of peer review as found in Policies H-320.968 [2,d], H-285.998 [5], and H-320.982 [2c,d] should be adhered to in the conduct of medical staff supervision.
- (4) The medical staff member serving as supervisor should be determined through a formal process by the department chair or medical staff executive committee.
- (5) The scope of the medical staff supervision should be limited to the provision of services that have been restricted, are clearly questionable, or are under question, as determined by the department chair or medical staff executive committee.
- (6) The duration of the medical staff supervision should be limited to the amount of time necessary to adequately assess the degree of clinical competence in the area of skill being assessed.
- (7) Medical staff supervision should include a sufficient volume of procedures or admissions for meaningful assessment.
- (8) Medical staff supervisors should provide periodic performance reports on each patient to the appropriate designated medical staff committee. The reports should be transcribed or transcribed by the medical staff office to assure confidentiality. The confidentiality of medical staff supervision reports must be strictly maintained.
- (9) Physicians whose performance is supervised should have access to the performance reports submitted by medical staff supervisors and should be given the opportunity to comment on the contents of the reports. [CMS Rep. 3, A-99 Reaffirmed: CLRPD Rep. 1, A-09 Reaffirmed: CMS Rep. 01, A-19]

Medical Staff Development Plans H-225.961

All hospitals/health systems incorporate the following principles for the development of medical staff development plans: (a) The medical staff and hospital/health system leaders have a mutual responsibility to: cooperate and work together to meet the overall health and medical needs of the community and preserve quality patient care; acknowledge the constraints imposed on the two by limited financial resources; recognize the need to preserve the hospital/health system's economic viability; and respect the autonomy, practice prerogatives, and professional responsibilities of physicians. (b) The medical staff and its elected leaders must be involved in the hospital/health system's leadership function, including: the process to develop a mission that is reflected in the long-range, strategic, and operational plans; service design; resource allocation; and organizational policies. (c) Medical staffs must ensure that quality patient care is not harmed by economic motivations. (d) The medical staff should review and approve and make recommendations to the governing body prior to any decision being made to close the medical staff and/or a clinical department. (e) The best interests of patients should be the predominant consideration in granting staff membership and clinical privileges. (f) The medical staff must be responsible for professional/quality criteria related to appointment/reappointment to the medical staff and granting/renewing clinical privileges. The professional/quality criteria should be based on objective standards and the standards should be disclosed. (g) The medical staff should be consulted in establishing and implementing institutional/community criteria. Institutional/community criteria should not be used inappropriately to prevent a particular practitioner or group of practitioners from gaining access to staff membership. (h) Staff privileges for physicians should be based on training, experience, demonstrated competence, and adherence to medical staff bylaws. No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, religion, disability, ethnic origin sexual orientation, gender identity or physical or mental impairment that does not pose a threat to the quality of patient care. (i) Physician profiling must be adjusted to recognize case mix, severity of illness, age of patients and other aspects of the physician's practice that may account for higher or lower than expected costs. Profiles of physicians must be made available to the physicians at regular intervals. [BOT Rep. 14, A-98Modified: BOT Rep. 11, A-07Reaffirmation A-10Modified: CMS Rep. 01, A-20]

Credentialing and the Quality of Care H-225.971

It is the policy of the AMA: (1) that the hospital medical staff be recognized within the hospital as the entity with the overall responsibility for the quality of medical care; (2) that hospital medical staff bylaws reaffirm The Joint Commission standard that medical staffs have "overall responsibility for the quality of the professional services provided by individuals with clinical privileges"; (3) that each hospital's quality assurance, quality improvement, and other quality-related activities be coordinated with the hospital medical staff's overall responsibility for quality of medical care; (4) that the hospital governing body, management, and medical staff should jointly establish the purpose, duties, and responsibilities of the hospital administrative personnel involved in quality assurance and other quality-related activities; establish the qualifications for these positions; and provide a mechanism for medical staff participation in the selection, evaluation, and credentialing of these individuals; (5) that the hospital administrative personnel performing quality assurance and other quality activities related to patient care report to and be accountable to the medical staff committee responsible for quality improvement activities; (6) that the purpose, duties, responsibilities, and reporting relationships of the hospital administrative personnel performing quality assurance and other quality-related activities be included in the medical staff and hospital corporate bylaws; (7) that the general processes and policies related to patient care and used in a hospital quality assurance system and other quality-related activities should be developed, approved, and controlled by the hospital medical staff; and (8) that any physician hired or retained by a hospital to be involved solely in medical staff quality of care issues be credentialed by the medical staff prior to employment in the hospital. [BOT Rep. T, I-92Reaffirmed: CMS Rep. 10, A-03Modified: CMS Rep. 4, A-13 Reaffirmed: CMS Rep. 5, A-21]

On-Call Physicians H-130.948

Our AMA:

- (1) strongly encourages physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage and will monitor and oppose any state legislative or regulatory efforts mandating emergency room on-call coverage as a requirement for medical staff privileges and state licensure that are not supported by the state medical association;
- (2) advocates that physician on-call coverage for emergency departments be guided by the following principles:
 - (a) The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients.
 - (b) Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that are available for consultation and treatment of patients.
 - (c) The organization and function of on-call services should be determined through hospital policy and medical staff by-laws, and include methods for monitoring and assuring appropriate on-call performance.
 - (d) Physicians should be provided adequate compensation for being available and providing on-call and emergency services.
 - (e) Hospital medical staff by-laws and emergency department policies regarding on-call physicians' responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.
 - (f) Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage.
 - (g) Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care.
 - (h) Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained.
 - (i) The decision to operate or close an emergency department should be made jointly by the hospital and medical staff;
- (3) supports the enforcement of existing laws and regulations that require physicians under contract with health plans to be adequately compensated for emergency services provided to the health plans' enrollees; and
- (4) supports the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans' enrollees or be subject to significant fines similar to the civil monetary penalties that can be imposed on hospitals and physicians for violation of EMTALA. [CMS Rep. 3, I-99 Reaffirmation A-00Modified: Sub. Res. 217, I-00 Reaffirmation I-01Reaffirmation A-07Appended and Reaffirmed: CMS Rep. 1, I-09 Modified: Res. 818, I-17]

Professional Nurse Staffing in Hospitals H-360.986

- The AMA: (1) encourages medical and nursing staffs in each facility to closely monitor the quality of medical care to help guide hospital administrations toward the best use of resources for patients;
- (2) encourages medical and nursing staffs to work together to develop and implement in-service education programs and promote compliance with established or pending guidelines for unlicensed assistive personnel and technicians that will help assure the highest and safest standards of patient care;
 - (3) encourages medical and nursing staffs to use identification mechanisms, e.g. badges, that provide the name, credentials, and/or title of the physicians, nurses, allied health personnel, and unlicensed assistive personnel in facilities to enable patients to easily note the level of personnel providing their care;
 - (4) encourages medical and nursing staffs to develop, promote, and implement educational guidelines for the training of all unlicensed personnel working in critical care units, according to the needs at each facility; and
 - (5) encourages medical and nursing staffs to work with hospital administrations to assure that patient care and safety are not compromised when a hospital's environment and staffing are restructured. [BOT Rep. 11, I-96Reaffirmed: CMS Rep. 8, A-06Reaffirmed: CMS Rep. 01, A-16]

Supervision of Non-Physician Practitioners by Physicians D-35.978

Our AMA will advocate: (1) to ensure physicians on staff receive written notification when their license is being used to document supervision of non-physician practitioners; (2) that physician supervision should be explicitly defined and mutually agreed upon; (3) for advanced notice and disclosure to the physician before they are hired or as soon as practicably known by provider organizations and institutions that anticipate physician supervision of non-physician practitioners as a condition for physician employment; (4) that organizations, institutions, and medical staffs that have physicians who participate in supervisory duties for non-physician practitioners have processes and procedures in place that have been developed with appropriate clinical physician input; and (5) that physicians be able to report professional concerns about care provided by the non-physician practitioners to the appropriate leadership with protections against retaliation. [Res. 017, I-22]

Emergency Department Boarding and Crowding H-130.940

Our AMA:

1. congratulates the American College of Emergency Physicians for developing and promulgating solutions to the problem of emergency department boarding and crowding;
2. supports collaboration between organized medical staff and emergency department staff to reduce emergency department boarding and crowding;
3. supports dissemination of best practices in reducing emergency department boarding and crowding;
4. continues to encourage entities engaged in measuring emergency department performance (e.g., payers, licensing bodies, health systems) to use evidence-based, clinical performance measures that enable clinical quality improvement and capture variation such as those developed by the profession through the Physician Consortium for Performance Improvement;
5. continues to support physician and hospital use and reporting of emergency medicine performance measures developed by the Physician Consortium for Performance Improvement; and
6. continues to support the harmonization of individual physician, team-based, and facility emergency medicine performance metrics so there is consistency in evaluation, methodology, and limited burden associated with measurement. [CMS Rep. 3, A-09Reaffirmed: CMS Rep. 01, A-19Reaffirmed: BOT Rep. 16, A-19]

Managed Care Organizations' Use of Physicians to Provide Second Opinions to Physicians Providing Emergency Services H-285.950

The AMA adopts the following principles to guide the use by managed care plans of physicians employed or contracted with to specifically provide second opinions to physicians providing emergency services. The AMA encourages managed care plans to follow these guidelines when employing or contracting with physicians to provide second opinions to physicians providing emergency services.

- (1) All managed care plans shall disclose to their enrollees and prospective enrollees any plan requirements or the existence of contractual arrangements whereby physicians are required to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities.
- (2) The required use of physicians to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall not impede the immediate diagnosis and therapy of acute cardiac, trauma, and other critical patient situations for which delay may result in death or an increase in severity of illness.
- (3) Any physician with a contractual arrangement to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall be licensed to practice medicine and actively practicing emergency medicine in the same state in which the second opinion is provided.
- (4) Any physician with a contractual arrangement to provide second opinions to physicians providing emergency services regarding the care provided to patients presenting at emergency departments or facilities shall have active staff privileges in any facility in which the second opinion is provided.
- (5) To the degree possible, patients presenting at an emergency department or facility should be involved in the decisions regarding the treatment, referral, and follow-up care for their condition.

(6) In the event of disagreements over second opinions, final decisions regarding the treatment, referral, and follow-up care provided to patients presenting at emergency departments or facilities shall be made by the attending emergency physician or other appropriate physicians on staff at the facility. [CMS Rep. 1, I-96Reaffirmed: CMS Rep. 8, A-06Reaffirmed: CMS Rep. 01, A-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(A-24)

Introduced by: Medical Student Section, American Association of Public Health Physicians

Subject: Medical-Legal Partnerships & Legal Aid Services

Referred to: Reference Committee B

Whereas, medical-legal partnerships (MLPs) address social determinants of health relating to civil law, such as family violence, child support and custody, workplace conditions, employment conflicts, financial exploitation, post-incarceration rehabilitation, housing, utility shutoffs, disability access, debt relief, and veteran benefits, by integrating lawyers in clinical settings team to meet patient's legal needs¹⁻⁶; and

Whereas, 70% of low-income households experience civil legal problems, with 40% experiencing at least 5, 20% experiencing at least 10, and the average low-income individual managing 2 to 3 legal issues at a time⁷⁻⁸; and

Whereas, unmet civil legal needs may lead to or exacerbate both physical and mental illness, as seen with inadequate housing, eviction, and even threat of eviction being connected to anxiety, depression, bodily injury, asthma, and respiratory infection⁹⁻¹¹; and

Whereas, MLPs demonstrate success in access to retroactive benefits, improved asthma control and neonatal preventive care use, and decreased length of hospitalization, readmission rates, and emergency department visits⁷; and

Whereas, while MLPs are found at only 26% of medical schools, studies indicate that MLPs can help educate physicians and medical students on screening for social determinants and legal needs, addressing issues impacting health through legal advocacy, and referring patients to reliable legal resources^{1,12-15}; and

Whereas, civil legal aid often includes free or low-cost direct legal services by lawyers as well as legal education to help low- and middle-income people navigate social systems¹⁶; and

Whereas, the high cost of civil legal aid is a significant barrier to access, with low-income Americans reporting only seek aid for 1 out of 4 civil legal problems and receiving inadequate legal aid for 92% of their needs^{8,17}; and

Whereas, civil legal aid services in the US are chronically underfunded, turning away an average of 50% of eligible individuals who seek services due to inadequate funds¹⁶; and

Whereas, the Association of American Medical Colleges and the American Bar Association both conduct initiatives relating to MLPs, including creation of models and directories¹⁸⁻¹⁹; therefore be it

RESOLVED, that our American Medical Association support the establishment and funding of medical-legal partnerships and civil legal aid services to meet patients' legal needs. (New HOD Policy)

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

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REFERENCES

1. Regenstein M, Trott J, Williamson A, Theiss J. Addressing Social Determinants Of Health Through Medical-Legal Partnerships. *Health Affairs*. 2018;37(3):378-385. doi:10.1377/hlthaff.2017.1264
2. Cloud DH, Bassett MT, Graves J, Fullilove RE, Brinkley-Rubinstein L. Documenting and addressing the health impacts of carceral systems. *Am J Public Health*. 2020;110(suppl 1) S5–S5.
3. Swope CB, Hernández D. Housing as a determinant of health equity: a conceptual model. *Soc Sci Med*. 2019;243:112571.
4. Gong, G., Phillips, S. G., Hudson, C., Curti, D., & Phillips, B. U. Higher US rural mortality rates linked to socioeconomic status, physician shortages, and lack of health insurance. *Health Affairs*, 2019; 38(12), 2003-2010.
5. Keith-Jennings B, Llobrera J, Dean S. Links of the Supplemental Nutrition Assistance Program with food insecurity, poverty, and health: evidence and potential. *Am J Public Health*. 2019;109(12):1636–1640.
6. Girard, V. et al. The Academic Medical-Legal Partnership. September 26, 2022.
7. Mead, Allee. Bringing Law and Medicine Together to Help Rural Patients. Rural Health Information Hub. Last accessed September 22, 2022. <https://www.ruralhealthinfo.org/rural-monitor/medical-legal-partnerships>
8. 2022 Justice Gap Study, Legal Services Corporation. Last accessed August 31, 2022. <https://justicegap.isc.gov/resource/executive-summary>
9. Jassar, Sunam. Access to Justice as a Social Determinant of Health: The Basis for Reducing Health Disparity and Advancing Health Equity of Marginalized Communities, Windsor Yearbook of Access to Justice 37 (2021), <https://wyai.uwindsor.ca/index.php/wyai/article/view/7283>
10. Cannon, Yael. Unmet Legal Needs as Health Injustice. University of Richmond Law Review, Vol. 56, pp. 801-877 (2022). <https://scholarship.law.georgetown.edu/facpub/2452>
11. Making Justice Equal, Center for American Progress (Dec. 8, 2016). <https://www.americanprogress.org/article/making-justice-equal>
12. Girard, V. W., Moore, E. S., Kessler, L. P., Perry, D., & Cannon, Y. An Interprofessional Approach to Teaching Advocacy Skills: Lessons from an Academic Medical–Legal Partnership. *Journal of Legal Medicine*, 2020; 40(2), 265-278.
13. Pettignano, R., Bliss, L., McLaren, S., & Caley, S. Interprofessional medical–legal education of medical students: assessing the benefits for addressing social determinants of health. *Academic Medicine*, 2017; 92(9), 1254-1258.
14. Coleman, R., Dunn, C., & McDonald, D. Medical Legal Partnerships: A Novel Way to Help Address Health-harming Legal Needs and Social Determinants of Health in Pediatric Patients with Asthma. *The Florida Pediatrician*, 2022; 41(1).
15. John, J. et al. Efficacy of Medical Legal Partnerships to Address Health Harming Legal Needs: A Systematic Review of Experimental Studies in the Field. 2022. <https://doi.org/10.21203/rs.3.rs-1625222/v1>
16. U.S. Department of Justice, Civil Legal Aid 1010. Last accessed September 22, 2022. <https://www.justice.gov/atj/civil-legal-aid-101>
17. Emery G. Lee, Law Without Lawyers: Access to Civil Justice and the Cost of Legal Services, University of Miami Law Review 69:499 (April 2015). <https://lawreview.law.miami.edu/wp-content/uploads/2015/04/Lee.pdf>.
18. AAMC releases three tools to help MLPs measure their impact on health and health equity. National Center for Medical-Legal Partnership, Milken Institute School of Public Health, The George Washington University. Published September 26, 2019. <https://medical-legalpartnership.org/aamc-evaluation-tools>
19. Medical-Legal Partnerships. American Bar Association. https://www.americanbar.org/groups/health_law/interest_groups/educational_outreach/medical-legal-partnerships-

RELEVANT AMA POLICY

H-165.822 Health Plan Initiatives Addressing Social Determinants of Health

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs. [CMS Rep. 7, I-20Reaffirmed: CMS Rep. 5, I-21Reaffirmed: CMS Rep. 5, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(A-24)

Introduced by: Medical Student Section

Subject: Indian Health Service Youth Regional Treatment Centers

Referred to: Reference Committee B

1 Whereas, nearly 13% of AI/AN youth ages 12-24 experienced a depressive episode or related
2 mental illness in 2018, and an estimated 20% require treatment due to early alcohol use¹⁻²; and
3

4 Whereas, the Indian Health Service (IHS) uses Youth Regional Treatment Centers (YRTCs) for
5 acute behavioral healthcare for AI/AN adolescents, but national capacity only meets 4% of the
6 need²⁻³; and
7

8 Whereas, YRTCs help adolescents develop independent living skills, provide schooling attuned
9 to individual needs, create post-discharge sobriety plans, and coordinate prison diversion
10 programs⁴⁻⁵; and
11

12 Whereas, while 61% of arrested AI/AN youth are eligible for YRTC diversion programs, only
13 14% ultimately receive care at YRTCs²; and
14

15 Whereas, the IHS, in consultation with Tribal leaders and key parties, has voiced concerns
16 regarding AI/AN youth traveling across state lines to seek care at non-IHS treatment centers⁶;
17 and
18

19 Whereas, non-IHS treatment centers are not equipped to address the complex effects of
20 intergenerational trauma, systematic discrimination, and displacement on AI/AN youth mental
21 health⁷⁻⁹; therefore be it
22

23 RESOLVED, that our American Medical Association support the expansion of Indian Health
24 Service Youth Regional Treatment Centers, recognizing them as a model for culturally-rooted,
25 evidence-based behavioral health treatment, and prompt referral of eligible AI/AN youth to Youth
26 Regional Treatment Centers (YRTCs) for community-directed care. (New HOD Policy)

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

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REFERENCES

1. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2019). *National Survey on Drug Use and Health 2019* (NSDUH-2019-DS0001). Retrieved from <https://datafiles.samhsa.gov/>
2. Paschane DM, James TD, Kinlacheeny. American Indian and Alaska Native Youth Treatment Aftercare. Indian Health Service, U.S. Department of Health and Human Services. 2022.
3. 25 U.S.C. § 1665g (2020). Retrieved from <https://law.justia.com/codes/us/2020/title-25/chapter-18/subchapter-v-a/part-a/sec-1665g/>
4. IHS. Youth Regional Treatment Centers. <https://www.ihs.gov/yrtc/>
5. Greene, C, Espinosa, M. Caring for Native Youth with Substance Use Disorders. Retrieved from https://www.resourcebasket.org/wp-content/uploads/2019/01/caring_for_native_youth_with_substance_use_disorders.pdf

6. IHS. IHS Holds Grand Opening for New Youth Regional Treatment Center in California. 2022. <https://www.ihs.gov/newsroom/pressreleases/2022-press-releases/ihs-holds-grand-opening-for-new-youth-regional-treatment-center-in-california/>
7. Woods C, Kim B, Calvert D, Aronowitz T. The development and pandemic-related adaptation of a resilience program for native middle-school youth: A case study. *Public Health Nurs.* 2023;40(2):298-305. doi:10.1111/phn.13154
8. Daily RS, Vana G, Andrade JKL, Pruett J. Evaluating Native Youth: Issues and Considerations in Clinical Evaluation and Treatment. *Child Adolesc Psychiatr Clin N Am.* 2022;31(4):779-788. doi:10.1016/j.chc.2022.06.008
9. Dixon AL, Yabiku ST, Okamoto SK, Tann SS, Marsiglia FF, Kulis S, Burke AM. The efficacy of a multicultural prevention intervention among urban American Indian youth in the southwest U.S. *J Prim Prev.* 2007 Nov;28(6):547-68. doi: 10.1007/s10935-007-0114-8. Epub 2007 Dec 6. PMID: 18058235; PMCID: PMC3042736.

RELEVANT AMA POLICY

H-160.963 Community-Based Treatment Centers

Our AMA supports the use of community-based treatment centers for substance use disorders, mental health disorders and developmental disabilities. [BOT Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21]

D-350.988 American Indian / Alaska Native Adolescent Suicide

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. [Sub Res. 404, A-11; Reaffirmed: BOT Rep. 7, A-21]

H-345.974 Culturally, Linguistically Competent Mental Health Care and Outreach for At-Risk Communities

Our AMA supports adequate attention and funds being directed towards culturally and linguistically competent mental health direct services for the diverse, multi-ethnic communities at greatest risk, and encourages greater cultural and linguistic-competent outreach to ethnic communities including partnerships with ethnic community organizations, health care advocates, and respected media outlets. [Res. 917, I-13; Reaffirmed: Res. 426, A-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(A-24)

Introduced by: Medical Student Section

Subject: Biosimilar Use Rates and Prevention of Pharmacy Benefit Manager Abuse

Referred to: Reference Committee B

- 1 Whereas, biologics account for only 2% of prescriptions but 40% of US pharmaceutical
2 spending and 90% of the net pharmaceutical spending growth over the past decade¹⁻⁶; and
3
4 Whereas, biologics are often significantly more expensive than small-molecule drugs, costing on
5 average \$10,000 to \$40,000 per patient annually with some prices up to \$500,000¹⁻⁶; and
6
7 Whereas, biosimilars exhibit no clinically meaningful differences in safety, purity, and potency
8 compared to their corresponding “brand-name” (originator, or reference product) biologic⁷; and
9
10 Whereas, the US has only approved 50% of the biosimilars approved in other industrialized
11 nations, with an average uptake rate of 20% compared to over 80%⁸⁻¹⁶; and
12
13 Whereas, average US price decreases due to biosimilar entry are only 15 to 40% compared to
14 70% in other industrialized nations⁸⁻¹⁶; and
15
16 Whereas, other industrialized nations improve biosimilar uptake through lucrative financial
17 incentives for physicians to maintain robust reimbursement while saving on medication costs,
18 including rewards for biosimilar usage targets and shared savings programs¹⁷⁻²³; and
19
20 Whereas, “brand-name” biologics manufacturers have blocked biosimilar uptake in the US via
21 long-term exclusivity agreements with pharmacy benefit managers (PBMs) for preferential
22 coverage in insurance plans, such as Johnson & Johnson with Remicade (infliximab) and
23 AbbVie with Humira (adalimumab)²⁴⁻²⁵; and
24
25 Whereas, biologics manufacturers’ efforts to prevent biosimilar coverage by insurers interfere
26 with physician’s prescriptive authority, conflict with analogous AMA policy supporting physicians’
27 right to prescribe generic drugs, and maintain exorbitant pharmaceutical costs; and
28
29 Whereas, the Federal Trade Commission (FTC) and Department of Justice (DOJ) have the
30 authority to investigate and block exclusive distribution clauses as antitrust violations, and AMA
31 advocacy can help ensure that PBM exclusivity agreements are an antitrust priority²⁵⁻²⁷;
32 therefore be it
33
34 RESOLVED, that our American Medical Association support economic incentives to increase
35 physician use of less expensive biosimilars instead of their reference biologics (New HOD
36 Policy); and be it further
37
38 RESOLVED, that our AMA encourage the Federal Trade Commission (FTC) and Department of
39 Justice (DOJ) Antitrust Division to closely scrutinize long-term exclusive contracts signed

- 1 between biologics originators and PBMs to ensure they do not impede biosimilar development
- 2 and uptake. (New HOD Policy)

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

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REFERENCES

1. Medicare Payment Advisory Commission, "Prescription Drugs." *Health Care Spending and the Medicare Program: Data Book*, July 2021. https://www.medpac.gov/wp-content/uploads/2021/10/July2021_MedPAC_DataBook_Sec10_SEC.pdf.
2. Tichy EM, Hoffman JM, Suda KJ, et al. National trends in prescription drug expenditures and projections for 2022. *Am J Health Syst Pharm*. 2022;79(14):1158-1172. doi:10.1093/ajhp/zxac102
3. IQVIA Institute for Human Data and Science, Biosimilars in the United States 2020-2024: Competition, Savings and Sustainability (September 29, 2020), <https://www.iqvia.com/insights/the-iqvia-institute/reports/biosimilars-in-theunited-states-2020-2024>.
4. Mulchachy et al. Projected US Savings From Biosimilars, 2021-2025. 2022. *Am J Manag Care*. 2022;28(7):329-335.
5. Roy, A. Biologic Medicines: The Biggest Driver of Rising Drug Prices. *Forbes*, <https://www.forbes.com/sites/theapothecary/2019/03/08/biologic-medicines-the-biggest-driver-of-rising-drug-prices/?sh=72e153a118b0>. March 8, 2019, Accessed August 28, 2022.
6. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Medicare Part B Drugs: Trends in Spending and Utilization, 2006-2017, (ASPE, November 2020), <https://aspe.hhs.gov/system/files/pdf/264416/Part-B-Drugs-Trends-Issue-Brief.pdf>.
7. FDA. Biological Product Innovation and Competition Act. <https://www.fda.gov/drugs/biosimilars/biological-product-innovation-and-competition#:~:text=The%20Biologics%20Price%20Competition%20and,safe%20and%20effective%20biological%20products>.
8. Michael S. Reilly and Philip J. Schneider. "Policy Recommendations for a Sustainable Biosimilars Market: Lessons from Europe" *Generics and Biosimilars Initiative Journal* 9, no. 2 (February 2020): 76–83. <https://doi.org/10.5639/gabij.2020.0902.013>.
9. Uptake of Biosimilars in Different Countries Varies," *Generics and Biosimilars Initiative*, August 11, 2019. <https://www.gabionline.net/Reports/Uptake-of-biosimilars-in-different-countries-varies>
10. "Humira Biosimilars Available at up to 80 Percent Discount in Europe: AbbVie," Reuters, November 2, 2018, <https://www.reuters.com/article/us-abbvie-results-humira-idUSKCN1N71NZ>.
11. IQVIA Institute for Human Data and Science, Biosimilars in the United States 2020-2024: Competition, Savings and Sustainability (September 29, 2020), <https://www.iqvia.com/insights/the-iqvia-institute/reports/biosimilars-in-theunited-states-2020-2024>.
12. San-Juan-Rodriguez et al. 2019. Trends in List Prices, Net Prices, and Discounts for Originator Biologics Facing Biosimilar Competition. *JAMA Netw Open*. 2019;2(12):e1917379.
13. Benjamin Yu. 2016. Greater Potential Cost Savings With Biosimilar Use. *Am J Manag Care*. 2016;22(5):378
14. Mulchachy et al. Projected US Savings From Biosimilars, 2021-2025. 2022. *Am J Manag Care*. 2022;28(7):329-335.
15. Kay J. The Dawn of the Biosimilars in the Management of IMiDs: Understanding and Integrating Biosimilar Data into Informed Collaborative Care. Presented at: IAS 2018; April 27-29, 2018; Boston.
16. Scott Morton et al. 2018. The Impact of the Entry of Biosimilars: Evidence from Europe. *Review of Industrial Organization*. <https://link.springer.com/article/10.1007/s11151-018-9630-3#Sec14>
17. Evelien Moorkens et al., "Policies for Biosimilar Uptake in Europe: An overview," *PLoS ONE* 12, no. 12 (December 28, 2017), <https://doi.org/10.1371/journal.pone.0190147>.
18. Sabine Vogler et al., Medicines reimbursement policies in Europe, World Health Organization (WHO), 2018, <http://www.euro.who.int/en/health-topics/Health-systems/health-technologies-and-medicines/publications/2018/medicines-reimbursement-policies-in-europe>
19. Etienne Nedellec, "France National Health Strategy and Biosimilar Pilot Sharing Scheme" (Presentation, DIA Biosimilars Conference 2020, October 7, 2020).
20. Evelien Moorkens Eet et al., "Learnings from Regional Market Dynamics of Originator and Biosimilar Infiximab and Etanercept in Germany," *Pharmaceuticals* 13(10):324, (October 2020), doi: 10.3390/ph13100324.
21. Alex Brill, Shared Savings Demonstration for Biosimilars in Medicare: An Opportunity to Promote Biologic Drug Competition, Matrix Global Advisors (MGA), May 2020, http://getmga.com/wpcontent/uploads/2020/05/Biosimilar_Shared_Savings.pdf.
22. Cécile Rémuzat et al., "Supply-Side and Demand-Side Policies for Biosimilars: An Overview in 10 European Member States." *Journal of Market Access & Health Policy* 5, no. 1 (April 28, 2017), <https://doi.org/10.1080/20016689.2017.1307315>
23. "CMA Warns Businesses After Ending Remicade Investigation", GOV.UK, March, 2019, <https://www.gov.uk/government/news/cma-warns-businesses-after-ending-remicade-investigation>
24. Michael A. Carrier. 2017. High Prices & No Excuses: 6 Anticompetitive Games (Presentation Slides). Testimony for FTC Workshop on "Understanding Competition in Prescription Drug Markets".
25. Herman B. As Humira biosimilars take over the market, CVS has created a new ploy: the drug 'rebate credit.' *STAT+*. Published March 18, 2024. <https://www.statnews.com/2024/03/18/humira-pbms-cvs-caremark-rebate-credits>
26. Joseph Farrell. 2006. Exclusive Dealing: Substance and Process. Testimony for the DOJ. <https://www.justice.gov/atr/exclusive-dealing-substance-and-process>
27. US Department of Justice. 2008. Competition and Monopoly: Single-Firm Conduct Under Section 2 of the Sherman Act, Chapter 8. <https://www.justice.gov/archives/atr/competition-and-monopoly-single-firm-conduct-under-section-2-sherman-act-chapter-8>
28. Lina Khan. 2022. Statement of Chair Lina M. Khan Regarding 6(b) Study of Pharmacy Benefit Managers https://www.ftc.gov/system/files/ftc_gov/pdf/Statement-Khan-6b-Study-Pharmacy-Benefit-Managers.pdf

RELEVANT AMA POLICY

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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(A-24)

Introduced by: Medical Student Section and American College of Physicians

Subject: Improving Supplemental Nutrition Programs

Referred to: Reference Committee B

1 Whereas, food insecurity is a public health crisis, especially among American Indian and Alaska
2 Native (AI/AN) persons, who were relocated and gave up 98% of their lands and ability to survive
3 under coercion and threats of violence by state and federal actors^{3,4}; and
4

5 Whereas, the burden of chronic diseases such as obesity and diabetes on AI/AN communities is
6 directly attributable to settler colonialism and interruption of AI/AN knowledge systems^{5,6}; and
7

8 Whereas, AI/AN persons experience food insecurity at twice the rate of whites, with 25% being
9 consistently food insecure⁴; and
10

11 Whereas, climate change uniquely affects AI/AN communities, including disproportionate
12 exposure of Alaska Native Villages to marine foods polluted by plastic and poor nutritional
13 offerings with significant price markups at grocery and convenience stores⁷; and
14

15 Whereas, US nutrition programs for AI/AN persons, including the Food Distribution Program on
16 Indian Reservations (FDPIR) and the recently launched Indian Health Service (IHS) Produce
17 Prescription Pilot Program, differ from other nutrition programs by including staple foods and
18 ingredients commonly used in pre-contact AI/AN societies and food systems⁸⁻⁹; and
19

20 Whereas, federally-recognized AI/AN Tribes and Villages without a reservation or land base and
21 the 2.8 million AI/AN persons in urban areas (greater than the population on Tribal lands) are all
22 ineligible for federal nutrition assistance programs for AI/AN persons⁸⁻¹³; and
23

24 Whereas, AI/AN persons in urban areas were 1.4 times as likely to experience food insecurity as
25 other AI/AN persons, with rates exacerbated by COVID^{4,14}; and
26

27 Whereas, the reduction of AI/AN food insecurity (by increasing AI/AN food choices, availability,
28 and household purchasing power and intervening preventively via early education and farm-to-
29 school programs) can decrease risk of gestational diabetes, sleep apnea, and metabolic
30 syndrome, promote AI/AN self-determination and self-governance, and improve AI/AN youth
31 health behavior¹⁵⁻¹⁸; therefore be it
32

33 RESOLVED, that our American Medical Association support regulatory and legal reforms to
34 extend multieligibility for USDA Food Assistance to enrolled members of federally-recognized
35 American Indian and Alaska Native Tribes and Villages to all federal feeding programs, such as,
36 but not limited to, Supplemental Nutrition Assistance Program (SNAP) and Food Distribution
37 Program on Indian Reservations (FDPIR). (New HOD Policy)

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

Received: 4/19/2024

REFERENCES

1. United States Department of Agriculture: Food and Nutrition Service. SNAP Eligibility. U.S. Department of Agriculture; 2021. <https://www.fns.usda.gov/snap/recipient/eligibility>.
2. United States Department of Agriculture: Food and Nutrition Service. WIC Eligibility Requirements. U.S. Department of Agriculture; 2023. <https://www.fns.usda.gov/wic/wic-eligibility-requirements>.
3. Farrell J, Burow PB, McConnell K, Bayham J, Whyte K, and Koss G. Effects of land dispossession and forced migration on Indigenous peoples in North America. *Science*. 2021;374(6567). Doi: 10.1126/science.abe4943.
4. Jernigan VBB, Huyser KR, Valdes J, and Simonds VW. Food Insecurity among American Indians and Alaska Natives: A National Profile using the Current Population Survey - Food Security Supplement. *J Hunger Environ Nutr*. 2017;12(1):1-10. doi: 10.1080/19320248.2016.1227750
5. McKinley CE, Jernigan VBB. "I don't remember any of us ... having diabetes or cancer": How historical oppression undermines indigenous foodways, health, and wellness. *Food Foodways*. 2023;31(1):43-65. doi:10.1080/07409710.2023.2172795
6. National Education Policy Center. What is Tribal Crit? NEPC Newsletter November 26, 2020.
7. Aker A, Ayotte P, Caron-Beaudoin É, De Silva A, Ricard S, Lemire M. Associations between dietary profiles and perfluoroalkyl acids in Inuit youth and adults. *Sci Total Environ*. 2023;857(Pt 3):159557. doi:10.1016/j.scitotenv.2022.159557
8. United States Department of Agriculture: Food and Nutrition Service. Food Distribution Program on Indian Reservations. U.S. Department of Agriculture; 2023. <https://www.fns.usda.gov/fdpir/food-distribution-program-indian-reservations>.
9. United States Department of Health and Human Services: Indian Health Service. Produce Prescription Programs. U.S. Department of Health and Human Services; 2023. <https://www.ihs.gov/nutrition/produce-prescription-programs/>.
10. National Congress of American Indians. Trust Land. NCAI; 2023. <https://www.ncai.org/policy-issues/land-natural-resources/trust-land>.
11. National Conference of State Legislatures. State Recognition of American Indian Tribes. NCSL; 2016. <https://www.ncsl.org/quad-caucus/state-recognition-of-american-indian-tribes>.
12. Urban Indian Health Commission. Invisible Tribes: Urban Indians and Their Health in a Changing World. Urban Indian Health Commission; 2007. <https://www2.census.gov/cac/nac/meetings/2015-10-13/invisible-tribes.pdf>.
13. National Council on Aging. American Indians and Alaska Natives: Key Demographics and Characteristics. National Council on Aging; 2023. <https://www.ncoa.org/article/american-indians-and-alaska-natives-key-demographics-and-characteristics>.
14. Maudrie TL, Nguyen CJ, Jernigan VBB, et al. Impacts of COVID-19 on a Food Security Study with the Baltimore Native Community. *Am Indian Alsk Native Ment Health Res*. 2022;29(2):8-31. doi:10.5820/aian.2902.2022.8
15. Stotz SA, Hebert LE, Charron-Prochownik D, et al. Relationship between food insecurity and a gestational diabetes risk reduction intervention: outcomes among American Indian and Alaska Native adolescent and young adult females [published online ahead of print, 2023 Jun 24]. *Transl Behav Med*. 2023;:ibad029. doi:10.1093/tbm/ibad029
16. Dong L, D'Amico EJ, Dickerson DL, et al. Food insecurity, sleep, and cardiometabolic risks in urban American Indian/Alaska Native youth. *Sleep Health*. 2023;9(1):4-10. doi:10.1016/j.sleh.2022.10.003
17. Brockington M, Beale D, Gaupholm J, et al. Identifying Barriers and Pathways Linking Fish and Seafood to Food Security in Inuit Nunangat: A Scoping Review. *Int J Environ Res Public Health*. 2023;20(3):2629. Published 2023 Feb 1. doi:10.3390/ijerph20032629
18. Taniguchi T, Haslam A, Sun W, Sisk M, Hayman J, Jernigan VBB. Impact of a Farm-to-School Nutrition and Gardening Intervention for Native American Families from the FRESH Study: A Randomized Wait-List Controlled Trial. *Nutrients*. 2022;14(13):2601. Published 2022 Jun 23. doi:10.3390/nu14132601

RELEVANT AMA Policy

H-150.925 Food Environments and Challenges Accessing Healthy Food

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]

H-150.937 Improvements to Supplemental Nutrition Programs

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 unhealthy 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; Reaffirmed: Res. 259, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(A-24)

Introduced by: Medical Student Section

Subject: Native American Voting Rights

Referred to: Reference Committee B

1 Whereas, our American Medical Association “acknowledges voting is a social determinant of
2 health and significantly contributes to the analyses of other social determinants of health as a
3 key metric”; and be it further
4

5 Whereas, the Association of American Medical Colleges (AAMC) supports medical schools and
6 teaching hospitals facilitating nonpartisan voter registration efforts¹; and
7

8 Whereas, health facilities’ nonpartisan voter registration efforts demonstrate improved civic
9 engagement and are protected by the National Voter Registration Act and IRS code²⁻⁵; and
10

11 Whereas, 1.2 million Native Americans (34%) are not registered to vote due to vast differences
12 in experiences and opportunities, especially for voters on reservations who experience
13 discrimination and unique challenges with voter identification laws (e.g., no addresses on
14 reservations, inability to use tribal-federal membership cards)⁶⁻¹¹; and
15

16 Whereas, the distinct political and dual citizenship status of Native Americans as members of
17 sovereign Tribal nations underscores the importance of their voter participation, as federal and
18 state elected officials are responsible for working with their Tribal governments to enact laws
19 governing Tribal authority and treaty rights⁸; and
20

21 Whereas, as Native Americans comprise over 10% of the electorate in many states, Congress
22 has repeatedly introduced the Native American Voting Rights Act, which would in part establish
23 a Native American voting task force grant program to increase turnout⁸; and
24

25 Whereas, President Biden’s Executive Order on Promoting Access to Voting strongly
26 encourages federal agencies, including Veterans Health Administration (VHA) and Indian Health
27 Service sites to seek designation as voter registration sites¹²; and
28

29 Whereas, other federal health and social programs such as the VHA, Medicaid, and SNAP/WIC
30 offer voter registration services, and the Health Resources and Services Administration even
31 offers guidance for Federally Qualified Health Centers to organize such efforts^{3,13-14}; and
32

33 Whereas, civic engagement efforts are limited at Indian Health Service, Tribal, and Urban Indian
34 Health Programs, which are crucial interfaces with Native American patients and Tribal
35 governments¹⁵⁻¹⁶; therefore be it
36

37 RESOLVED, that our American Medical Association support Indian Health Service, Tribal, and
38 Urban Indian Health Programs becoming designated voter registration sites to promote
39 nonpartisan civic engagement among the American Indian and Alaska Native population. (New
40 HOD Policy)

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

Received: 4/19/2024

REFERENCES

1. Fact Sheet for Nonpartisan Voter Registration at Health Care Institutions. AAMC. Accessed May 14, 2023. <https://www.aamc.org/advocacy-policy/voterregistration>
2. The National Voter Registration Act Of 1993 (NVRA). US Department of Justice. Published online July 20, 2022. <https://www.justice.gov/crt/national-voter-registration-act-1993-nvra>
3. Tang OY, Wong KE, Ganguli R, et al. Emergency Absentee Voting for Hospitalized Patients and Voting During COVID-19: A 50-State Study. *West J Emerg Med.* 2021;22(4):1000-1009. Published 2021 Jul 15. doi:10.5811/westjem.2021.4.50884
4. Lickiss S, Lowery L, Triemstra JD. Voter Registration and Engagement in an Adolescent and Young Adult Primary Care Clinic. *J Adolesc Health.* 2020;66(6):747-749. doi:10.1016/j.jadohealth.2019.11.316
5. Chamberlain C, Jaime H, Wohler D. Emergency Patient Voting Initiative in a Community Hospital During a Global Pandemic:: Lessons and a Call-to-Action for Expanded Voter Access. *Dela J Public Health.* 2021;7(1):76-77. Published 2021 Jan 21. doi:10.32481/djph.2021.01.015
6. Tucker J, De Leon J, McCool D. Obstacles at Every Turn: Barriers to Political Participation Faced by Native Americans. Native American Rights Fund. Published online September 16, 2020. https://vote.narf.org/wp-content/uploads/2020/06/obstacles_at_every_turn.pdf
7. Indian Health Service Voter Registration. National Congress of American Indians. Published online 2020. <https://vote.narf.org/wp-content/uploads/2022/09/ihs-vote-explanation.pdf>
8. Luján BR. Native American Voting Rights Act of 2021.; 2021 <https://www.congress.gov/bill/117th-congress/senate-bill/2702/text?=&f=1&q=%7B%22search%22%3A%22native+american+voting+rights%22%7D>
9. Friel, K., Pablo, E. How Voter Suppression Laws Target Native Americans. Brennan Center. Published May 23, 2022. Last Accessed September 17, 2023. <https://www.brennancenter.org/our-work/research-reports/how-voter-suppression-laws-target-native-americans>
10. Ferguson-Bohnee, P. How the Native American Vote Continues to be Suppressed. American Bar Association. Published February 9, 2020. Last Accessed September 17, 2023. https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/voting-rights/how-the-native-american-vote-continues-to-be-suppressed/
11. Thomas-Lundborg, A., Alvernaz, L. This Law Makes Voting Nearly Impossible for Native Americans in Montana. American Civil Liberties Union. Published March 12, 2020. Last Accessed September 17, 2023. <https://www.aclu.org/news/voting-rights/this-law-makes-voting-nearly-impossible-for-native-americans-in-montana>
12. Biden J. Executive Order on Promoting Access to Voting. The White House. Published online March 7, 2021. <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/03/07/executive-order-on-promoting-access-to-voting>
13. VA promotes greater access to voter information to Veterans and families. Veterans Affairs. Published online March 24, 2022. <https://news.va.gov/press-room/va-promotes-greater-access-to-voter-information-to-veterans-and-families>
14. Hess D. Using Medicaid Automatic Voter Registration to Address Persistent Voter Registration Problems: Helping the National Voter Registration Act Achieve its Potential. Institute for Responsive Government. Published online June 23, 2023. <https://responsivegoverning.org/research/using-medicare-automatic-voter-registration-to-address-persistent-voter-registration-problems-helping-the-national-voter-registration-act-achieve-its-potential>
15. Title I | Office of Direct Service and Contracting Tribes. Title I | Office of Direct Service and Contracting Tribes. Office of Direct Service and Contracting Tribes. Current as of 2023. <https://www.ihs.gov/odsct/title1/>
16. Martin A, Raja A, Meese H. Health care-based voter registration: a new kind of healing. *International Journal of Emergency Medicine.* Published online April 30, 2021. doi:<https://doi.org/10.1186/s12245-021-00351-y>

RELEVANT AMA Policy

Support for Safe and Equitable Access to Voting H-440.805

1. Our AMA supports measures to facilitate safe and equitable access to voting as a harm-reduction strategy to safeguard public health and mitigate unnecessary risk of infectious disease transmission by measures including but not limited to: (a) extending polling hours; (b) increasing the number of polling locations; (c) extending early voting periods; (d) mail-in ballot postage that is free or prepaid by the government; (e) adequate resourcing of the United States Postal Service and election operational procedures; (f) improved access to drop off locations for mail-in or early ballots; and (g) use of a P.O. box for voter registration.
2. Our AMA opposes requirements for voters to stipulate a reason in order to receive a ballot by mail and other constraints for eligible voters to vote-by-mail.
3. Our AMA: (a) acknowledges voting is a social determinant of health and significantly contributes to the analyses of other social determinants of health as a key metric; (b) recognizes that gerrymandering which disenfranchises individuals/communities limits access to health care, including but not limited to the expansion of comprehensive medical insurance coverage, and negatively impacts health outcomes; and (c) will collaborate with appropriate stakeholders and provide resources to firmly establish a relationship between voter participation and health outcomes. [Res. 18, I-21; Appended: Res. 422, A-22]

AMERICAN MEDICAL ASSOCIATION HOOUSE OF DELEGATES

Resolution: 210
(A-24)

Introduced by: Oregon, American College of Physicians

Subject: Support for Physicians Pursuing Collective Bargaining and Unionization

Referred to: Reference Committee B

1 Whereas, the American Medical Association (AMA) supports the right of physicians to engage in
2 collective bargaining, and it is AMA policy to work for expansion of the numbers of physicians
3 eligible for that right under federal law; and
4

5 Whereas, while AMA policy supports expanding rights for physicians rights and abilities to
6 collectively bargain, the last study of this policy area last occurred pre-pandemic as the
7 paradigm shift of physician as employee continues to expand, particularly for younger
8 generations of physicians who would be more likely to leverage and seek unionization; and
9

10 Whereas, the AMA points out that bargaining units composed entirely of physicians are
11 presumed appropriate, a recommendation that makes sense in recognition of physicians' unique
12 skills and ethical and professional obligations; and
13

14 Whereas, in 1999 the AMA provided financial support for the establishment of a national labor
15 organization - Physicians for Responsible Negotiation (PRN) - under the National Labor
16 Relations Board (NLRA) to support the development and operation of local physician
17 negotiating units as an option for employed physicians and physicians in-training, but ultimately
18 withdrew support in 2004 as few physicians signed up; and
19

20 Whereas, the numbers of physicians who are union members is estimated to have grown
21 significantly since then with a 26% increase from 2014 to 2019 when 67,673 physicians were
22 members of a union; and
23

24 Whereas, the percentage of physicians now employed by hospitals, health systems, or
25 corporate entities has increased significant, most recently reported up to 73.9% as of January,
26 2022 (up from 47.4% in 2018), and the number of physician practices acquired by hospitals and
27 corporate entities between 2019-2022 also accelerated during the pandemic; and
28

29 Whereas, dominant hospitals, healthcare systems, and other corporate entities employing
30 physicians may present limited alternatives to physicians working in a market largely controlled
31 by their employer or where covenants-not-to-compete may further contribute to the employer's
32 bargaining advantage; and
33

34 Whereas, the transition from independent professional physician workforce to employed
35 physician workforce fundamentally alters the dynamics between hospitals, health systems,
36 corporate entities and physicians, with a risk of negatively affecting the conditions of care
37 delivery and quality of care provided; and

1 Whereas, the corporatization of medicine, including involvement of private equity in healthcare,
2 raises questions about incentive alignment, costs, and downstream effects on patients; and
3

4 Whereas, recent years have seen an increase in physician burnout, which accelerated during
5 the COVID-19 pandemic, directly related to time spent on electronic health record
6 documentation, bureaucratic administrative tasks, and moral injury related to an incongruence
7 between what physicians care about and what they are incentivized to do by the health care
8 system; and
9

10 Whereas, physicians face a dominant power when negotiating with hospital employers and may
11 not have countervailing influence without collective bargaining; and
12

13 Whereas, collective bargaining is an effective tool for protecting patient care safety standards,
14 improving work conditions, ensuring pay and job security, and a providing a process for
15 grievances; and
16

17 Whereas, the National Labor Relations Board determined in 2022 that employed physicians are
18 not in a supervisory role and are therefore eligible to unionize; and
19

20 Whereas, interest in exploring collective bargaining for residents and practicing physician
21 groups has increased in some parts of the country including in Oregon, likely driven by
22 dynamics seen in the profession's shift to "employed status" for the majority of physicians;
23 therefore be it
24

25 RESOLVED, that our American Medical Association convenes an updated study of
26 opportunities for the AMA or physician associations to support physicians initiating a collective
27 bargaining process, including but not limited to unionization. (Directive to Take Action)
28

Fiscal Note: \$43,308; Consult experts and coordinate with medical societies to identify and
communicate ways to aid physicians in collective bargaining efforts.

Received: 4/5/2024

REFERENCES

1. <https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf>
2. AMA analysis shows most physicians work outside of private practice | American Medical Association
3. https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/PAI%20Avalere%20Physician%20Employment%20Trends%20Study%202019-21%20Final.pdf?ver=ksWkjKXB_yZflmFdXlvGq%3d%3d
4. <https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf>
5. https://jamanetwork.com/journals/jama/fullarticle/2799930?guestaccesskey=4b40dae9-69a2-4ec1-b2db-b5f235c67122&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jama&utm_content=etoc&utm_term=122722
6. <https://acpinternist.org/archives/2022/03/3-cs-corporatization-consolidation-commodification.htm>
7. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01535>
8. [https://www.mayoclinicproceedings.org/article/S0025-6196\(22\)00515-8/fulltext](https://www.mayoclinicproceedings.org/article/S0025-6196(22)00515-8/fulltext)
9. <https://academic.oup.com/jamia/article/26/2/106/5230918>
10. https://www.medscape.com/slideshow/2022-lifestyle-burnout-6014664?icd=login_success_email_match_norm#1
11. <https://www.acpjournals.org/doi/10.7326/M16-0961>
12. <https://nap.nationalacademies.org/catalog/25521/taking-action-against-clinician-burnout-a-systems-approach-to-professional>
13. <https://www.jdsupra.com/legalnews/following-the-doctor-s-orders-nlr-7925443/>
14. <https://www.nytimes.com/2016/01/10/business/doctors-unionize-to-resist-the-medical-machine.html>
15. <https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html?smid=nytcore-ios-share&referringSource=articleShare>
16. <https://www.medpagetoday.com/special-reports/features/104210>

RELEVANT AMA POLICY

Collective Bargaining for Physicians H-385.946

The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation.

Citation: Res. 239, A-97Reaffirmation I-98Reaffirmation A-01Reaffirmation A-05Reaffirmation A-06Reaffirmation A-08Reaffirmation I-10

Physician Collective Bargaining H-385.976

Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians.

(2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature.

(3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively.

(4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.

(5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.

Citation: BOT Rep. P, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-04; Reaffirmed in lieu of Res. 105, A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 17, A-09; Reaffirmation I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed: Res. 206, A-19;

Employee Associations and Collective Bargaining for Physicians D-383.981

Our AMA will study and report back on physician unionization in the United States.

Citation: Res. 601, I-14; Reaffirmed: Res. 206, A-19

Investigation into Residents, Fellows and Physician Unions D-383.977

Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment. Citation: Res. 606, A-19

Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988

Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare. Citation: Res. 229, A-12; Reaffirmed: Res. 206, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(A-24)

Introduced by: Organized Medical Staff Section

Subject: Deceptive Hospital Badging 2.0

Referred to: Reference Committee B

1 Whereas, the public is wholly unaware of the false labeling for care personnel in the hospital,
2 with the increasing introduction of lesser trained people appearing to be equivalent caregivers;
3 and
4
5 Whereas, the most recent addition to this group of non-physicians are certified registered nurse
6 anesthetists (CRNAs), increasingly replacing anesthesiologists; and
7
8 Whereas, this has crept into the cardiac suites of our operating rooms with increasing fallout as
9 surgeons are being tasked with assuming responsibility and therefore enhanced liability for
10 these non-physician personnel; and
11
12 Whereas, anesthesia was also overing perfusion, which will now fall to surgeons who may not
13 be up to speed to perform these additional tasks; and
14
15 Whereas, this is unquestionably a quality of care issue as well as safety related, along with a
16 public relations, cost, and billing problem; and
17
18 Whereas, we were able to correct the previous deception at our hospital with a push by the
19 organized medical staff taking action, along with the support of the AMA; therefore be it
20
21 RESOLVED, that our American Medical Association promote and prioritize public awareness of
22 the difference and importance of having the proper level of training and clear identification and
23 labeling of caregivers as that relates to quality and safety of healthcare (Directive to Take
24 Action); and be it further
25
26 RESOLVED, that our AMA work with state and county medical societies to highlight to
27 physicians the growing practice of creating false equivalencies between physicians and non-
28 physicians in the healthcare team and encourage action in local institutions to assure the quality
29 and safety of patient care. (Directive to Take Action)
30

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

Received: 4/17/2024

RELEVANT AMA POLICY

Clarification of the Title "Doctor" in the Hospital Environment D-405.991

1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.
2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969, ?that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.
3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

Citation: Res. 846, I-08; Modified: BOT Rep. 9, I-09; Reaffirmed: CCB/CLRPD Rep. 01, A-23

Need to Expose and Counter Nurse Doctoral Programs (NDP) Misrepresentation D-35.992

Our AMA will: (1) work jointly with state attorneys general to identify and prosecute those individuals who misrepresent themselves as physicians to their patients and mislead program applicants as to their future scope of practice; (2) pursue all other appropriate legislative, regulatory and legal actions through the Scope of Practice Partnership, as well as actions within hospital staff organizations, to counter misrepresentation by nurse doctoral programs and their students and graduates, particularly in clinical settings; and (3) work with all appropriate entities to ensure that all persons engaged in patient contact be clearly identified either verbally, or by name badge or similar identifier, with regard to their professional licensure in order that patients are aware of the professional educational background of that person.

Citation: Res. 211, A-06; Reaffirmed: BOT Rep. 6, A-16

Professional Nurse Staffing in Hospitals H-360.986

The AMA: (1) encourages medical and nursing staffs in each facility to closely monitor the quality of medical care to help guide hospital administrations toward the best use of resources for patients; (2) encourages medical and nursing staffs to work together to develop and implement in-service education programs and promote compliance with established or pending guidelines for unlicensed assistive personnel and technicians that will help assure the highest and safest standards of patient care; (3) encourages medical and nursing staffs to use identification mechanisms, e.g. badges, that provide the name, credentials, and/or title of the physicians, nurses, allied health personnel, and unlicensed assistive personnel in facilities to enable patients to easily note the level of personnel providing their care; (4) encourages medical and nursing staffs to develop, promote, and implement educational guidelines for the training of all unlicensed personnel working in critical care units, according to the needs at each facility; and

(5) encourages medical and nursing staffs to work with hospital administrations to assure that patient care and safety are not compromised when a hospital's environment and staffing are restructured.

Citation: BOT Rep. 11, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(A-24)

Introduced by: Organized Medical Staff Section

Subject: Advocacy Education Towards a Sustainable Medical Care System

Referred to: Reference Committee B

- 1 Whereas, extensive AMA policy and actions address the education of medical students and
2 physicians on advocacy techniques and their involvement in AMA advocacy efforts; and
3
4 Whereas, our AMA believes that “better-informed and more active citizens will result in better
5 legislators, better government, and better health care” (AMA Policy G-640.020); and
6
7 Whereas, the AMA currently facilitates some patient education and engagement in advocacy
8 efforts via is Patient Action Network (PAN); and
9
10 Whereas, greater involvement of the public in AMA advocacy efforts potentially could make the
11 AMA more effective in its advocacy on behalf of patients and the profession; and
12
13 Whereas, any attempt to engage the public must consider the potential difficulties that can arise
14 from blending the perspectives of physicians and patients; therefore be it
15
16 RESOLVED, that our American Medical Association explore innovative opportunities for
17 engaging the public in advocacy on behalf of an improved healthcare environment. (Directive to
18 Take Action)
19

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

Received: 4/17/2024

RELEVANT AMA POLICY

Medical Student, Resident and Fellow Legislative Awareness H-295.953

1. The AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students.
2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum.
3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.
4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows.

Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy G-615.103

Our AMA will: (1) study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy; (2) study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy; (3) identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy; and (4) study mechanisms to mitigate costs incurred by medical students, residents and fellows who participate at national, in person AMA conferences.

Political Action Committees and Contributions G-640.020

Our AMA: (1) believes that better-informed and more active citizens will result in better legislators, better government, and better health care; (2) encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process; (3) opposes legislative initiatives that improperly limit individual and collective participation in the democratic process; (4) supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates; (5) encourages AMPAC to continue to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions; (6) urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs; (7) will continue to work through its constituent societies to achieve a 100 percent rate of contribution to AMPAC by members; (8) calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries; and (9) calls upon all candidates for public office to refuse contributions from any organization that opposes evidence-based public health measures to reduce firearm violence.

Physician Health Policy Opportunity G-640.035

Our AMA encourages and supports efforts to educate interested medical students, residents, fellows, and practicing physicians about health policy and assist them in starting or transitioning to careers that involve health policy.

Our AMA: (a) recognizes, encourages, and supports the primary health policy training found in the physician specialties of Public Health / General Preventive Medicine, Occupational and Environmental Medicine, and Aerospace Medicine; (b) will significantly increase its collaborative efforts with the National Academy of Medicine (NAM) to make physicians aware of existing health policy training opportunities and help them to apply for and participate in them; (c) will engage with alumni of health policy training programs and joint degree programs and provide opportunities for them to share their health policy experiences with medical students, residents, fellows, and practicing physicians; (d) will include health policy content in its educational resources for members; (e) will work with the Office of the U.S. Surgeon General to disseminate information to medical students, residents, fellows, and practicing physicians about opportunities to join the Commissioned Corps of the U.S. Public Health Service; and (f) will consider options for funding a 1-year educational training program for practicing physicians who wish to transition from clinical practice to employment within the health policy sector.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(A-24)

Introduced by: Private Practice Physicians Section

Subject: Access to Covered Benefits with an Out of Network Ordering Physician

Referred to: Reference Committee B

1 Whereas, physicians have not had inflationary increases like other service providers have for
2 decades in the Medicare program; and

3
4 Whereas, physicians' ability to continue to serve patients independent of hospital systems,
5 private equity, vertically and/or horizontally consolidated systems has narrowed under current
6 reimbursement settings⁶; and

7
8 Whereas, between 2019 and 2020, 48,400 physicians left independent practice according to a
9 2021 Physicians Advocacy Institute study¹; and

10
11 Whereas, as a result there is a growing number of private practice physicians using the Direct
12 Primary Care (DPC) model not accepting insurance or otherwise treating patients in models that
13 are not in-network with health maintenance organizations (HMOs), Medicare Advantage, or
14 other health plans^{2,3}; and

15
16 Whereas, there are 2,060 direct primary care practices spanning 48 states⁴; and

17
18 Whereas, patients with catastrophic insurance plans with high deductibles are well-served by
19 having access to direct primary care physicians⁵; and

20
21 Whereas, physicians who care for patients under the direct primary care model or other out-of-
22 network models are not compensated by insurers for physician services rendered to patients
23 with these plans; and

24
25 Whereas, many of the patients served in direct primary care or out-of-network models have
26 HMOs, Medicare Advantage or other health plans for their primary insurance while using a
27 direct-pay physician for their medical care; and

28
29 Whereas, these health plans often will not cover laboratory studies, radiology studies, referral or
30 even prescription medications when ordered by one of these out-of-network physicians; and

31
32 Whereas, non-coverage of valid orders for health plan benefits for the insured leads to delays in
33 case, increased cost to patients and redundancy and inefficiency in the healthcare system;
34 therefore be it

35
36 RESOLVED, that our American Medical Association develop model legislation to protect
37 patients in direct primary care plans and non-network plans thus furthering the ability of direct
38 primary care physicians and other out-of-network physicians to provide covered services,
39 including imaging, laboratory testing, referrals, medications, and other medically-necessary

1 services for patients under their commercial insurance, even if it is an HMO or point of service
2 plan (Directive to Take Action); and be it further

3
4 RESOLVED, that our AMA develop resources, tool kits, education, and internal experts to
5 support direct primary care and other out-of-network models. (Directive to Take Action)
6

Fiscal Note: Resolved 1, Modest - between \$1,000 - \$5,000. Resolved 2, \$22,980. Develop a comprehensive portfolio of education, experts, and toolkits

Received: 4/17/2024

REFERENCES

1. Physicians Advocacy Group, Covid 19's Impact on Physician Practices and Physician Employment 2019-2020- Prepared by Avalere Health June 2021 tma.tips/PAIStudy2021.
2. Cobra KL. Direct primary care may be the link to the "fourth aim" of healthcare. Medical Economics. Published July 11, 2018. Accessed January 12, 2021. <https://www.medicaleconomics.com/view/direct-primary-care-may-be-link-fourth-aim-healthcare>
3. AM J Lifestyle Med, 2021 Sept-Oct 15(5):557-562.
4. Mapper.dpcfrontier.com
5. Direct Primary Care: Update and Roadmap for Patient Centered Reforms. The Heritage Foundation Backgrounder No. 3635. June 28, 2021.
6. State of Maine Department of Professional and Financial Regulation, Bureau of Insurance, Bulletin 434 Referrals by Out of Network Direct Primary Care Providers, June 7, 2019
7. Health Services Research 2020 Aug;55(4) 491-495.

RELEVANT AMA POLICY

Direct Primary Care H-385.912

1. Our AMA supports: (a) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (b) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.
2. AMA policy is that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense.
3. Our AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health "plans" and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty.

Citation: Res. 103; A-16; Appended: Res. 246, A-18; Reaffirmed: A-18; Reaffirmed: I-18; Appended: Res. 102, A-19

Subacute Care Standards for Physicians H-160.945

AMA guidelines for physicians' responsibilities in subacute care include:

- (1) Physicians are responsible to their patients for delivery of care in all subacute care settings, 24 hours a day, 7 days a week.
- (2) Patients who might benefit from subacute care should be admitted to and discharged under the orders of the physician who is responsible for the continuous medical management needed to meet the patient's needs and safety and maintaining quality of care.
- (3) Physicians are responsible for coordinating care for their patients with other physicians including medical directors, primary care physicians, and appropriate specialists, to optimize the quality of care in subacute settings.
- (4) Physicians are responsible for supervision and coordination of the medical care for their patients and providing leadership for all other health care providers in subacute care.
- (5) Physicians should guide procedures for their patients performed within integrated practices and direct other health care providers, consistent with federal and state regulations.

(6) Physicians are responsible for: (a) Fulfilling their roles and identifying the medical skills needed to deliver care in subacute facilities and for creating and developing continuing medical education to meet the special needs of patients in subacute care. (b) Identifying and appropriately utilizing subacute care facilities in their communities. (c) Oversight of physician credentialing in subacute settings (d) Promoting medical staff organization and by-laws that may be needed to support peer evaluations. (e) Planning care of their patients with acute and chronic conditions in subacute care, as well as pursuing efforts to restore and maintain functions for quality of life.

(7) Subacute units and/or programs need physician medical directors to assure quality of medical care, provide peer group liaisons, and coordinate and supervise patients and families input and needs.

(8) Physicians provide a plan of care for medically necessary visits after completing an initial assessment within 24 hours of admission that identifies the medical services expected during subacute care.

(9) Attending physicians should: (a) make an on-site visit to review the interdisciplinary care plan within seventy two hours of admission. (b) Determine the number of medically necessary follow up visits; these may occur daily but never less often than weekly. (c) Document active involvement of physicians in interdisciplinary care and all major components of the patient care plan including completing a progress note for each patient visit.

(10) Physicians should implement these guidelines through organized medical staff by-laws in subacute settings to assure quality patient care.

Citation: BOT Rep. 21, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15

Out-of-Network Care H-285.904

1. Our AMA adopts the following principles related to unanticipated out-of-network care:

A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.

B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.

C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.

D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.

2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.

Citation: Res. 108, A-17; Reaffirmed: A-19; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, A-18; Reaffirmed: A-19; Reaffirmed: Res. 210, A-19; Appended Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 236, A-22

Out-of-Network Care D-285.962

Our AMA will develop model state legislation addressing the coverage of and payment for unanticipated out-of-network care.

Citation: Res. 108, A-17

Physician Penalties for Out-of-Network Services H-180.952

Our AMA vehemently opposes any penalties implemented by insurance companies against physicians when patients independently choose to obtain out-of-network services.

Citation: Res. 702, A-07; Reaffirmed: CMS Rep. 01, A-17

Out of Network Restrictions of Physicians H-285.907

Our American Medical Association opposes the denial of payment for a medically necessary prescription of a drug or service covered by the policy based solely on the network participation of the duly licensed physician ordering it.

Citation: Res. 126, A-15

Out of Network Coverage Denials for Physician Prescriptions and Ordered Services D-285.963

Our American Medical Association will pursue regulation or legislation to prohibit any insurer from writing individual or group policies which deny or unreasonably delay coverage of medically necessary prescription drugs or services based on network distinctions of the licensed health care provider ordering the drug or service.

Citation: Res. 119, A-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(A-24)

Introduced by: Medical Student Section

Subject: Support for Paid Sick Leave

Referred to: Reference Committee B

1 Whereas, sick leave can be used by employees to recover from illness, attend medical
2 appointments, care for sick relatives, and seek assistance for domestic violence, and access
3 disproportionately impacts women who take on caregiver responsibilities¹⁻⁴; and
4

5 Whereas, all but 10 countries feasibly fund paid sick leave via governments and/or employers,
6 but the US' Family and Medical Leave Act (FMLA) only ensures unpaid leave⁵⁻⁷; and
7

8 Whereas, 75% of voters support a national paid leave policy, but currently 25% of private sector
9 workers do not receive paid sick leave, including 62% of those in the lowest income decile, 45%
10 of those in the lowest income quartile, 54% of Latine workers, 47% of Indigenous workers, and
11 38% of Black workers⁸⁻¹¹; and
12

13 Whereas, multiple studies demonstrate that paid sick leave increases primary care use and
14 reduces occupational injuries and infectious spread, with one estimating over \$1 billion in
15 annual savings from over 1 million prevented ED visits¹²⁻²²; and
16

17 Whereas, paid sick leave is guaranteed in 15 states including DC, 4 counties, and 17 cities, with
18 early adopters showing sustainable success for over a decade^{2,23-24}; and
19

20 Whereas, the Healthy Families Act would guarantee paid sick leave and is currently being
21 considered in both the House and Senate²⁵; therefore be it
22

23 RESOLVED, that our American Medical Association amend Policy H-440.823, "Paid Sick
24 Leave," as follows:
25

26 Paid Sick Leave H-440.823

27 Our AMA: (1) recognizes the public health benefits of paid sick
28 leave and other discretionary paid time off; (2) supports employer
29 policies that allow employees to accrue paid time off and to use
30 such time to care for themselves or a family member; ~~and~~ (3)
31 supports employer policies that provide employees with paid sick
32 days to use to care for themselves or a family member where
33 providing paid leave is overly burdensome; and (4) advocates for
34 federal and state policies that guarantee employee access to
35 protected paid sick leave. (Modify Current HOD Policy)
36

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

Received: 4/5/2024

REFERENCES

1. Understanding the difference between paid sick days & paid family and medical leave. National Partnership for Women & Families [web]. Published November 2022. Accessed August 27, 2023. <https://nationalpartnership.org/report/paid-sick-days-family-medical-leave>
2. Paid leave in the U.S. Kaiser Family Foundation. Published December 17, 2021. Accessed August 27, 2023. <https://www.kff.org/womens-health-policy/fact-sheet/paid-leave-in-u-s>
3. California paid sick leave: frequently asked questions. State of California Department of Industrial Relations. Updated March 29, 2017. Accessed August 27, 2023. https://www.dir.ca.gov/dlse/paid_sick_leave.htm
4. Ranji U, Long M, and Salganicoff A. Coronavirus puts a spotlight on paid leave policies. Kaiser Family Foundation. Published December 14, 2020. Accessed August 27, 2023. <https://www.kff.org/coronavirus-covid-19/issue-brief/coronavirus-puts-a-spotlight-on-paid-leave-policies>
5. The Family and Medical Leave Act of 1993, as amended. U.S. Department of Labor. Accessed August 27, 2023. <https://www.dol.gov/agencies/whd/fmla/law>
6. Heymann J and Sprague A. Why adopting a national paid sick leave law is critical to health and to reducing racial and socioeconomic disparities—long past due. *JAMA Health Forum*. May 6, 2021;2(5):e210514. doi: 10.1001/jamahealthforum.2021.0514
7. Raub A, Chung P, Batra P, Earle A, Bose B, Jou J, Chorny NDG, Wong E, Franken D, and Heymann J. Paid leave for personal illness: a detailed look at approaches across OECD countries. *WORLD Policy Analysis Center*. Published 2018. Accessed August 27, 2023. https://www.worldpolicycenter.org/sites/default/files/WORLD%20Report%20-%20Personal%20Medical%20Leave%20OECD%20Country%20Approaches_0.pdf
8. Paid sick leave benefits factsheet. U.S. Bureau of Labor Statistics. Updated January 12, 2021. Accessed August 27, 2023. <https://www.bls.gov/ebs/factsheets/paid-sick-leave.htm>
9. Higher paid workers more likely than lower paid workers to have paid leave benefits in 2022. U.S. Bureau of Labor Statistics, *The Economics Daily*. Published February 15, 2023. Accessed August 27, 2023. <https://www.bls.gov/opub/ted/2023/higher-paid-workers-more-likely-than-lower-paid-workers-to-have-paid-leave-benefits-in-2022.htm>
10. Xia J, Hayes J, Gault B, and Nguyen H. Paid sick days access and usage rates vary by race/ethnicity, occupation, and earnings. *Institute for Women's Policy Research*. Published February 2016. Accessed August 27, 2023. <https://iwpr.org/wp-content/uploads/2020/08/B356-paid-sick-days.pdf>
11. New polling confirms strong, broad support for paid family and medical leave. National Partnership for Women & Families. Published April 2020. Accessed August 27, 2023. <https://nationalpartnership.org/wp-content/uploads/2023/02/new-polling-paid-family-and-medical-leave.pdf>
12. Ranji U, Long M, and Salganicoff A. Coronavirus puts a spotlight on paid leave policies. Kaiser Family Foundation. Published December 14, 2020. Accessed August 27, 2023. <https://www.kff.org/coronavirus-covid-19/issue-brief/coronavirus-puts-a-spotlight-on-paid-leave-policies>
13. Pichler S, Wen K, and Ziebarth NR. COVID-19 emergency sick leave has helped flatten the curve in the United States. *Health Affairs*. October 15, 2020; 39 (12). doi: 10.1377/hlthaff.2020.00863
14. Pichler S and Ziebarth N. The pros and cons of sick pay schemes: Testing for contagious presenteeism and noncontagious absenteeism behavior. *Journal of Public Economics*. 2017;156:14-33. doi: 10.1016/j.jpubeco.2017.07.003
15. Stearns J and White C. Can paid sick leave mandates reduce leave-taking? *Labour Economics*. 2018;51:227-246. doi: 10.1016/j.labeco.2018.01.002
16. Callison K, Pesko MF, Phillips S, and Sosa JA. Cancer screening after the adoption of paid-sick-leave mandates. *N Engl J Med*. March 2, 2023; 388(9):824-832. doi: 10.1056/NEJMsa2209197
17. Ko H and Glied SA. Associations between a New York City paid sick leave mandate and health care utilization among Medicaid beneficiaries in New York City and New York State. *JAMA Health Forum*. 2021;2(5):e210342. doi: 10.1001/jamahealthforum.2021.0342
18. DeRigne L, Stoddard-Dare, Collins C, and Quinn L. Paid sick leave and preventive health care service use among US working adults. *Preventive Medicine*. June 2017;99:58-62. doi: 10.1016/j.ypmed.2017.01.020
19. Hegland TA and Berdahl TA. High job flexibility and paid sick leave increase health care access and use among US workers. *Health Affairs*. June 2022;41(6):873-882. doi: 10.1377/hlthaff.2021.01876
20. Miller K, Williams C, and Yi Y. Paid sick days and health: cost savings from reduced emergency department visits. *Institute for Women's Policy Research*. Published November 2011. Accessed August 27, 2023. <https://iwpr.org/wp-content/uploads/2022/10/IWPR-Miller-et-al-2011-PSD-and-emergency-hospital-visits.pdf>
21. Ma Y, Johnston KJ, Yu H, Wharam JF, and Wen H. State mandatory paid sick leave associated with a decline in emergency department use in the US, 2011-19. *Health Affairs*. August 2022;41(8):1169-1175. doi: 10.1377/hlthaff.2022.00098
22. Asfaw A, Pana-Cryan R, and Rosa R. Paid sick leave and nonfatal occupational injuries. *Am J Public Health*. September 2012;102(9):e59-e64. doi: 10.2105/AJPH.2011.300482
23. Paid sick leave. National Conference of State Legislatures. Updated July 21, 2020. Accessed August 27, 2023. <https://www.ncsl.org/labor-and-employment/paid-sick-leave>
24. Current paid sick days laws fact sheet. National Partnership for Women & Families. Published June 2023. Accessed August 27, 2023. <https://nationalpartnership.org/wp-content/uploads/2023/02/current-paid-sick-days-laws.pdf>
25. The Healthy Families Act Fact Sheet. National Partnership for Women & Families. Published November 2023. Accessed March 15, 2024. <https://nationalpartnership.org/wp-content/uploads/2023/02/the-healthy-families-act-fact-sheet.pdf>

RELEVANT AMA POLICY**H-420.979 AMA Statement on Family, Medical, and Safe Leave**

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid:

1) Medical leave for the employee, including pregnancy, abortion, and stillbirth; 2) Maternity leave for the employee-mother; 3) Leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; 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.

Our AMA recognizes the positive impact of paid safe leave on public health outcomes and supports legislation that offers safe leave.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(A-24)

Introduced by: Medical Student Section

Subject: American Indian and Alaska Native Language Revitalization and Elder Care

Referred to: Reference Committee B

- 1 Whereas, American Indian and Alaska Native (AI/AN) elders ages 65 and over are expected to
2 increase from 13% of the AI/AN population in 2012 to 20% by 2030¹; and
3
- 4 Whereas, AI/AN elders are considered essential to community identity, as extended family and
5 clanship leaders are valued as protectors, mentors, teachers, and intergenerational transmitters
6 of cultural knowledge, a well-recognized protective health factor for AI/AN youth²⁻⁵; and
7
- 8 Whereas, AI/AN elders experience significant health and socioeconomic disparities including
9 the lowest life expectancy of all racial/ethnic groups in the US, a 25% uninsured rate, and a 25%
10 rate of having at least one documented disability¹; and
11
- 12 Whereas, a study in Canada of AI/AN elders found that Indigenous-led health service
13 partnerships improve holistic health outcomes, as well as access to care, prevention uptake and
14 adherence to care plans for First Nations⁶; and
15
- 16 Whereas, a survey with southwestern Tribal Nations found that AI/AN elders consistently shared
17 themes of healthcare insecurity due to failed systems and IHS underfunding⁷; and
18
- 19 Whereas, while AI/AN elders receive primary care through the IHS, underfunding and
20 understaffing has forced IHS to rely on non-IHS facilities for more specialized elder care,
21 including hospice and respite care, forcing AI/AN elders to navigate unknown health systems
22 not respective of their cultural values and traditions⁸; and
23
- 24 Whereas, despite the well-documented comorbidities AI/AN people carry into elderhood, AI/AN
25 elders are less likely to create end-of-life care plans compared to non-Hispanic Whites and
26 remain one of the least studied populations regarding their use of advance care planning⁷⁻⁹; and
27
- 28 Whereas, terminally ill AI/AN elders are less likely to receive hospice and palliative care than
29 other racial/ethnic groups, with fewer than a third receiving these services compared to over
30 45% of the non-Hispanic white population¹⁰; and
31
- 32 Whereas, according to data collected by the Mayo Clinic Spirit of Eagles program, Tribal Health
33 Directors reported pain management, advanced care planning, hospice contracts, care for the
34 dying, and bereavement support as their most pressing needs, with 60% reporting limited
35 access to end-of-life care¹¹; and
36
- 37 Whereas, by 2060, the number of AI/AN elders with memory loss is expected to increase by
38 400%, requiring additional resources for the IHS to provide dementia services¹²; and

1 Whereas, language and cultural barriers severely restrict AI/AN elder access to federal and
2 state programs, such as Social Security, Medicare, and Medicaid¹³⁻¹⁴; and
3

4 Whereas, over 20% of AI/AN elders mostly speak their native language, and in several counties
5 on the Navajo Nation, over 40% speak their native language as their primary language¹⁵; and
6

7 Whereas, the National Indian Council on Aging considers Native languages as key for improving
8 health and social services and well-being for AI/AN elders¹⁶; and
9

10 Whereas, the White House Office of Science and Technology Policy (OSTP) has directed the
11 Department of Health and Human Services, Centers for Medicare and Medicaid Services, IHS,
12 and other federal agencies to value and prioritize Indigenous knowledge, including languages
13 and knowledge holders, in federal grantmaking and other funding opportunities¹⁷; and
14

15 Whereas, the Biden-Harris Administration's 2024 budget request for Indian Affairs programs
16 makes significant investments in Tribal native language revitalization¹⁸; therefore be it
17

18 RESOLVED, that our American Medical Association recognize that access to language
19 concordant services for AI/AN patients will require targeted investment as Indigenous languages
20 in North America are threatened due to a complex history of removal and assimilation by state
21 and federal actors (New HOD Policy); and be it further
22

23 RESOLVED, that our AMA support federal-tribal funding opportunities for American Indian and
24 Alaska Native language revitalization efforts, especially those that increase health information
25 resources and access to language-concordant health care services for American Indian and
26 Alaska Native elders living on or near tribal lands (New HOD Policy); and be it further
27

28 RESOLVED, that our AMA collaborate with stakeholders, including but not limited to the
29 National Indian Council on Aging and Association of American Indian Physicians, to identify best
30 practices for AI/AN elder care to ensure this group is provided culturally-competent healthcare
31 outside of the umbrella of the Indian Health Service. (Directive to Take Action)

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

Received: 4/5/2024

REFERENCES

1. Sinnett GM. The state of tribal elders. NICOA. June 2, 2022. Accessed August 26, 2023. <https://www.nicoa.org/the-state-of-tribal-elders/>.
2. Elders. National Congress of the American Indian. Accessed August 26, 2023. <https://www.ncai.org/policy-issues/education-health-human-services/elders>
3. Whitewater S, Reinschmidt KM, Kahn C, Attakai A, Teufel-Shone NI. Flexible Roles for American Indian Elders in Community-Based Participatory Research. *Prev Chronic Dis*. 2016;13:E72. Published 2016 Jun 2. doi:10.5888/pcd13.150575
4. Henson M, Sabo S, Trujillo A, Teufel-Shone N. Identifying Protective Factors to Promote Health in American Indian and Alaska Native Adolescents: A Literature Review. *J Prim Prev*. 2017;38(1-2):5-26. doi:10.1007/s10935-016-0455-2
5. Dellinger M, Poupart AE. Lessons Native American Culture Can Teach Us About Resilience During Pandemics and Health Care Crises. *WMJ*. 2021;120(S1):S80-S84.
6. Lindsay Allen, Andrew Hatala, Sabina Ijaz, Elder David Courchene and Elder Burma Bushie CMAJ March 02, 2020 192 (9) E208-E216; DOI: <https://doi.org/10.1503/cmaj.190728>
7. Jaramillo ET, Willging CE. Producing insecurity: Healthcare access, health insurance, and wellbeing among American Indian elders. *Soc Sci Med*. 2021;268:113384. doi:10.1016/j.socscimed.2020.113384
8. Haozous EA, Jaramillo ET, Willging CE. Getting to Know: American Indian Elder Health Seeking in an Under-funded Healthcare System. *SSM Qual Res Health*. 2021;1:100009. doi:10.1016/j.ssmqr.2021.100009
9. Kwak J, Cho Y, Lee Y, Noh H, Roh S. Advance Care Planning Among American Indians. *Innov Aging*. 2018;2(Suppl 1):189-190. Published 2018 Nov 11. doi:10.1093/geroni/igy023.695
10. Jervis LL, Cox DW. End-of-Life Services in Tribal Communities. *Innov Aging*. 2019;3(Suppl 1):S667-S668. Published 2019 Nov 8. doi:10.1093/geroni/igz038.2469
11. Isaacson MJ, Lynch AR. Culturally Relevant Palliative and End-of-Life Care for U.S. Indigenous Populations: An Integrative Review. *Journal of Transcultural Nursing*. 2018;29(2):180-191. doi:10.1177/1043659617720980

12. Dementia Models of Care Grantees. Indian Health Service. Accessed August 26, 2023. [Dementia Models of Care Grantees | Grantees and Awardees \(ihs.gov\)](https://www.ihs.gov/grantees-and-awardees/)
13. Mangla A, Agarwal N. Clinical Practice Issues in American Indians and Alaska Natives. [Updated 2023 May 29]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK570601/>
14. B. M.-. *Elders*. National Congress of American Indians. Retrieved September 9, 2023, from <https://www.ncai.org/policy-issues/education-health-human-services/elders>
15. *Navajo & Apache Counties Puma*, AZ. Data USA. Retrieved September 9, 2023, from <https://datausa.io/profile/geo/navajo-apache-counties-puma-az>
16. Sawyer, K., Matter, M., Biggar, A., & Vanderburg, J. (2022, Nov 9). *Effective effort to revive native languages*. ASA Generations. Retrieved September 9, 2023, from <https://generations.asaging.org/effective-effort-revive-native-languages>
17. Prabhakar, A., & Mallory, B. (2022, November 30). *White House releases first-of-a-kind Indigenous Knowledge Guidance for federal agencies*. The White House. Retrieved September 9, 2023, from <https://www.whitehouse.gov/ostp/news-updates/2022/12/01/white-house-releases-first-of-a-kind-indigenous-knowledge-guidance-for-federal-agencies/>
18. Statement by assistant secretary for Indian affairs Bryan Newland on the president's fiscal year 2024 budget. U.S. Department of the Interior Bureau of Indian Affairs. March 9, 2023. Accessed September 17, 2023. <https://www.bia.gov/news/statement-assistant-secretary-indian-affairs-bryan-newland-presidents-fiscal-year-2024-budget>

RELEVANT AMA POLICY

H-295.897 Enhancing the Cultural Competence of Physicians

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]

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.

[CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(A-24)

Introduced by: American College of Legal Medicine

Subject: The AMA Supports H.R. 7225, the Bipartisan “Administrative Law Judges Competitive Service Restoration Act”

Referred to: Reference Committee B

- 1 Whereas, Medicare and Medicaid beneficiaries and providers must appeal their
2 coverage and payment disputes to the Health and Human Services Administrative Law
3 Judges (ALJs); and
4
- 5 Whereas, from 1946 until 2018, attorney candidates who wanted to become federal
6 ALJs were required:
- 7 a. to pass an examination on administrative law given by the U.S. Department of
8 Personnel Management, and only the top three scoring candidates were
9 offered positions as federal ALJs; and
 - 10 b. to have at least seven years of experience in an area of law relevant to
11 administrative proceedings; and
 - 12 c. to prove they had the ability to write clear and understandable decisions
13 following an administrative proceeding; and
14
- 15 Whereas, following the Supreme Court decision in *Lucia v. SEC*¹, Executive Order
16 (E.O.) 13,843 was signed²; and
17
- 18 Whereas, E.O. 13,843 removed federal ALJs from the competitive civil service; and
19
- 20 Whereas, the only current requirements for a new federal ALJ are a license to practice
21 law somewhere in the United States and an appointment made by a temporary,
22 politically appointed agency head; and
23
- 24 Whereas, E.O. 13,843 politicized the federal ALJ service, potentially resulting in the
25 appointment of questionably competent ALJs³; and
26
- 27 Whereas, Medicare and Medicaid coverage and payment disputes are more likely to be
28 correctly decided by informed, competent, and truly neutral ALJs; and
29
- 30 Whereas, the bipartisan “Administrative Law Judges Competitive Service Restoration
31 Act,” H.R.7225, was introduced on February 4, 2024, by Congressman Gerry Connolly
32 (D-VA-11) and is co-sponsored by Congressman Brian Fitzpatrick (R-PA-1) and
33 Congressman Michael Lawler (R-NY-17) and is endorsed by the American College of
34 Legal Medicine (ACLM), the Association of Administrative Law Judges (AALJ), and the

1 International Federation of Professional and Technical Engineers (IFPTE); therefore be
2 it
3
4 RESOLVED, that our American Medical Association support H.R. 7225, the bipartisan
5 “Administrative Law Judges Competitive Service Restoration Act” that supports the
6 merit-based process for the selection of all Medicare/Medicaid Administrative Law
7 Judges. (New HOD Policy)

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

Received: 4/21/2024

REFERENCES

1. 138 S. Ct. 2044 (2018)
2. <https://www.federalregister.gov/documents/2018/07/13/2018-15202/excepting-administrative-law-judges-from-the-competitive-service>.
3. <https://www.govexec.com/oversight/2018/07/judges-union-supreme-court-decision-excuse-politicize-aljs/149773/>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(A-24)

Introduced by: American Society for Reproductive Medicine, American College of
Obstetricians and Gynecologists, The Endocrine Society

Subject: Protecting Access to IVF Treatment

Referred to: Reference Committee B

1 Whereas, on Friday 2/16/24, the Alabama Supreme Court¹ ruled that

2 (a) “an embryo created through in vitro fertilization (IVF) is a child protected by
3 Alabama’s wrongful death act and the Alabama Constitution;” and that

4 (b) “a human frozen embryo is a ‘child’ which is an unborn or recently born [child];” and
5 that

6 (c) “the Constitution ... commands the judge to ... upholding the sanctity of unborn life,
7 including unborn life that exists outside the womb;” and that

8 (d) “the Court would not create an exception in the statute for these IVF embryo children
9 just because they were located outside the womb;” and

10
11 Whereas, in current IVF practice in the United States, over half of embryo transfers will *not*
12 result in live birth, as many embryos after transfer will either (a) not result in a pregnancy, or (b)
13 result in a miscarriage, or (c) result in a non-viable ectopic or molar pregnancy; and

14
15 Whereas, cryopreserved embryos also do *not* have a 100% thaw-survival rate, and a small
16 percentage of embryos will not survive freeze-thaw; such that if embryos in the IVF lab have the
17 same legal status as children, then an embryology laboratory that fails to have a 100% thaw-
18 survival rate may also have some potential liability; and

19
20 Whereas, not all IVF patients (a) can afford the long-term storage fees to cryopreserve embryos
21 for future use or (b) wish to donate those embryos; and

22
23 Whereas, defining all embryos as “children” promotes the dangerous notion that all embryos
24 should somehow be transferred in an IVF cycle (instead of cryopreserving extra embryos of
25 adequate quality), which could potentially increase the rate of dangerous higher-order multiple
26 gestation pregnancies (triplets, quadruplets, etc); and

27
28 Whereas, defining all embryos as “children” may promote the dangerous and misguided notion
29 that an ectopic pregnancy could somehow be safely implanted into the uterus (as is erroneously
30 reported on various “Personhood” websites⁹); and

31
32 Whereas, the American Society for Reproductive Medicine (ASRM) Position Statement on
33 Personhood Measures states that

- 34 - “The ASRM is strongly opposed to measures granting constitutional rights or protections
35 and “personhood” status to fertilized reproductive tissues.
36 - In a growing number of states, vaguely worded and often misleading measures are...
37 defining when life begins and granting legal “personhood” status to embryos at varying
38 stages of development.

- 39 - ..., these broadly worded measures will have significant effects on a number of medical
40 treatments available to women of reproductive age.
41 o Personhood measures would make illegal some commonly used birth control
42 methods.
43 o Personhood measures would make illegal a physician's ability to provide
44 medically appropriate care to women experiencing life-threatening complications
45 due to a tubal pregnancy.
46 o Personhood measures would consign infertility patients to less effective, less
47 safe treatments for their disease.
48 o Personhood measures would unduly restrict infertile patients' right to make
49 decisions about their own medical treatments, including determining the fate of
50 any embryos created as part of the IVF process.
51 - ASRM will oppose any personhood measure;" and
52

53 Whereas, partly in response to a movement to allow the establishment of college savings
54 accounts for undelivered pregnancies; our AMA established policy H-140.835 which states that:
55 "our AMA opposes any policies that interfere with the patient-physician relationship by
56 giving probate, inheritance, a social security number, or other legal rights to
57 an undelivered pregnancy, or imposing legislative barriers to medical decision-making by
58 changes in tax codes or in definitions of beneficiaries." therefore, be it
59

60 RESOLVED, that our American Medical Association oppose any legislation or ballot measures
61 that could criminalize in-vitro fertilization (New HOD Policy); and be it further
62

63 RESOLVED, that our AMA work with other interested organizations to oppose any legislation or
64 ballot measures or court rulings that equate gametes (oocytes and sperm) or embryos with
65 children (New HOD Policy); and be it further
66

67 RESOLVED, that our AMA report back at A-25, on the status of, and AMA's activities
68 surrounding, ballot measures, court rulings, and legislation that equate embryos with children.
69 (Directive to Take Action)

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

Received: 4/23/2024

REFERENCES

1. AP news on "Alabama's IVF embryo ruling explained. And what's next?" at <https://apnews.com/article/alabama-frozen-embryos-ivf-storage-questions-1adbc349e0f99851973a609e360c242c>; posted 2/22/24, accessed 3/14/24
2. "Personhood" amendment fails by 3-1 margin. Denver Post 11/3/10 at http://www.denverpost.com/headlines/ci_16506253
3. Mississippi's "Personhood Amendment" fails at the polls. CBS News 11/8/11 at http://www.cbsnews.com/8301-250_162-57321126/mississippi-personhood-amendment-fails-at-polls/
4. Virginia House of Delegates, House Bill No 1 at <http://lis.virginia.gov/cgi-bin/legp604.exe?121+ful+HB1+pdf>
5. 'Personhood' bill killed for this year by Virginia Senate. Washington Post 2/23/12 at http://www.washingtonpost.com/blogs/virginia-politics/post/personhood-bill-killed-for-this-year-by-virginiasenate/2012/02/23/gIQAYvBWR_blog.html
6. Anti-abortion "personhood" bill clears Oklahoma senate. Reuters 12/1/12 at <http://www.reuters.com/article/2012/02/16/us-oklahoma-personhood-idUSTRE81F0ES20120216>
7. "Mississippi 'Personhood' law could cause legal mayhem, experts warn. Huffington post 11/7/11 at http://www.huffingtonpost.com/2011/11/07/mississippi-personhood-la_n_1079710.html
8. "Successful Ectopic Pregnancies" by Bill Fortenberry on www.personhoodinitiative.com, at <<http://www.personhoodinitiative.com/successful-ectopic-pregnancies.html>>, accessed 3/14/24
9. American Society for Reproductive Medicine (ASRM) Position Statement on Personhood Measures, at <<https://www.asrm.org/advocacy-and-policy/media-and-public-affairs/asrm-position-statement-on-personhood-measures/>>, accessed 3/14/24
10. Letterie G, Fox D. Legal personhood and frozen embryos: implications for fertility patients and providers in post-Roe America. J Law Biosci. 2023 May 19;10(1):lsad006. doi: 10.1093/jlb/lsad006. PMID: 37220567; PMCID: PMC10200124.

11. Jones HW. The ethics of in vitro fertilization--1982. *Fertil Steril.* 1982 Feb;37(2):146-9. doi: 10.1016/s0015-0282(16)46030-9. PMID: 11643718.

RELEVANT AMA POLICY

D-5.999 “Preserving Access to Reproductive Health Services”

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 other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges 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; Reaffirmation: A-23, Appended: Res 711, A-23)

G-605.009 “Establishing a Task Force to Preserve the Patient-Physician Relationship when Evidence-Based Appropriate Care is Banned or Restricted”

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.

3. Our American Medical Association will appoint an ad hoc committee or task force, composed of physicians from specialties who routinely provide gender-affirming care, payers, community advocates, and state Medicaid directors and/or insurance commissioners, to identify issues with physician payment and reimbursement for gender-affirming care and recommend solutions to address these barriers to care.

(Res 621, A-22; Appended: Res 816, I-23)

H-160.954 Criminalization of Medical Judgment

(1) Our AMA continues to take all reasonable and necessary steps to insure that medical decision-making exercised in good faith, does not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties.

(Sub. Res. 223, I-93; Reaffirmed: Res. 227, I-98; Reaffirmed: Res. 237, A-99; Reaffirmed and Appended: Sub. Res. 215, I-99; Reaffirmation A-09; Reaffirmed: CEJA Rep. 8, A-09)

H-160.946 The Criminalization of Health Care Decision-making

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.

(Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09)

D-160.999 Opposition to Criminalizing Health Care Decisions

Our AMA will educate physicians regarding the continuing threat posed by the criminalization of healthcare decision-making and the existence of our model legislation "An Act to Prohibit the Criminalization of Healthcare Decision-Making."

(Res. 228, I-98; Reaffirmed: BOT Rep. 5, A-08)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(A-24)

Introduced by: Michigan
Subject: Designation of Descendants of Enslaved Africans in America
Referred To: Reference Committee B

1 Whereas, the designation of African American and Black has been expanded to include any
2 person who immigrated from Africa or Caribbean countries and obtained American citizenship at
3 any point in recent history; and
4
5 Whereas, since 2003 the United States Supreme Court, ruled the definition of "Black" included
6 every person who identifies as Black on a census form including people who check the box for
7 Black and any other racial or ethnic category such as white, Asian, and Hispanic or Latino, which
8 the federal government considers to be an ethnicity that can be of any race; and
9
10 Whereas, anyone Black or White who was born in Africa, immigrated to the United States, and
11 legally becomes an American citizen is considered an African American (i.e., Elon Musk); and
12
13 Whereas, the number of immigrants entering the United States legally rose from 3.3 million in the
14 1960s to a record 7.3 million in the 1980s; and during the 1990s, some 900,000 Black immigrants
15 came from the Caribbean; another 400,000 came from Africa; still many others came from Europe,
16 Pacific Rim, Arab and Asian countries; and
17
18 Whereas, today, nearly one in ten Black Americans is an immigrant or the child of an immigrant in
19 the United States; and
20
21 Whereas, the "Intelligent" survey found 34 percent of white students who applied to colleges and
22 universities falsely claimed they were a racial minority on their application; 81 percent of students
23 who faked minority status did so to improve their chances of getting accepted and 50 percent did it
24 to get minority-focused financial aid; and
25
26 Whereas, the "Intelligent" survey found that 3 in 4, or 77 percent, of white applicants who faked
27 minority status on their applications were accepted to those colleges; and
28
29 Whereas, Descendants of Enslaved Africans in America are the only people in U.S. history
30 classified as nonhuman and property, to undergo chattel slavery, and to be deemed by the U.S.
31 constitution 3/5 of a human, according to the 13th, 14th, and 15th amendments; and
32
33 Whereas, the Descendants of Enslaved Africans in America are the only people for whom it was
34 illegal to attend school or learn how to read and write in the United States; and
35
36 Whereas, it is important to disaggregate data to make sure everyone is recognized and that the
37 data influencing policies, programs, and solutions is accurate; therefore be it
38
39 RESOLVED, that our American Medical Association work with appropriate organizations including,
40 but not limited to, the Association of American Medical Colleges to adopt and define the term
41 Descendants of Enslaved Africans in America and separate it from the generic terms African
42 American and Black in glossaries and on medical school applications. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

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REFERENCES

Bibliography: Evidence of Non-African Americans Claiming to be African Americans for personal gain:

1. American Medical Association. New AMA policy recognizes racism as a public health threat. American Medical Association. November 16, 2020. Accessed January 16, 2023. <https://www.ama-assn.org/press-center/press-releases/new-ama-policy-recognizes-racism-public-health-threat>.
2. Vijay Chokal-Ingam. Why I faked being black for med school. New York Post. April 12, 2015, 5:05am. Viewed February 6, 2023
3. Leah Asmelash. A White professor says she has been pretending to be Black for her entire professional career. CNN. Updated 11:59 AM EDT, Fri September 4, 2020
4. Colleen Flaherty. More White Lies. Jessica Krug resigns from George Washington as a graduate student from her alma mater also admits to being dishonest about racial identity. Inside Higher Ed. September 10, 2020
5. Colleen Flaherty. Feeling the Need to Defend Your Credentials Why did Elizabeth Warren divulge her genetic test results, which show she is in fact part Native American, while simultaneously insisting that she's always been evaluated professionally as a white person? Inside Higher Ed. October 16, 2018
6. Colleen Flaherty. Passing in the Classroom. Academics weigh in on the curious case of Rachel Dolezal, a white woman who allegedly passed as a black instructor of African-American studies for five years. Inside Higher Ed. June 15, 2015
7. Scott Jaschik. Professor Answers Charges of Faking Cherokee Status. Inside Higher Ed. July 13, 2015
8. Wanda Thompson. How White Women On Instagram Are Profiting Off Black Women. Blackfishing. Paper Magazine. 14 November 2018. Internet February 6, 2023
9. Cambridge Advanced Learner's Dictionary & Thesaurus Â© Cambridge University Press. Cultural Appropriation: the act of taking or using things from a culture that is not your own, especially without showing that you understand or respect this culture.
10. Maha Ikram Cherid. "Ain't Got Enough Money to Pay Me Respect": Blackfishing, Cultural Appropriation, and the Commodification of Blackness. Maha Ikram Cherid https://orcid.org/0000-0002-2768-4698_maha_cherid@mail.mcgill.caView all authors and affiliations Volume 21, Issue 5 <https://doi.org/10.1177/15327086211029357> Internet February 6, 2023

Evidence of the invention of Race as a Matter of Politics and Not Science

1. Barzun, J (1965). Race: A Study in superstition. NY:Harper
2. Ben-Jochanan, Y. (1972). Cultural genocide in the black and African studies curriculum. NY: Alkebu-Lan Books
3. Benedict, R. (1959). Race: Science and Politics. NY: Viking
4. Biddis, M.D. (1970). Father of racist ideology: The social and political thought of Count Gobineau. NY: Weinriht and Talley
5. Chase, A. (1977). The Legacy of Malthus: The social costs of the new scientific racism. NY: Alfred A. Knopf
6. Gregory, D. (1971). No more Lies: The myth and reality of American history. NY: Harper and Row
7. Gossett, T. F. (1973). Race: The history of an idea in America. NY: Schoken
8. Hodges, J. L., Struckmann, D. K. and Trost, L. D. (1975). Cultural bases of racism and group oppression: An examination of traditional "Western" concepts, values and institutional structures which support racism, sexism and elitism Berkeley: Two Riders Press, Berkeley, CA 94704
9. Montagu, A. (1974) Man's most dangerous myth: The fallacy of race. NY
10. Stoddard, L (1971). The rising tide of color against white world supremacy. Westport, Connecticut: Negro University Press. (First published 1920)
11. Weinreich, M. (1946). Hitler's professors: The part of scholarship in Germany's crimes against the Jewish people. NY: Yiddish Scientific Institute-YIVO 12. Wobogo, V. (1976). Diop's two cradle theory and the origin of white racism. Black books Bulletin, 4(4), pp. 20-37

Definition of African American(s)

1. African Americans are an ethnic group consisting of Americans with partial or total ancestry from sub-Saharan Africa. The term "African American" generally denotes descendants of enslaved Africans who are from the United States (Ref)
2. The glossary that is available on the AAMC FACTS website, as well as the FACTS tables that display the full race/ethnicity response options does not include DOESAA: FACTS Glossary: <https://www.aamc.org/data-reports/students-residents/interactive-data/facts-glossary> Example FACTS Table with response options: <https://www.aamc.org/media/6046/download?attachment>
3. AAMC DATA FACTS TABLE 12-A of the freshman class acceptees for medical schools in the United States in 2021: 456 African Americans, who are not distinguished as immigrant or non-immigrant; 203 individuals indicating more than 1 Black or African American response, which implies an immigrant status or admixture; 33 "other Black or African American" which implies immigrant status.

RELEVANT AMA POLICY

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.

3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.

4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.

5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(A-24)

Introduced by: American College of Obstetricians and Gynecologists

Subject: Bundling for Maternity Care Services

Referred to: Reference Committee B

1 Whereas, maternal mortality in the US continues to rise, up from 861 deaths in 2020 to 1,205
2 deaths in 2021¹; and
3
4 Whereas, rates of severe maternal morbidity (SMM) continues to climb and of particular
5 significance, the increasing gap in SMM between the national average (88.2/10,000 in 2020)
6 and among Black mothers (139.0/10,000)²; and
7
8 Whereas, access to maternity care continues to decline, with 35.6 percent of counties classified
9 as “maternity care deserts” and only 45.4 percent of counties classified as having “full access”
10 to maternity care and 56 counties losing obstetric providers³; and
11
12 Whereas, state Medicaid programs and private commercial plans are developing Alternative
13 Payment Models and that inappropriately bundle community and wrap-around services under
14 the physician payment^{4,5}; and
15
16 Whereas, insurers are not recognizing separate billing for services such as immediate
17 postpartum long-acting reversible contraception, care coordination, transfers during labor,
18 increased time in delivery, screening, counseling and treatment for health-related social needs
19 or co-morbid conditions that increase pregnancy risk, postpartum care, and many other
20 services^{6,7}; and
21
22 Whereas, the American Medical Association opposes the incorrect use of CPT by insurers and
23 others (Improper Use of AMA-CPT by Carriers/Software Programs (H-70.954); and
24
25 Whereas, the AMA has several policies that call for advocacy to third party payers for
26 inappropriate bundling of services (D-70.983, H-70.983); and
27
28 Whereas, the AMA CPT instructions for use of the maternity global codes includes “services
29 normally provided in uncomplicated maternity cases include antepartum care, delivery, and
30 postpartum care” and that services for high-risk pregnancies and hospital stays more than 24
31 hours before delivery should be reported separately; therefore be it
32
33 RESOLVED, that our American Medical Association advocates for the separate payment of
34 services not accounted for in the valuation of the maternity global codes and opposes the
35 inappropriate bundling of related services. (Directive to Take Action)

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

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REFERENCES

1. Hoyert DL. Maternal mortality rates in the United States, 2021. NCHS Health E-Stats. 2023. DOI: <https://dx.doi.org/10.15620/cdc.124678>.
2. Hirai, A. Severe Maternal Morbidity: Trends and Disparities. Health Resources & Services Administration. Presentation to Advisory Committee on Infant and Maternal Mortality. March 20, 2023. Available at: <https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/infant-mortality/meetings/hirai-severe-maternal-morbidity.pdf>.
3. Brigrance, C., Lucas R., Jones, E., Davis, A., Oinuma, M., Mishkin, K. and Henderson, Z. (2022). Nowhere to Go: Maternity Care Deserts Across the U.S. (Report No. 3). March of Dimes. <https://www.marchofdimes.org/research/maternity-care-deserts-report.aspx>.
4. Centers for Medicare & Medicaid Services. Transforming Maternal Health (TMaH) Model. Available at: <https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle>.
5. Connecticut Department of Social Services. HUSKY Maternity Bundle. Available at: <https://portal.ct.gov/DSS/Health-And-Home-Care/HUSKY-Maternity-Bundle>.
6. Guiahi M. Immediate Postpartum Long-Acting Reversible Contraception: An Effective and Underutilized Strategy. *JAMA Netw Open*. 2022;5(10):e2238098. doi:10.1001/jamanetworkopen.2022.38098.
7. Geissler K, Ranchoff BL, Cooper MI, Attanasio LB. Association of Insurance Status With Provision of Recommended Services During Comprehensive Postpartum Visits. *JAMA Netw Open*. 2020 Nov 2;3(11):e2025095. doi: 10.1001/jamanetworkopen.2020.25095. PMID: 33170263; PMCID: PMC7656283.

RELEVANT AMA POLICY

H-70.954 Improper Use of AMA-CPT by Carriers/Software Programs

Our AMA: (1) continues to seek endorsement of Current Procedural Terminology (CPT) as the national coding standard for physician services; in collaboration with state and specialty societies, will urge the Secretary of HHS and CMS and all other payers to adopt CPT as the single uniform coding standard for physician services in all practice settings; and will oppose the incorrect use of CPT by insurers and others, taking necessary actions to insure compliance with licensing agreements, which include provisions for termination of the agreement;

(2) will work with the American Academy of Pediatrics and other specialty societies to support state and federal legislation requiring insurers to follow the coding as defined in the Current Procedural Terminology Manual and interpreted by the CPT Assistant for all contracts in both the public and private sectors, as long as the CPT process is simple, user friendly, and does not undergo frequent changes; and

(3) seeks legislation and/or regulation to ensure that all insurance companies and group payers recognize all published CPT codes including modifiers.

D-70.983 Inappropriate Bundling of Medical Services by Third Party Payers

Our AMA will: (1) continue to promote its Private Sector Advocacy activities and initiatives associated with the collection of information on third party payer modifier acceptance and inappropriate bundling practices;

(2) use the data collected as part of its Private Sector Advocacy information clearinghouse to work, in a legally appropriate manner, with interested state medical associations and national medical specialty societies to identify and address inappropriate third party payer coding and reimbursement practices, including inappropriate bundling of services, rejection of CPT modifiers, and denial and delay of payment;

(3) continue to monitor the class action lawsuits of state medical associations, and provide supportive legal and technical resources, as appropriate;

4) develop model state legislation to prohibit third party payers from bundling services inappropriately by encompassing individually coded services under other separately coded services unless specifically addressed in CPT guidelines, or unless a physician has been specifically advised of such bundling practices at the time of entering into a contractual agreement with the physician;

(5) urge state medical associations to advocate the introduction and enactment of AMA model state legislation on claims bundling by their state legislatures; and.

(6) highlight its Private Sector Advocacy document on bundling and downcoding, the related section of the AMA Model Managed Care Contract, and its advocacy initiatives on its web site and other communications measures to assure that physicians are aware of the AMA's advocacy on this issue.

H-70.937 Bundling and Downcoding of CPT Codes

Our AMA: (1) vigorously opposes the practice of unilateral, arbitrary recoding and/or bundling by all payers;

(2) makes it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards;

(3) formulates a national policy for intervention with carriers or payers who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services, and support legislation to accomplish this; and

(4) along with medical specialty societies, calls on its members to identify to our AMA specific CPT code bundling problems by payers in their area and that our AMA develop a mechanism for assisting our members in dealing with these problems with payers.

H-70.949 Bundling of Codes for Physician Services

Our AMA: (1) advocates and will take steps to ensure that public and private payers do not bundle services inappropriately by encompassing individually coded services under other separately coded services unless specifically addressed in CPT guidelines; and (2) will enhance and fully coordinate its activities to prevent the inappropriate bundling of CPT codes (and other coding systems for supplies, injections, etc) used for payment by both public and private payers.

H-70.962 Changes in the Bundling of Medical Services by Managed Care Plans

Our AMA will introduce or support legislation or regulation that would require that managed care plans be monitored and prohibited from the arbitrary and inappropriate bundling of services to reduce payment to participating physicians; and that the medically indicated patient services such as consultations and diagnostic procedures provided by physicians on the same day be paid on a separate basis in conformity with the AMA Current Procedural Terminology (CPT) coding policy and not inappropriately bundled as they currently are by managed care plans.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(A-24)

Introduced by: California

Subject: Restorative Justice for the Treatment of Substance Use Disorders

Referred to: Reference Committee B

1 Whereas, Restorative Justice (RJ) is a correctional model featuring relationship building,
2 rehabilitation, and community empowerment. Examples of Restorative Justice models include
3 Restorative Community Conferencing (RCC) and Drug Treatment Courts, which have reduced
4 recidivism, cut costs (one RCC estimates a cost savings of \$18,500 per case per year), and
5 promoted familial connectedness, particularly among people of color; and
6

7 Whereas, police brutality, racist sentencing practices, and implicit biases that created health
8 inequities have contributed to the US having the highest incarceration rate in the world, with one
9 in three black men currently incarcerated; and
10

11 Whereas, the “war on drugs” prioritized punishment over treatment for non-violent drug
12 offenses, leading to an eight-fold increase in incarceration to 400,000 people by 1997. The Anti-
13 Drug Abuse Act diverted \$1.7 billion away from education, drug treatment, and research
14 towards law enforcement and now the U.S. spends \$12 billion annually on the war on drugs;
15 and
16

17 Whereas, during the crack cocaine epidemic of the mid 1980s where there were an estimated
18 1.6 million users, the black community was devastated because of an inequitable response by
19 law enforcement and mass incarceration due to racist sentencing practices, such as unequal
20 mandatory minimum sentences for crack cocaine - as 80% of crack users were black (due to its
21 affordability) as compared to more expensive powdered cocaine used preferentially by white
22 users; and
23

24 Whereas, injected powdered cocaine delivers a fast, intense high similar to crack, and has been
25 found to have the highest risk of overdose and death; and
26

27 Whereas, the U.S. Sentencing Commission reported in 1995 that 52% of all crack users were
28 white and 38% were black. However, only 4.1% of those sentenced for crack offenses were
29 White and 88% were Black. Prisoners have a higher rate of suicide, self harm, violence, HIV,
30 and other infectious diseases and public health experts recommend that substance abuse
31 impacts are best addressed through community resources such as family counseling, and
32 mental health programs; and
33

34 Whereas, black patients are less likely to receive pain medication and decreasing opiate
35 prescriptions increases the use of fentanyl and heroin. Conversely, increasing services such as
36 medication-assisted addiction treatment, needle exchange, naloxone availability, and
37 psychosocial treatment improve outcomes; and
38

39 Whereas, the U.S. Office of National Drug Control Policy estimated that in 1996, 3.6 million
40 people required medical treatment for their addiction, but only one million were receiving

1 treatment because 19% of the \$13.5 billion budget was dedicated to drug treatment as
2 compared to 58% for criminal justice and thus, the crack cocaine epidemic caused a multitude
3 of negative health outcomes including a four-fold increase in emergency room visits, as well as
4 a significant increase in Sexually Transmitted Diseases; and
5

6 Whereas, some minor steps in line with “Restorative Justice” have been taken, such as The Fair
7 Sentencing Act of 2010 and The First Step Act of 2018 which applied the Fair Sentencing Act
8 retroactively, and reduced the sentencing disparity from 100:1 to 18:1; and
9

10 Whereas, by contrast, the opioid epidemic, which has predominantly affected white individuals,
11 has been combatted using a “Disease Model” featuring a reduction in stigmatizing language, the
12 expenditure of \$59 million by the U.S. Department of Justice for community health interventions,
13 and sentencing individuals to rehabilitation as opposed to incarceration; and
14

15 Whereas, in 2019 alone, the Centers for Disease Control and Prevention (CDC) granted \$475
16 million for opioid overdose prevention and has (1) funded research to identify effective
17 strategies for combating the epidemic, (2) worked with health departments and community-
18 based organizations to implement evidence-based prevention strategies, (3) created an
19 evidence-based “CDC Guideline for Prescribing Opioids for Chronic Pain” and implemented
20 quality-improvement measures, (4) created the “Rx Awareness” campaign to educate users on
21 the risks of opioid use, and (5) partnered with first responders, including police, with an
22 emphasis on saving lives through naloxone administration rather than incarceration; and
23 Whereas, approaches, such as the CDC models for the opioid epidemic, are examples of the
24 application of the Restorative Justice model and can be applied retroactively to those negatively
25 impacted by the crack cocaine epidemic; therefore be it
26

27 RESOLVED, that our American Medical Association (1) continues to support the right of
28 incarcerated individuals to receive appropriate care for substance use disorders, (2) supports
29 providing incentives for incarcerated individuals to overcome substance use disorders, such as
30 participation in treatment as a condition for early release, and (3) supports providing access to
31 social services and family therapy during and after incarceration (New HOD Policy); and be it
32 further
33

34 RESOLVED, that our AMA (1) recognizes that criminalization of substance use
35 disproportionately impacts minoritized and disadvantaged communities due to structural racism
36 and implicit bias, (2) acknowledges inequitable sentencing structures, such as towards crack
37 cocaine versus opioids, have contributed to unjust imprisonments, and (3) supports implicit bias
38 and antiracism training for medical professionals working in correctional facilities. (New HOD
39 Policy)
40

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

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RELEVANT AMA POLICY

H-95.931 AMA Support for Justice Reinvestment Initiatives

Our American Medical Association 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. [Reaffirmed: CSAPH Rep. 4, I-23, Res. 205, A-16.]

H-430.986 Health Care While Incarcerated

1. Our American Medical Association 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, including correctional settings having sufficient resources to assist incarcerated persons' timely access to mental health, drug and residential rehabilitation facilities upon release.
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.
13. Our AMA encourages the following qualifications for the Director and Assistant Director of the Health Services Division within the Federal Bureau of Prisons:
 - a. MD or DO, or an international equivalent degree with at least five years of clinical experience at a Bureau of Prisons medical facility or a community clinical setting;
 - b. knowledge of health disparities among Black, American Indian and Alaska Native, and people of color, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities; and
 - c. knowledge of the health disparities among individuals who are involved with the criminal justice system.
14. Our AMA will collaborate with interested parties to promote the highest quality of health care and oversight for those who are involved in the criminal justice system by advocating for health administrators and executive staff to possess credentials and experience comparable to individuals in the community in similar professional roles

[Appended: Res. 429, A-23; Appended: Res. 244, A-23; Modified: Res. 127, A-22; Reaffirmed: Res. 229, A-21; Modified: Res. 503, A-21; Modified: Res. 216, I-19; Appended: Res 420, A-19; Appended: Res. 417, A-19; CMS Rep. 02, I-16.]

H-430.997 Standards of Care for Inmates of Correctional Facilities

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.
[Modified: CSAPH Rep. 1, A-22; Reaffirmation: I-12; Modified in lieu of Res. 502, A-12; Reaffirmation I-09; Reaffirmed: CEJA Rep. 8, A-09; Amended: Res. 416, I-99; Reaffirmed by CLRPD Rep. 3 – I-94; Res 60, A-84.]

H-95.922 Substance Use and Substance Use Disorders

Our AMA: (1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;

(2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and

(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

[Reaffirmed: CSAPH Rep. 01, A-23; Reaffirmed: BOT Rep. 14, I-20; CSAPH Rep. 01, A-18]

H-95.975 Substance Use Disorders as a Public Health Hazard

Our AMA: (1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach;

(2) declares substance use disorders are a public health priority;

(3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction;

(4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and
(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances.

[Reaffirmed: CSAPH Rep. 01, A-19; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: Sunset Rep., I-99; Appended: Sub. Res. 401; Res. 7, I-89.]

D-95.962 Enhanced Funding for and Access to Outpatient Addiction Rehabilitation

Our AMA will advocate for: (1) the expansion of federal grants in support of treatment for a substance use disorder to states that are conditioned on that state's adoption of law and/or regulation that prohibit drug courts, recovery homes, sober houses, correctional settings, and other similar programs from denying entry or ongoing care if a patient is receiving medication for an opioid use disorder or other chronic medical condition; and (2) sustained funding to states in support of evidence-based treatment for patients with a substance use disorder and/or co-occurring mental disorder, such as that put forward by the American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry and other professional medical organizations. [BOT Rep. 14, I-20]

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.

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

D-405.970 Racism - A Threat to Public Health

Our American Medical Association advocates for the creation of an International Classification of Diseases (ICD) code for patients presenting with conditions related to experiencing racism (including systemic racism and unconscious bias), a code that will provide physicians with a tool to document the clinical impact of racism, and capture the data needed to help provide more effective patient care.

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

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.

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

H-65.943 Redressing the Harms of Misusing Race in Medicine

1. Our American Medical Association recognizes the exacerbation of health and economic inequities due to race-based algorithms as a manifestation of racism within the medical field.

2. Our AMA will revise the AMA Guides to the Evaluation of Permanent Impairment, in accordance with existing AMA policy on race as a social construct and national standards of care, to modify recommendations that perpetuate racial essentialism or race-based medicine.

3. Our AMA advocates for and promotes racism-conscious, reparative, community engaged interventions at the health system, organized medical society, local, and federal levels which seek to identify, evaluate, and address the health, economic, and other consequences of structural racism in medicine.

[Modified: Speakers Rep., A-22, Reaffirmed: Res. 013, A-22, Res. 5, I-20.]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(A-24)

Introduced by: California

Subject: Reforming Medicare Part B Drug Reimbursement to Promote Patient
Affordability and Physician Practice Sustainability

Referred to: Reference Committee B

1 Whereas, the skyrocketing cost of drugs is a key driver of U.S. healthcare costs; In 2021,
2 Medicare spent \$215B and \$33B on Part D and Part B drugs respectively, with Part B clinically-
3 administered drugs costs rising at an average rate of 9.2% annually from 2008-2021;^{1,2} and
4

5 Whereas, Medicare Part B reimburses for Part B drugs under the “Buy and Bill” method, in
6 which healthcare systems or physicians purchase, stock, maintain inventory for and administer
7 drugs, and are reimbursed at an amount equal to the Average Sales Price (ASP) of the drug
8 plus 6% of the ASP;^{3,4} and
9

10 Whereas, multiple factors contribute to the high cost of Part B drugs, including longer patent
11 exclusivity periods, lack of market competition and generic alternatives, and historical prohibition
12 of Medicare in negotiating drug prices; and
13

14 Whereas, the “Buy and Bill” reimbursement structure which ties reimbursement directly to drug
15 prices disincentivizes healthcare systems or physicians to choose the lowest-cost drugs;⁵ and
16

17 Whereas, Part B drugs have high levels of patient cost-sharing, as patients are charged a
18 coinsurance of 20% of the cost of the drug rather than a fixed copay;⁶ and
19

20 Whereas, more than half of patients with a chronic illness are in medical debt, and 25% of
21 cancer patients experience eviction, home foreclosure or bankruptcy;⁷ and
22

23 Whereas, The Inflation Reduction Act authorized Medicare to begin drug price negotiations for
24 Part B drugs in 2026, with these prices taking effect in 2028;⁸ and
25

26 Whereas, while lower drug prices will undoubtedly improve affordability for patients, as noted in
27 an AMA Letter to CMS in 2018⁹, tying reimbursement to the ASP over time as prices drop “may
28 no longer be sufficient to cover the administrative costs to the practice”, threatening practice
29 viability and therefore patient access to care; and
30

31 Whereas, ASP-based Medicare reimbursement for physicians has a six-month lag period,
32 contributing to the financial vulnerability of small/medium-sized physician practices, practices in
33 rural and/or underserved areas, and practices serving a significant proportion of Medicare
34 patients;¹⁰ and
35

36 Whereas, While the administration of Part B drugs is most prevalent in the fields of oncology,
37 rheumatology, ophthalmology, dermatology and gastroenterology, this issue affects all
38 physicians serving Medicare patients, as the anticipated billions saved annually through drug
39 price negotiations could be reappropriated towards improving physician reimbursement across-
40 the-board; therefore be it

- 1 RESOLVED, that our American Medical Association support the creation of a new
2 reimbursement model for Part B drugs that 1) Disentangles reimbursement from the drug price,
3 or any weighted market average of the drug price, by reimbursing physicians for the actual cost
4 of the drug, and 2) Ensures adequate compensation for the cost of acquisition, inventory,
5 storage, and administration of clinically-administered drugs that is based on physician costs, not
6 a percent of the drug price (New HOD Policy); and be it further
7
8 RESOLVED, that our AMA maintain the principles that any revised Part B reimbursement
9 models should promote practice viability, especially for small physician practices, practices in
10 rural and/or underserved areas, and practices with a significant proportion of Medicare patients,
11 to promote continued treatment access for patients. (New HOD Policy)

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

Received: 4/23/2024

REFERENCES

1. A Small Number of Drugs Account for a Large Share of Medicare Part D Spending. Kaiser Family Foundation. Jul 12, 2023 <https://www.kff.org/medicare/press-release/10-prescription-drugs-accounted-for-48-billion-in-medicare-part-d-spending-in-2021-or-more-than-one-fifth-of-part-d-spending-that-year/#:~:text=In%202021%2C%20Part%20D%20covered,manufacturers%20to%20pharmacy%20benefit%20managers>
2. Medicare Payment Advisory Commission, "Prescription Drugs." *Health Care Spending and the Medicare Program: Data Book*, July 2021. https://www.medpac.gov/wp-content/uploads/2021/10/July2021_MedPAC_DataBook_Sec10_SEC.pdf.
3. Ginsburg P, Lieberman SM. Medicare payment for physician-administered (Part B) drugs. Brookings. Published February 10, 2021. Accessed March 21, 2022. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/02/10/medicare-payment-for-physician-administered-part-b-drugs/>
4. Ginsburg P, Brandt C, Lieberman SM. The use of vendors in Medicare Part B drug payment. Brookings. Published August 2, 2019. Accessed March 21, 2022. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/08/02/the-use-of-vendors-in-medicare-part-b-drug-payment/>
5. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Health Care Services; Committee on Ensuring Patient Access to Affordable Drug Therapies; Nass SJ, Madhavan G, Augustine NR, editors. *Making Medicines Affordable: A National Imperative*. Washington (DC): National Academies Press (US); 2017:3/73-124. Accessed April 16, 2024.3, Factors Influencing Affordability. <https://www.ncbi.nlm.nih.gov/books/NBK493090>
6. Medicare Part B Drugs: Cost Implications for Beneficiaries in Traditional Medicare and Medicare Advantage. Kaiser Family Foundation. Mar 15, 2022 <https://www.kff.org/medicare/issue-brief/medicare-part-b-drugs-cost-implications-for-beneficiaries-in-traditional-medicare-and-medicare-advantage/>
7. In America, Cancer Patients Endure Debt on Top of Disease. Kaiser Health News. July 9, 2022 <https://kffhealthnews.org/news/article/in-america-cancer-patients-endure-debt-on-top-of-disease/>
8. Medicare Part B Drugs: Trends in Spending and Utilization, 2008-2021. Assistant Secretary for Planning and Evaluation Issue Brief. June 9, 2023 <https://aspe.hhs.gov/sites/default/files/documents/fb7f647e32d57ce4672320b61a0a1443/aspe-medicare-part-b-drug-pricing.pdf>
9. AMA Letter: Advance Notice of Proposed Rulemaking: Medicare Program; International Pricing Index Model for Medicare Part B Drugs. December 20, 2018 <https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-12-20-Letter-to-Verma-re-Comments-on-IPI-Model-ANPRM.pdf>
10. Polite B, Conti RM, Ward JC. Reform of the Buy-and-Bill System for Outpatient Chemotherapy Care Is Inevitable: Perspectives from an Economist, a Realpolitik, and an Oncologist. *Am Soc Clin Oncol Educ Book*. 2015;e75-e80. doi:10.14694/EdBook_AM.2015.35.e75

RELEVANT AMA POLICY

H-330.888 Exempt Physician-Administered Drugs from Medicare Sequestration

Our AMA supports passage of federal legislation 1) exempting payments for biologics and other drugs provided under Medicare Part B from sequestration cuts, and 2) reimbursing providers for reductions in payments for biologics and other drugs furnished under Medicare Part B on or after April 1, 2013. [Reaffirmed: Res. 212, I-21; Reaffirmation A-15; Res. 235, A-13]

D-330.960 Cuts in Medicare Outpatient Infusion Services

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.

[Reaffirmation: I-18; Reaffirmed: CMS Rep. 10, A-16; Reaffirmation A-15; Reaffirmed and Modified: CMS Rep. 3, I-08; Res. 926, I-03]

D-330.904 Opposition to the CMS Medicare Part B Drug Payment Model

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.

[Res. 241, A-16]

H-110.983 Medicare Part B Competitive Acquisition Program (CAP)

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.

[Reaffirmed: CMS Rep. 4, A-22; Reaffirmed: CMS Rep. 4, I-19; Res. 216, I-18]

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.
- [Reaffirmed: Res. 801, I-23; Reaffirmed in lieu of: Res. 810, I-22; Appended: Res. 113, I-21; Reaffirmed: Res. 105, A-19; Appended: BOT Rep. 14, A-19; Appended: CMS Rep. 07, A-18; Reaffirmed: BOT Rep. 14, A-18; Appended: Alt. Res. 806, I-17; Modified: Speakers Rep. 01, A-17; Reaffirmed in lieu of Res. 107, A-17; Appended: Res. 201 A-17; Reaffirmed in lieu of: Res. 817, I-16; CMS Rep. 2, I-15]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(A-24)

Introduced by: Resident and Fellow Section

Subject: Studying Avenues for Parity in Mental Health & Substance Use Coverage

Referred to: Reference Committee B

1 Whereas, the Mental Health Parity Act passed in 1996 and was the first law to impose any sort
2 of parity between mental and physical health care, with an imposition on the annual or lifetime
3 dollar limits on mental health benefits being any less favorable than those imposed on
4 medical/surgical benefits¹; and

5
6 Whereas, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act
7 of 2008 took this concept further by preventing group health plans and health insurance insurers
8 from imposing less favorable benefit limitations for mental health or substance use disorder
9 benefits than on medical/surgical benefits¹; and

10
11 Whereas, prior to and since the inception of these federal laws, our AMA has been advocating
12 for parity in insurance benefits for those receiving mental health and substance use care (H-
13 185.974, H-168.888); and

14
15 Whereas, despite violations being found in every investigation of insurance companies, as well
16 as multiple AMA policies supporting parity and calling for compliance with parity laws (D-
17 180.998, H-185.916, H-185.974), parity still does not exist and health plans are not remotely
18 close to following parity laws regarding mental health/substance use benefits^{2,3}; and

19
20 Whereas, both the 2022 DOL/HHS/IRS Report to Congress & July 2023 MHPAEA Comparative
21 Analysis Report to Congress showed widespread violations and repeated failure of health plans
22 to provide sufficient, accurate information to regulators to perform the comparative analyses
23 required by law^{2,3}; and

24
25 Whereas, a 2023 Robert Wood Johnson Foundation Report found that cost-sharing was
26 decreased for mental health when compared to primary care visits, such that 17% of plans
27 required that a deductible be satisfied for mental health visits but not primary care visits, and
28 that despite reporting these deficits year after year, they remain unchanged^{4,5}; and

29
30 Whereas, in Georgia, 24 health plans provided no information to the state Department of
31 Insurance (DOI) to perform its statutorily-required comparative analyses and of the 28 plans that
32 did submit information, none submitted sufficient information for the DOI to perform the
33 comparative analyses⁶; and

34
35 Whereas, lack of compliance occurs at both the federal and the state level, without significant
36 consequences including continuing to allow insurer participation in state-delivered insurance
37 plans⁶; therefore be it

38
39 RESOLVED, that our American Medical Association study potential penalties to insurers for not
40 complying with mental health and substance use parity laws. (Directive to Take Action)

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

Received: 4/24/2024

REFERENCES:

1. The Mental Health Parity and Addiction Equity Act (MHPAEA). CMS.gov. September 6, 2023. Accessed September 25, 2023. <https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity>.
2. Realizing Parity, Reducing Stigma, and Raising Awareness: Increasing Access to Mental Health and Substance Use Disorder Coverage. 2022 MHPAEA Report to Congress. 2AD. Accessed September 25, 2023. <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022-realizing-parity-reducing-stigma-and-raising-awareness.pdf>.
3. 2023 MHPAEA Comparative Analysis Report to Congress. 2AD. Accessed September 25, 2023. <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2023-mhpaea-comparative-analysis.pdf>
4. Hempstead K. Cost-sharing for mental health services and primary care in the individual and small group markets. is it always the same? RWJF. October 17, 2022. Accessed September 25, 2023. <https://www.rwjf.org/en/insights/our-research/2022/10/marketplace-pulse-cost-sharing-for-mental-health-services-and-primary-care-in-the-individual-and-small-group-markets.html>.
5. Hempstead K. Differences in cost-sharing for mental health and primary care services persist. RWJF. August 24, 2023. Accessed September 25, 2023. <https://www.rwjf.org/en/insights/our-research/2023/08/marketplace-pulse-differences-in-cost-sharing-for-mental-health-and-primary-care-services-persist.html>.
6. Jordan Sieder J. Georgia insurance companies flout mental health parity reporting requirements. State Affairs. September 8, 2023. Accessed September 25, 2023. <https://stateaffairs.com/georgia/healthcare/georgia-insurance-companies-flout-mental-health-parity-reporting-requirements/>.

RELEVANT AMA POLICY:

Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care H-185.916

Our AMA supports requirements of all health insurance plans to implement a compliance program to demonstrate compliance with state and federal mental health parity laws. [Res. 216, I-22]

Parity for Mental Health and Substance Use Disorders in Health Insurance Programs H-185.974

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

Insurance Parity for Mental Health and Psychiatry D-180.998

Our AMA in conjunction with the American Psychiatric Association and other interested organizations will develop model state legislation for the use of state medical associations and specialty societies to promote legislative changes assuring parity for the coverage of mental illness, alcoholism, and substance abuse. [Res. 215, I-98, Reaffirmation I-03, Reaffirmed in lieu of Res. 910, I-06, Reaffirmation A-15]

Maintaining Mental Health Services by States H-345.975

Our AMA:

1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with

significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;

3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;

4. supports enforcement of the Mental Health Parity Act at the federal and state level; and

5. will take these resolves into consideration when developing policy on essential benefit services.

[Res. 116, A-12, Reaffirmation A-15, Reaffirmed: Res. 414, A-22]

Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.

B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.

C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.

D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.

E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.

F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.

G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.

H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

[Res. 118, I-91, Res. 102, I-92, BOT Rep. NN, I-92, BOT Rep. S, A-93, Reaffirmed: Res. 135, A-93, Reaffirmed: BOT Reps. 25 and 40, I-93, Reaffirmed in lieu of Res. 714, I-93, Res. 130, I-93, Res. 316, I-93, Sub. Res. 718, I-93, Reaffirmed: CMS Rep. 5, I-93, Res. 124, A-94, Reaffirmed by BOT Rep. 1- I-94, CEJA Rep. 3, A-95, Reaffirmed: BOT Rep. 34, I-95, Reaffirmation A-00, Reaffirmation A-01, Reaffirmed: CMS Rep. 10, A-03, Reaffirmed: CME Rep. 2, A-03, Reaffirmed and Modified: CMS Rep. 5, A-04, Reaffirmed with change in title: CEJA Rep. 2, A-05, Consolidated: CMS Rep. 7, I-05, Reaffirmation I-07, Reaffirmed in lieu of Res. 113, A-08, Reaffirmation A-09, Res. 101, A-09, Sub. Res. 110, A-09, Res. 123, A-09, Reaffirmed in lieu of Res. 120, A-12, Reaffirmation: A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(A-24)

Introduced by: American Academy of Pediatrics, American College of Obstetricians and Gynecologists

Subject: Increase in Children's Hospital Graduate Medical Education Funding

Referred to: Reference Committee B

1 Whereas, the Children's Hospitals Graduate Medical Education (CHGME) program has been a
2 vital component of supporting pediatric residency training programs in the United States since
3 its inception in the 1990s^{1,4} and was established to address the unique funding challenges faced
4 by children's hospitals in providing quality graduate medical education, recognizing the
5 importance of specialized pediatric training^{1,3} for pediatricians and other specialties who care for
6 children; and
7

8 Whereas, since the 1990s, the funding for the CHGME program has not kept pace with the
9 evolving needs of pediatric residency programs, leading to a widening gap between the funding
10 provided and the increasing demands on pediatric healthcare^{2,3,6-7}; and
11

12 Whereas, the lack of adequate adjustments to CHGME funding over the years has created
13 financial strains on children's hospitals and pediatric residency programs, limiting their ability to
14 expand training capacities and adequately respond to the growing healthcare needs of
15 children^{4,7}; and
16

17 Whereas, investing in pediatric medical education contributes to the overall improvement of
18 child health outcomes and strengthens the healthcare system as a whole⁵; and
19

20 Whereas, the American Medical Association has a longstanding commitment to advocating for
21 policies that enhance medical education and improve the healthcare workforce; therefore be it
22

23 RESOLVED, that our American Medical Association collaborate with other relevant medical
24 organizations to support and advocate for increased funding for the Children's Hospitals
25 Graduate Medical Education program, recognizing the vital role it plays in shaping the future of
26 pediatric healthcare in the United States. (Directive to Take Action)

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

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REFERENCES

1. Catherine G. Coughlin, Kenneth A. Michelson, Amy J. DeLong, Amanda M. Stewart; Federal Funding for Children's Hospitals: Challenges and Critical Shortages for Pediatric Care. *Pediatrics* October 2023; 152 (4): e2023061714. 10.1542/peds.2023-061714
2. COMMITTEE ON PEDIATRIC WORKFORCE, Mary Ellen Rimsza, Andrew J. Hotaling, Harold K. Simon, Mary E. Keown, James P. Marcin, William B. Moskowitz; Financing Graduate Medical Education to Meet the Needs of Children and the Future Pediatrician Workforce. *Pediatrics* April 2016; 137 (4): e20160211. 10.1542/peds.2016-0211
3. Association of American Medical Colleges. Proportion of charity care provided at COH, other teaching, and non-teaching hospitals, 2012. Updated 2014.

4. Chandra A, Khullar D, Wilensky GR. The economics of graduate medical education. *N Engl J Med.* 2014;370(25):2357–2360 [PubMed]
5. Cushing AM, Bucholz EM, Chien AT, Rauch DA, Michelson KA. Availability of Pediatric Inpatient Services in the United States. *Pediatrics.* 2021 Jul;148(1):e2020041723. doi: 10.1542/peds.2020-041723. Epub 2021 Jun 14. PMID: 34127553; PMCID: PMC8642812.
6. VonAchen P, Gaur D, Wickremasinghe W, Hall M, Goodman DM, Agrawal R, Berry JG. Assessment of Underpayment for Inpatient Care at Children's Hospitals. *JAMA Pediatr.* 2021 Sep 1;175(9):972-974. doi: 10.1001/jamapediatrics.2021.1133. PMID: 34047755; PMCID: PMC8424474.
7. Dobson DaVanzo & Associates. Comparative analysis of GME funding programs for children's hospitals and general acute care teaching hospitals. Available at: https://www.childrenshospitals.org/-/media/files/public-policy/chgme_workforce/reports/chgme_dobson_davanzo_report_032422.pdf. Accessed February 2, 2022

RELEVANT AMA POLICY

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.

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and

other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary

care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

34. Our AMA will publicize best practice examples of state-funded Graduate Medical Education positions and develop model state legislation where appropriate.

Securing Funding for Graduate Medical Education H-310.917

Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(A-24)

Introduced by: Medical Student Section

Subject: Antidiscrimination Protections for LGBTQ+ Youth in Foster Care

Referred to: Reference Committee B

- 1 Whereas, 30% of youth in foster care are LGBTQ+, triple the rate of those not in care¹⁻⁴; and
2
3 Whereas, in the foster care system, LGBTQ+ identifying youth encounter unique and significant
4 threats associated with their identity including rejection, harassment, violence, and discrimination
5 from social workers, foster parents, residential staff, and peers in addition to poorer health
6 outcomes compared to their non-LGBTQ+ counterparts including worse physical, mental, and
7 sexual health alongside higher prevalence of trauma, substance use, survival sex, sexual
8 victimization, and unintended pregnancy¹⁻¹⁹; and
9
10 Whereas, studies demonstrate LGBTQ+ youth are twice as likely to enter foster care, more likely
11 to spend longer time in care, be removed from placements due to hostility based on LGBTQ+
12 identity, and to age out of care without adequate preparation for higher education, employment,
13 and housing^{6,7,20-26}; and
14
15 Whereas, in 2016, the United States Children’s Bureau confidentially collected data on foster
16 youth’s sexual orientation as well as family conflicts related to a child’s gender identity, sexual
17 orientation, and or gender expression, demonstrating the ability of the system to obtain
18 demographic information confidentially to improve the system for LGBTQ+ youth²⁷; and
19
20 Whereas, in 2020, the United States Children’s Bureau eliminated requirements for collection of
21 demographics on sexual orientation in the Foster Care Analysis and Reporting System, which
22 limited child welfare agencies’ ability to analyze LGBTQ+ youth in foster care and increase
23 programs, laws, and funds protecting LGBTQ+ foster youth²⁷⁻³⁰; and
24
25 Whereas, social care professionals at religiously-affiliated foster care facilities in the United States
26 were found to propagate negative stereotypes about same-sex relationships³¹; and
27
28 Whereas, in recent years, New Jersey child welfare officials successfully recruited and licensed
29 120 new foster homes that affirm and support LGBTQ+ youth, demonstrating through local
30 LGBTQ+ community organization, home studies, and training sessions that child services can
31 successfully recruit inclusive families for the foster care system³²; and
32
33 Whereas, the Children’s Bureau and Child Welfare League of America provide fact sheets and
34 brochures with passive guidance on supporting LGBTQ+ youth in foster care as an accessible
35 and feasible means of improving care for LGBTQ+ youth³³⁻³⁸; and
36
37 Whereas, implementation of the *RISE Care Coordination Team Program* in Los Angeles helped
38 LGBTQ+ youth in the Los Angeles foster care system feel supported in their identities and
39 demonstrated an accessible model by which other programs can support LGBTQ+ youth³⁹; and

1 Whereas, the Civil Rights Act of 1964 does not protect against discrimination of LGBTQ+
2 individuals in federally-funded programs, including adoption and foster care, with recent attempts
3 to expand nondiscrimination protections failing to pass⁴⁰⁻⁴⁶; and
4

5 Whereas, the lack of inclusive protections for LGBTQ+ individuals in federal legislation, such as
6 the Civil Rights Act of 1964, the Fair Housing Act, and the Affordable Care Act, has enabled rule
7 changes and proposals that permit discrimination against LGBTQ+ individuals⁴⁷⁻⁴⁹; and
8

9 Whereas, only 28 states and the District of Columbia have specific laws and policies in place to
10 protect LGBTQ+ foster youth from discrimination based on both sexual orientation and gender
11 identity, six other states include sexual orientation but not gender identity as a protected class in
12 child welfare, and some states have no protections at all^{21,33,50}; and
13

14 Whereas, only four states had regulatory guidance regarding placement of transgender youth in
15 out-of-home care in alignment with gender identity as of 2016, and child welfare agency officials
16 from three states reported placing transgender youth in gender-segregated residential facilities
17 by their sex assigned at birth rather than their gender identity^{32,51}; and
18

19 Whereas, the relationship between LGBTQ+ protections and availability of foster families is
20 unclear, but court cases in states challenging those protections are pending^{52,53}; and
21

22 Whereas, because youth may begin to identify as LGBTQ+ after being placed with a family not
23 supportive of those identities, screening for unsupportive families is necessary to reduce harm
24 toward LGBTQ+ youth⁵⁴⁻⁵⁶; and
25

26 Whereas, though AMA policies H-60.910 and H-160.991 separately address the healthcare needs
27 of youth in foster care and of LGBTQ+ individuals, the AMA has only written one letter to the
28 Department of Housing and Urban Development opposing the removal of protections for housing
29 allocation based on gender identity⁵⁷; therefore be it
30

31 RESOLVED, that our American Medical Association collaborate with state medical societies and
32 other appropriate stakeholders to support policies on the federal and state levels that establish
33 nondiscrimination protections within the foster care system on the basis of sexual orientation and
34 gender identity (New HOD Policy); and be it further
35

36 RESOLVED, that our AMA support efforts by the Department of Health and Human Services and
37 other appropriate stakeholders to establish a reporting mechanism for the collection of
38 anonymized and aggregated sexual orientation and gender identity data in the Foster Care
39 Analysis and Reporting System only when strong privacy protections exist (New HOD Policy);
40 and be it further
41

42 RESOLVED, that our AMA encourage child welfare agencies to implement practices, policies,
43 and regulations that: (a) provide training to child welfare professionals, social workers, and foster
44 caregivers on how to establish safe, stable, and affirming care placements for LGBTQ+ youth; (b)
45 adopt programs to prevent and reduce violence against LGBTQ+ youth in foster care; (c) improve
46 recruitment of foster families that are affirming of LGBTQ+ youth; and (d) allow gender diverse
47 youth to be placed in residential foster homes that are willing to accept their gender identity.
48 (New HOD Policy)

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

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REFERENCES

1. Baams L, Wilson BDM, Russell ST. LGBTQ Youth in Unstable Housing and Foster Care. *Pediatrics*. 2019;143(3):e20174211. doi:10.1542/peds.2017-4211
2. Grooms J. No Home and No Acceptance: Exploring the Intersectionality of Sexual/Gender Identities (LGBTQ) and Race in the Foster Care System. *The Review of Black Political Economy*. 2020;47(2):177-193. doi:10.1177/0034644620911381
3. The Cuyahoga Youth Count: A Report on LGBTQ+ Youth Experience in Foster Care, 2021. Accessed March 6, 2023 from: <https://theinstitute.umaryland.edu/media/ssw/institute/Cuyahoga-Youth-Count.6.8.1.pdf>
4. Dettlaff AJ, Washburn M, Carr LC, Vogel AN. Lesbian, gay, and bisexual (LGB) youth within in welfare: Prevalence, risk and outcomes. *Child Abuse Negl*. 2018;80:183-193. doi:10.1016/j.chiabu.2018.03.009
5. Wilson BD, Cooper K, Kastanis A, Nezhad S. Sexual and Gender Minority Youth in Foster Care: Assessing Disproportionality and Disparities in Los Angeles. Published online August 1, 2014. Accessed March 5, 2023 from: <https://escholarship.org/uc/item/6mg3n153>
6. Schaub J, Stander WJ, Montgomery P. LGBTQ+ Young People's Health and Well-being Experiences in Out-of-home Social Care: A scoping review. *Child Youth Serv Rev*. 2022;143:106682. doi:10.1016/j.chilyouth.2022.106682
7. Dank M, Yu L, Yahner J, et al. Surviving the Streets of New York: Experiences of LGBTQ Youth, YMSM, and YWSW Engaged in Survival Sex, Urban Institute, 2015. Accessed March 6, 2023 from: <https://www.urban.org/sites/default/files/publication/42186/2000119-Surviving-the-Streets-of-New-York.pdf>
8. 2022 National Survey on LGBTQ Youth Mental Health. The Trevor Project. Published 2022. Accessed March 5, 2023. <https://www.thetrevorproject.org/survey-2022/>
9. Information Memorandum: Lesbian, Gay, Bisexual, Transgender and Questioning Youth in Foster Care, April 2011. Accessed March 6, 2023 from: <https://www.acf.hhs.gov/sites/default/files/documents/cb/im1103.pdf>
10. Craig-Oldsen H, Craig JA, Morton T. Issues of Shared Parenting of LGBTQ Children and Youth in Foster Care: Preparing Foster Parents for New Roles. *Child Welfare*. 2006;85(2):267-280.
11. Feinstein R, Greenblatt A, Hass L, Kohn S, Rana J. Justice for All? A Report on Lesbian, Gay, Bisexual and Transgendered Youth in the New York Juvenile Justice System.; 2001. Accessed March 5, 2023. <https://eric.ed.gov/?id=ED471676>
12. Clements JA, Rosenwald M. Foster Parents' Perspectives on LGB Youth in the Child Welfare System. *J Gay Lesbian Soc Serv*. 2007;19(1):57-69. doi:10.1300/J041v19n01_04
13. Gallegos A, Roller White C, Ryan C, O'Brien K, Pecora PJ, Thomas P. Exploring the Experiences of Lesbian, Gay, Bisexual, and Questioning Adolescents in Foster Care. *J Fam Soc Work*. 2011;14(3):226-236. doi:10.1080/10522158.2011.571547
14. Rosenwald M. A Glimpse Within: An Exploratory Study of Child Welfare Agencies' Practices With LGBTQ Youth. *J Gay Lesbian Soc Serv*. 2009;21(4):343-356. doi:10.1080/10538720802498124
15. Sullivan C, Sommer S, Moff J. Youth in the Margins: A Report on the Unmet Needs of Lesbian, Gay, Bisexual, and Transgender Adolescents in Foster Care. Lambda Legal Defense and Education Fund; 2001. Accessed March 6, 2023 from: <https://www.lambdalegal.org/publications/youth-in-the-margins>
16. Wilber S, Reyes C, Marksamer J. The model standards project: creating inclusive systems for LGBT youth in out-of-home care. *Child Welfare*. 2006;85(2):133-149.
17. Woronoff R, Estrada R. Regional listening forums: an examination of the methodologies used by the child welfare league of America and lambda legal to highlight the experiences of LGBTQ youth in care. *Child Welfare*. 2006;85(2):341-360.
18. Scannapieco M, Painter KR, Blau G. A comparison of LGBTQ youth and heterosexual youth in the child welfare system: Mental health and substance abuse occurrence and outcomes. *Child Youth Serv Rev*. 2018;91:39-46. doi:10.1016/j.chilyouth.2018.05.016
19. Brandon-Friedman RA, Pierce B, Wahler E, Thigpen J, Fortenberry JD. Sexual identity development and sexual well-being: Differences between sexual minority and non-sexual minority former foster youth. *Child Youth Serv Rev*. 2020;117:105294. doi:10.1016/j.chilyouth.2020.105294
20. Poirier JM, Wilkie S, Sepulveda K, Uruchima T. Jim Casey Youth Opportunities Initiative: Experiences and Outcomes of Youth who are LGBTQ. *Child Welfare*. 2018;96(1):1-26.
21. Child welfare nondiscrimination laws. Movement Advancement Project. Accessed September 21, 2023. https://www.lgbtmap.org/equality-maps/foster_and_adoption_laws.
22. Jacobs J, Freundlich M. Achieving permanency for LGBTQ youth. *Child Welfare*. 2006;85(2):299-316.
23. Mallon GP, Aledort N, Ferrera M. There's no place like home: achieving safety, permanency, and well-being for lesbian and gay adolescents in out-of-home care settings. *Child Welfare*. 2002;81(2):407-439.
24. Capous-Desyllas M, Mountz S. Using Photovoice Methodology to Illuminate the Experiences of LGBTQ Former Foster Youth. *Child Youth Serv*. 2019;40(3):267-307. doi:10.1080/0145935X.2019.1583099
25. Erney R, Weber K. Not all Children are Straight and White: Strategies for Serving Youth of Color in Out-of-Home care who Identify as LGBTQ. *Child Welfare*. 2018;96(2):151-177.
26. Mountz S, Capous-Desyllas M. Exploring the families of origin of LGBTQ former foster youth and their trajectories throughout care. *Children and Youth Services Review*. 2020;109:104622. doi:10.1016/j.chilyouth.2019.104622
27. Adoption and Foster Care Analysis and Reporting System. Federal Register. Published December 14, 2016. Accessed March 6, 2023 from: <https://www.federalregister.gov/documents/2016/12/14/2016-29366/adoption-and-foster-care-analysis-and-reporting-system>
28. Adoption and Foster Care Analysis and Reporting System. Federal Register. Published May 12, 2020. Accessed March 6, 2023 from: <https://www.federalregister.gov/documents/2020/05/12/2020-09817/adoption-and-foster-care-analysis-and-reporting-system>
29. Woods JB. The Regulatory Erasure of LGBTQ+ Foster Youth. *The Regulatory Review*. Published June 22, 2021. Accessed March 6, 2023 from: <https://www.theregview.org/2021/06/22/woods-regulatory-erasure-lgbtq-youth/>
30. Greeno E, Matarese M, Weeks A. Attitudes, beliefs, and behaviors of child welfare workers toward LGBTQ youth. *J Public Child Welf*. 2022;16(5):555-574. doi:10.1080/15548732.2021.1940415
31. Bermea AM, Rueda HA, Toews ML. Queerness and Dating Violence Among Adolescent Mothers in Foster Care. *Affilia*. 2018;33(2):164-176. doi:10.1177/0886109917737880

32. Foster Care: Further Assistance from HHS Would be Helpful in Supporting Youth's LGBTQ+ Identities and Religious Beliefs. Us. Government Accountability Office. Published April 2022. Accessed September 21, 2023. <https://www.gao.gov/assets/gao-22-104688.pdf>
33. Child Welfare. Lambda Legal. Accessed March 5, 2023 from: <https://www.lambdalegal.org/map/child-welfare>
34. Desano A. Youth and Family Services - RISE. Published April 2, 2019. Accessed March 5, 2023 from: <https://rise.lalgbtcenter.org/youth-and-family-services/>
35. REACHING HIGHER: A Curriculum for Foster/Adoptive Parents and Kinship Caregivers Caring for LGBTQ Youth. Accessed March 6, 2023 from: <http://www.nccwe.org/downloads/LGBTQ-FosterParentFacilitatorGuide.pdf>
36. Training, Consultation & Program Development. San Francisco State University | Family Acceptance Project. Accessed March 5, 2023 from: <https://familyproject.sfsu.edu/training>
37. Paul JC. Exploring support for LGBTQ youth transitioning from foster care to emerging adulthood. *Child Youth Serv Rev.* 2020;119:105481. doi:10.1016/j.chldyouth.2020.105481
38. RECOMMENDED PRACTICES: PRACTICES To Promote the Safety and Well-Being of Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) Youth and Youth at Risk of or Living with HIV in Child Welfare Settings, 2012. Accessed March 6, 2023 from: <https://www.lambdalegal.org/sites/default/files/publications/downloads/recommended-practices-youth.pdf>
39. Phillips L, Parrish L, Khavar V, Rodriguez E, Islas A. 2016 RISE Project Care Coordination Team Program Manual, 2016. Accessed March 6, 2023 from: <https://files.lalgbtcenter.org/pdf/rise/Los-Angeles-LGBT-Center-RISE-Care-Coordination-Services-Program-Manual.pdf>
40. Title VI, Civil Rights Act of 1964. U.S. Department of Labor: Office of the Assistant Secretary for Administration & Management. Accessed March 5, 2023 from: <http://www.dol.gov/agencies/oasam/regulatory/statutes/title-vi-civil-rights-act-of-1964>
41. Civil Rights Requirements- A. Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d et seq. ("Title VI"). HHS.gov. Published July 26, 2013. Accessed March 5, 2023 from: <https://www.hhs.gov/civil-rights/for-individuals/special-topics/needier-families/civil-rights-requirements/index.html>
42. Greenberg MH, Lopez R, Samuels J. Title VI Child Welfare Guidance. Published online October 19, 2016. Accessed March 6, 2023 from: <https://www.justice.gov/crt/title-vi-child-welfare-guidance>
43. Cicilline D. H.R.5 - Equality Act. *Congress.gov*. Published March 17, 2021. Accessed March 5, 2023 from: <https://www.congress.gov/bill/117th-congress/house-bill/5>
44. Merkley J. S.393 - Equality Act. *Congress.gov*. Published February 23, 2021. Accessed March 5, 2023 from: <http://www.congress.gov/>
45. Cicilline D. H.R. 5 (117th): Equality Act. *GovTrack.us*. Published March 2, 2021. Accessed March 5, 2023 from: <https://www.govtrack.us/congress/bills/117/hr5>
46. Gillibrand K. S.1791 - Every Child Deserves a Family Act. *Congress.gov*. Published June 11, 2019. Accessed March 5, 2023 from: <https://www.congress.gov/bill/116th-congress/senate-bill/1791>
47. Nondiscrimination in Health and Health Education Programs or Activities, Delegation of Authority. *Fed Regist.* 2020;85(119). Accessed March 5, 2023 from: <https://www.govinfo.gov/content/pkg/FR-2020-06-19/pdf/2020-11758.pdf>
48. Battle S, Wheeler II TE. Dear Colleague Letter. Published online February 22, 2017. Accessed March 6, 2023 from: <https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201702-title-ix.pdf>
49. Carson. Letter to Chairwoman Maxine Waters and Congresswoman Jennifer Wexton. Published online July 13, 2020. Accessed March 6, 2023 from: https://wexton.house.gov/uploadedfiles/hud_response_to_waters-wexton_6.29.20_letter.pdf
50. Remlin C, Cook MC, Erney R. SAFE HAVENS: Closing the Gap Between Recommended Practice and Reality for Transgender and Gender-Expansive Youth in Out-of-Home Care, April 2017. Accessed March 6, 2023 from: https://www.lambdalegal.org/sites/default/files/publications/downloads/tgnc-policy-report_2017_final-web_05-02-17.pdf
51. Erney R. 50 State Survey: Licensing regulations in Child Welfare, Juvenile Justice and systems serving runaway and homeless youth relating to sexual orientation, gender identity and gender expression, 2016. Accessed March 6, 2023 from: <https://cssp.org/wp-content/uploads/2019/01/50-State-Survey-Licensing-regulations-in-Child-Welfare-Juvenile-Justice.pdf>
52. *Burke v. Walsh*. U.S. District Court for the District of Massachusetts. Case 1:23-cv-11798. Filed August 8, 2023. Accessed September 21, 2023. <https://becketnewsite.s3.amazonaws.com/20230808154524/Burke-Complaint-and-Exhibits.pdf>.
53. *Bates v. Pakseresht et al.* U.S. District Court for the District of Oregon. Case 2:2023cv00474. Filed April 3, 2023. Accessed September 21, 2023. <https://dockets.justia.com/docket/oregon/ordce/2:2023cv00474/172578>
54. Livingston NA, Flentje A, Brennan J, Mereish EH, Reed O, Cochran BN. Real-time associations between discrimination and anxious and depressed mood among sexual and gender minorities: The moderating effects of lifetime victimization and identity concealment. *Psychol Sex Orientat Gend Divers.* 2020;7(2):132-141. doi:10.1037/sgd0000371
55. Reisner SL, White Hughto JM, Gamarel KE, Keuroghlian AS, Mizock L, Pachankis JE. Discriminatory experiences associated with posttraumatic stress disorder symptoms among transgender adults. *J Couns Psychol.* 2016;63(5):509-519. doi:10.1037/cou0000143
56. Valentine SE, Livingston NA, Salomaa AC, Shipherd JC. Trauma, Discrimination and PTSD Among LGBTQ+ People. U.S. Department of Veteran Affairs, National Center for PTSD. Accessed September 21, 2023. https://www.ptsd.va.gov/professional/treat/specific/trauma_discrimination_lgbtq.asp.
57. Madara JL. Re: Making Admission or Placement Determinations Based on Sex in Facilities Under Community Planning and Development Housing Programs (Docket No. FR—6152—P—01). Published online September 22, 2020. Accessed March 6, 2023 from: <https://searchf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-9-22-Letter-to-Carson-on-HUD-NPRM-re-Single-Sex-Housing-Facilities.pdf>

RELEVANT AMA Policy

Addressing Healthcare Needs of Children in Foster Care, H-60.910

Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care. [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]

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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(A-24)

Introduced by: Medical Student Section

Subject: Humanitarian Efforts to Resettle Refugees

Referred to: Reference Committee B

1 Whereas, “refugee” is defined in the Immigration and Nationality Act as an individual
2 experiencing persecution or a well-founded fear of persecution on account of their race, religion,
3 nationality, membership in a particular social group, or political opinion¹⁻³; and
4

5 Whereas, refugees in the US undergo an extensive and complex admission process involving
6 evaluation and referral by UNHCR (the UN’s refugee agency) to the US State Department’s
7 Refugee Admissions Program (USRAP), and are a distinct population from asylum seekers or
8 migrants crossing at the US’ southern border, who follow a completely separate process¹; and
9

10 Whereas, the US consistently admits fewer refugees than its cap, leading to 5,000 to 40,000
11 unallocated refugees⁴; and
12

13 Whereas, 29 million refugees are estimated in 2023, including 14 million children⁵⁻⁶; and
14

15 Whereas, over a 20-year period, refugees in the US ages 18 to 45 pay on average \$21,000-
16 \$43,707 more in taxes than they receive in benefits⁷⁻¹⁰; and
17

18 Whereas, refugees in general contribute \$21 billion in taxes annually, including to Social
19 Security and Medicare, offsetting the costs our aging population¹³; and
20

21 Whereas, analyses from Ohio, Michigan, and Minnesota demonstrate how refugees produce
22 billions of dollars in economic activity annually and create thousands of jobs^{9,11}; and
23

24 Whereas, 77% of refugees are working age, as opposed to the 39.7% of the US-born population
25 and male refugees participate in the labor force at higher rates than US males^{7,12,14}; and
26

27 Whereas, under 3% of refugees return to their country of origin, and 84% of long-term refugees
28 make the US their home by taking steps to become citizens^{6,10,15}; and
29

30 Whereas, when annual refugee admissions decreased 86% between 2016-2020, the 295,000
31 person gap actually harmed the US economy by nearly \$10 billion annually⁸; and
32

33 Whereas, decreased resettlement caps and worsening backlogs delay family reunification and
34 leave people displaced for decades, remaining indefinitely in refugee camps¹⁶; and
35

36 Whereas, forced displacement and restrictions on refugee admissions result in distinct chronic
37 physical and mental phenomena and generational trauma¹⁶⁻¹⁸; therefore be it
38

39 RESOLVED, that our American Medical Association support increases and oppose decreases
40 to the annual refugee admissions cap in the United States. (New HOD Policy)

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

Received: 4/24/2024

REFERENCES

1. Roy D, Klobucista C, McBride J. How Does the U.S. Refugee System Work? Council on Foreign Relations. Published March 11, 2024. Accessed March 15, 2024. <https://www.cfr.org/background/how-does-us-refugee-system-work-trump-biden-afghanistan>
2. 8 USC 1101: Definitions. Accessed March 5, 2023. <https://uscode.house.gov/view.xhtml?req=granuleid%3AUSC-prelim-title8-section1101&num=0&edition=prelim>
3. Refugee Admissions. United States Department of State. Accessed March 5, 2023. <https://www.state.gov/refugee-admissions>
4. Bruno A. Refugee Admissions and Resettlement Policy. Congr Res Serv Rep Congr. Published online August 8, 2013.
5. UNHCR. Global Appeal 2023. Accessed March 5, 2023. <https://reporting.unhcr.org/globalappeal2023/pdf>
6. Global Trends - Forced Displacement in 2018 - UNHCR. UNHCR Global Trends 2018. Accessed March 5, 2023. <https://www.unhcr.org/globaltrends2018>
7. Evans W, Fitzgerald D. The Economic and Social Outcomes of Refugees in the United States: Evidence from the ACS. National Bureau of Economic Research; 2017:w23498. doi:10.3386/w23498
8. Clemens MA. The Economic and Fiscal Effects on the United States from Reduced Numbers of Refugees and Asylum Seekers. Published online 2022.
9. National Immigration Forum. Immigrants as Economic Contributors: Refugees Are A Fiscal Success Story for America. <https://www.immigrationresearch.org/system/files/Economic-and-Fiscal-Impact-of-Refugees.pdf>
10. New American Economy. From Struggle to Resilience.; 2017. https://www.immigrationresearch.org/system/files/NAE_Struggle_to_Resilience.pdf
11. New American Economy. New Americans in Minneapolis: The Demographic and Economic Contributions of Immigrants and Refugees in the Area.
12. Immigrants Contribute Greatly to U.S. Economy, Despite Administration's "Public Charge" Rule Rationale Center on Budget and Policy Priorities. Published August 15, 2019. Accessed March 6, 2023. <https://www.cbpp.org/research/poverty-and-inequality/immigrants-contribute-greatly-to-us-economy-despite-administrations>
13. Schneider MJ. Introduction to Public Health. Jones & Bartlett Learning; 2020.
14. Capps R. The Integration Outcomes of U.S. Refugees. Migr Policy Inst.
15. Protecting the Nation From Foreign Terrorist Entry Into the United States. Federal Register. Published February 1, 2017. Accessed March 6, 2023. <https://www.federalregister.gov/documents/2017/02/01/2017-02281/protecting-the-nation-from-foreign-terrorist-entry-into-the-united-states>
16. Lorenz ML. U.S. Refugee Resettlement Is in Ruins-It Is Our Duty to Rebuild It. J Gen Intern Med. 2022;37(4):940-943. doi:10.1007/s11606-021-07373-5
17. Murray KE, Davidson GR, Schweitzer RD. Review of refugee mental health interventions following resettlement: best practices and recommendations. Am J Orthopsychiatry. 2010;80(4):576-585. doi:10.1111/j.1939-0025.2010.01062.x
18. Asylum in the United States. American Immigration Council. <https://www.americanimmigrationcouncil.org/research/asylum-united-states>. Published June 11, 2020. Accessed April 9, 2023.

RELEVANT AMA Policy

D-65.984 Humanitarian and Medical Aid Support to Ukraine

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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(A-24)

Introduced by: Missouri

Subject: Protecting Access to IVF Treatment

Referred to: Reference Committee B

1 Whereas, on Friday, 2/16/24, the Alabama Supreme Court ruled that “an embryo created
2 through in vitro fertilization (IVF) is a child protected by Alabama’s wrongful death act and the
3 Alabama Constitution;” and that “a human frozen embryo is a ‘child’ which is an unborn or
4 recently born children;” and that “the Constitution ... commands the judge to ... upholding the
5 sanctity of unborn life, including unborn life that exists outside the womb;” and that “the Court
6 would not create an exception in the statute for these IVF embryo children just because they
7 were located outside the womb; and

8
9 Whereas, historically, multiple states have already rejected attempts through legislation,
10 constitutional amendments or ballot measures to establish and expand the definition of
11 personhood and associated rights:

12 1. In 2008 and 2010, Colorado voters rejected ballot measures, to give constitutional
13 rights to individuals “at the beginning of biological development;” and

14 2. In 2011, Mississippi considered Proposition 26: "Should the term ‘person’ be defined
15 to include every human being from the moment of fertilization, cloning, or the equivalent
16 thereof?" which was voted down; and

17 3. In 2012, the Virginia House of Delegates passed House Bill 1 that was subsequently
18 tabled by the state Senate until 2013, which if passed would “construe the word ‘person’ under
19 Virginia Law ... to include unborn children” and enact that “the life of each human being begins
20 at conception;” and

21 4. Similar “Personhood” bills have also been passed by a single legislative chamber in
22 North Dakota, Oklahoma, and Mississippi; and

23
24 Whereas, these “Personhood” bills and ballot measures define a person as being a legal
25 entity from the moment of conception, and thus define fertilized eggs and embryos, as persons
26 with constitutional rights; and

27
28 Whereas, giving constitutional rights to a fertilized oocyte or embryo would interfere with the
29 physician-patient relationship in the provision of in vitro fertilization (IVF) services; and

30
31 Whereas, in current IVF practice in the United States, over half of embryo transfers will *not*
32 result in live birth, as many embryos after transfer will either (a) not result in a pregnancy, (b)
33 result in a miscarriage, or (c) result in a non-viable ectopic or molar pregnancy; and

34
35 Whereas, cryopreserved embryos also do *not* have a 100% thaw-survival rate, and a small
36 percentage of embryos will not survive freeze-thaw; and if embryos in the IVF lab have the
37 same legal status as children, then an embryology laboratory that fails to have a 100% thaw-
38 survival rate may also have some potential liability; and

1 Whereas, not all IVF patients can afford the long-term storage fees to cryopreserve embryos for
2 future use or to donate those embryos to others; and
3

4 Whereas, defining all embryos as “children” promotes the dangerous notion that all embryos
5 should somehow be transferred in an IVF cycle (instead of cryopreserving extra embryos of
6 adequate quality), which could potentially increase the rate of dangerous higher-order multiple
7 gestation pregnancies (triplets, quadruplets, etc.); and
8

9 Whereas, defining all embryos as “children” may promote the dangerous and misguided notion
10 that an ectopic pregnancy could somehow be safely implanted into the uterus (as is erroneously
11 reported on various “Personhood” websites); and
12

13 Whereas, considering embryos to be “children” also raises potential legal complications, such
14 as how inheritance and probate laws would apply to embryos; and
15

16 Whereas, defining all embryos as “children” may promote the dangerous and misguided notion
17 that a molar pregnancy can somehow be “rescued” instead of being a potential cancer; and
18

19 Whereas, considering abandoned embryos to be “children” raises questions about whether
20 states would then be liable to provide support for cryopreserved embryos and long-term storage
21 costs, such as under Medicaid as if they were “wards” of the state; and
22

23 Whereas, giving “rights” to embryos in the IVF lab will potentially complicate the practice of IVF
24 by inappropriately pressuring physicians to transfer abnormally-growing and arrested embryos;
25 and
26

27 Whereas, the American Society for Reproductive Medicine (ASRM) Position Statement on
28 Personhood Measures states that:

29 1. The ASRM is strongly opposed to measures granting constitutional rights or
30 protections and “personhood” status to fertilized reproductive tissues.

31 2. In a growing number of states, vaguely worded and often misleading measures are
32 appearing either in legislation or as proposed constitutional amendments, defining when life
33 begins and granting legal “personhood” status to embryos at varying stages of development. If
34 approved, these measures will have profound consequences for women and their families.

35 3. ..., these broadly worded measures will have significant effects on a number of
36 medical treatments available to women of reproductive age.

37 a. Personhood measures would make illegal some commonly used birth control
38 methods.

39 b. Personhood measures would make illegal a physician's ability to provide medically
40 appropriate care to women experiencing life-threatening complications due to a tubal
41 pregnancy.

42 c. Personhood measures would consign infertility patients to less effective, less safe
43 treatments for their disease.

44 d. Personhood measures would unduly restrict infertile patients' right to make decisions
45 about their own medical treatments, including determining the fate of any embryos created as
46 part of the IVF process.

47 4. ASRM will oppose any personhood measure that is unclear, confusing, ambiguous, or
48 not based on sound scientific or medical knowledge, and which threatens the safety and
49 effective treatment of patients; therefore be it
50

51 RESOLVED, that our American Medical Association oppose any legislation that could
52 criminalize in-vitro fertilization (New HOD Policy); and be it further

1 RESOLVED, that our AMA work with other interested organizations to oppose Court rulings that
2 equate gametes (oocytes and sperm) or embryos with children. (Directive to Take Action)
3

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

Received: 4/16/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(A-24)

Introduced by: Missouri

Subject: Medicare Reimbursement for Telemedicine

Referred to: Reference Committee B

1 Whereas, during the COVID-19 pandemic, Medicare billing rules were revised to enable and
2 facilitate reimbursement to clinicians for services rendered by telemedicine links to their
3 patients; and
4

5 Whereas, these rules were adopted during the COVID-19 pandemic, and did not differentiate
6 reimbursement rates for office-based vs telemedicine-based patient care; and
7

8 Whereas, commercial insurers have generally adopted Medicare’s methodology for
9 reimbursement; and
10

11 Whereas, reimbursement for telemedicine services has had two salutatory effects: 1) greater
12 convenience for patients, and 2) decreased need to utilize petroleum-powered vehicles for
13 patients’ and doctors’ transit from their homes to physicians’ offices; and
14

15 Whereas, for mobility-challenged patients telemedicine links offer an increased level of
16 convenience; and
17

18 Whereas, American Medical Association Policy D-135.966, “Declaring Climate Change a Public
19 Health Crisis”, states that a goal for America’s health care sector is to decrease its greenhouse
20 gas emissions by 50% by 2030, and to achieve “carbon neutrality” by 2050; and
21

22 Whereas, under Medicare, through December 31, 2024, Medicare will reimburse physicians for
23 charges that accrue for the provision of medical care to patients via telehealth services; and
24

25 Whereas, the remission of the COVID pandemic has enabled much medical care to again be
26 provided in “brick and mortar” offices, which makes it imperative that reimbursement rates for
27 office-based care should be greater than reimbursement rates for telemedicine-based care, due
28 to the greater overhead expenses associated with office-based care; and
29

30 Whereas, to extend indefinitely the policy of reimbursement to physicians for services provided via
31 telemedicine links (at rates lower than provided for office-based care) would be salutatory toward
32 patient convenience and toward reducing the greenhouse gas emissions attributable to the
33 healthcare sector, a previously-established goal of our AMA via its Policy D-135.9661; therefore
34 be it
35

36 RESOLVED, that our American Medical Association support removal of the December 31, 2024
37 “sunset” date currently set for Medicare to cease reimbursement for services provided via
38 telemedicine, such that reimbursement of medical services provided by telemedicine be
39 continued indefinitely into the future, consistent with what would be determined by the Relative
40 Value Update Committee (“RUC”). (New HOD Policy)

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

Received: 4/16/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(A-24)

Introduced by: Missouri
Subject: Waiver of Due Process Clauses
Referred to: Reference Committee B

1 Whereas, the right to and access to due process protections is a fundamental right enjoyed by all
2 employed Americans, unless specifically waived by the employee; and
3
4 Whereas, approximately half of all physicians are employed by employers that are not local,
5 physician-owned groups; and
6
7 Whereas, many employment agreements offered to such employed physicians contain “Waiver
8 of Due Process” clauses, which the non-physician employer has inserted to nullify the physician-
9 employee’s due process rights; and
10
11 Whereas, by working at the patient care interface, physicians are uniquely situated to detect
12 threats to patients’ health and well-being that have not been recognized or acknowledged by
13 members of hospitals’ administrations; and
14
15 Whereas, hospital administrators have occasionally retaliated against physicians who have
16 reported threats to patient or hospital worker safety in a manner that adversely impacts the
17 physician’s employment security, income stream and access to ongoing opportunities to provide
18 patient care, especially after within-organization reporting has failed to result in the employer
19 addressing or resolving those threats; and
20
21 Whereas, due process protections are thus essential for physicians, because they are duty-
22 bound to advocate for the best interest of patients and co-workers, without fear of adverse job
23 actions on the part of their employer; and
24
25 Whereas, federal legislation proposing to ban waiver of due process provisions in the
26 employment contracts of some physicians was introduced in the 116th Congress of the United
27 States of America, the “ER Hero and Patient Safety Act”, also known as HR 69102, a proposed
28 law that was not enacted; and
29
30 Whereas, the AMA House of Delegates adopted Resolution I-205-2022, advocating that our
31 AMA work for the abolition of waiver of due process clauses in physicians’ employment
32 agreements; and
33
34 Whereas, the AMA has since developed model state legislation on this topic, yet has not
35 developed model federal legislation regarding this matter as had been envisioned within the “ER
36 Hero and Patient Safety Act”; therefore be it
37
38 RESOLVED, that our American Medical Association advocate that waiver of due process
39 clauses be eliminated from all employment agreements between employed physicians and their
40 non-physician employers, and be declared unenforceable in physicians’ previously-executed

1 employment agreements between physicians and their non-physician employers that currently
2 exist (Directive to Take Action); and be it further

3

4 RESOLVED, that our AMA will engage in advocacy for adoption of such legislation at the
5 federal level. (Directive to Take Action)

6

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

Received: 4/16/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(A-24)

Introduced by: Illinois

Subject: Opposition to Legalization of Psilocybin

Referred to: Reference Committee B

1 Whereas, the effects of psilocybin, psilocin, baeocystin, norbaeocystin, and indole alkaloids
2 similar to LSD (d-lysergic acid) are primarily central (hallucinogenic) but there are some
3 peripheral effects, probably through the serotonin-norepinephrine pathways similar to
4 bufotenine; and

5
6 Whereas, according to the Drug Enforcement Administration (DEA), "The physical effects
7 include: nausea, vomiting, muscle weakness, and lack of coordination. The psychological
8 consequences of psilocybin use include hallucinations and an inability to discern fantasy from
9 reality. Panic reactions and a psychotic-like episode also may occur, particularly if a user
10 ingests a high dose." (<https://www.dea.gov/factsheets/psilocybin>); and

11
12 Whereas, mild to moderate effects of hallucinogenic mushrooms include dilated pupils
13 (develops in over 90% of cases), confusion, vertigo, drowsiness, nausea, vomiting, tachycardia,
14 and mild hypertension. Psychotropic effects include sense of exhilaration, hallucinations
15 including vivid bright colors and shapes, euphoria, distortion of sense of time, dysesthesias,
16 anxiety, perceptual distortions (may result in either a pleasant or apprehensive mood; "good" or
17 "bad" trip), and impaired judgement. Although hallucinations usually do not persist after 4 to 5
18 hours, prolonged hallucinations persisting for up to 4 days have rarely been reported. Flashback
19 phenomena have occurred from 2 weeks to 8 months after ingestion; and

20
21 Whereas, severe toxic physical effects include: muscular weakness, increased deep tendon
22 reflexes, fever (particularly in children), flushing (primarily face and upper trunk), tachycardia,
23 hypertension, ataxia, paresthesias, seizures (more common in children), rhabdomyolysis (very
24 rarely), renal failure, or cardiopulmonary arrest. Intravenous injection of mushroom extract can
25 cause fever, hypoxia, or mild methemoglobinemia. Severe psychotropic effects include: mood
26 alterations, acute psychosis, panic reactions, and powerful distortions of space and time; and

27
28 Whereas, psilocybin can induce complex changes at various levels of the brain which lead to
29 altered states of consciousness; and

30
31 Whereas, there is little correlation between the quantity ingested and clinical effects. One to four
32 large Psilocybes (10 to 30 grams fresh weight) may yield 5 to 15 mg of psilocybin, and produce
33 hallucinations. A dose of 12 mg or more of psilocybin can produce vivid hallucinations; and

34
35 Whereas, Psilocybin or it's related substances should not be used in any safety sensitive
36 position in that impairment is likely to occur; and

37
38 Whereas, quality control (for dose confirmation and contaminant detection) is difficult to obtain
39 for a fungal based product; and

- 1 Whereas, Psilocybin is not detected with usual toxicological screening methods and blood/urine
2 concentrations of the active ingredient (Psilocin or 4-hydroxy-dimethyltryptamine; 4-OH-DMT) is
3 not possible for the clinical application (requiring at least one-week turnaround from most
4 reference labs (<https://www.nmslabs.com/tests?test=psilocybin>); and
5
6 Whereas, therapeutic drug monitoring, dose titration to effects and prediction of toxic sequelae
7 is not possible with Psilocybin; therefore be it
8
9 RESOLVED, that our American Medical Association oppose any legislative efforts relatable to
10 legalization of Psilocybin/Psilocin or its related substances use. (New HOD Policy)

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

Received: 4/24/2024

References:

1. Tylš, Filip, Tomáš Páleníček, and Jiří Horáček. "Psilocybin—summary of knowledge and new perspectives." *European Neuropsychopharmacology* 24.3 (2014): 342-356.
2. Leikin, J. B., Krantz, A. J., Zell-Kanter, M., Barkin, R. L., & Hryhorczuk, D. O. (1989). Clinical features and management of intoxication due to hallucinogenic drugs. *Medical toxicology and adverse drug experience*, 4, 324-350.
3. Leikin, Jerrold B., and Frank P. Paloucek. "Poisoning and toxicology handbook." CRC Press (2008). Page 913
4. MUSHROOMS-HALLUCINOGENIC in: Merative™ Micromedex® POISINDEX® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: <https://www.micromedexsolutions.com/> (cited: July 5, 2023).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(A-24)

Introduced by: American Academy of Dermatology, American Society for Dermatologic Surgery Association, American Contact Dermatitis Society and American College of Mohs Surgery

Subject: Protecting Patients from Inappropriate Dentist and Dental Hygienist Scope of Practice Expansion

Referred to: Reference Committee B

1 Whereas, procedures performed by any means, methods, devices, or instruments that can alter
2 or cause biologic change or damage the skin and subcutaneous tissue constitute the practice of
3 medicine and surgery; and
4

5 Whereas, there are increased legislative and regulatory efforts to allow dentists and dental
6 hygienists to administer neurotoxins and dermal fillers for therapeutic or cosmetic purposes
7 without physician supervision; and
8

9 Whereas, in order to ensure patient safety, administration of neurotoxins and dermal fillers
10 requires supervision by a trained physician, education, training, specific knowledge of facial
11 anatomy (particularly in the periocular region), and the ability to manage complications that may
12 arise; and
13

14 Whereas, the focus of dental education is on oral health, rather than the skin and facial tissue;
15 and
16

17 Whereas, dentists and dental hygienists are not required to demonstrate competency in
18 procedures that augment skin and soft tissues using products that can alter or damage such
19 living tissue; and
20

21 Whereas, the American Dental Association and the American Dental Hygienist Association are
22 silent on the issue of dentists and dental hygienists performing medical procedures related to
23 fillers and neurotoxins; and
24

25 Whereas, in 2023 the Food and Drug Administration (FDA) updated consumer guidance to state
26 that anyone considering a neurotoxin or dermal filler should consult with a licensed health care
27 provider who has experience in the fields of dermatology or plastic surgery, who is experienced
28 in injecting dermal fillers, who is knowledgeable about fillers, anatomy and managing
29 complications, and who knows the risks and benefits of treatment³; and
30

31 Whereas, preventing and treating adverse events of injectable fillers requires the development
32 of evidence-based clinical practice guidelines to support decision-making in daily practice and
33 knowledge of vascular anatomy is *crucial* for all filler injections⁴; and
34

35 Whereas, intravascular injection is possible at any location on the face, but certain locations
36 carry a higher risk of filler embolization, necrosis, visual abnormalities, blindness and stroke⁵;
37 and

1 Whereas, allowing dentists and dental hygienists to administer neurotoxins and dermal fillers for
2 therapeutic or cosmetic purposes jeopardizes patient safety and disregards what is considered
3 adequate and appropriate medical education and training; therefore be it
4

5 RESOLVED, that our American Medical Association advocacy efforts recognize the threat
6 posed to patient safety when dentists and dental hygienists are authorized to practice medicine
7 and administer procedures outside their level of education and training (New HOD Policy); and
8 be it further
9

10 RESOLVED, that our AMA actively oppose regulatory and legislative efforts authorizing dentists
11 and dental hygienists to practice outside their level of education and training. (Directive to Take
12 Action)

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

Received: 4/24/2024

REFERENCES

1. General Dentistry. Retrieved from <http://www.ada.org/en/education-careers/careers-in-dentistry/general-dentistry>
2. Dental Hygienist Education and Training Requirements. Retrieved from <http://www.ada.org/en/education-careers/careers-in-dentistry/dental-team-careers/dental-hygienist/education-training-requirements-dental-hygienist>
3. Dermal filler Do's and Don'ts For Wrinkles, Lips and More. U.S. Food and Drug Administration. Retrieved from <https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm049349.htm>
4. Jones D, Fitzgerald R, Cox S, Butterwick K, et al. Preventing and Treating Adverse Events of Injectable Fillers: Evidence-Based Recommendations From the American Society for Dermatologic Surgery Multidisciplinary Task Force. *Dermatol Surg* 2021;47:214-26.
5. Ibid.
6. Scope of Practice. ADHA. Retrieved from <https://www.adha.org/advocacy/scope-of-practice/>
7. Advocacy. American Dental Association. Retrieved from <https://www.ada.org/advocacy>

RELEVANT AMA POLICY

D-35.983 Addressing Safety and Regulation in Medical Spas

Our AMA will: (1) advocate for state regulation to ensure that cosmetic medical procedures, whether performed in medical spas or in more traditional medical settings, have the same safeguards as "medically necessary" procedures, including those which require appropriate training, supervision and oversight; (2) advocate that cosmetic medical procedures, such as botulinum toxin injections, dermal filler injections, and laser and intense pulsed light procedures, be considered the practice of medicine; (3) take steps to increase the public awareness about the dangers of those medical spas which do not adhere to patient safety standards by encouraging the creation of formal complaint procedures and accountability measures in order to increase transparency; and (4) continue to evaluate the evolving issues related to medical spas, in conjunction with interested state and medical specialty societies. (Res. 209, I-11; Reaffirmed: BOT Rep. 7, A-21)

D-160.995 Physician and Nonphysician Licensure and Scope of Practice

1. Our AMA will: (a) continue to support the activities of the Advocacy Resource Center in providing advice and assistance to specialty and state medical societies concerning scope of practice issues to include the collection, summarization and wide dissemination of data on the training and the scope of practice of physicians (MDs and DOs) and nonphysician groups and that our AMA make these issues a legislative/advocacy priority; (b) endorse current and future funding of research to identify the most cost effective, high-quality methods to deliver care to patients, including methods of multidisciplinary care; and (c) review and report to the House of Delegates on a periodic basis on such data that may become available in the future on the quality of care provided by physician and nonphysician groups.
2. Our AMA will: (a) continue to work with relevant stakeholders to recognize physician training and education and patient safety concerns, and produce advocacy tools and materials for state level advocates to use in scope of practice discussions with legislatures, including but not limited to infographics, interactive maps, scientific overviews, geographic comparisons, and educational experience; (b) advocate for the inclusion of non-physician scope of practice characteristics in various

analyses of practice location attributes and desirability; (c) advocate for the inclusion of scope of practice expansion into measurements of physician well-being; and (d) study the impact of scope of practice expansion on medical student choice of specialty.

3. Our AMA will consider all available legal, regulatory, and legislative options to oppose state board decisions that increase non-physician health care provider scope of practice beyond legislative statute or regulation. (CME Rep. 1, I-00; Reaffirmed: CME Rep. 2, A-10; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 251, A-18; Appended: Res. 222, I-19)

H-160.949 Practicing Medicine by Non-Physicians

Our AMA: (1) urges all people, including physicians and patients, to consider the consequences of any health care plan that places any patient care at risk by substitution of a non-physician in the diagnosis, treatment, education, direction and medical procedures where clear-cut documentation of assured quality has not been carried out, and where such alters the traditional pattern of practice in which the physician directs and supervises the care given;

(2) continues to work with constituent societies to educate the public regarding the differences in the scopes of practice and education of physicians and non-physician health care workers;

(3) continues to actively oppose legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(4) continues to encourage state medical societies to oppose state legislation allowing non-physician groups to engage in the practice of medicine without physician (MD, DO) training or appropriate physician (MD, DO) supervision;

(5) through legislative and regulatory efforts, vigorously support and advocate for the requirement of appropriate physician supervision of non-physician clinical staff in all areas of medicine; and

(6) opposes special licensing pathways for "assistant physicians" (i.e., those who are not currently enrolled in an Accreditation Council for Graduate Medical Education training program or have not completed at least one year of accredited graduate medical education in the U.S). (Res. 317, I-94; Modified by Res. 501, A-97; Appended: Res. 321, I-98; Reaffirmation A-99; Appended: Res. 240, Reaffirmed: Res. 708 and Reaffirmation A-00; Reaffirmed: CME Rep. 1, I-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: Res. 208, I-10; Reaffirmed: Res. 224, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Res. 107, A-14; Appended: Res. 324, A-14; Modified: CME Rep. 2, A-21)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(A-24)

Introduced by: American College of Medical Genetics and Genomics

Subject: Supporting the Establishment of Rare Disease Advisory Councils

Referred to: Reference Committee B

- 1 Whereas, a rare disease is defined as a disease or condition that impacts fewer than 200,000
2 people in the United States¹; and
3
- 4 Whereas, given the current estimate for the number of known rare diseases is more than
5 10,000, the rare disease population comprises of more than 30 million people in the United
6 States²; and
7
- 8 Whereas, the economic burden of rare diseases surpasses that of some of the most prevalent
9 chronic diseases in the United States³; and
10
- 11 Whereas, rare diseases are often chronic, progressive, and debilitating, and lead to significant
12 morbidity and mortality⁴; and
13
- 14 Whereas, rare disease patients continue to face hurdles with accessing new available
15 medications due to costs and payor policies, including prior authorizations and denials⁵; and
16
- 17 Whereas, patients with rare disorders face other unique challenges in healthcare including
18 limited access to specialists, the cost-sharing mechanism of prescriptions, insurance coverage
19 issues without a proper diagnosis, and more^{5,6}; and
20
- 21 Whereas, rare patients report significantly lower quality of life scores due to facing these hurdles
22 and experiencing a longer diagnostic journey than typical patients^{5,6}; and
23
- 24 Whereas, a Rare Disease Advisory Council (RDAC) is an advisory body that informs
25 policymakers on the issues relevant to the rare community and gives said community a stronger
26 voice⁷; and
27
- 28 Whereas, since 2015, Rare Disease Advisory Councils have been established in 27 states,
29 leaving many states without advocates for proper rights for rare patients⁷; and
30
- 31 Whereas, Rare Disease Advisory Councils have been actively working on state and federal
32 policies addressing barriers to obtaining proper care for patients with rare diseases such as
33 Medicaid eligibility, newborn screening processes, coverage of medical nutrition, out-of-pocket
34 prescription drug costs, reforming step therapy, and more⁸; and
35
- 36 Whereas, AMA Policy H 460.880 recognizes the under-treatment and under-diagnosis of
37 orphan diseases but fails to sufficiently include how to act on this recognition to actively support
38 rare disease patients and their families; therefore be it

1 RESOLVED, that our American Medical Association will support state legislation for the
2 establishment of Rare Disease Advisory Councils in each state (New HOD Policy).
3

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

Received: 4/24/2024

REFERENCES

1. Orphan Drug Act. P.L. 97-414 (Jan 4, 1983). <https://www.congress.gov/bill/97th-congress/house-bill/5238/text>
2. Haendel M, Vasilevsky N, Unni D, et al. How many rare diseases are there?. *Nat Rev Drug Discov.* 2020;19(2):77-78. doi:10.1038/d41573-019-00180-y
3. Yang G, Cintina I, Pariser A, Oehrlein E, Sullivan J, Kennedy A. The national economic burden of rare disease in the United States in 2019. *Orphanet J Rare Dis.* 2022;17(1):163. doi:10.1186/s13023-022-02299-5
4. Gopal-Srivastava R, Kaufmann P. Facilitating Clinical Studies in Rare Diseases. *Adv Exp Med Biol.* 2017;1031:125-140. doi:10.1007/978-3-319-67144-4_6
5. Barriers to Rare Disease Diagnosis, Care and Treatment in the US: A 30-Year Comparative Analysis. National Organization for Rare Disorders; 2020. https://rarediseases.org/wp-content/uploads/2022/10/NRD-2088-Barriers-30-Yr-Survey-Report_FNL-2.pdf
6. Bogart K, Hemmesch A, Barnes E, et al. Healthcare access, satisfaction, and health-related quality of life among children and adults with rare diseases. *Orphanet Journal of Rare Diseases.* 2022;17(1):196. doi:10.1186/s13023-022-02343-4
7. Rare Disease Advisory Councils (RDAC). National Organization for Rare Disorders. https://rarediseases.org/wp-content/uploads/2023/07/NRD-2301-RDAC-Sell-Sheet_FNL-1.pdf. Updated 2023. Accessed April 9, 2024.
8. Rare Disease Advisory Councils - National Organization for Rare Disorders. Published April 15, 2022. Accessed August 20, 2023. <https://rarediseases.org/policy-issues/rare-disease-advisory-councils/>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(A-24)

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

Subject: Medicare Advantage Part B Drug Coverage

Referred to: Reference Committee B

1 Whereas, 66% of Medicare beneficiaries have been diagnosed with at least two chronic
2 diseases; and
3
4 Whereas, the majority of patients enrolled in traditional (fee-for-service) Medicare have
5 additional coverage that limits their financial exposure to the 20% coinsurance required for Part
6 B drugs and biologicals; and
7
8 Whereas, over half of all Medicare-eligible patients were enrolled in a Medicare Advantage (MA)
9 plan in 2023; and
10
11 Whereas, Medicare patients are increasingly choosing MA plans because many of those plans
12 have lower premiums and are more affordable for less affluent patients; and
13
14 Whereas, more MA plans are listing specialty drugs and biologicals as either non-covered
15 benefits or are covering only 80% of the cost of physician administered drugs and biologicals;
16 and
17
18 Whereas, patients enrolled in MA are prohibited from purchasing Medigap policies; and
19
20 Whereas, less affluent patients may not be able to afford the remaining 20% coinsurance for
21 essential drugs and biologicals required by most MA plans, potentially leading to disparities in
22 health outcomes; and
23
24 Whereas, prior to a chronic disease diagnosis, patients enrolling in MA can have no knowledge
25 of which expensive drugs and biologicals they may require and, further, that those drugs and
26 biologicals may be designated as non-covered by the plan or require a 20% coinsurance
27 payment; and
28
29 Whereas, when a patient enrolled in MA is diagnosed with a chronic disease where costly
30 physician-administered drugs and biologicals are necessary, they cannot revert to traditional
31 (fee-for-service) Medicare or purchase a Medigap policy; therefore be it
32
33 RESOLVED, that our American Medical Association will advocate with Congress, through the
34 appropriate oversight committees, and with the Centers for Medicare & Medicaid Services
35 (CMS) to require that Medicare Advantage (MA) plans cover physician-administered drugs and
36 biologicals in such a way that the patient out of pocket cost is the same or less than the amount
37 that a patient with traditional Medicare plus a Medigap plan would pay. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 4/24/2024

REFERENCES

1. Chronic Condition Data Warehouse, "Medicare Beneficiary Summary Files," 2018. <https://www2.cdwdata.org/documents/10280/19099065/b2-prevalence-current-year.jpg>
2. Ochieng N, Clerveau G, Cubanski J, & Neuman T. (2023). A snapshot of sources of coverage among Medicare beneficiaries. Kaiser Family Foundation. [https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/#:~:text=PNG-,Medigap,12.5%20million%20beneficiaries\)%20in%202021](https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/#:~:text=PNG-,Medigap,12.5%20million%20beneficiaries)%20in%202021)
3. Ochieng N, Biniek JF, Freed M, Damico A & Neuman T. (2023). Medicare Advantage in 2023: Enrollment update and key trends. Kaiser Family Foundation. <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/>
4. Neuman T, Freed M, & Biniek JF. (2024). 10 reasons why Medicare Advantage enrollment is growing and why it matters. Kaiser Family Foundation. <https://www.kff.org/medicare/issue-brief/10-reasons-why-medicare-advantage-enrollment-is-growing-and-why-it-matters/>
5. Centers for Medicare and Medicaid Services. Learn how Medigap works. US Department of Health and Human Services. <https://www.medicare.gov/health-drug-plans/medigap/basics/how-medigap-works#:~:text=When%20you%27re%20getting%20started,switching%20back%20to%20Original%20Medicare.>

RELEVANT AMA POLICY

Medicare Advantage Policies H-330.878

1. Our AMA supports that Medicare Advantage plans must provide enrollees with coverage for, at a minimum, all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts.
2. Our AMA will advocate: (a) for better enforcement of Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS) accountable for presenting transparency of minimum standards and to determine if those standards are being met for physicians and their patients; (b) that Medicare Advantage plans be required to post all components of Medicare covered and not covered in all plans across the US on their website along with the additional benefits provided; and (c) that CMS maintain a publicly available database of physicians in network under Medicare Advantage and the status of each of these physicians in regard to accepting new patients in a manner least burdensome to physicians.

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930

Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.

Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans H-330.870

Our AMA will: (1) advocate for provision of transparent print and audio/video patient educational resources to patients and families in multiple languages from health care systems and from Medicare - directly accessible - by consumers and families, explaining clearly the different benefits, as well as the varied, programmatic and other out-of-pocket costs for their medications under Medicare, Medicare Supplemental and Medicare Advantage plans; (2) advocate for printed and audio/video patient educational resources regarding personal costs, changes in benefits and provider panels that may be incurred when switching (voluntarily or otherwise) between Medicare, Medical Supplemental and Medicare Advantage or other plans, including additional information regarding federal and state health insurance assistance programs that patients and consumers could access directly; and (3) advocate for increased funding for federal and state health insurance assistance programs and educate physicians, hospitals, and patients about the availability of and access to such programs.

Medicare Cost-Sharing D-330.951

Our AMA will urge the Centers for Medicare and Medicaid Services to require companies that participate in the Medicare Advantage program to provide enrollees and potential enrollees timely information in a comparable, standardized, and clearly-written format that details enrollment restrictions, as well as all coverage restrictions and beneficiary cost-sharing requirements for all services.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(A-24)

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

Subject: Prohibiting Mandatory White Bagging

Referred to: Reference Committee B

- 1 Whereas, many health insurers and pharmacy benefit managers (PBMs) have adopted policies
- 2 that condition coverage of a clinician-administered drug, such as an IV infusion, on the drug
- 3 being dispensed from a PBM-affiliated mail order pharmacy; and
- 4
- 5 Whereas, this practice is commonly referred to as “white bagging”; and
- 6
- 7 Whereas, mandatory white bagging policies exclude payment for medically necessary drugs
- 8 from any health care provider that is not under common ownership with the insurer or PBM,
- 9 including in-network pharmacies; and
- 10
- 11 Whereas, drugs commonly subject to mandatory white bagging policies are often needed to
- 12 treat the most vulnerable patient populations with complex treatment plans who require efficient
- 13 and timely delivery of clinician-administered drugs for successful outcomes; and
- 14
- 15 Whereas, white bagging requires each individual patient-specific treatment dose to be shipped
- 16 in a separate parcel, via common carrier, to the administering provider, even if the administering
- 17 provider already has the drug in stock and available for administration; and
- 18
- 19 Whereas, shipments from specialty pharmacies can be delayed and are difficult for providers to
- 20 track; and
- 21
- 22 Whereas, if a patient’s clinical status changes from when the medication was ordered, the
- 23 adjusted medication must be re-ordered from the third-party pharmacy, which can result in
- 24 increases in canceled appointments, days to initiation of therapy, and frequency of past-due
- 25 administrations; and
- 26
- 27 Whereas, day-of treatment changes lead to drug waste when an unused portion of the drug
- 28 cannot be used for another patient, and practices and hospitals must then discard the unused
- 29 portion of highly toxic drugs according to state and federal safety standards, creating additional
- 30 administrative burden; and
- 31
- 32 Whereas, providers have no control over the shipping process, limiting their ability to prevent
- 33 improper storage or mishandling of white bagged drugs; and
- 34
- 35 Whereas, a 2023 analysis found that, on average, bagging increased oncology patients’ out-of-
- 36 pocket costs by \$180 per month, or \$2,160 per year; and
- 37
- 38 Whereas, since 2021, eight states have prohibited the use of payer-mandated white bagging;
- 39 therefore be it

1 RESOLVED, that our American Medical Association urge state and federal policymakers to
2 enact legislation to prohibit the mandatory use of white bagging (Directive to Take Action).
3

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

Received: 4/24/2024

REFERENCES

1. White Bagging Policy Brief. American Society of Clinical Oncology, 2024. <https://society.asco.org/sites/new-www.asco.org/files/content-files/2024-White-Bagging-Brief.pdf>
2. Komorny et. al, Payer site of care mandates with oncology medications: It's time to demand payer accountability on behalf of patients, American Journal of Health-System Pharmacy, 2023; zxad078, <https://doi.org/10.1093/ajhp/zxad078>
3. Shih YT, Xu Y, Yao JC. Financial Outcomes of "Bagging" Oncology Drugs Among Privately Insured Patients With Cancer. JAMA Netw Open. 2023;6(9):e2332643. doi:10.1001/jamanetworkopen.2023.32643
4. State of Play: White Bagging. American Society of Clinical Oncology. December 2023. <https://society.asco.org/news-initiatives/policy-news-analysis/state-play-white-bagging#:~:text=Arkansas%20and%20Louisiana%20became%20the,added%20guardrails%20around%20the%20practice>

RELEVANT AMA POLICY

Medication Brown Bagging H-100.951

1. Our AMA affirms that decisions to accept or refuse "brown bagged" (patient-acquired, physician-administered) pharmaceuticals be made only by physicians responsible for administering these medications.
2. Our AMA affirms that "brown bagged" pharmaceuticals be accepted for in-office or hospital administration only after the physician responsible for administering these medications determines that the individual patient, or his or her agent, is fully capable of safely handling and transporting the medication.
3. Our AMA will work with interested national medical specialty societies and state medical associations to oppose third party payer policies and legislative and regulatory actions that require patients to utilize "brown bagging" to ensure coverage of office-administered medications.
4. Our AMA will work with interested national medical specialty societies and state medical associations to oppose third party payer policies that reimburse office-administered drug costs at less than the provider's cost of acquiring the drug if the provider does not accept "brown bagging."

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(A-24)

Introduced by: Association for Clinical Oncology, American Academy of Dermatology
Association, American College of Mohs Surgery, American Contact
Dermatitis Society, American College of Rheumatology

Subject: State Prescription Drug Affordability Boards - Study

Referred to: Reference Committee B

- 1 Whereas, in an effort to control high prescription drug costs, states are increasingly considering
2 prescription drug affordability boards (PDABs); and
3
4 Whereas, PDABs in Colorado, Maryland and Minnesota have the authority to set upper
5 payment limits (UPLs) for certain high-cost medications; and
6
7 Whereas, a UPL is the maximum reimbursement rate above which purchasers throughout the
8 state may not pay for prescription drug products; and
9
10 Whereas, Medicare pays most separately payable Part-B covered drugs and biologics at a rate
11 of the drug's average sales price plus 6%; and
12
13 Whereas, the 6% add-on payment for Medicare Part B drugs is intended to cover expenses
14 associated with administering drugs in-office, including storage and handling; and
15
16 Whereas, similar to the concept of an upper payment limit, the Inflation Reduction Act (IRA)
17 establishes a "maximum fair price" for a negotiated drug; and
18
19 Whereas, under the IRA, Medicare's payment to providers for Part B drugs with negotiated
20 prices will be at 106% of the maximum fair price; and
21
22 Whereas, reimbursement for physician administered drugs can be up to 125% of a drug's
23 average sales price in the private insurance market; and
24
25 Whereas, state PDAB legislation that includes UPL authority often lacks language that would
26 allow physicians to seek reimbursement for storage and handling of a physician-administered
27 drug subject to a UPL; therefore be it
28
29 RESOLVED, that our American Medical Association conduct a study to determine how upper
30 payment limits (UPLs) established by state prescription drug affordability boards (PDABs) will
31 impact reimbursement for physician-administered drugs and what impact state UPLs will have
32 on patient access to care (Directive to Take Action); and be it further
33
34 RESOLVED, that our AMA report the results of the study on UPLs to the House of Delegates at
35 A-25. (Directive to Take Action)
36

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

Received: 4/24/2024

REFERENCES

1. Comparison of State Prescription Drug Affordability Review Initiatives. National Academy for State Health Policy. January 2024. <https://nashp.org/comparison-of-state-prescription-drug-affordability-review-initiatives/>
2. Enacted Prescription Drug Affordability Boards 2019-2023. Aimed Alliance. January 2024. <https://aimedalliance.org/wp-content/uploads/2024/01/AA-PDAB-Enacted-Chart-Jan-2024.pdf>
3. Q&A on NASHP's Model Act to Reduce the Cost of Prescription Drugs. August 2022. <https://nashp.org/qa-on-nashps-model-act-to-reduce-the-cost-of-prescription-drugs/>
4. Cubanski et al. Explaining the Prescription Drug Provisions in the Inflation Reduction Act. KFF. January 2023. <https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/>

RELEVANT AMA POLICY

Reducing Prescription Drug Prices D-110.993

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.

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.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(A-24)

Introduced by: New Jersey

Subject: Establish a Cyber-Security Relief Fund

Referred to: Reference Committee B

- 1 Whereas, Cyber-attacks are becoming frequent and that they will continue to escalate and
2 become more complex; and
3
4 Whereas, the recent cyber-attack on “Optum” resulted in thousands of Physician payments to
5 be withheld for several weeks or months resulting in devastating consequences to the several
6 thousand families because of inability to meet the payroll of the physicians and their employees;
7 and
8
9 Whereas, the financial impact is global, affecting private practicing Physicians, Medical groups,
10 and healthcare systems; and
11
12 Whereas, United Healthcare’s full year 2023 earnings from operations were \$32.4 billion;
13 therefore be it
14
15 RESOLVED, that our American Medical Association, through appropriate channels, advocate
16 for a ‘Cyber Security Relief Fund” to be established by Congress (Directive to Take Action); and
17 be it further
18
19 RESOLVED, that the “Cyber Security Relief Fund” be funded through contributions from health
20 insurance companies and all payers - as a mandated requirement by each of the payer
21 (Directive to Take Action); and be it further
22
23 RESOLVED, that the “Cyber Security Relief Fund” only be utilized for ‘uninterrupted’ payments
24 to all providers- in a structured way, in the event of future cyber-attacks affecting payments.
25 (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 5/3/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(A-24)

Introduced by: Delaware

Subject: Support of Physicians Pursuing Collective Bargaining and Unionization

Referred to: Reference Committee B

1 Whereas, the American Medical Association supports physicians' entitlement to engage in
2 collective bargaining, and it is AMA policy to advocate for broadening the scope of eligibility for
3 this right under federal law, thereby expanding the number of physicians eligible to join unions¹;
4 and

5
6 Whereas, the AMA highlights that bargaining units consisting solely of physicians are presumed
7 appropriate,¹ a recommendation that aligns with the acknowledgment of physicians' unique
8 skills, distinct expertise, and ethical and professional obligations; and

9
10 Whereas, in 1999 the AMA provided financial support for the establishment of a national labor
11 organization, the Physicians for Responsible Negotiation (PRN), under the National Labor
12 Relations Board (NLRB), an initiative aimed to support the development and operation of local
13 physician negotiating units as an option for employed physicians and physicians in-training, but
14 due to limited participation from physicians, the AMA withdrew this support in 2004¹; and

15
16 Whereas, since 2004, the number of physicians belonging to unions in the United States has
17 reportedly surged, with a notable 26% increase from 2014 to 2019 reaching a total of 67,673
18 physicians that were union members¹; and

19
20 Whereas, the percentage of physicians in the United States now employed by hospitals, health
21 systems, or corporate entities has seen a substantial rise, reaching 73.9% as of January 2022,
22 compared to 47.4% in 2018, and the acquisition of physician practices by hospitals and
23 corporate entities escalated between 2019-2022 during the pandemic^{2,3}; and

24
25 Whereas, the shift from a workforce of independent professional physicians to one composed of
26 employed physicians fundamentally alters the dynamics among hospitals, health systems,
27 corporate entities and physicians, with a risk of adversely affecting the conditions under which
28 care is delivered and quality of care provided,⁴ consequently altering the physician-patient
29 relationship; and

30
31 Whereas, major hospitals, health care systems, and other corporate entities that employ
32 physicians may restrict employment options available to these professionals in a market largely
33 influenced by their employer or where covenants not to compete may further contribute to an
34 employer's bargaining advantage¹; and

35
36 Whereas, the increasing corporatization of medicine, encompassing private equity involvement
37 in health care, raises concerns about alignment of incentives, costs, impacts on physician
38 wellness, and subsequent downstream effects on patients^{5,6}; and

1 Whereas, in recent years, there has been a rise in physician burnout, exacerbated by the
2 COVID-19 pandemic, primarily stemming from the excessive time dedicated to electronic health
3 record documentation, bureaucratic administrative duties, and moral distress arising from a
4 misalignment between physicians' values and the incentivized actions dictated by the health
5 care system⁷⁻¹¹; and
6

7 Whereas, as physicians increasingly transition to employment, there's a trend toward
8 standardization of work schedules, time of appointments, and other aspects of work conditions.
9 Studies indicate that burnout is directly impacted by a lack of control over work conditions and
10 that granting more autonomy can mitigate stress and burnout, and even reduce cardiovascular
11 risk¹²; and
12

13 Whereas, physicians encounter significant power differentials when negotiating with hospital
14 systems as employers and may lack sufficient influence without collective bargaining to
15 counterbalance the dynamic¹; and
16

17 Whereas, collective bargaining serves as an effective mechanism for safeguarding patient care
18 safety standards, enhancing work conditions, securing fair compensation and job stability, and
19 establishing a structured process for addressing grievances; and
20

21 Whereas, unionization is linked with enhanced wages and benefits, as well as diminished
22 disparities in compensation for minority groups¹³; and
23

24 Whereas, in 2022, the National Labor Relations Board concluded that employed physicians are
25 not in a supervisory role simply by virtue of their position in the organization and, therefore, may
26 be eligible to unionize¹⁴; and
27

28 Whereas, collective bargaining and unionization do not necessarily require resorting to strikes.
29 For example, first responder unions often utilize binding arbitration as an alternative tactic.
30 Other potential strategies may include work slowdowns, picketing, mass resignation,
31 whistleblowing to regulatory and accrediting bodies, boycotting administrative tasks, and
32 suspending billing activities, among other options; therefore be it
33

34 RESOLVED, that our American Medical Association investigate avenues for the AMA and other
35 physician associations to aid physicians in initiating and navigating collective bargaining efforts,
36 encompassing but not limited to unionization. (Directive to Take Action)
37

Fiscal Note: \$43,308: Consult experts and coordinate with medical societies to identify and
communicate ways to aid physicians in collective bargaining efforts.

Received: 5/3/2024

REFERENCES

1. American Medical Association. ARC Issue brief: Collective bargaining for physicians and physicians-in-training. Available at: <https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf>. Accessed March 30, 2024.
2. Matthews, S. Physicians Advocacy Institute. Report: Supermajority of U.S. Physicians are Employed by Health Systems or Corporate Entities. Available at: <https://www.physiciansadvocacyinstitute.org/Portals/0/assets/docs/PAI-Research/2022%20Avalere%20Employment%20Release%20-%20FINAL.pdf?ver=Cy6aAKaFIM56SND598Xlvw%3d%3d>. Accessed March 30, 2024.
3. Kane, C. American Medical Association. Policy Research Perspectives. Updated on Physician Practice Arrangements: For the First Time, Fewer Physicians are Owners Than Employees. <https://www.ama-assn.org/system/files/2019-07/prp-fewer-owners-benchmark-survey-2018.pdf>. Accessed March 30, 2024.
4. Richman, BD, and Schulman KA. Restoring Physician Authority in an Era of Hospital Dominance. *Jama*. 2022;328(24):2400-2401. Doi.10.1001/jama.2022.23610. Accessed online at: <https://jamanetwork.com/journals/jama/fullarticle/2799930>.
5. Gooney, T. I.M. Matters from ACP. 3 C's: Corporatization, consolidation, commodification. Current trends in health care emphasize the importance of our continued advocacy efforts for our patients and our profession. <https://acpinternist.org/archives/2022/03/3-cs-corporatization-consolidation-commodification.htm>. Accessed March 30, 2024
6. Offodile AC, Cerullo M, Rauh-Hain JA, and Ho V. Private Equity Investments In Health Care: An Overview of Hospital and Health System Leveraged Buyouts, 2003-17. *Hlth Aff* 2021;40(5). DOI.10.1377/hlthaff.2020.01535. Accessed online at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.01535>.
7. Shanafelt TD, West CP, Dyrbye LN, Wang H, Carlasare LE, and Sinsky C. Changes in Burnout and Satisfaction with Work-Life Integration in Physicians during the First 2 Years of the COVID-19 Pandemic. *Mayo CP*. 2022;97(12):2248-2258. DOI: <https://doi.org/10.1016/j.mayocp.2022.09.002>.
8. Gardner RL, Cooper E, Haskell J, Harris DA, Poplay S, Kroth P, Linser L. Physician stress and burnout: the impact of health information technology. *Journal of American Medical Informatics Association*. 2019;26(2):106-114. DOI: <https://academic.oup.com/jamia/article/26/2/106/5230918>.
9. Kane, L. Medscape Internal Medicine. Physician Burnout & Depression Report 2022: Stress, Anxiety, and Anger. https://www.medscape.com/slideshow/2022-lifestyle-burnout-6014664?icd=login_success_email_match_norm#1. Accessed March 30, 2024.
10. Sinsky C, Colligan L, Li L, Prgomet M, Reynolds S, Goeders L, Westbrook J, Tutty M, Blike G. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. *Annals of Int Med*. 2016;165(11):753-761. DOI: <https://doi.org/10.7326/M16-0961>.
11. National Academies of Sciences, Engineering, and Medicine. 2019. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25521>.
12. Linzer M, Levine R, Meltzer D, Poplau S, Warde C, West CP. 10 Bold Steps to Prevent Burnout in General Internal Medicine. *J Gen Intern Med* 2014;29:18-20. DOI: <https://doi.org/10.1007/s11606-013-2597-8>.
13. Ahmed AM, Kadakia K, Ahmed A, Shultz B, Li X. Trends in Labor Unionization Among US Health Care Workers, 2009-2021. *JAMA*. 2022;328(24):2404-2411. doi:10.1001/jama.2022.22790.
14. Mastrony M, Pariano C, Stanevich J. Following the Doctor's Orders: NLRB Decision Prescribes Union Election for Physicians. Available at: <https://www.jdsupra.com/legalnews/following-the-doctor-s-orders-nlr-7925443/>. Accessed March 30, 2024.

RELEVANT AMA POLICY

D-383.977 Investigation into Residents, Fellows, and Physician Unions

Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment. [Res. 606, A-19]

D-383.988 Collective Bargaining and the Definition of Supervisors

Our AMA will support legislative efforts by other organizations and entities that would overturn the Supreme Court's ruling in *National Labor Relations Board v. Kentucky River Community Care, Inc., et al.* [BOT Action in response to referred for decision Res. 248, A-01; Modified: BOT Rep. 22, A-11; Reaffirmed: Res. 206, A-19]

Update:

2022: In Piedmont Health Services, Inc. and Piedmont Health Services Medical Providers United, Case No. 10-RC-286648, Region 10 of the National Labor Relations Board (Region) issued a Decision and Direction of Election (DDE) in which it held that physicians are not supervisors under the National Labor Relations Act (the Act) simply by virtue of their position in the healthcare institution.

This DDE is notable, as it confirms that physicians will not automatically be considered supervisors under the Act and may seek union representation. Indeed, Piedmont's physicians and providers ultimately voted in favor of union representation. Healthcare employers should consider reviewing their physicians' job descriptions and job duties to determine whether they potentially can be considered supervisors under the Act.

H-385.946 Collective Bargaining for Physicians

The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation. [Res. 239, A-97; Reaffirmation I-98; Reaffirmation A-01; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-10; Reaffirmed: Res. 206, A-19]

H-383.998 Resident Physicians, Unions and Organized Labor

Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients. [CME Rep. 7, A-00; Reaffirmed: CME Rep. 2, A-10; Modified: Speakers Rep. 01, A-17; Reaffirmed: BOT Rep. 13, A-19]

H-385.976 Physician Collective Bargaining

Our AMA's present view on the issue of physician collective negotiation is as follows:

- (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians.
- (2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature.
- (3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively.
- (4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.
- (5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.

[BOT Rep. P, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-04; Reaffirmed in lieu of Res. 105, A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: BOT Rep. 17, A-09; Reaffirmation I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: Res. 215, A-11; Reaffirmed: BOT action in response to referred for decision Res. 201, I-12; Reaffirmed: Res. 206, A-19]

H-383.988 Physicians' Ability to Negotiate and Undergo Practice Consolidation

Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare. [Res. 229, A-12; Reaffirmed: Res. 206, A-19]

AMA Code of Medical Ethics

1.2.10 Political Action by Physicians

Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However, they have a responsibility to do so in ways that are not disruptive to patient care.

Physicians who participate in advocacy activities should:

- (a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.
- (b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.
- (c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians primary and overriding commitment to patients.
- (d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

[AMA Principles of Medical Ethics: I,III,VI](#)

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

[Issued: 2016]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237
(A-24)

Introduced by: American College of Preventive Medicine

Subject: Encouraging the Passage of the Preventive Health Savings Act (S.114)

Referred to: Reference Committee B

1 Whereas, the Congressional Budget Office (CBO) was established in 1974 to provide objective,
2 nonpartisan information to support the U.S. budget process and aid Congress in making
3 effective budget and economic policy¹; and
4

5 Whereas, the CBO is directed to estimate and project the cost of legislation approved by
6 Congressional committees for a specified period of time, usually 10 years²; and
7

8 Whereas, the CBO estimates the United States Federal Budget deficit will increase substantially
9 over the next 30 years³; and
10

11 Whereas, the CBO is evaluating the economic impact of legislation pertaining to roles of health
12 behaviors and preventive measures beyond the 10-year budget window in specific cases⁴; and
13

14 Whereas, the 118th House of Representatives has passed legislation in a bipartisan vote to
15 direct the CBO to expand the scoring window to estimate the budgetary effects of legislation
16 related to preventive health care services up to a 30-year period⁵; and
17

18 Whereas, expanding the CBO scoring window to estimate the budgetary effects over a 30-year
19 period of legislation related to preventive health care services would not significantly increase
20 the cost of generating economic estimates for legislation⁶; and
21

22 Whereas, the United States spends \$4.1 trillion in annual health care expenditure⁷; and
23

24 Whereas, 70% of the U.S. health care expenditure is spent on the management and treatment
25 of chronic disease⁷; and
26

27 Whereas, the American Medical Association encourages the CBO to more comprehensively
28 measure long-term budget deficit reductions and costs associated with legislation related to the
29 preventive health services⁸; therefore be it
30

31 RESOLVED, that our American Medical Association encourages continued advocacy to federal
32 and state legislatures of the importance of more accurately and effectively measuring the health
33 and economic impacts of investing in preventive health services to improve health and reduce
34 healthcare spending costs in the long term. (Directive to Take Action); and be it further
35

36 RESOLVED, that our AMA reaffirm the following policy: D-155.994, "Value-Based Decision
37 Making in the Health Care System" to encourage legislation and efforts to allow the
38 Congressional Budget Office to more effectively project long-term budget deficit reductions and
39 costs associated with legislation related to preventive health services. (Reaffirm HOD Policy)
40

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

Received: 5/8/2024

REFERENCES

1. 93rd Congress (1974). "H.R.7130 - Congressional Budget and Impoundment Control Act of 1974". Congress.gov, Library of Congress, <https://www.congress.gov/bill/93rd-congress/house-bill/7130/text>.
2. Congressional Budget Office (2024). "An Introduction to the Congressional Budget Office". CBO.gov, Congressional Budget Office, Accessed May 3, 2024. <https://www.cbo.gov/system/files/2024-01/59687-Intro-to-CBO.pdf>
3. Congressional Budget Office (2024). "The Long-Term Budget Outlook: 2024 to 2054". CBO.gov, Congressional Budget Office, Accessed May 3, 2024. <https://www.cbo.gov/publication/59711>
4. Swagel, P. (2024). "The Federal Budget and Health Care Policy". CBO.gov, Congressional Budget Office. Accessed May 3, 2024. <https://www.cbo.gov/system/files/2024-04/60224-FederalBudgetandHealthCare.pdf>
5. 118th Congress (2024). "H.R.766 - Dr. Michael C. Burgess Preventive Health Savings Act". Congress.gov, Library of Congress, Accessed May 3, 2024. <https://www.congress.gov/bill/118th-congress/house-bill/766>.
6. Pickford, M., Robillard, L., Chirico, C., Swagel, P (2024). "H.R. 766, Dr. Michael C. Burgess Preventive Health Savings Act Cost Estimate". CBO.gov, Congressional Budget Office. Accessed May 3, 2024. <https://www.cbo.gov/system/files/2024-02/hr766.pdf>
7. Centers for Disease Control and Prevention (2023). "Health and Economic Costs of Chronic Disease". CDC.gov, Accessed May 3, 2024. <https://www.cdc.gov/chronicdisease/about/costs/index.htm>
8. American Medical Association (2015). "Value-Based Decision-Making in the Health Care System D-155.994". PolicySearch.ama-assn.org, Accessed May 3, 2024. <https://policysearch.ama-assn.org/policyfinder/detail/congressional%20budget%20office?uri=%2FAMADoc%2Fdirectives.xml-0-289.xml>

RELEVANT AMA POLICY

Value-Based Decision-Making in the Health Care System D-155.994

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

American Medical Association House of Delegates

Resolution: 238
(A-24)

Introduced by: New York

Subject: AMA Supports Efforts to Fund Overdose Prevention Sites

Referred to: Reference Committee B

1 Whereas, the federal “Defund Heroin Injections Centers of 2023” Act prohibits federal funding
2 for injection sites; and
3

4 Whereas, this Act states: No Federal funds may be used by any Federal agency to operate or
5 control, or to pay the salaries of officers and employees of such an agency to operate or control,
6 an injection center in violation of section 416 of the Controlled Substances Act (21 U.S.C. 856;
7 commonly referred to as the “Crack House Statute”); and
8

9 Whereas, OPS (Overdose Prevention Sites) have been shown to be effective at reducing
10 overdoses, refer patients for ongoing drug treatment, prevent communicable disease and
11 decrease health care costs; therefore be it
12

13 RESOLVED, that our American Medical Association support legislation or regulation that would
14 fund overdose prevention sites. (New HOD Policy)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 5/7/2024

REFERENCES

<https://www.congress.gov/117/bills/hr6741/BILLS-117hr6741ih.pdf>

American Medical Association House of Delegates

Resolution: 239
(A-24)

Introduced by: New York

Subject: Requiring stores that sell tobacco products to display NYS Quitline information

Referred to: Reference Committee B

1 Whereas, state laws already only allow only certain stores (not pharmacies) to sell to certain
2 persons (those over age 20) in certain locations (not near schools); and
3

4 Whereas, the states various Tobacco Control Programs allow Quitline phone number and
5 website which offers to persons who smoke the ability to get help with stopping by texting,
6 calling, or chatting; free nicotine patches, gum or lozenges, and other tools for cessation
7 assistance, therefore be it
8

9 RESVOLVED, that our American Medical Association seek federal legislation and/or regulation
10 requiring all stores licensed to sell tobacco or nicotine products to display easily visible
11 information about the CDC hotline 1-800-QUIT-NOW in multiple languages and/or the
12 information for the corresponding state or territory. (Directive to Take Action)

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

Received: 5/8/2024

REFERENCES

<https://www.nysmokefree.com/>

https://www.health.ny.gov/prevention/tobacco_control/current_policies.htm

American Medical Association House of Delegates

Resolution: 240
(A-24)

Introduced by: New York

Subject: Expanding Visa Requirement Waivers for NY IMGs Working in Underserved Areas

Referred to: Reference Committee B

1 Whereas, the most common visa that international medical graduates (IMG) use to participate in
2 US graduate medical education programs is the J-1 visa¹; and
3
4 Whereas, the J-1 visa traditionally requires a mandatory two-year foreign residency after
5 completion of their graduate medical education , forcing many IMGs who may wish to begin
6 practice inside the US to undergo a long and painful transition out of the country before
7 reapplication under a new visa²; and
8
9 Whereas, the Conrad 30 waiver program is a federal exemption to the J-1 visa residency
10 requirement, which allows up to 30 IMGs per State under a J-1 visa to avoid the two-year
11 foreign residency requirement after graduation if they practice in a federally designated
12 medically underserved area or with a medically underserved population³; and
13
14 Whereas, some studies have suggested that US residency-trained IMG physicians may yield
15 superior patient outcomes relative to their US medical graduate peers⁶; and
16
17 Whereas, reapproval or expansion of the Conrad 30 waiver program is unlikely to meaningfully
18 harm the economic competitiveness of native New York physicians or physician practices due to
19 requirements that waiver recipients be employed by health systems that have been
20 unsuccessful in attracting US medical graduates to the same position⁹; and
21
22 Whereas, the Conrad State 30 and Physician Access Reauthorization Act would extend and
23 expand the Conrad 30 waiver exemption program, allowing for approximately ~50% additional
24 waivers to be granted on a per-year basis over the next decade¹¹; therefore be it
25
26 RESOLVED, that our American Medical Association supports reauthorization and expansion of
27 the Conrad-30 J-1 visa waiver program, including permitting reallocation of unused slots to
28 states that have already used the maximum number of waivers. (New HOD Policy)

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

Received: 5/8/2024

REFERENCES

1. <https://www.ama-assn.org/education/international-medical-education/immigration-information-international-medical-graduates>
2. <https://internationalaffairs.uchicago.edu/twoyearreq>
3. <https://bhwh.hrsa.gov/workforce-shortage-areas/shortage-designation#maps>
4. <https://cbkimmigration.com/health-care-workers/conrad-flex-program/>
5. <https://www.graham-center.org/content/dam/rqc/documents/maps-data-tools/state-collections/workforce-projections/New%20York.pdf>
6. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9334519/#REF5>
7. <https://www.ruralhealthinfo.org/charts/5?state=NY>
8. <https://www.ruralhealthinfo.org/charts/7?state=NY>
9. <https://www.irvine-legal.com/irvine-articles/2019/10/21/conrad-30-overview-by-state-j-1-waivers-for-physicians>

10. <https://www.niskanencenter.org/the-bipartisan-immigration-policy-that-helps-rural-americans-get-access-to-local-physicians/>
11. <https://www.collins.senate.gov/newsroom/collins-klobuchar-rosen-tillis-introduce-bipartisan-legislation-to-build-healthcare-workforce-in-rural-and-medically-underserved-areas>
12. <https://stefanik.house.gov/2024/1/stefanik-helps-introduce-bill-to-address-doctor-shortage>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 241
(A-24)

Introduced by: New York

Subject: Healthcare Cybersecurity Breaches

Referred to: Reference Committee B

1 Whereas, cybersecurity attacks by malicious criminals on Healthcare entities: Insurers, Health
2 systems and Medical Practices are becoming more and more common; and
3
4 Whereas, the recent 2024 attack on Change Healthcare website has crippled Healthcare
5 operations across multiple insurers and threatens the financial viability of thousands of practices
6 and healthcare systems; and
7
8 Whereas, the timely delivery of healthcare to millions of patients is jeopardized by healthcare
9 Cybercrime, thus jeopardizing the health and safety of New Yorkers and the US population as a
10 whole ; making Healthcare Cybercrimes especially heinous and deserving of more vigorous
11 punishment and prevention efforts than are currently in effect; therefore be it
12
13 RESOLVED, that our American Medical Association advocate for the development of an
14 adequately funded multidisciplinary task-force including representation of AMA, health insurers,
15 the FBI and other pertinent stakeholders to prevent future healthcare cyberattacks throughout
16 the country and to increase the apprehension of cybercriminals who prey on patients and
17 healthcare entities, and to recommend appropriate penalties for their crimes. (Directive to Take
18 Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 5/8/24

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 242
(A-24)

Introduced by: Minority Affairs Section

Subject: Cancer Care in Indian Health Services Facilities

Referred to: Reference Committee B

- 1 Whereas, cancer is the leading cause of death among American Indian and Alaska Native
2 (AI/AN) persons in the United States (US)^{1,2}; and
3
4 Whereas, AI/AN Tribes and Villages are sovereign governments that have unique needs and
5 challenges; and
6
7 Whereas, AI/AN patients, as dual citizens of their Tribal Nations and the US, are entitled to the
8 same rights and privileges of US citizens, including those relating to healthcare (H-350.976 and
9 H-350.977); and
10
11 Whereas, the Indian Health Service (IHS) was established by Article I, Section 8 of the
12 Constitution to provide adequate and timely healthcare, in honoring the government-to-
13 government relationship between the United States and these Tribal organizations^{3,4}; and
14
15 Whereas, federal IHS facilities do not offer on-site cancer care or provide payment for cancer
16 treatment, unlike other federal health programs like the VA, unless funds are available for
17 referral^{5,6}; and
18
19 Whereas, several Indian Health Service Areas do not have a single comprehensive cancer
20 care center, increasing the likelihood that AI/AN patients have to obtain care from other public
21 and private payors and shoulder out-of-pocket costs⁷; and
22
23 Whereas, funding limitations to the IHS primarily limit health care to direct ambulatory care
24 services, thus denying access to comprehensive, specialty healthcare services to their patients
25 (H-350.977); and
26
27 Whereas, many cancers, including liver, stomach, kidney, lung, melanoma, and colorectal
28 cancer have a significantly higher prevalence among AI/AN persons⁸; and
29
30 Whereas, for the ten most populated AI/AN reservations, the median travel distance to a
31 National Cancer Institute (NCI) cancer center is 186.5 miles (range 77.8 - 629 miles), and the
32 median travel time is 3.37 hours (range 1.32 - 10.42 hours), while 45.2% of the general US
33 population lives <1 hour from an NCI cancer center⁹; and
34
35 Whereas, 14% of the US population lives >2 hours from an NCI cancer center, with 37% of
36 these individuals being identified as AI/AN persons⁹; and
37
38 Whereas, a study analyzing the effects of distance on cancer treatment outcomes found that
39 patients who traveled 50 miles or 1+ hour in driving time were associated with a more advanced

1 disease at diagnosis, and patients in rural areas were found to be twice as likely to have
2 unstaged cancer and/or more advanced disease when compared to urban counterparts¹⁰; and

3
4 Whereas, counties with poor access to healthcare are known to have statistically lower cancer
5 screening rates and higher cancer-related mortality rates¹¹; and

6
7 Whereas, oncology patients not first seen at NCI-designated Comprehensive Cancer Care
8 Centers have worse outcomes, even when adjusting for sociodemographic and clinical factors¹²;
9 and

10
11 Whereas, it is unethical to deny appropriate and timely cancer care to American Indian and
12 Alaska Native patients; therefore be it

13
14 RESOLVED, that our American Medical Association actively advocate for the federal
15 government to continue enhancing and developing alternative pathways for American Indian
16 and Alaska Native patients to access the full spectrum of cancer care and cancer-directed
17 therapies outside of the established Indian Health Service system (Directive to Take Action);
18 and be it further

19
20 RESOLVED, that our AMA (a) support collaborative research efforts to better understand the
21 limitations of IHS cancer care, including barriers to access, disparities in treatment outcomes,
22 and areas for improvement and (b) encourage cancer linkage studies between the IHS and the
23 CDC to better evaluate regional cancer rates, outcomes, and potential treatment deficiencies
24 among American Indian and Alaska Native populations. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 5/4/2024

REFERENCES

1. Leading causes of death-non-Hispanic American Indian or Alaska native males - United States, 2017. Centers for Disease Control and Prevention. November 20, 2019. Accessed August 27, 2023. <https://www.cdc.gov/minorityhealth/lcod/men/2017/nonhispanic-native/index.htm>.
2. Leading causes of death – females – non-Hispanic American Indian or Alaska native – United States, 2018. Centers for Disease Control and Prevention. March 3, 2022. Accessed August 27, 2023. <https://www.cdc.gov/women/lcod/2018/nonhispanic-native/index.htm>.
3. Morton v. Mancari, 417 U.S. 535 (1974). Justia Law. Accessed August 27, 2023. <https://supreme.justia.com/cases/federal/us/417/535/>.
4. Indian Health Service (IHS). About IHS. Accessed August 27, 2023. <https://www.ihs.gov/aboutihs/>.
5. National Oncology Program. VA. Accessed August 27, 2023. <https://www.cancer.va.gov/>.
6. Chapter 3 - purchased/referred care: Part 2. The Indian Health Manual (IHM). Accessed August 27, 2023. <https://www.ihs.gov/ihtm/pc/part-2/chapter-3-purchased-referred-care/>.
7. Find an NCI-designated cancer center. National Cancer Institute. Accessed August 27, 2023. <https://www.cancer.gov/research/infrastructure/cancer-centers/find>.
8. Melkonian SC, Weir HK, Jim MA, Preikschat B, Haverkamp D, White MC. Incidence of and trends in the leading cancers with elevated incidence among American Indian and Alaska native populations, 2012–2016. OUP Academic. October 14, 2020. Accessed August 27, 2023. <https://academic.oup.com/aje/article/190/4/528/5922784?login=false>.
9. Onega T, Alford-Teaster J, Wang F. Population-based geographic access to parent and satellite National Cancer Institute Cancer Center Facilities. *Cancer*. 2017;123(17):3305-3311. doi:<https://doi.org/10.1002/cncr.30727>
10. Ambroggi M, Biasini C, Del Giovane C, Fornari F, Cavanna L. Distance as a barrier to cancer diagnosis and treatment: Review of the literature. *The oncologist*. December 2015. Accessed August 27, 2023. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4679078/>.
11. Belasco EJ, Gong G, Pence B, Wilkes E. The impact of Rural Health Care Accessibility on cancer-related behaviors and outcomes - applied health economics and health policy. SpringerLink. June 3, 2014. Accessed August 27, 2023.
12. Wolfson JA, Sun C-L, Wyatt LP, Hurria A, Bhatia S. Impact of care at comprehensive cancer centers on outcome: Results from a population-based study. *Cancer*. November 1, 2015. Accessed August 27, 2023. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4892698/>.

RELEVANT AMA Policy

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of 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 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. [CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23]

Cancer and Health Care Disparities Among Minority Women D-55.997

Our AMA encourages research and funding directed at addressing racial and ethnic disparities in minority women pertaining to cancer screening, diagnosis, and treatment. [Res. 509, A-08; Modified: CSAPH Rep. 01, A-18]

Clinical Preventive Services H-410.967

The AMA: (1) recommends the USPSTF guidelines to clinicians and medical educators as one resource for guiding the delivery of clinical preventive services. USPSTF recommendations should not be construed as AMA policy on screening procedures and should not take the place of clinical judgment and the need for individualizing care with patients; physicians should weigh the utility of individual recommendations within the context of their scope of practice and the situation presented by each clinical encounter; (2) will continue to encourage the adoption of practice guidelines as they are developed based on the best scientific evidence and methodology available; and (3) will continue to promote discussion, collaboration, and consensus among expert groups and medical specialty societies involved in preparation of practice guidelines. [CSA Rep. 1, A-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Sub. Res. 517, A-12; Modified: CSAPH Rep. 1, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 243
(A-24)

Introduced by: Minority Affairs Section

Subject: Disaggregation of Demographic Data for Individuals of Federally Recognized Tribes

Referred to: Reference Committee B

1 Whereas, the Indian Health Service (IHS) is a health care system for federally recognized
2 American Indians and Alaska Natives in the United States;¹ and
3
4 Whereas, the Snyder Act of 1921 and the Indian Health Care Improvement Act (IHCIA) of 1976
5 recognized treaty obligations in codifying federal responsibility for Native American health in the
6 creation of the IHS; and
7
8 Whereas, the Supreme Court decision of Morton v. Mancari 417 U.S. 535 (1974) ruled that
9 members of federally recognized tribes possess a unique political status of quasi-sovereign
10 tribal entities; and
11
12 Whereas, the IHS currently delivers care to over 2.8 million American Indians and Alaska
13 Natives;² and
14
15 Whereas, eligibility for IHS services is strictly restricted to members of federally recognized
16 American Indian or Alaska Native tribes;³ and
17
18 Whereas, the Indian Health Service (IHS) Physician Scholarship program, as well as many
19 other Native scholarship programs, require applicants to be enrolled members of federally
20 recognized tribes;⁴ and
21
22 Whereas, the IHS has severe physician vacancy issues;⁵ and
23
24 Whereas, American Indians and Alaska Natives carry the lowest life expectancy (65.2 years old)
25 of all races;⁶ and
26
27 Whereas, American Indians and Alaska Natives have the least representation in the physician
28 workforce of any racial group per capita;⁷ and
29
30 Whereas, the American Medical Association and its partners, such as the Association of
31 American Medical Colleges (AAMC) and the Accreditation Council for Graduate Medical
32 Education (ACGME), currently do not collect demographic data on federally recognized tribal
33 members; and
34
35 Whereas, demographic data of federally recognized tribal members is a necessary first step
36 towards better aiding the Indian Health Service (IHS); therefore be it
37
38 RESOLVED, that our American Medical Association add “Enrolled Member of a Federally
39 Recognized Tribe” on all AMA demographic forms (Directive to Take Action); and be it further

1 RESOLVED, that our AMA advocate for the use of “Enrolled Member of a Federally Recognized
2 Tribe” as an additional category in all uses of demographic data including but not limited to
3 medical records, government data collection and research, and within medical education
4 (Directive to Take Action); and be it further

5
6 RESOLVED, that our AMA support the Association of American Medical Colleges (AAMC)
7 inclusion of “Enrolled Member of a Federally Recognized Tribe” on all AAMC demographic
8 forms (New HOD Policy); and be it further

9
10 RESOLVED, that our AMA advocate for the Accreditation Council for Graduate Medical
11 Education (ACGME) to include “Enrolled Member of a Federally Recognized Tribe” on all
12 ACGME demographic forms. (Directive to Take Action)

13
Fiscal Note: To Be Determined

Received: 5/24/2024

REFERENCES

1. About, Indian Health Service. U.S. Department of Health and Human Services. Accessed March 31, 2024. <https://www.ihs.gov/aboutihs/>
2. FY2024 Budget in Brief; US Department of Health and Human Services, pg. 33. <https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf>
3. Eligibility - Indian Health Service. U.S. Department of Health and Human Services. Accessed March 31, 2024. <https://www.ihs.gov/aboutihs/eligibility/>
4. IHS Scholarship Program. U.S. Department of Health and Human Services. Accessed March 31, 2024. <https://www.ihs.gov/scholarship/apply/>
5. Agency Faces Ongoing Challenges Filling Provider Vacancies. U.S. Government Accountability Office. Published August 2018. Accessed March 31, 2022. <https://www.gao.gov/assets/gao-18-580.pdf>
6. United States Life Tables 2021, National Vital Statistics Reports. National Center for Health Statistics. November 2023. <https://www.cdc.gov/nchs/data/nvsr/nvsr72/nvsr72-12.pdf>
7. Active Physicians who identified as American Indian or Alaska Native, 2021. Association of American Medical Colleges. Accessed March 31, 2024. <https://www.aamc.org/data-reports/workforce/data/active-physicians-american-indian-alaska-native-2021>

RELEVANT AMA POLICY

Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) descent D-350.979

Our AMA will: (1) add “Middle Eastern/North African (MENA)” as a separate racial category on all AMA demographics forms; (2) advocate for the use of “Middle Eastern/North African (MENA)” as a separate race category in all uses of demographic data including but not limited to medical records, government data collection and research, and within medical education; and (3) study methods to further improve disaggregation of data by race which most accurately represent the diversity of our patients. [Res.19, I-21]

Disaggregation of Demographic Data Within Ethnic Groups H-350.954

1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.

2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine. [Res. 001, I-17; Appended: Res. 403, A-19]

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. [BOT Rep. 24, I-06; Modified: CCB/CLRPD Rep. 3, A-12; Reaffirmed: CME Rep. 1, A-22; Appended: Res. 612, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 244
(A-24)

Introduced by: Minority Affairs Section

Subject: Graduate Medical Education Opportunities for American Indian and Alaska Native Communities

Referred to: Reference Committee B

1 Whereas, the federal government has a unique government-to-government relationship with
2 574 federally recognized tribes based on Article I, Section 8 of the U.S. Constitution; and
3
4 Whereas, the federal government has committed itself to provide health care services to Tribal
5 nations under the enforceable federal Indian trust responsibility, a legal fiduciary obligation to
6 provide basic social, medical, and educational services for American Indians and Alaska
7 Natives (AI/ANs);¹ and
8
9 Whereas, AI/AN are disproportionately affected by many chronic conditions, including heart
10 disease, cancer, diabetes, stroke, and accidental injuries;² and
11
12 Whereas, AI/AN have the lowest life expectancy of any racial group (65.2 years), with AI/AN
13 communities experiencing a 6.6-year decline between 2019 and 2021;³ and
14
15 Whereas, the Indian Health Service (IHS) provides health care to over 2.8 million AI/AN through
16 IHS and Tribal Health Programs and Urban Indian Organizations, often referred to as the I/T/U
17 or the Indian Health system;⁴ and
18
19 Whereas, the IHS is chronically under-funded compared to other federal health care systems,
20 and the lack of funds has contributed to health disparities in Tribal communities;⁵ and
21
22 Whereas, the IHS is the only large federal health care system to lack formalized partnerships
23 with academic medical centers, unlike the Veterans Health Administration and the Military
24 Health System;⁶ and
25
26 Whereas, IHS and Tribal medical facilities often suffer from high physician staffing vacancy
27 rates, contributing to negative outcomes;⁷ and
28
29 Whereas, Congress mandated that IHS form workforce partnerships with teaching hospitals in
30 the Indian Health Care Improvement Act of 1976 but has failed to appropriate funds to that
31 effect;⁸ and
32
33 Whereas, the President of the United States in the FY 2023 and FY 2024 Budget Proposals to
34 Congress has recommended establishing and funding a Division of Graduate Medical Education
35 in the IHS that would be tasked with expanding and supporting graduate medical education
36 programs to create a pathway and an enhanced ecosystem for future physicians to address
37 longstanding vacancy issues at IHS;⁹ and

1 Whereas, the AMA reaffirmed its recommendation in 2023 to support efforts in Congress to
2 enable the IHS to meet its obligation to bring American Indian health up to the general
3 population level, and support efforts to establish closer ties with teaching centers to increase
4 both the available manpower and the level of professional expertise available in Tribal clinics;¹⁰
5 and

6
7 Whereas, the AMA also reaffirmed its commitment to advocate that the IHS establish an Office
8 of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-
9 accredited medical schools and ACGME-accredited residency programs, and encourage the
10 development of funding streams to promote rotations and learning opportunities at IHS, Tribal,
11 and Urban Indian Health Programs;¹¹ and

12
13 Whereas, the AMA reaffirmed its recommendation in 2023 that the federal government provide
14 sufficient funds to support needed health services for American Indians, and encourage further
15 development and use of innovative delivery systems and staffing configurations to meet
16 American Indian health needs;¹² and

17
18 Whereas, the AMA acknowledges the importance of graduate medical education in training the
19 next generation of physicians, reducing physician shortages, and benefiting communities;¹³ and

20
21 Whereas, the AMA reaffirmed in 2022 that it will strenuously advocate for increasing the number
22 of GME positions to address the future physician workforce needs of the nation;¹⁴ and

23
24 Whereas, the AMA also is committed to strongly advocate that Congress fund additional
25 graduate medical education positions for the most critical workforce needs;¹⁵ and

26
27 Whereas, the AMA is also committed to utilizing its resources to share its content expertise with
28 policymakers and the public to ensure greater awareness of the significant societal value of
29 graduate medical education in terms of patient care, particularly for underserved and at-risk
30 populations, as well as global health, research, and education;¹⁶ and

31
32 Whereas, the AMA included in its Recovery Plan for America's Physicians the need to expand
33 the number of residency training slots and remove caps to Medicare-funded positions;¹⁷
34 therefore be it

35
36 RESOLVED, that our American Medical Association supports policy and communication efforts
37 to (1) advance legislative and regulatory policies and actions that establish, authorize, fund, and
38 incentivize the creation of graduate medical education opportunities in IHS, Tribal-administered,
39 and urban Indian health organizations and facilities and (2) establish associated partnerships
40 with accredited medical schools and teaching hospitals (New HOD Policy); and be it further

41
42 RESOLVED, that our AMA supports collaboratively working with Tribal nations, Tribal
43 organizations, academic medical centers, policy professionals, medical schools, teaching
44 hospitals, coalition builders, and other stakeholders to advocate to Congress, The White House,
45 the Department of Health and Human Services, and other government entities to establish
46 dedicated graduate medical education funding and programs that benefit Tribal communities,
47 increase physician training sites, and reduce physician shortages, particularly among
48 underserved populations. (New HOD Policy)

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

Received: 5/8/2024

REFERENCES

1. "What is the federal Indian trust responsibility?" Bureau of Indian Affairs. U.S Department of the Interior.
2. "Disparities." Indian Health Service. US Department of Health and Human Services. See also "Infant Mortality and American Indians/Alaska Natives." Office of Minority Health. US Department of Health and Human Services.
3. Hill, L. and Artiga S. "What is Driving Widening Racial Disparities in Life Expectancy?" Kaiser Family Foundation. May 23, 2023. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/what-is-driving-widening-racial-disparities-in-life-expectancy/>
4. FY2024 Budget in Brief; US Department of Health and Human Services, pg. 33
5. FY2024 Budget in Brief; US Department of Health and Human Services, pg. 33. See also Government Accountability Office Report: Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs
6. Tobey M, Ott A, Owen M. The Indian Health Service and the Need for Resources to Implement Graduate Medical Education Programs. JAMA. 2022;328(4):327. doi:10.1001/jama.2022.10359
7. <https://aspe.hhs.gov/sites/default/files/documents/1b5d32824c31e113a2df43170c45ac15/aspe-ihs-funding-disparities-report.pdf>
8. 25 USC Chapter 18 – Indian Health Care, §1616n – p. See Indian Health Care Improvement Act, Public Law 94-437. See also Tobey M, Ott A, Owen M. The Indian Health Service and the Need for Resources to Implement Graduate Medical Education Programs. JAMA. 2022;328(4):327. doi:10.1001/jama.2022.10359
9. FY 2024 Justification of Estimates for Appropriations Committees; Indian Health Service; US Department of Health and Human Services; pg. CJ-47.
10. American Medical Association Policy: Indian Health Service H-350.977
11. American Medical Association Policy: Indian Health Service H-350.977
12. American Medical Association Policy: Improving Health Care of American Indians H-350.976
13. "Save Graduate Medical Education." American Medical Association. <https://www.ama-assn.org/education/gme-funding/save-graduate-medical-education>
14. American Medical Association Directive: The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
15. American Medical Association Directive: The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
16. American Medical Association Directive: The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967
17. American Medical Association. "AMA Recovery Plan for America's Physicians." <https://www.ama-assn.org/amaone/ama-recovery-plan-america-s-physicians>. See also "AMA unveils Recovery Plan for America's Physicians." June 10, 2022. <https://www.ama-assn.org/press-center/press-releases/ama-unveils-recovery-plan-america-s-physicians>

RELEVANT AMA Policy

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration

should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

(6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.

(7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Appended: Res. 305, A-23; Reaffirmed: BOT Rep. 09, A-23]

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. [CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23]

Reference Committee C

Report(s) of the Board of Trustees

- 31 The Morrill Act and Its Impact on the Diversity of the Physician Workforce

Report(s) of the Council on Medical Education

- 01 Council on Medical Education Sunset Review of 2014 House of Delegates' Policies
- 02 The Current Match Process and Alternatives

Resolutions

- 301 Fairness for International Medical Students
- 302 The Role of Maintenance of Certification
- 303 Amend Policy D-275.948 Title "Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training". Creation of an AMA Task Force to Address Conflicts of Interest on Physician Boards.
- 304 Spirituality in Medical Education and Practice
- 305 Public Service Loan Forgiveness Reform
- 306 Unmatched Graduating Physicians
- 307 Access to Reproductive Health Services When Completing Physician Certification Exams
- 308 Transforming the USMLE Step 3 Examination to Alleviate Housestaff Financial Burden, Facilitate High-Quality Patient Care, and Promote Housestaff Well-Being
- 309 Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine
- 310 Accountability & Transparency in GME funding with Annual Report
- 311 Physician Participation in Healthcare Organizations
- 312 AMA Collaboration with FSMB to Assist in Licensing Reentrant Physicians
- 313 CME for Rural Preceptorship
- 314 Reducing the Lifetime Earnings Gap in the U.S. with Similar Educational Attainment by Employing the Gainful Employment Rule
- 315 Cease Reporting of Total Attempts of USMLE STEP1 and COMLEX-USA Level 1 Examinations
- 316 Reassessment of Continuing Board Certification Process
- 317 Physician Participation in the Planning and Development of Accredited Continuing Education for Physicians
- 318 Variation in Board Certification and Licensure Requirements for Internationally-Trained Physicians and Access to Care
- 319 AMA Support of U.S. Pathway Programs

REPORT 31 OF THE BOARD OF TRUSTEES (A-24)
The Morrill Act and Its Impact on the Diversity of the Physician Workforce
Reference Committee C

EXECUTIVE SUMMARY

This report was written in response to Resolution 308 brought forth by the Medical Student Section at the 2022 Annual Meeting of the House of Delegates. This resolution was referred for decision due to concern about legal implications of the first resolve related to both federal and state laws regarding affirmative action, land grant status, and federal trust responsibilities. To inform this action, a management report was subsequently submitted to the Board of Trustees (BOT) entitled “University Land Grant Status in Medical School Admissions.” The management report summarized concerns about implementing original Resolution 308-A-22 due to unknown legal implications and potentially unintended and negative consequences for communities that have been historically excluded from medicine. Also, it emphasized the importance of improving the health status of American Indian and Alaska Native (AI/AN) communities and increasing the number of AI/AN physicians who are uniquely qualified to provide care to these communities as well as the need to better understand the Morrill Act and its impact on efforts to diversify the physician workforce. Thus, the management report recommended that in lieu of Resolution 308-A-22, the AMA “study the historical and economic significance of the Morrill Act as it relates to its impact on diversity of the physician workforce.”

This report summarizes the extensive history of land acquisition, public education, federal recognition of tribes, the Morrill Act, economic impacts, and current physician workforce. It also reviews the role of the American Medical Association in that history as well as more recent improvement efforts. The report addresses concerns cited by the original author and notes the substantial role that medical education and organized medicine has played and can continue to play for the betterment of the physician workforce and AI/AN students and populations. Diversification of the physician workforce is imperative to meeting the health care needs in underserved communities across the U.S., particularly AI/AN populations. Medical education and organized medicine have much to learn from tribal nations, schools, and agencies to provide more culturally responsive information, understanding, and support. The report offers recommendations to strengthen its existing policies and provide leadership in more actionable efforts.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 31-A-24

Subject: The Morrill Act and Its Impact on the Diversity of the Physician Workforce
Presented by: Willie Underwood, III, MD, MSc, MPH, Chair
Referred to: Reference Committee C

1 INTRODUCTION

2
3 At the 2022 Annual Meeting of the House of Delegates, the Medical Student Section authored
4 Resolution 308 that asked the American Medical Association (AMA) to:

5 (1) work with the Association of American Medical Colleges, Liaison Committee on Medical
6 Education, Association of American Indian Physicians, and Association of Native American
7 Medical Students to design and promulgate medical school admissions recommendations in
8 line with the federal trust responsibility; and (2) amend Policy H-350.981, “AMA Support of
9 American Indian Health Career Opportunities,” by addition to read as follows: (2) Our AMA
10 support the inclusion of American Indians in established medical training programs in numbers
11 adequate to meet their needs. Such training programs for American Indians should be operated
12 for a sufficient period of time to ensure a continuous supply of physicians and other health
13 professionals. These efforts should include, but are not limited to, priority consideration of
14 applicants who self-identify as American Indian or Alaska Native and can provide some form
15 of affiliation with an American Indian or Alaska Native tribe in the United States, and robust
16 mentorship programs that support the successful advancement of these trainees. (3) Our AMA
17 utilize its resources to create a better awareness among physicians and other health providers of
18 the special problems and needs of American Indians and that particular emphasis be placed on
19 the need for stronger clinical exposure and a greater number of health professionals to work
20 among the American Indian population. (5) Our AMA acknowledges long-standing federal
21 precedent that membership or lineal descent from an enrolled member in a federally recognized
22 tribe is distinct from racial identification as American Indian or Alaska Native and should be
23 considered in medical school admissions even when restrictions on race-conscious admissions
24 policies are in effect. (6) Our AMA will engage with the Association of Native American
25 Medical Students and Association of American Indian Physicians to design and disseminate
26 American Indian and Alaska Native medical education curricula that prepares trainees to serve
27 AI/AN communities.

28
29 This resolution was referred for decision, due to concern about legal implications of the first
30 resolve related to both federal and state laws regarding affirmative action, land grant status, and
31 federal trust responsibilities. To inform this action, a management report was subsequently
32 submitted to the Board of Trustees (BOT) entitled “University Land Grant Status in Medical
33 School Admissions.” That report noted the central issue is improving the health status of AI/AN
34 communities and the need to increase the number of AI/AN physicians who are uniquely qualified
35 to provide culturally humble care to these communities. Further, it noted there may be risks
36 associated with implementing original Resolution 308-A-22 due to unknown legal implications and
37 potentially unintended and negative consequences for communities that have been historically

1 excluded from medicine. The management report identified a need to further understand all
2 components of the Morrill Act that may impact efforts to diversify the physician workforce prior to
3 developing any new policy recommendations. It recommended that in lieu of Resolution 308-A-22,
4 the AMA:

- 5
6 1. Work with the Association of American Medical Colleges, American Association of
7 Colleges of Osteopathic Medicine, Association of American Indian Physicians, and
8 Association of Native American Medical Students to increase representation of American
9 Indian physicians in medicine by promoting effective practices in recruitment,
10 matriculation, retention and graduation of American Indian medical students. (Directive to
11 Take Action)
- 12 2. Amend Policy H-350.981, “AMA Support of American Indian Health Career
13 Opportunities,” by addition and deletion to read as follows:
14 (2) Our AMA support the inclusion of American Indians in established medical training
15 programs in numbers adequate to meet their needs. Such training programs for American
16 Indians should be operated for a sufficient period of time to ensure a continuous supply of
17 physicians and other health professionals, prioritize consideration of applicants who self-
18 identify as American Indian or Alaska Native and can provide some form of affiliation
19 with an American Indian or Alaska Native tribe in the United States, and support the
20 successful advancement of these trainees. (3) Our AMA utilize its resources to create a
21 better awareness among physicians and other health providers of the special problems and
22 needs of American Indians and that particular emphasis be placed on the need for stronger
23 clinical exposure and a greater number of health professionals to work among the
24 American Indian population. (5) Our AMA acknowledges long-standing federal precedent
25 that membership or lineal descent from an enrolled member in a federally recognized tribe
26 is distinct from racial identification as American Indian or Alaska Native and should be
27 considered in medical school admissions even when restrictions on race-conscious
28 admissions policies are in effect. (Modify Current HOD Policy)
- 29 3. **Study the historical and economic significance of the Morrill Act as it relates to its**
30 **impact on diversity of the physician workforce. (Directive to Take Action)**

31
32 This BOT report is in response to Recommendation #3 above.

33 34 BACKGROUND

35
36 To better understand the Morrill Act and its impact, it is important to review the history of land
37 acquisition and public education as well as the federal recognition of tribes.

38 39 *Public education and land acquisition*

40
41 Support for public education was realized early in the formation of the republic. According to the
42 [Northwest Ordinance](#) of 1787, “Knowledge, being necessary to good government and the
43 happiness of mankind, schools and the means of education shall forever be encouraged.”¹ Those
44 who did receive instruction were primarily white children. Financing for early schools varied and
45 often charged tuition. Thus, many children were not included, depending on income, race,
46 ethnicity, gender, geographic location, and other reasons. Some rural areas had no schools. The
47 nation’s leaders at the time “believed strongly that preserving democracy would require an
48 educated population that could understand political and social issues and would participate in civic
49 life, vote wisely (only white men could vote), protect their rights and freedoms, and resist tyrants

1 and demagogues.”² Free public education began to expand in the 1830s, with states taking on the
2 provision of public education. Land acquisition, however, was key to implementing such education
3 widely. The largest occupier and ‘owner’ of such land at the time were American Indians — the
4 native and original caregivers of what is now the United States.

5
6 By 1887, American Indian tribes owned 138 million acres. However, the passage of the [General](#)
7 [Allotment Act](#) of 1887 (The Dawes Act) greatly impacted such ownership as their land became
8 subject to state and local taxation, of which many could not afford. By 1934, the total had dropped
9 to 48 million acres.³ [The Indian Reorganization Act](#) of 1934 (IRA) tamed this era of allotment and
10 marked a shift toward the promotion of tribal self-government. Subsequent Congressional acts
11 impacting tribes and their land — ownership, use, and development — include the following:

- 12 • [Indian Mineral Leasing Act](#): 1938
- 13 • [Indian Self-Determination and Education Assistance Act](#): 1975
- 14 • [Indian Mineral Development Act](#): 1982
- 15 • [Indian Tribal Energy Development and Self-Determination Act](#): 2005
- 16 • [Indian Tribal Energy Development and Self-Determination Act Amendments](#): 2017

17
18 There are approximately 2.4 billion acres in today’s United States.⁴ About 56 million acres of that
19 land (2.3%) is currently held in trust by the U.S. for various American Indian tribes and
20 individuals, making up the majority of American Indian land.² With trust land, the federal
21 government holds legal title but the beneficial interest remains with the individual or tribe. Trust
22 lands held on behalf of individuals are known as allotments. Fee land, on the other hand, is
23 purchased by tribes whereby the tribe acquires legal title under specific statutory authority.

24 *The Morrill Act and land-grant universities*

25
26
27 In 1862, Congress passed the [Morrill Act](#) named after Senator Justin Morrill of Vermont. “This act
28 made it possible for states to establish public colleges funded by the development or sale of
29 associated federal land grants. The original intention was to fund colleges of agriculture and
30 mechanical arts.⁵ Over 10 million acres provided by these grants were expropriated from tribal
31 lands of Native communities. The new land-grant institutions, which emphasized agriculture and
32 mechanic arts, opened opportunities to thousands of farmers and working people previously
33 excluded from higher education.”⁶ Much of this land was taken from American Indian tribes for the
34 benefit of white people by way of treaties and agreements (many of which the federal government
35 did not uphold its end) as well as seizure. In other words, “The government took the land for which
36 it paid little or nothing, from tribes with little bargaining power, that were impoverished, and that
37 were sometimes subject to threats to withhold rations and other benefits if they did not comply.”⁷
38 These now ‘public lands’ were surveyed into townships, and sections were reserved for public
39 schools; however, the land itself was often sold off, with proceeds used to fund the school program.
40 “The system invited misuse by opportunists, and substantial portions of the educational land-grants
41 never benefited education.”⁶ Support for land-grants was a significant factor in providing education
42 to white American children.

43
44 By way of the Morrill Act, the government granted each state 30,000 acres of public land, issued to
45 its Congressional representatives and senators to be used in establishing a “land grant” university.
46 Some of the land sales financed existing institutions while others chartered new schools. This
47 allocation grew to over 100 million acres. The Morrill land grants put into place a national system
48 of state colleges and universities. Examples of major universities that were chartered as land-grant
49 schools are Cornell University, Washington State University, Clemson University, and University
50 of Nebraska-Lincoln.

1 Following the Civil War, a [Second Morrill Act](#) was passed in 1890 to address the exclusion of
2 Black individuals from these educational opportunities due to their race. “It required states to
3 establish separate land-grant institutions for Black students or demonstrate that admission was not
4 restricted by race. The act granted money instead of land.”⁶ The [1890 Foundation](#) provides
5 additional information about these 19 historically Black colleges and universities (HBCUs), which
6 include Tuskegee University, Tennessee State University, and Alabama A&M University. In 1994,
7 a third land-grant act was passed — the Equity in Educational Land-Grant Status Act — that
8 bestowed land-grant status to American Indian tribal colleges. As a result, these colleges are
9 referred to as the “1994 land-grants.”⁸ Today’s land grant university (LGU) system is comprised of
10 institutions resulting from the above-mentioned acts passed in 1862 (57 original), 1890 (19
11 HBCUs), and 1994 (35 Tribal). “LGUs are located in all 50 states as well as the District of
12 Columbia and six U.S. territories. Of note, the “1994 institutions receive fewer federal funds
13 administered by National Institute of Food and Agriculture — in total — than 1862 and 1890
14 institutions, and they are ineligible for certain grant types available to 1862 and 1890 institutions.
15 Whereas the 1862 and 1890 institutions receive federal capacity funds specific to agricultural
16 research and extension (which brings research to the public through nonformal education
17 activities), 1994 institutions do not. Although 1994 institutions have more limited enrollment and
18 offer fewer postsecondary degrees than 1862 and 1890 institutions, some argue that funding for
19 agricultural research and extension at the 1994 institutions is insufficient and should be increased.”⁹

20

21 *Education of American Indians*

22

23 The inaccurate perception of American Indians as unintelligent and uncivilized led Congress to
24 pass the Indian Civilization Act in 1819 which paid missionaries to educate Natives and promote
25 the government’s notion of civility. Most American Indian children at that time were forcefully
26 relocated and brought to these schools to begin the assimilation into the “Western way of life”
27 under the authority of that Act — thus beginning the troubled history of American Indian boarding
28 schools that is still felt by current generations. One such school built in 1879, the Carlisle Indian
29 Industrial School, coined the term “Kill the Indian to save the man” summarizing a belief system to
30 erase Native culture through assimilation.¹⁰ These children were forcibly separated from their
31 families and not allowed to practice their spirituality, speak their language, or live according to
32 their culture under threat of punishment. They were even given new names. These practices
33 continued through the 1960s. In 1969, a Senate report of the Committee on Labor and Public
34 Welfare, entitled “Indian Education: A National Tragedy--A National Challenge“,” summarized
35 the devastating effects of forced assimilation of Native children and the failures of the education
36 system where students also experienced physical abuse, sexual violence, hunger, forced
37 sterilizations, and exposure to diseases. The trauma associated with this contributes to a well-
38 documented historical trauma that has been correlated to the high number of suicides and health
39 inequities experienced by American Indians in the U.S.¹¹ This trauma has had a devastating impact
40 on the potential number of students who consider enrollment in higher education due to a distrust
41 of any system associated with the U.S. government. Many who have been directly affected by
42 historical traumas have to overcome barriers like depression or other chronic diseases to participate
43 in a system that still does not align to their way of knowing. There was little consideration for the
44 higher education of American Indians (nor how to include a non-colonial perspective) until 1972
45 with the formation of the [American Indian Higher Education Consortium](#) (AIHEC). Through its
46 network of tribal colleges and universities (TCUs), AIHEC “provides leadership and influences
47 public policy on American Indian higher education issues through advocacy, research, and program
48 initiatives; promotes and strengthens indigenous languages, cultures, communities, and tribal
49 nations; and through its unique position, serves member institutions and emerging TCUs.”¹²

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American Indian affairs and federal recognition of tribes

In 1775, Congress created a Committee on Indian Affairs under the leadership of Benjamin Franklin. The [U.S. Constitution](#) (Article I, Section 8, Clause 3) gave Congress the power “to regulate commerce with foreign nations, and among the several States, and with the Indian tribes.” The [Bureau of Indian Affairs](#) (BIA) — known over the years as the Indian Office, the Indian Bureau, the Indian Department, and the Indian Service — was established in 1824 to oversee and carry out the government’s trade and treaty relations with the tribes. The BIA received statutory authority from Congress in 1832; in 1849, it was transferred to the newly created U.S. Department of the Interior.¹³ “Over the years, the BIA has been involved in the implementation of federal laws that have directly affected all Americans. The General Allotment Act of 1887 opened tribal lands west of the Mississippi to non-Indian settlers, the [Indian Citizenship Act](#) of 1924 granted American Indians and Alaska Natives U.S. citizenship and limited rights to vote, and the New Deal and the Indian Reorganization Act of 1934 restored self-determination and dictated a model the United States expected tribal governments to use. The World War II period of relocation and the post-War termination era of the 1950s led to the activism of the 1960s and 1970s that saw the takeover of the BIA’s headquarters and resulted in the creation of the Indian Self-Determination and Education Assistance Act of 1975. This act as well as the [Tribal Self-Governance Act](#) of 1994 have fundamentally changed how the federal government and the tribes conduct business with each other.”¹³ Although the BIA was once responsible for providing health care services to American Indians and Alaska Natives, that role was legislatively transferred to the U.S. Department of Health, Education, and Welfare (now known as the Department of Health and Human Services) in 1954.¹³ It remains there under the auspices of the [Indian Health Service](#) (IHS). However, funding for this continues to be a problem. In 2019, IHS spending per capita was only \$4,078 while the national average spending per capita was \$9,726.¹⁴ At that time, it was also reported that American Indians and Alaska Natives (AI/AN) had a life expectancy 5.5 years less than the U.S. all races population (73.0 years compared to 78.5 years) and “die at higher rates than other Americans in many categories, including chronic liver disease and cirrhosis, diabetes mellitus, unintentional injuries, assault/homicide, intentional self-harm/suicide, and chronic lower respiratory diseases.”¹⁵ Groups such as the [Tribal Sovereign Leaders on the national Tribal Budget Formulation Workgroup](#) (TBFWG) have provided, and continue to provide, significant insights to inform IHS budget requests.

According to the BIA, “a federally recognized tribe is an AI/AN tribal entity that is recognized as having a government-to-government relationship with the United States, with the responsibilities, powers, limitations, and obligations attached to that designation, and is eligible for funding and services from the BIA. Furthermore, federally recognized tribes are recognized as possessing certain inherent rights of self-government (i.e., tribal sovereignty) and are entitled to receive certain federal benefits, services, and protections because of their special relationship with the United States.”¹⁶ Over the years, most of today’s federally recognized tribes received federal recognition status by way of treaties, acts of Congress, presidential executive orders or other federal administrative actions, or federal court decisions. In 1978, the Department of the Interior issued procedures for federal acknowledgment of Indian tribes to more uniformly handle requests — found in Part 83 of Chapter 25 of the [Code of Federal Regulations](#).¹⁷ In 1994, Congress enacted the [Federally Recognized Indian Tribe List Act](#). It formally established three ways to achieve federal recognition: (1) by act of Congress, (2) by the administrative procedures under 25 C.F.R. Part 83, or (3) by decision of a United States court. Congress has the authority to terminate a relationship with a tribe, and only Congress can restore its federal recognition. The act also requires the Secretary of the Interior to annually publish information on federally recognized tribal entities.¹⁸

1 As of January 2023, there were 574 federally recognized Tribal entities.¹⁹ There are also many
2 tribes that are not state or federally recognized. There are 324 federally recognized American
3 Indian reservations where 13 percent of the AI/AN population lives. The 2020 Census indicates
4 that 87 percent live outside of tribal statistical areas. It also shows that 9.1 million people identify
5 as AI/AN alone or in combination (2.9 percent of total U.S. population).²⁰

6 7 DISCUSSION

8 9 *Economic and educational impacts*

10
11 The Morrill Act, as well as the [Homestead Act](#) of 1862, had a significant impact on American
12 expansion. The Homestead Act encouraged western migration by providing settlers with 160 acres
13 of land. Such settlers were required to live on and cultivate the land. After five years, they were
14 entitled to the property upon payment of a small filing fee. While they certainly fostered prosperity
15 and educational opportunities for new American settlers, these came at the expense of the original
16 people — American Indians. The economic significance of these acts cannot be understated. In
17 2019, sixteen land-grant universities retained over half a million acres of Indigenous lands,
18 generating at least \$8.7 million.²¹ See Appendix A for a table of remaining Morrill Act lands and
19 revenue by university.

20
21 In addition to the economic impact, thousands of American Indian families were affected by the
22 Indian Civilization Act and boarding schools. Given the lingering effects to this day, it stands to
23 reason that many AI/AN students have a negative attitude toward the education system. According
24 to the Bureau of Indian Education (BIE), “Native youth have the lowest high school graduation rate
25 of students across all schools. Nationally, the AI/AN high school graduation rate is 69 percent, far
26 below the national average of 81 percent.”²² The BIE funds elementary and secondary schools on
27 64 reservations in 23 states, serving approximately 42,000 Indian students.²³ These BIE schools
28 hold an average graduation rate of 53 percent. The BIE also serves AI/AN post-secondary students
29 through higher education scholarships, supports funding for tribal colleges and universities, and
30 directly operates two post-secondary institutions — Haskell Indian Nations University in Kansas
31 and the Southwestern Indian Polytechnic Institute in New Mexico.

32 33 *Medical education and the physician workforce*

34
35 Significant school dropout rates and lower enrollment in higher education have negatively
36 impacted AI/AN representation in medical education and the physician workforce. According to
37 2023-2024 data from the Association of American Medical Colleges (AAMC), 1,0451 AI/AN
38 students were enrolled in MD-granting medical schools (about 1percent of the total student
39 population). Further, only 188 AI/AN students graduated from MD-granting medical schools.²⁴
40 This significant decline from enrollment to graduation is very concerning; medical education needs
41 to figure out why and what to do about it. The entire educational pathway (PreK-12 and
42 undergraduate) may need to be considered to help AI/AN students to prepare for their studies,
43 promote a sense of belonging, and avail themselves of mentorship opportunities. Tribes have a
44 vested interest in the training of AI/AN students, given they are more likely to return to and serve
45 their own communities as physicians. Such efforts will ultimately foster tribal self-governance and
46 self-determination.

47
48 Several universities have taken steps to increase AI/AN representation in medical schools. In 1973,
49 the University of North Dakota launched the Indians Into Medicine (INMED) program, which has
50 recruited, supported, and trained 250 AI/AN physicians. This program has served as a model for
51 other health professions within the university as well as for other medical schools that receive IHS

1 funding. Since many students face financial hardship, INMED offers a free summer program called
2 Med Prep that provides students with stipends, and it helps its medical school students identify
3 potential scholarship options. The university went one step further in 2020 to launch the country's
4 first PhD. program in Indigenous health.²⁵ Another example is Oregon Health & Science
5 University (OHSU) School of Medicine and its Wy'east Pathway, a 10-month postbaccalaureate
6 program for AI/AN students who unsuccessfully applied to medical school, have an MCAT score
7 below a certain cutoff, or lack clinical experience. The program provides biomedical and MCAT
8 classes as well as cultural support and skills-building to promote success in medical school.²⁶ Not
9 only do programs like these directly support AI/AN students, but they also promote collaboration
10 with and inclusion of non-indigenous allies. This combination can help to turn the tide on the
11 workforce issue.

12
13 The impact of low representation in medical schools is evident when examining the diversity of
14 physician workforce. In 2022, 0.3% of active physicians identified as AI/AN.²⁷ According to a
15 2018 [report](#) from the U.S. Government Accountability Office, the vacancy rate at IHS clinics
16 among staff physician positions was about 29% across the eight IHS geographic regions; the
17 highest vacancy was 46% in the areas servicing Bemidji, Minnesota, and Billings, Montana.²⁸ In
18 addition to representation in practicing medicine, there are also deficits in AI/AN representation in
19 academic positions. One study found that, compared with their white peers, AI/AN individuals had
20 48% lower odds of holding a full-time faculty position post residency.²⁹

21
22 As mentioned in other parts of this report, there is distrust in colonial constructs (U.S. laws,
23 policies, and institutions), but there may also be distrust in the colonial medicine through IHS
24 because of the history of forced sterilization and because traditional forms of medicine were
25 outlawed (as well as any religious/cultural beliefs associated with them). In fact, the Department of
26 the Interior's 1883 Code of Indian Offenses noted that "any medicine man convicted of
27 encouraging others to follow traditional practices was to be confined in the agency prison for not
28 less than 10 days or until he could provide evidence that he had abandoned his beliefs."³⁰ This
29 context has given rise to a distrust of medicine and medical education that continues today.

30
31 In June 2023, the Supreme Court of the U.S. (SCOTUS) issued a ruling on affirmative action that
32 eliminated race as a consideration in college and universities' admission processes. This ruling
33 should not change tribal colleges; however, will it likely impact AI/AN students who attend non-
34 tribal institutions because most wrongly collect tribal identity as a racial category. "Most, if not all,
35 mainstream colleges and universities rely entirely on self-reporting when it comes to determining
36 tribal identity of students. This means if a Native student doesn't indicate they are a tribal citizen,
37 then they are not counted as such."³¹ This lack of data can impact the understanding of student
38 enrollment as well as funding opportunities. It is critical to re-emphasize that "Native American" is
39 not only a racial category but also the designation which gives those who are enrolled in federally
40 recognized tribes a protected classification by treaty and is not subject to the SCOTUS decision on
41 race/ethnicity. Many schools may not include identifying Native Americans in their admissions
42 consideration as they may fear violation of the SCOTUS decision.

43 44 *The AMA's role: accountability and restitution*

45
46 The AMA and its members play a complicated role in the history of American Indians. AMA
47 members were party to the claiming of land in the "Western territories" in the mid-1850s, as
48 described in the A-1857 report "[Report on the Fauna and Medical Topography of Washington](#)
49 [Territory](#). AMA archives contain a 1865 report entitled "[On Some Causes Tending to Promote the](#)
50 [Extinction of the Aborigines of America](#)" which details study of the Onondoga tribe, concluding
51 "But those of us who pity and strive to arrest the downward course of this remnant of the original

1 lords of the forest, may delay what we are wholly unable to prevent, for I much fear that before the
2 poor Indian has learned the laws of his physical nature and how to obey them, economy of time and
3 means, industry, and reliance upon his own muscles and broad acres for his support, instead of
4 looking for the government to hire his teacher and physician, and for his wants to be met by others,
5 without forecast and plan of us own — before these radical changes in his habits are effected — the
6 waning remnant of the Onondagas will forever have passed away.”³²

7
8 Physicians were involved in American Indian boarding schools, the development of the Indian
9 Health Service, and the study of illnesses and healing practices on AI/AN tribes. Their works were
10 published in JAMA and included:

- 11 • [The Medicine and Surgery of the Winnebago and Dakota Indians \(1883\)](#)
- 12 • [Improved Sanitary and Social Conditions of the Seminoles of Florida \(1896\)](#)
- 13 • [Indian Method of Treating Measles \(1903\)](#)
- 14 • [The Indian Medical Service \(1913\)](#)

15
16 Past harms also include the AMA’s role in promulgating discriminatory practices resulting from
17 the [Flexner Report](#), a landmark 1910 criticism of U.S. medical education resulting in a reduction in
18 the number of medical schools including the closing of 5 out of the 7 historically black medical
19 schools. Past decisions such as these continue to negatively impact populations in need. The AMA
20 acknowledges that AI/AN populations experience significant health disparities up to the present
21 including lower access to care and underfunding of public programs such as the Indian Health
22 Service serving AI/AN communities. In addition, AI/AN persons continue to be severely
23 underrepresented in the physician and healthcare workforce.

24
25 The AMA launched various supportive efforts such as:

- 26 • Asked the federal government to step in to stop the spread of trachoma in Native
27 communities ([A-1924](#)) and provide better health services for the population ([A-1929](#));
 - 28 • Issued AMA Statement on Infant Mortality ([A-1968](#));
 - 29 • Advocated for the transfer of functions relating to health and hospitalization of American
30 Indians from the Bureau of Indian Affairs to the U.S. Public Health Service ([I-1953](#));
 - 31 • Appealed for more funding for hospitals and health services on reservations ([I-1957](#));
 - 32 • Collaborated with the IHS on efforts related to health care delivery and health aide training
33 programs ([I-1970](#));
 - 34 • Led large-scale study of health care for American Indians that was used to guide the
35 Senate’s “Indian Health Care Improvement Act” of 1976 ([I-1973](#));
 - 36 • Created Project USA to recruit physicians to medically underserved areas, including
37 AI/AN reservations ([I-1975](#));
 - 38 • Sought to exempt Indian Health Services from competitive procurement practices
39 regulations ([A-1984](#));
 - 40 • Initiated a project with the AAIP to improve health care for American Indians ([A-1995](#));
 - 41 • With the National Medical Association, established the Commission to End Health Care
42 Disparities in 2004 – a collaboration of health care organizations to address racial and
43 ethnic health care disparities and diversity in the physician workforce.
 - 44 • In 2013, the AMA launched its innovative “Accelerating Change in Medical Education”
45 initiative to rebuild medical education from the ground up. Now known as the
46 [ChangeMedEd](#) initiative, this effort has fostered collaborations with schools like Oregon
47 Health & Science University School of Medicine and the University of Washington School
48 of Medicine to increase the numbers of AI/AN students and faculty.
- 49

1 Although the Commission was retired in 2016, a new effort emerged in 2018 through the adoption
2 of policy calling for a strategic framework to address health equity on a national scale — resulting
3 in the creation of the [AMA Center for Health Equity](#). Among other things, the Center is leading a
4 task force that will “guide organizational transformation within and beyond the AMA toward
5 restorative justice to promote truth, reconciliation, and healing in medicine and medical education.
6 ...The task force will inform and advise the AMA on ways to establish restorative justice dialogues
7 between AMA leaders, physicians from historically marginalized racial and ethnic groups and their
8 physician associations, and other critical stakeholders.”³³

9
10 Recently, an AMA [article](#) from December 2023 addressed vacancies at the Indian Health Service.
11 Also, an [AMA Update](#) on January 8, 2024 discussed how tribal medical education programs could
12 solve the rural health care crisis. Featuring Oklahoma State University College of Osteopathic
13 Medicine’s unique partnership with The Cherokee Nation, the discussion addressed the importance
14 of physicians truly understanding the communities they serve.

15
16 AMA Advocacy has been actively participating in efforts to support AI/AN populations and related
17 physicians. Federal efforts in just the last two years include:

- 18 • May 2022: [Letter](#) sent to Senators Mastro and Murkowski in support of the Indian Health
19 Service Health Professions Tax Fairness Act (S.2874).
- 20 • April 2023: [Letter](#) sent to U.S. Department of Agriculture addressing Menu Planning
21 Options for American Indian and Alaska Native Students.
- 22 • October 2023: [Letter](#) sent to U.S. Department of Health and Human Services and Indian
23 Health Service to highlight the importance of high quality, timely care for American
24 Indians, Alaska Natives, and Native Hawaiians, particularly as it related to physician and
25 medical student members.
- 26 • February 2024: Multi-organizational [letter](#) sent to both the House Appropriations
27 Subcommittee on Interior and Senate Appropriations Subcommittee on Interior,
28 Environment, and Related Agencies, Environment, and Related Agencies. This letter
29 detailed support for the inclusion of \$30 million in new funding in the FY2025 Interior,
30 Environment, and Related Agencies appropriations bills to address chronic clinical staff
31 shortages across Indian Country through GME programming.

32
33 The AMA Foundation (AMAF) funds the [Physicians of Tomorrow Program](#). This program
34 distributes a \$10,000 tuition assistance scholarship to medical students approaching their final year
35 of school with the goal of creating a diverse cohort of students who are dedicated to serving
36 underserved communities. The AMAF is also bringing attention to AI/AN issues in medical
37 education, as seen in a 2022 [article](#) featuring AMA members.

38 The [AMA Ed Hub](#)TM offers a variety of equity-related educational opportunities — from its panel
39 discussion on [Truth and Reconciliation in Medicine](#) to its Prioritizing Equity series. Titles of
40 relevance include:

- 41 • [For Us, By Us: Advocating for Change in Native Health Policy](#)
- 42 • [Getting to Justice in Education](#)
- 43 • [The Root Cause and Considerations for Health Care Professionals](#)
- 44 • [How the Past Informs the Present in Healthcare](#)

45 46 RELEVANT AMA POLICIES

47
48 The AMA has several policies in support of AI/AN tribes and communities as well as students and
49 trainees in order to foster diversity of the physician workforce in an effort to improve public health
50 including AI/AN populations. For example:

- 1 • [AMA Support of American Indian Health Career Opportunities H-350.981](#) promotes
2 recruitment of AI/AN into health careers including medicine and the concept of AI/AN
3 self-determination.
- 4 • [Promising Practices Among Pathway Programs to Increase Diversity in Medicine D-
5 350.980](#) establishes a task force to guide organizational transformation within and beyond
6 the AMA toward restorative justice to promote truth, reconciliation, and healing in
7 medicine and medical education.
- 8 • [Underrepresented Student Access to US Medical Schools H-350.960](#) recognizes some
9 people have been historically underrepresented, excluded from, and marginalized in
10 medical education and medicine because of their race, ethnicity, disability status, sexual
11 orientation, gender identity, socioeconomic origin, and rurality, due to racism and other
12 systems of exclusion and discrimination.
- 13 • [Strategies for Enhancing Diversity in the Physician Workforce H-200.951](#) supports
14 increased diversity across all specialties in the physician workforce in the categories of
15 race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin,
16 and rurality.
- 17 • [Cultural Leave for American Indian Trainees H-350.957](#) recognizes the importance of
18 cultural identity in fostering trainee success and supports accommodating cultural
19 observances.

20
21 See Appendix B for the full policies. Additional policies can be accessed in the [AMA Policy](#)
22 [Finder](#) database, which include:

- 23 • [Strategies for Enhancing Diversity in the Physician Workforce D-200.985](#)
- 24 • [Continued Support for Diversity in Medical Education D-295.963](#)
- 25 • [AMA Support of American Indian Health Career Opportunities H-350.981](#)
- 26 • [Indian Health Service H-350.977](#)
- 27 • [Desired Qualifications for Indian Health Service Director H-440.816](#)
- 28 • [Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987](#)
- 29 • [Improving Health Care of American Indians H-350.976](#)
- 30 • [Plan for Continued Progress Toward Health Equity H-180.944](#)

31 32 SUMMARY AND RECOMMENDATIONS

33
34 This report illuminates these concerns as well as the substantial part that medical education and
35 organized medicine has played and can continue to play for the betterment of the physician
36 workforce and AI/AN students and populations. Organizations like the [Association of American](#)
37 [Indian Physicians](#) (AAIP) hold an esteemed role in such efforts. AAIP was established in 1971 by a
38 group of 14 AI/AN physicians to support AI/AN communities and serve as an educational,
39 scientific, and charitable nonprofit.

40
41 As stated in the AAMC's [2018 publication](#), *Reshaping the Journey: American Indians and Alaska*
42 *Natives in Medicine*, "Medical schools are chiefly responsible for the development of what the
43 physician workforce looks like today and what it will look like in the future.... We must view this
44 issue as a national crisis facing not just the American Indian-Alaskan Native (AI/AN)
45 communities, but all medical schools and teaching hospitals.... We need transformative thinking
46 and a new systems-based approach if we are to resolve this crisis with a plausible solution."³⁴
47 Diversification of the physician workforce is imperative to meeting the health care needs in
48 underserved communities across the U.S., particularly AI/AN populations. Also, medical education
49 has much to learn from tribal nations, schools, and organizations to provide more culturally
50 responsive information, understanding, and support.

1 The Board of Trustees that the following recommendations be adopted, and the remainder of this
2 report be filed. That our AMA:

- 3
4 1. Amend [AMA Support of American Indian Health Career Opportunities H-350.981](#) by
5 addition to read:
6 (4) Our AMA will continue to support the concept of American Indian self-
7 determination as imperative to the success of American Indian programs and recognize
8 that enduring acceptable solutions to American Indian health problems can only result
9 from program and project beneficiaries having initial and continued contributions in
10 planning and program operations to include training a workforce from and for these
11 tribal nations.
12 (6) Our AMA acknowledges the significance of the Morrill Act of 1862, the resulting
13 land-grant university system, and the federal trust responsibility related to tribal
14 nations.
15
16 2. Amend [AMA Support of American Indian Health Career Opportunities D-350.976](#) by
17 deletion of clause (2) as having been accomplished by this report.
18 ~~(2) study the historical and economic significance of the Morrill Act as it relates to~~
19 ~~its impact on diversity of the physician workforce.~~
20
21 3. Amend [AMA Support of American Indian Health Career Opportunities D-350.976](#) by
22 addition of a new clause to read:
23 Convene key parties, including but not limited to the Association of American Indian
24 Physicians (AAIP) and American Indian/Alaska Native (AI/AN) tribes/entities such as
25 Indian Health Service and National Indian Health Board, to discuss the representation
26 of AI/AN physicians in medicine and promotion of effective practices in recruitment,
27 matriculation, retention, and graduation of medical students.
28
29 4. Reaffirm the following policies:
30 a. [Indian Health Service H-350.977](#)
31 b. [Underrepresented Student Access to US Medical Schools H-350.960](#)
32 c. [Strategies for Enhancing Diversity in the Physician Workforce H-200.951](#)
33 d. [Continued Support for Diversity in Medical Education D-295.963](#)
34 e. [AMA Support of American Indian Health Career Opportunities D-350.976.](#)
35
36
37

38 Fiscal note: \$1,000

APPENDIX A: Remaining Morrill Act lands and revenue by university

University	Total Morrill acres found	Endowment raised as of 1914	Remaining acres with surface rights	Surface royalties raised, FY 2019	Remaining acres with mineral rights	Mineral royalties raised, FY 2019
Colorado State University	89,321	\$185,956	19,130	\$77,526	42,572	\$662,596
Kansas State University	87,290	\$491,746	0	N/A	6,080	\$163,345
Montana State University	140,385	\$533,149	63,474	\$623,941	77,929	\$6,670
New Mexico State University	248,964	\$241,909	194,571	\$1,217,672	254,200	\$353,587
North Dakota State University	130,471	\$455,924	15,117	\$308,142	66,109	\$2,874,800
South Dakota State University	159,832	\$128,804	36,617	\$608,583	160,000	\$27,365
University of Arizona	143,684	\$450,000	UNKNOWN	UNKNOWN	UNKNOWN	UNKNOWN
University of California	150,525	\$732,233	0	N/A	441.6	\$1,947
University of Idaho	87,445	\$129,615	33,527	\$358,258	70,000	\$1,188
University of Minnesota	94,631	\$579,430	0	N/A	240	\$0
University of Missouri	270,613	\$363,441	14,787	UNKNOWN	0	N/A
University of Nebraska	89,920	\$560,072	6,173	\$426,619	0	N/A
University of Wisconsin	235,690	\$303,594	0	N/A	6,400	\$0
University of Wyoming	89,849	\$73,355	71,066	UNKNOWN	UNKNOWN	UNKNOWN
Utah State University	198,837	\$194,136	27,577	\$83,769	51,724	\$943,843
Washington State University	90,081	\$247,608	71,147	\$4,250,000	86,657	\$1,936

[The land-grant universities still profiting off Indigenous homelands](#), High Country News, 2020.

APPENDIX B – RELEVANT AMA POLICIES

[AMA Support of American Indian Health Career Opportunities H-350.981](#)

AMA policy on American Indian health career opportunities is as follows:

(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded. (2) Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees. (3) Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population. (4) Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. (5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.

[Promising Practices Among Pathway Programs to Increase Diversity in Medicine D-350.980](#)

Our AMA will establish a task force to guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education.

[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.

[Strategies for Enhancing Diversity in the Physician Workforce H-200.951](#)

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in

better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

[Cultural Leave for American Indian Trainees H-350.957](#)

Our AMA recognizes the importance of cultural identity in fostering trainee success and encourages residency programs, fellowship programs, and medical schools to accommodate cultural observances for trainees from American Indian, Alaska Native, and Native Hawaiian communities.

[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 their 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 unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population. 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.

[Continued Support for Diversity in Medical Education D-295.963](#)

Our AMA will: (1) publicly state and reaffirm its 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; (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; (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; (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty; (8) recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts; and (9) collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure.

[AMA Support of American Indian Health Career Opportunities H-350.981](#)

AMA policy on American Indian health career opportunities is as follows:

(1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded. (2)) Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees. (3) Our AMA will utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and particular emphasis will be placed on the need for stronger clinical exposure and a greater number of health professionals to work among the American Indian population. (4) Our AMA will continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations. (5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.

[Indian Health Service H-350.977](#)

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population. (2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian

care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation. (3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps. (4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued. (5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population. (6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs. (7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.

[Desired Qualifications for Indian Health Service Director H-440.816](#)

Our AMA supports the following qualifications for the Director of the Indian Health Service:

1. Health profession, preferably an MD or DO, degree and at least five years of clinical experience at an Indian Health Service medical site or facility.
2. Demonstrated long-term interest, commitment, and activity within the field of Indian Health.
3. Lived on tribal lands or rural American Indian or Alaska Native community or has interacted closely with an urban Indian community.
4. Leadership position in American Indian/Alaska Native health care or a leadership position in an academic setting with activity in American Indian/Alaska Native health care.
5. Experience in the Indian Health Service or has worked extensively with Indian Health Service, Tribal, or Urban Indian health programs.
6. Knowledge and understanding of social and cultural issues affecting the health of American Indian and Alaska Native people.
7. Knowledge of health disparities among Native Americans / Alaska Natives, including the pathophysiological basis of the disease process and the social determinants of health that affect disparities.
8. Experience working with Indian Tribes and Nations and an understanding of the Trust Responsibility of the Federal Government for American Indian and Alaska Natives as well as an understanding of the sovereignty of American Indian and Alaska Native Nations.
9. Experience with management, budget, and federal programs.

[Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987](#)

1. Our AMA 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 (IHS) Advanced Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations.
6. Our AMA supports an increase to 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 (IHS) and encourages state and federal governments to reinvest Medicaid savings from 100% FMAP into tribally driven health improvement programs.

[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 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.

[Plan for Continued Progress Toward Health Equity H-180.944](#)

Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

REFERENCES

1. National Archives. Northwest Ordinance. Accessed January 12, 2024. www.archives.gov/milestone-documents/northwest-ordinance.
2. The George Washington University, Graduate School of Education & Human Development, Center on Education Policy. History and Evolution of Public Education in the U.S. 2020. Accessed February 10, 2024. <https://files.eric.ed.gov/fulltext/ED606970.pdf>.
3. U.S. Department of the Interior, National Resources Revenue Data. Native American Ownership and Governance of Natural Resources. Accessed January 12, 2024. <https://revenue.data.doi.gov/how-revenue-works/native-american-ownership-governance/#:~:text=The%20policy%20of%20allotment%20reduced,extended%20the%20trust%20period%20indefinitely>.
4. A-Z Animals. How many acres are in the United States? Accessed January 12, 2024. <https://a-z-animals.com/blog/how-many-acres-are-in-the-united-states/>.
5. 1890 Universities Foundation. Land Grant and Universities: A Primer. Accessed January 20, 2024. www.1890foundation.org/history-of-land-grant-universities.
6. National Archives. Morrill Act (1862). Accessed January 12, 2024. www.archives.gov/milestone-documents/morrill-act.
7. Cornell University and Indigenous Dispossession Project, American Indian and Indigenous Studies Program. Breaking the Silence on Cornell's Morrill Act Lands. September 29, 2020. Accessed February 10, 2024. <https://blogs.cornell.edu/cornelluniversityindigenoussdispossession/2020/09/29/breaking-the-silence-on-cornells-morrill-act-lands/>.
8. Association of Public & Land-Grant Universities. Land-Grant University FAQ. Accessed January 20, 2024. www.aplu.org/about-us/history-of-aplu/what-is-a-land-grant-university/#:~:text=Grant%20University%20FAQ,What%20is%20a%20land%20grant%20university%3F,Grant%20Status%20Act%20of%201994.
9. Congressional Research Service. 1994 Land-Grant Universities: Background and Selected Issues. January 4, 2022. Accessed February 10, 2024. <https://crsreports.congress.gov/product/pdf/IF/IF12009>.
10. Native Hope. Native American Boarding Schools and Education History. September 12, 2023. Accessed January 20, 2024. <https://blog.nativehope.org/native-american-boarding-schools-and-education-history/#:~:text=In%201819%2C%20Congress%20passed%20the,promote%20the%20%22civilizati on%20process.%22&text=Thus%20began%20the%20long%20and,still%20felt%20by%20current%20generations>.
11. Heart MY, Chase J, Elkins J, Altschul DB. Historical trauma among Indigenous Peoples of the Americas: concepts, research, and clinical considerations. *J Psychoactive Drugs*. November 22, 2011;43(4):282-90. www.tandfonline.com/doi/abs/10.1080/02791072.2011.628913
12. American Indian Higher Education Consortium. About AIHEC. Accessed February 23, 2024. www.aihec.org/about-aihec/.
13. U.S. Department of the Interior, Indian Affairs. Bureau of Indian Affairs. Accessed January 12, 2024. www.bia.gov/bia.

14. U.S. Department of Health and Human Services, Indian Health Service, Federal Health Program for American Indians and Alaska Natives. IHS Profile. August 2020. Accessed February 23, 2024. www.ihs.gov/newsroom/factsheets/ihsprofile/.
15. Indian Health Service. Indian Health Disparities. October 2019. Accessed February 23, 2024. www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/factsheets/Disparities.pdf.
16. U.S. Department of the Interior, Indian Affairs. What is a federally recognized tribe? Accessed January 12, 2024. www.bia.gov/faqs/what-federally-recognized-tribe.
17. National Archives. Code of Federal Regulations. Accessed January 12, 2024. www.ecfr.gov/current/title-25.
18. U.S. Department of the Interior, Indian Affairs. How is federal recognition status conferred? Accessed January 12, 2024. www.bia.gov/faqs/how-federal-recognition-status-conferred.
19. National Archives. Federal Register. Accessed January 12, 2024. www.federalregister.gov/documents/2023/01/12/2023-00504/indian-entities-recognized-by-and-eligible-to-receive-services-from-the-united-states-bureau-of.
20. U.S. Department of Health and Human Services, Office of Minority Health. American Indian/Alaska Native Health. Accessed February 10, 2024. [https://minorityhealth.hhs.gov/american-indianalaska-native-health#:~:text=Together%2C%20the%20AI%2FAN%20alone,total%20U.S.%20population\)%%20in%202020%20](https://minorityhealth.hhs.gov/american-indianalaska-native-health#:~:text=Together%2C%20the%20AI%2FAN%20alone,total%20U.S.%20population)%%20in%202020%20).
21. Goodluck K, Ahtone R, Lee R. The land-grant universities still profiting off Indigenous homelands. *High Country News*. 2020. Accessed January 20, 2024. www.hcn.org/articles/indigenous-affairs-the-land-grant-universities-still-profiting-off-indigenous-homelands/.
22. U.S. Department of the Interior, Bureau of Indian Education. Blueprint for Reform Implementation. Accessed January 20, 2024. www.bie.edu/topic-page/blueprint-reform-implementation.
23. U.S. Department of the Interior: Indian Affairs. Bureau of Indian Education. Accessed January 20, 2024. www.bia.gov/bie.
24. Association of American Medical Colleges. 2023 Facts: Applicants and Matriculants Data. Accessed February 10, 2024. www.aamc.org/data-reports/students-residents/data/2023-facts-applicants-and-matriculants-data.
25. Kwon S. American Indians' Growing Presence In The Health Professions. *Health Affairs*. February 2021;40:2,192-196. <https://doi.org/10.1377/hlthaff.2020.02289>.
26. Morris P. Attracting more Native American students to medicine. *Viewpoints*. Association of American Medical Colleges. August 5, 2021. Accessed February 10, 2024. www.aamc.org/news/attracting-more-native-american-students-medicine.
27. Association of American Medical Colleges. U.S. Physician Workforce Data Dashboard. Accessed February 10, 2024. www.aamc.org/data-reports/data/2023-key-findings-and-definitions#keyfindings.
28. U.S. Government Accountability Office. Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies. August 15, 2018. Accessed February 10, 2024. www.gao.gov/products/gao-18-580.

29. Forrest LL, Leitner BP, Vasquez Guzman CE, Brodt E, Odonkor CA. Representation of American Indian and Alaska Native Individuals in Academic Medical Training. *JAMA Netw Open*. 2022;5(1):e2143398. [doi:10.1001/jamanetworkopen.2021.43398](https://doi.org/10.1001/jamanetworkopen.2021.43398).
30. Zotigh D. Native Perspectives on the 40th Anniversary of the American Indian Religious Freedom Act. *Smithsonian, National Museum of the American Indian*. November 30, 2018. Accessed February 23, 2024. www.smithsonianmag.com/blogs/national-museum-american-indian/2018/11/30/native-perspectives-american-indian-religious-freedom-act/
31. KickingWoman K. Supreme Court Ruling Won't Affect Tribal Colleges, Universities. *The 74*. August 9, 2023. Accessed February 9, 2024. www.the74million.org/article/supreme-court-ruling-wont-affect-tribal-colleges-universities/.
32. American Medical Association. On Some Causes Tending to Promote the Extinction of the Aborigines of America. *The Transactions of the American Medical Association*. 1865;0015(i.000). https://ama.nmtvault.com/jsp/psImageViewer.jsp?doc_id=6863b9b4-a8b5-4ea0-9e63-ca2ed554e876%2Fama_arch%2FAD200001%2F00000015&pg_seq=293.
33. American Medical Association. AMA assembles task force to guide truth, reconciliation, healing. June 9, 2023. Accessed February 8, 2024. www.ama-assn.org/delivering-care/health-equity/ama-assembles-task-force-guide-truth-reconciliation-healing.
34. Association of American Medical Colleges. Reshaping the Journey: American Indians and Alaska Natives in Medicine. October 2018. Accessed February 10, 2024. https://store.aamc.org/downloadable/download/sample/sample_id/243/.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-A-24

Subject: Council on Medical Education Sunset Review of 2014 House of Delegates’ Policies

Presented by: Cynthia Jumper, MD, MPH, Chair

Referred to: Reference Committee C

1 Policy [G-600.110](#), “Sunset Mechanism for AMA Policy,” calls for the decennial review of American
2 Medical Association (AMA) policies to ensure that our AMA’s policy database is current, coherent, and
3 relevant:
4

- 5 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will
6 typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action
7 of our AMA House that reaffirms or amends an existing policy position shall reset the sunset “clock,”
8 making the reaffirmed or amended policy viable for another 10 years.
9
- 10 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following
11 procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are
12 subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the
13 appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies
14 shall develop and submit a report to the House of Delegates identifying policies that are scheduled to
15 sunset; (d) For each policy under review, the reviewing council can recommend one of the following
16 actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the
17 policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy
18 in any fashion, the reviewing council shall provide a succinct, but cogent justification; (f) The
19 Speakers shall determine the best way for the House of Delegates to handle the sunset reports.
20
- 21 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its
22 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been
23 accomplished.
24
- 25 4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset:
26 (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been
27 accomplished; or (c) when the policy or directive is part of an established AMA practice that is
28 transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of
29 Delegates Reference Manual: Procedures, Policies and Practices.
30
- 31 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
32
- 33 6. Sunset policies will be retained in the AMA historical archives.
34

35 See Appendix for a table of 2014 policies and recommended actions.

36 RECOMMENDATION

37

- 1 The Council on Medical Education recommends that the House of Delegates policies listed in the
- 2 appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.
- 3 (Directive to Take Action)

Fiscal Note: \$1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendations
D-275.958	USMLE Step 1 Timing	<p>Our AMA will ask the appropriate stakeholders to track United States Medical Licensing Examination (USMLE) Step 1 Exam timing and subsequently publish aggregate data to determine the significance of advanced clinical experience on Step 1 Exam performance.</p> <p>(Res. 911, I-14)</p>	<p>Sunset - accomplished.</p> <p>After I-14, the Association of American Medical Colleges (AAMC), National Board of Medical Examiners (NBME), and Federation of State Medical Boards (FSMB) were notified of the HOD directive. It was also communicated via the <i>MedEd Update</i> newsletter to each medical school, residency program director, directors of medical education at U.S. teaching hospitals, and other interested groups.</p>
D-275.981	Potential Impact of the USMLE Step 2 CS and COMLEX-PE on Undergraduate and Graduate Medical Education	<p>Our AMA will: (1) continue to closely monitor the USMLE Step 2 CS and the COMLEX-USA Level 2-PE, collecting data on initial and final pass rates, delays in students starting residency training due to scheduling of examinations, economic impact on students, and the potential impact of ethnicity on passing rates; and (2) encourage residency program directors to proactively evaluate their access to resources needed to assist resident physicians who have not passed these examinations to remediate.</p> <p>(CME Rep. 4, A-04; Modified: CME Rep. 2, A-14)</p>	<p>Sunset – no longer relevant.</p> <p>USMLE Step 2 CS and the COMLEX-USA Level 2-PE were discontinued in 2021 and 2022 respectively.</p>
D.275.983	Physicians? Right to Reasonable Privacy Protection and the Federation Credentials Verification Service	<p>Our AMA will request the Federation Credentials Verification Service (FCVS) to (1) add to its "Affidavit and Release" and "Authorization for Release of Records" forms appropriate language that: (a) allows physicians to revoke a prior authorization to the FCVS at any time through an affirmative action on the part of the physician (e.g., written notice) and (b) informs physicians their authorization will remain in effect unless and until revoked by the physician in accordance with guidance provided by the FCVS; and (2) clarify its release does not extend to liability which arises from the gross negligence or willful misconduct of FCVS.</p> <p>(BOT Rep. 22, A-04; Reaffirmed: CMS Rep. 1, A-14)</p>	<p>Retain – still relevant. Amend title to read as follows:</p> <p>Physicians? Right to Reasonable Privacy Protection and the Federation Credentials Verification Service</p> <p>After A-04, the FSMB was notified of this HOD directive.</p> <p>The current FCVS waiver does not contain language contained in the AMA policy. FSMB has shared this AMA policy with their FCVS department and legal staff for review and welcome any AMA language for consideration.</p>

<p>D-275.995</p>	<p>Licensure and Credentialing Issues</p>	<p>Our AMA will: (1) support recognition of the Federation of State Medical Boards' (FSMB) Credentials Verification Service by all licensing jurisdictions; and (2) encourage the National Commission on Quality Assurance (NCQA) and all other organizations to accept the Federation of State Medical Boards' Credentials Verification Service, the Educational Commission for Foreign Medical Graduates' Certification Verification Service, and the AMA Masterfile as primary source verification of credentials. Res. 303, I-00; Reaffirmation A-04; Modified:</p> <p>(CCB/CLRPD Rep. 2, A-14; Reaffirmed: BOT Rep. 3, I-14)</p>	<p>Retain - still relevant. Amend policy with change in title to read as follows:</p> <p>Licensure and Credentialing Issues <u>Primary Source Verification of Credentials</u></p> <p>Our AMA will: (1) supports recognition of the Federation of State Medical Boards' (FSMB) Credentials Verification Service by all licensing jurisdictions; and (2) encourages the National Commission on Quality Assurance (NCQA) and all other organizations to accept recognition of the Federation of State Medical Boards' Credentials Verification Service, the Educational Commission for Foreign Medical Graduates' Certification Verification Service, and the AMA Masterfile as primary source verification of credentials.</p>
<p>D-300.984</p>	<p>Physician Reentry</p>	<p>Our AMA:</p> <ol style="list-style-type: none"> 1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs. 2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice. 3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics. 4. Will support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to PREPs. 5. Will make available to all interested parties the physician reentry program (PREP) system Guiding Principles for use as a basis for all reentry programs: a. Accessible: The PREP system is accessible by geography, time and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is 	<p>Retain – in part. Sunset clauses (2) and (3) as having been accomplished and (6) as no longer relevant. Amend policy to read as follows:</p> <p>Our AMA:</p> <ol style="list-style-type: none"> 1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs. 2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice. 3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics. 4. Will support efforts to ensure the affordability and accessibility and to address the unique liability issues related to PREPs <u>physician reentry programs.</u> 5. Will make available to all interested parties the continue to support physician reentry program (PREP) system these guiding principles for use as a basis for all reentry programs: (a): Accessible: The PREP system is accessible Obtainable by geography, time, and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is commensurate with the assessed clinical and

	<p>commensurate with the assessed clinical and educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions or the health care system. b. Collaborative: The PREP system is designed to be collaborative to improve communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible. c. Comprehensive: The PREP system is comprehensive to maximize program utility. Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice. d. Ethical: The PREP system is based on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statutes. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed. e. Flexible: The PREP system is flexible in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians. f. Modular: Physician reentry programs are modularized, individualized and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need. g. Innovative: Innovation is built into a PREP system allowing programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians. Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation. h.</p>	<p>educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions, or the health care system. (b)- Collaborative: The PREP system is <u>Designed</u> to be collaborative to improve communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible. (c)- Comprehensive: The PREP system is comprehensive <u>Broad</u> to maximize program utility. Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice. (d)- Ethical: The PREP system is <u>Based</u> on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statutes. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed. (e)- Flexible: The PREP system is flexible <u>Pliable</u> in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians. (f)- Modular: Physician reentry programs are modularized, individualized, and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need. (g)- Innovative: Innovation is built into a PREP system allowing <u>Allows</u> programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians. Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation. (h)- Accountable: The PREP system <u>Has</u> mechanisms for assessment and is open to evaluation. Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician's competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of</p>
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<p>D-300.988</p>	<p>Implications of the "Stark II" Regulations for Continuing Medical Education</p>	<p>Our AMA will (1) request that the Centers for Medicare & Medicaid Services develop an explicit exception within the regulations for Section 1877 of the Social Security Act (Stark law) that permits physician compensation without financial limit in the form of continuing medical education that is</p>	<p>Retain – in part. Amend policy to read as follows:</p> <p>Our AMA will (1) request that the Centers for Medicare & Medicaid Services develop an explicit exception within the regulations for Section 1877 of the Social Security Act (Stark law) that permits</p>

		<p>offered for the purpose of ensuring quality patient care; and (2) monitor the impact of the Section 1877 (Stark II) regulations on the ability of health care institutions to provide continuing medical education to their medical staffs.</p> <p>(CME Rep. 6, I-04; Reaffirmed: CME Rep. 2, A-14)</p>	<p>physician compensation without financial limit in the form of continuing medical education that is offered for the purpose of ensuring quality patient care; and (2) monitor the impact of the Section 1877 (Stark II) regulations on the ability of health care institutions to provide continuing medical education to their medical staffs.</p> <p>Sunset clause (1) as having been accomplished. After I-04, Centers for Medicare & Medicaid Services was notified of this HOD directive.</p> <p>Retain clause (2) as there remain situations where health care institutions seek guidance on whether providing certain types of continuing medical education violates section 1877.</p>
D-300.994	Reduced Continuing Medical Education (CME) Fees for Retired Physicians	<p>Our AMA supports reduced registration fees for retired physicians at all continuing medical education (CME) programs and encourages CME providers to consider a reduced fee policy for retired physicians.</p> <p>(Res. 302, I-01; Reaffirmed: CME Rep. 2, A-11; Modified: CME Rep. 2, A-14)</p>	Retain - still relevant.
D-310.967	Resident Pay During Orientation	<p>Our AMA will advocate that all resident and fellow physicians should be compensated, and receive benefits, at a level commensurate with the pay that they will receive while in their training program, for all days spent in required orientation activities prior to the onset of their contractual responsibilities.</p> <p>(Res. 302, A-07; Modified: CCB/CLRPD Rep. 2, A-14)</p>	Retain - still relevant.
D-310.980	Increase in ACGME Fees	<p>Our AMA will work with the Accreditation Council for Graduate Medical Education to limit the increase of the ACGME fees.</p> <p>(Res. 311, A-04; Reaffirmed: CME Rep. 2, A-14)</p>	<p>Sunset – not practical.</p> <p>ACGME has limited increases for many years. It is incumbent on organizations to be able to control their own fees.</p>
D-310.982	Protecting the Privacy of Physician Information Held by the ACGME	<p>Our AMA will request the Accreditation Council for Graduate Medical Education and any other organization with a similar case and procedure log for resident physicians to (1) develop and implement a system to remove or sufficiently protect identifying data from individual physicians? data logs; and (2) adopt a policy not to disseminate any data specific to individual physicians without the written consent of the physician.</p> <p>(Res. 301, A-04; Reaffirmed: CME Rep. 2, A-14)</p>	<p>Sunset – accomplished.</p> <p>After A-04, ACGME was notified of this HOD directive. Records of the correspondence state that “in discussing this issue last week with John Nysten, he assured me this is already ACGME policy.”</p> <p>The ACGME data systems include the Accreditation Data System (ADS), the Case Log System, the Medical School Portal, and ACGME surveys. Public-facing data is available here. The majority of data are available only to individuals with login credentials. Logins are provided to</p>

			<p>designated institutional officials (DIOs), program directors, program coordinators, residents, fellows, and designated medical school users. Users have access to the following systems:</p> <ul style="list-style-type: none"> • Program directors: ADS, including Case Logs for viewing reports. • DIOs: ADS, including Case Logs for viewing reports. • Residents and fellows: Case Logs and ACGME Surveys. • Faculty members: ACGME Surveys • Medical school users: Medical School Portal. • Others: ADS Public.
<p>D-310.992</p>	<p>Limits on Training Opportunities for J-1 Residents</p>	<p>Our AMA will request that the Bureau of Educational and Cultural Affairs, Accreditation Council for Graduate Medical Education (ACGME), American Board of Medical Specialties and the Educational Commission for Foreign Medical Graduates develop criteria by which J-1 exchange visitor physicians could seek extension of the length of their visa beyond the 7-year limit in order to participate in fellowship or subspecialty programs accredited by the ACGME.</p> <p>(Res. 303, A-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmation A-14)</p>	<p>Sunset – accomplished.</p> <p>After A-01, the Bureau of Educational and Cultural Affairs and the Educational Commission for Foreign Medical Graduates were notified of this HOD directive. It was also communicated to each residency program director and directors of medical education at U.S. teaching hospitals via the <i>Medical Education Bulletin</i>.</p> <p>According to ECFMG’s (now a member of Intealth) Exchange Visitor Sponsor Program (EVSP), “any international medical graduate seeking to extend his/her participation in ECFMG-sponsored training beyond seven years must file a formal extension request with the Department of State (DOS) through ECFMG.” In addition to the ECFMG fee and DOS fee, documentation must include: complete application for ECFMG sponsorship, letter of support from applicant’s current and proposed program directors, statement of educational objectives from applicant, and letter of “exceptional need” from the home country government; this letter must be signed by either the home country’s ambassador to the United States or the home country’s minister of health confirming an “exceptional need” for the applicant to be trained in the field of medicine being pursued.</p>
<p>D-373.999</p>	<p>Informed Patient Choice and Shared Decision Making</p>	<p>1. Our AMA will work with state and specialty societies, medical schools, and others as appropriate to educate and communicate to medical students and to physicians about the importance of shared decision-making guidance through publications and other educational methods and assist the medical community in moving towards patient-centered care.</p> <p>(Res. 817, I-08; Modified: Res. 301, A-14)</p>	<p>Retain - still relevant.</p>

<p>D-480.999</p>	<p>State Authority and Flexibility in Medical Licensure for Telemedicine</p>	<p>Our AMA will continue its opposition to a single national federalized system of medical licensure.</p> <p>(CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: BOT Rep. 3, I-14)</p>	<p>Retain - still relevant.</p> <p>This policy is central to Advocacy’s work on telehealth licensure.</p>
<p>G-620.065</p>	<p>Dues Exemption/ Adjustment for Physicians Unable to Attain Residency Training Program</p>	<p>Our AMA urges state societies to offer membership at significantly discounted rates for example, equal to the charge for medical students or residents, to physicians who have graduated from American medical schools or who have successfully completed Educational Commission on Foreign Medical Graduate (ECFMG) and United States Medical Licensing Examination (USMLE) examinations but have been unable to obtain American residency positions.</p> <p>(Res. 611, A-14)</p>	<p>Retain - still relevant.</p>
<p>H-40.977</p>	<p>Pay Equity for Physicians in Active and Reserve Uniformed Services</p>	<p>For reservists called to active duty or on short-term mobilization assignments, the AMA supports the adjustment of pay and allowances upwards to approach pay and allowances for those with similar rank and qualifications in regular and long-term reserve status.</p> <p>(Sub. Res. 233, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, I-04; Reaffirmed: CMS Rep. 1, A-14)</p>	<p>Retain - still relevant.</p>
<p>H-40.983</p>	<p>Active and Reserve Physicians and Physicians-In-Training</p>	<p>(1) Our AMA requests the Residency Review Committees and Specialty Boards to develop flexible policies to ensure that (a) resident physicians and fellows who are members of the active or reserve components of the uniformed services of the United States retain their academic and training status within their respective training programs during periods of reserve activation or active duty with the uniformed services; and (b) active duty or deployment time with the uniformed services during a residency or fellowship should be credited toward the usual training period for eligibility for matriculation and Board examinations when the trainee's experiences have been educationally appropriate.</p> <p>(2) Our AMA strongly encourages state licensing boards to waive requirements for continuing medical education credits for</p>	<p>Retain – still relevant.</p> <p>ACGME works closely with the Department of Defense around issues with deployment of both residents and faculty. The institutional review group is revising their requirements, which will likely be released in fall 2024 with an open comment period.</p>

		<p>physicians during periods of reserve or national guard activation or active duty with the uniformed services.</p> <p>(3) Our AMA supports the position that, at the time of national emergency, residents and fellows called to support their country in military service should be placed, when possible, in positions consistent with their specialty and level of training.</p> <p>(Res. 187, I-90; Modified: Sunset Report, I-00; Reaffirmed: CME Rep. 2, I-04; Modified: CME Rep. 2, A-14)</p>	
H-95.943	MDs/DOs as Medical Review Officers	<p>Our AMA: (1) reaffirms its policy that only licensed MDs/DOs with knowledge of substance use disorders should serve as Medical Review Officers (MROs); (2) reaffirms its policy that all MDs/DOs who serve as MROs should obtain continuing medical education credit in this subject area; (3) vigorously advocates that any legislation concerning drug testing in the workplace include a provision for a Medical Review Officer (MRO) who will review all positive test results and further that only a licensed physician may serve as the MRO and further that this physician MRO has knowledge of substance abuse disorders and has appropriate medical training to interpret and evaluate an individual's positive test results together with his or her medical history and any other relevant biomedical information ; and (4) vigorously opposes legislation that is inconsistent with these policies.</p> <p>(CCB/CLRPD Rep. 3, A-14)</p>	<p>Retain – still relevant. Amend policy to read as follows:</p> <p>Our AMA: (1) reaffirms its policy <u>affirms</u> that only licensed MDs/DOs with knowledge of substance use disorders should serve as Medical Review Officers (MROs); (2) reaffirms its policy <u>affirms</u> that all MDs/DOs who serve as MROs should obtain continuing medical education credit in this subject area; (3) vigorously advocates <u>affirms</u> that any legislation concerning drug testing in the workplace include a provision for a Medical Review Officer (MRO) who will review all positive test results and further that only a licensed physician may serve as the MRO and further that this physician MRO has knowledge of substance abuse disorders and has appropriate medical training to interpret and evaluate an individual's positive test results together with their medical history and any other relevant biomedical information-; and (4) vigorously opposes legislation that is inconsistent with these policies.</p> <p>Clauses (1) and (2) are consistent with ACOEM's MRO training. Language in clause (3) is redundant.</p>
H-275.929	Additions to United States Medical Licensure Examination and Comprehensive Osteopathic Medical Licensure Examination	<p>Our AMA opposes additions to the United States Medical Licensing Examination and Comprehensive Osteopathic Medical Licensure Examination that lack predictive validity for future performance as a physician.</p> <p>(Res. 308, A-04; Reaffirmed: CME Rep. 2, A-14)</p>	<p>Retain - still relevant. Amend policy with change in title to read as follows:</p> <p><u>Oppose Additions to United States Medical Licensure Examination and Comprehensive Osteopathic Medical Licensure Examination</u></p>
H-275.930	Opposition to Clinical Skills Examinations	<p>Our AMA: (1) opposes clinical skills examinations for the purpose of physician medical relicensure; (2) reaffirms its</p>	<p>Retain- in part. Amend policy to read as follows:</p>

	<p>for Physician Medical Relicensure</p>	<p>support for continuous quality improvement of practicing physicians, and supports research into methods to improve clinical practice, including practice guidelines; and (3) continues to support the implementation of quality improvement through local professional, non-governmental oversight.</p> <p>(Res. 307, A-04; Reaffirmed: CME Rep. 2, A-14)</p>	<p>Our AMA: (1) opposes clinical skills examinations for the purpose of physician medical relicensure; and (2) reaffirms its supports for continuous quality improvement of practicing physicians, and supports; research into methods to improve clinical practice, including practice guidelines; and (3) continues to supports the implementation of quality improvement through local professional, non-governmental oversight.</p> <p>Retain clause (1) as still relevant.</p> <p>Sunset clause (2) which is addressed in policies H-450.970, H-450.965, and D-478.984.</p> <p>Retain clause (3) and append to H-450.970 where it better aligns with the content and title.</p>
<p>H-275.945</p>	<p>Self-Incriminating Questions on Applications for Licensure and Specialty Boards</p>	<p>The AMA will:</p> <p>(1) encourage the Federation of State Medical Boards and its constituent members to develop uniform definitions and nomenclature for use in licensing and disciplinary proceedings to better facilitate the sharing of information;</p> <p>(2) seek clarification of the application of the Americans with Disabilities Act to the actions of medical licensing and medical specialty boards; and</p> <p>(3) until the applicability and scope of the Americans with Disabilities Act are clarified, will encourage the American Board of Medical Specialties and the Federation of State Medical Boards and their constituent members to advise physicians of the rationale behind inquiries on mental illness, substance abuse or physical disabilities in materials used in the licensure, reregistration, and certification processes when such questions are asked.</p> <p>(BOT Rep. 13, I-93; Reaffirmed: CME Rep. 10-I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)</p>	<p>Sunset – accomplished.</p> <p>Sunset clause (1) as having been accomplished. FSMB Physician Data Center (PDC) and Disciplinary Alert Service (DAS) foster the appropriate sharing of information and uniformity of definitions and nomenclature.</p> <p>Sunset clause (2) as having been accomplished. FSMB adopted policy Physician Wellness and Burnout (2018) that addresses the ADA related to licensing.</p> <p>Sunset clause (3), as it is addressed in policy H-275.970.</p>
<p>H-275.973</p>	<p>State Control of Qualifications for Medical Licensure</p>	<p>(1) The AMA firmly opposes the imposition of federally mandated restrictions on the ability of individual states to determine the qualifications of physician candidates for licensure by endorsement. (2) The AMA actively opposes the enactment of any legislation introduced in Congress that promotes these objectives.</p> <p>(Res. 84, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07; Reaffirmed: BOT Rep. 3, I-14)</p>	<p>Retain - still relevant. Amend policy with change in title to read as follows:</p> <p><u>Support</u> State Control of Qualifications for Medical Licensure</p>

<p>H-275.977</p>	<p>Verifying Physicians' Credentials</p>	<p>The AMA endorses the use of pluralistic approaches to the verification and validation of physicians' credentials. The AMA will seek legislation that managed care companies be required to request credentialing information in a uniform standardized format which all groups involved in credentialing would accept.</p> <p>(Sub. Res. 91, A-87; Amended by Res. 736, A-97; Reaffirmed: Sunset Report, I-97; Reaffirmed: CME Rep. 2, A-07; Reaffirmed: BOT Rep. 3, I-14)</p>	<p>Sunset – duplicative.</p> <p>Sunset the first sentence as superseded by policy D-275.995 that supports primary source verification of credentials via the AMA Masterfile, FSMB's Federation Credentials Verification Service, and the Educational Commission for Foreign Medical Graduates' Certification Verification Service.</p> <p>Sunset the second sentence, which is already addressed by policy H-285.979.</p>
<p>H-275.988</p>	<p>Identifying Persons with Illegally Obtained Medical Degrees</p>	<p>The AMA supports appropriate efforts of private and governmental agencies in identification of persons possessing illegally obtained medical degrees.</p> <p>(Res. 43, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)</p>	<p>Retain- still relevant.</p>
<p>H-275.996</p>	<p>Physician Competence</p>	<p>Our AMA:</p> <p>(1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence;</p> <p>(2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board certification as evidence of continuing competence for the purpose of re-registration of licensure; and</p> <p>(3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base.</p> <p>(CME Rep. J, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 7, A-02; Reaffirmed: CME Rep. 7, A-07; Reaffirmed: CME Rep. 16, A-09; Reaffirmed in lieu of Res. 302, A-10; Reaffirmed in lieu of Res. 320, A-14)</p>	<p>Sunset – accomplished.</p> <p>Sunset clause (1) as having been accomplished. According to the ABMS, “member board certification is a voluntary specialty credential that indicates a physician or medical specialist’s proficiency in a particular specialty area of medicine.”</p> <p>Sunset clause (2) as having been accomplished, given the FSMB was notified of this policy after A-80. In 2012, the FSMB House of Delegates adopted a policy that states “The Federation of State Medical Boards (FSMB) supports the use of, and encourages state boards to recognize, a licensee’s participation in an ABMS MOC and/or AOA BOS OCC program as an acceptable means of meeting CME requirements for license renewal.” FSMB is aware of a small but growing number of state medical boards that accept participation in continuing certification as evidence of substantive compliance with CME requirements.</p> <p>Sunset clause (3) as duplicative. Addressed in AMA policy Support for Continuing Medical Education H-300.958.</p>
<p>H-295.863</p>	<p>Impairment Prevention and Treatment in the Training Years</p>	<p>Our AMA: (1) reaffirms the importance of preventing and treating psychiatric illness, alcoholism and substance abuse in medical students, residents and fellows; (2) strongly encourages medical schools and teaching</p>	<p>Retain - still relevant. Amend policy to read as follows:</p> <p>Our AMA: (1) reaffirms the importance of preventing and treating psychiatric illness,</p>

		<p>hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents and fellows; (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse; (4) advocates (a) further study (and continued monitoring of other studies) concerning the problem of substance abuse among students, residents, and faculty in U.S. medical schools, and (b) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians.</p> <p>(CCB/CLRPD Rep. 3, A-14)</p>	<p>alcoholism, and substance abuse use in medical students, residents, and fellows; (2) strongly encourages medical schools and teaching hospitals to develop and maintain impairment prevention and treatment programs with confidential services for medical students, residents, and fellows; (3) urges medical schools, hospitals with graduate medical education programs, and state and county medical societies to initiate active liaison with local impaired physician committees in order to more effectively diagnose and treat medical student and resident substance abuse use; (4) advocates (a) further study (and continued monitoring of other studies) concerning the problem of substance abuse use among students, residents, and faculty in U.S. medical schools, and (b) development of model policy and programmatic guidelines which might assist in the establishment of programs for medical students, residents, and faculty and which could significantly impact this problem and potentially reduce the risk of future impairment among physicians.</p> <p>Change from “abuse to “use” in keeping with policy Destigmatizing the Language of Addiction H-95.917.</p>
H-295.880	Service Learning in Medical Education	<p>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.</p> <p>(Res. 321, A-04; Reaffirmed: CME Rep. 2, A-14)</p>	Retain - still relevant.
H-295.929	Faculty/Staff Appointments at More Than One Medical School	<p>The AMA encourages medical schools that currently do not permit volunteer faculty members to hold appointments at more than one medical school to review this policy, to ensure that it is in the best interests of medical education and program integrity. Nonsalaried faculty members of medical schools should be allowed to hold concurrent appointments at more than one medical school as long as the individual physician agrees to carry out all responsibilities assigned by each medical school.</p> <p>(CME Rep. 3, I-93; Reaffirmed: CME Rep. 2, A-05; Modified: CME Rep. 2, A-14)</p>	Retain - still relevant.
H-295.983	Extramural Clerkships and	<p>The AMA (1) recognizes the essential role of the medical school faculty in the</p>	Retain - still relevant.

	Early Career Decisions	determination of the core clinical education of medical students; and (2) opposes resident recruitment practices which would interfere with scheduled core clinical clerkships at the student's medical school. (Res. 77, I-84; CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)	
H-295.985	Humanism in Graduate Medical Education	The AMA encourages medical schools and teaching hospitals to strengthen educational programs for undergraduates and resident physicians in recognizing and meeting the emotional needs of patients and their families. (Sub. Res. 154, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)	Retain - still relevant.
H-305.950	Fairness in Publication of Names of Loan Defaulters	The AMA opposes the selective publication of names of defaulters on federally funded student loans. (Res. 309, A-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME Rep. 2, A-14)	Retain - still relevant.
H-310.990	Shared Residency Positions	The AMA supports the concept of shared residency positions and the continued collection and publication of data on these positions, and encourages residency program directors to offer such positions where feasible. (Res. 81, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Modified: CME Rep. 2, A-14)	Retain – still relevant. Amend policy to read as follows: The AMA supports the concept of shared residency positions and the continued collection and publication of data on these positions, and encourages residency program directors to offer such positions where feasible.
H-355.977	Reporting of Resident Physicians to the National Practitioner Data Bank	1. Our AMA: (A) seeks opportunities to limit reports concerning residents to the National Practitioner Data Bank to only those situations where a final adverse action has been taken by a medical licensing jurisdiction; (B) opposes attempts to extend reports concerning residents to the National Practitioner Data Bank beyond those covered in Item 1 of this policy; and (C) advocates for legislation amending, as appropriate, the NPDB reporting requirements regarding resident physicians to be consistent with this policy, and opposes the expansion of existing reporting requirements. (CCB/CLRPD Rep. 3, A-14)	Retain - still relevant. Amend policy to read as follows: 1. Our AMA: (A) seeks opportunities to support <u>the limiting of</u> reports concerning residents to the National Practitioner Data Bank to only those situations where a final adverse action has been taken by a medical licensing jurisdiction; and (B) opposes attempts to extend reports concerning residents to the National Practitioner Data Bank beyond those covered in Item 1 of this policy; and (C) advocates for legislation amending, as appropriate, the NPDB reporting requirements regarding resident physicians to be consistent with this policy, and opposes the expansion of existing reporting requirements.

REPORT 2 OF THE COUNCIL ON MEDICAL EDUCATION (A-24)
The Current Match Process and Alternatives (Resolution 302-A-23)

EXECUTIVE SUMMARY

This report was written in response to Resolution 302, brought forth by the Resident and Fellow Section at the 2023 Annual Meeting of the House of Delegates. This resolution was referred for study. Now AMA Policy [D-310.944](#), it asks that that the American Medical Association “study alternatives to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants.”

This report summarizes the history of The Match[®] and time before The Match, differentiates between the application process versus The Match, explains aspects of The Match process as well as independent match processes, and offers perspective from the National Resident Matching Program[®] (NRMP[®]). The Council on Medical Education understands the concerns presented by the authors of Resolution 302-A-23 and their frustrations related to lack of control over their own destinies. This report illuminates the importance of ongoing communication and transparency by the NRMP as well as collaboration among all invested parties. Further, this report makes clear that there are no currently identified alternatives other than an unstructured, open market approach, which the Council believes would be detrimental to the majority of trainees in comparison to the current Match process. Thus, attention should be focused on what can be done to improve The Match and other specialty matches rather than focusing on its replacement, as a match process continues to be the best solution for trainees at this time.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 02-A-24

Subject: The Current Match Process and Alternatives (Resolution 302-A-23)

Presented by: Cynthia Jumper, MD, MPH, Chair

Referred to: Reference Committee C

1 INTRODUCTION

2
3 At the 2023 Annual Meeting of the House of Delegates, Resolution 302-A-23 entitled “Antitrust
4 Legislation Regarding the AAMC, ACGME, NRMP and Other Relevant Associations or
5 Organizations” asked “that our American Medical Association study alternatives to the current
6 residency and fellowship Match process which would be less restrictive on free market competition
7 for applicants.” The Resident and Fellow Section (RFS), authors of the resolution, noted concerns
8 related to preservation of the process of free market competition, antitrust laws, and The Match®.
9 Their resolution stated, “The Match poses significant anticompetition concerns and the
10 procompetitive effect of streamlining residency job applications and increasing percentage of
11 position filled needs to be outweighed by the anticompetitive effect of the lack of negotiation
12 power of residents.”¹

13
14 The resolution, now American Medical Association (AMA) Policy [D-310.944](#), was referred for
15 study. This report seeks to address this directive by providing historical context, differentiating
16 between the application process versus The Match, explaining aspects of The Match process as
17 well as independent match processes, and offering perspective from the National Resident
18 Matching Program® (NRMP®). It seeks to illuminate what can be done within the confines of The
19 Match to make it better and clarify that there are no currently identified “alternatives” other than
20 the free market approach. To provide context, The Match is defined by the NRMP as “a
21 computerized mathematical algorithm, ‘the matching algorithm,’ to place applicants into the most
22 preferred residency and fellowship positions at programs that also prefer them.”² It is intended to
23 favor the rank list of the applicant.

24 25 BACKGROUND

26 27 *History of The Match*

28
29 The trainee internship experience began in the late 1800s and was formalized shortly thereafter.
30 Such positions began to outnumber the students available. “In the early 1900s, competition among
31 hospitals for interns and among medical students for good internships led to increasingly early
32 offers of internships to students. By the 1940s, appointments were often made as early as the
33 beginning of the junior year of medical school. ...From 1945 through 1951, efforts were made to
34 enforce a uniform date for accepting offers. However, students were still faced with offers having
35 very short deadlines, compelling them to accept or reject offers without knowing what other offers
36 might be forthcoming.”³ Such challenges led to the creation of a centralized clearinghouse to allow
37 for students to benefit from uniform appointment dates while reducing congestion and pressure.

1 The clearinghouse was created by the National Interassociation Committee on Internships, who
2 later changed its name to the National Intern Matching Program (NIMP). It included national
3 organizations such as the AMA (Council on Medical Education), American Hospital Association,
4 Association of American Medical Colleges (AAMC) and federal hospitals involved in resident
5 training.⁴ Dissatisfaction among students led to proposals of algorithms that were felt to be more
6 equitable.

7
8 The NIMP was established as a 501c(3) and operated through the 1960s. In 1966, the [Millis](#)
9 [Commission Report](#), authorized by the AMA Council on Medical Education, examined medical
10 education in the U.S., particularly the length and quality of graduate medical education. It
11 supported a broader move to integrated residency training.⁵ The NIMP became the NIRMP in
12 1968. The organization, in 1972, revised its participation requirements such that The Match
13 expanded to include all first-year resident positions and required all institutions participating in The
14 Match to select U.S. senior students in allopathic medical schools through it. By 1975, the NIRMP
15 had become the NRMP.

16
17 The NRMP oversees The Match, which is the mathematical algorithm to match applicants and
18 programs to their most preferred ranked choices. In 2012, researchers Lloyd Shapley and Alvin
19 Roth won the Nobel Prize in Economics for developing the “theory of stable allocations and the
20 practice of market design” which led to the development of the algorithm used for The Match.
21 They “pioneered theoretical concepts to understand and solve the matching problem and clarified
22 those ideas and applied them to engineer algorithms that are now widely used in the real world.”⁶
23 The current algorithm has been used since 1998. The Match continues to be updated to address the
24 changing needs of applicants and to yield a favorable match while producing a stable outcome.

25
26 In the past, osteopathic medical students could also participate in the [American Osteopathic](#)
27 [Association](#) (AOA) national match process through the [National Matching Services](#) (NMS).
28 Starting in July 2015, the AOA and the Accreditation Council for Graduate Medical Education
29 (ACGME) began a transition to a single accreditation system (SAS) to combine the AOA and
30 NRMP match programs. Between 2015 and 2020, AOA programs applied for accreditation to the
31 ACGME, and if granted, these programs could take residents through the NRMP match. By 2020,
32 most AOA programs had transitioned to the SAS or had withdrawn and were no longer taking new
33 residents but were allowed to complete the training of the residents remaining in their programs
34 under AOA accreditation until the last resident finished. The intent of the SAS was to foster
35 inclusion for osteopathic medical students as well as residents at former AOA programs. Data from
36 2020-2023 indicates that Doctor of Osteopathic Medicine (DO) applicants have an increased match
37 rate from 90.7% to 91.6%, which also correlates with the opening of more DO schools.⁷

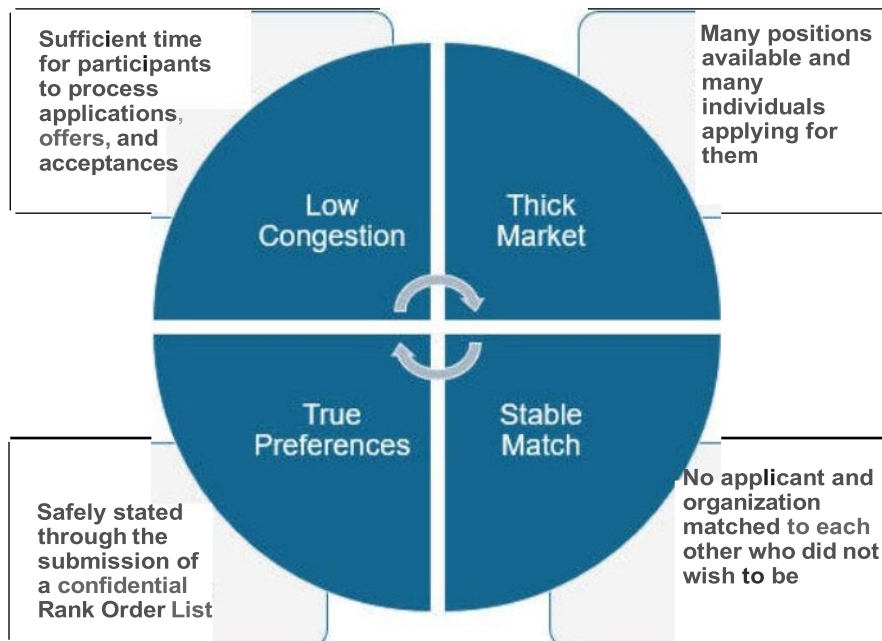
38 39 *The Match process*

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41 The intention of The Match is to make the best possible match for all participants and ensure the
42 uniform process is fair, efficient, transparent, and reliable. Referred to as the Main Residency
43 Match, it is part of a larger undertaking that begins with applying to and interviewing with training
44 programs. Most applicants use the [Electronic Residency Application Service](#)[®] (ERAS[®]), a product
45 of the AAMC, to apply to programs per their chosen specialty. This centralized online application
46 service delivers applications and supporting documents to residency programs. Next, applicants
47 register for The Match in the NRMP’s [Registration, Ranking, and Results](#)[®] (R3[®]) system.
48 Applicants are invited to interview per the criteria set by each program. Both applicants and
49 programs submit their rank order preferences in the R3 system by a predetermined deadline,
50 usually in early March. The NRMP runs their matching [algorithm](#) according to the preferences
51 submitted and all parties are notified of the results later that month. Matched applicants and

1 programs enter into an agreement. Unmatched applicants and programs may elect to participate in
 2 the NRMP’s [Supplemental Offer and Acceptance Program](#) (SOAP) during Match Week. See
 3 Appendix A for an infographic of this process. The NRMP website provides [data](#) on the Main
 4 Residency Match (including 2023) as well as research reports, survey reports, and research briefs.

5
 6 The NRMP’s [Main Residency All In Policy](#) asserts that if a program is registering for the Main
 7 Residency Match®, then they must register and attempt to fill all positions through the Match (or
 8 another national matching plan).⁸ This policy only applies to those positions a program wishes to
 9 fill. Programs planning to participate in The Match cannot offer positions outside The Match. If
 10 that were to happen prior to program registration and activation, then the program is ineligible to
 11 enroll in The Match (unless the NRMP grants an exception). Per the [Fellowship Match All In](#)
 12 [Policy, Specialties Matching Service®](#) (SMS®) Match sponsors may *voluntarily* implement the All
 13 In Policy for their fellowship matches. AMA Policy [D-310.977\(6\)](#) “does not support the current
 14 ‘All-In’ policy for the Main Residency Match to the extent that it eliminates flexibility within the
 15 match process.”⁹

16
 17 In its current form, the NRMP contends that The Match process is uncongested, defers acceptance,
 18 promotes true preferences, and establishes a thick market “which allows for multi-specialty
 19 applications and couple matching (including for mixed-specialty couples).”¹⁰ It is built upon the
 20 following core components:



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 42 [Principles of Market Design](#). Copyright National Resident Matching Program. Reprinted with permission.

43
 44 *Independent match processes*

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 46 According to the NRMP, “U.S. medical school graduates and students and graduates of
 47 international medical schools can be offered positions outside of the Main Residency Match
 48 provided it is in a program that does not participate in the Match and thus not subject to the All In
 49 Policy. No applicant can accept a position outside of the Match after the Rank Order List
 50 Certification Deadline.”¹¹ Some programs choose to participate in an early match process, and the
 51 percentage of outside-the-match offers varies by specialty.¹² Not all are affiliated with the NRMP.

1 For example, students in the Health Professions Scholarship Program and the Uniformed Services
 2 University of the Health Sciences who wish to apply for military PGY-1 positions go through a
 3 similar process overseen by the Joint Service Graduate Medical Education Selection Board. While
 4 they still use the ERAS system, military medical students complete a different application that
 5 includes ranking programs. Deadlines also differ, as materials are submitted late August through
 6 mid-October, and results are announced in mid-December. The military does not use a computer-
 7 generated algorithm, rather it is a process of discussions and negotiations. An applicant can be
 8 placed in a program that they did not even rank.¹³ Other examples include:

- 9
- 10 • Preventive Medicine and Public Health: First implemented in 2017, the American College
 11 of Preventive Medicine (ACPM) oversees their own match called the [Residency](#)
 12 [Standardized Acceptance Process](#) (SAP).¹⁴
- 13
- 14 • Plastic Surgery and Ophthalmology: The San Francisco Residency Match, more commonly
 15 referred to as [SF Match](#), is a residency and fellowship matching service that has been used
 16 by several specialties and subspecialties for over 40 years. It includes residencies in plastic
 17 surgery and ophthalmology, overseen by the American Council of Academic Plastic
 18 Surgeons and Association of University Professors of Ophthalmology respectively. It also
 19 currently includes 25 fellowship matches, ranging from abdominal transplant surgery to
 20 rhinology.
- 21
- 22 • Urology: For over 30 years, the American Urological Association, in conjunction with the
 23 Society of Academic Urologists, has overseen the [Urology Residency Match Program](#).
- 24
- 25 • Neuromuscular medicine: Starting in 2020, the American Association of Neuromuscular &
 26 Electrodiagnostic Medicine started its own standardized match process called the
 27 Neuromuscular Fellowship Application Portal that uses an online hub through which
 28 residents submit application materials, communicate with programs, and receive offers.¹⁵
 29 The first cycle hosted a partial match process, whereby programs submitted rank lists but
 30 applicants did not rank programs. The following cycle was a full match process.¹⁵

31

32 DISCUSSION

33

34 *Before The Match and other match processes*

35

36 The time before The Match and other match processes presented real challenges, added stress to
 37 the residency application process, and fueled unequal treatment. One reflection written about the
 38 time before The Match noted, “Medical students and hospitals once negotiated directly with each
 39 other. Competition for talent was fierce amid a tight labor market, with residency programs
 40 extending offers to medical students up to two years before graduation. This process had significant
 41 downsides: Students had to deal with exploding offers and felt pressure to commit to a program
 42 before getting sufficient exposure to different medical specialties. Medical students, residents, and
 43 hospitals all backed reform.”¹⁶ While The Match offered solutions to those who experienced life
 44 before it, a new generation of residency applicants has questioned its efficacy.

45

46 *Perceived challenges faced by residency applicants*

47

48 As summarized in the introduction, the RFS, as authors of the original resolution, noted concerns
 49 about lack of negotiation power of residents. Consternations were also raised regarding the
 50 possibility of residency/fellowship out-of-match offers being better than those in The Match;

1 however, there is no data to support this notion. Discussions of these concerns among trainees are
2 evident on social media platforms and the internet. For example, [The Student Doctor Network](#), “a
3 non-profit educational website dedicated to building a diverse doctor workforce,” has hosted
4 forums that debate this very issue.¹⁶ In a 2021 forum called “What are the alternatives to the
5 Match? What do you think would happen if it were abolished?”, trainees raised several points for
6 consideration. They shared that it is within the realm of possibility that programs would have zero
7 incentive to increase wages to be more competitive if The Match went away. Without The Match
8 or some unified system of application, programs could try to fill their spots earlier and such timing
9 may not align with the applicant’s desired specialty training. In the non-physician job market, a
10 candidate often has to make a decision about accepting a position without knowing the full extent
11 of the employment details.¹⁷ The NRMP and other matches are not involved in any negotiations or
12 agreements between programs and applicants, and if what a program is willing to offer to an
13 applicant is unacceptable to the applicant, the applicant can simply not include that program in
14 their rank list.

15 *The impact of The Match on competition for residency positions*

16 Another concern raised by the RFS is alleged lack of competition. In 1890, Congress passed The
17 Sherman Act, the first antitrust law, followed in 1914 by two additional antitrust laws—the Federal
18 Trade Commission Act (which formed the FTC) and the Clayton Act. Challenges to The Match
19 were brought forth in a class-action lawsuit in 2002, alleging The Match as violating the Sherman
20 Antitrust Act as described in the [AMA Journal of Ethics](#).¹⁸ However, [U.S. Code 37b](#) was passed
21 into law in 2004, entitled “Confirmation of antitrust status of graduate medical resident matching
22 programs,” to “confirm that the antitrust laws do not prohibit sponsoring, conducting, or
23 participating in a graduate medical education residency matching program, or agreeing to do so;
24 and ensure that those who sponsor, conduct or participate in such matching programs are not
25 subjected to the burden and expense of defending against litigation that challenges such matching
26 programs under the antitrust laws.”¹⁹

27 Concern was also raised about The Match possibly having a negative impact on resident salaries. A
28 2006 economic study by [Bulow and Levin](#) is frequently cited to support this claim²⁰. However,
29 Bulow and Levin also noted that The Match “was developed for efficiency reasons, and on that
30 score, it appears to do quite well.”²⁰ Research published since the Bulow-Levin paper does not
31 support their conclusions. Agarwal noted that “The Match is not the likely cause of low salaries.”²¹
32 According to Konishi & Sapozhnikov, “competitive salary vector is the best-case scenario for
33 applicants in the decentralized market. [... T]he reference salary vector adopted by Bulow and
34 Levin (2006) for the decentralized market outcome might not have a strong justification and could
35 be regarded as rather optimistic.”²² Also, it is important to consider that most resident salaries are
36 funded by clinical revenues from the sponsoring institution and federal government sources,
37 particularly Medicare graduate medical education funds from a budget set by Congress. Since
38 clinical revenue and institutional funding can vary by specialty and setting, disparities in pay may
39 result, even across residency programs at the same institution unfortunately.

40 Resolution 308 implied that a free-market approach may be more beneficial for trainees. As
41 described earlier in this report regarding the history of The Match and the era before its
42 implementation, the free market posed many problems. Returning to such a process would not
43 likely improve the challenges experienced previously. Economists agree that a free-market
44 approach is not without flaws.^{23,24} For example, “Apart from agriculture, few real-world markets
45 are perfectly competitive.”²⁵ Roth asserts that a centralized matching system can improve the
46 welfare of all participants in that market and, depending on its design, can address the problems of
47 unraveling and the congestion.²⁶ It seems that further analysis of what works well and what does
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1 not work well is warranted in order to improve The Match process. As described in this report, the
2 NRMP and others are committed to continued review and improvement.

3
4 The Council on Medical Education recently addressed mechanisms to advocate for the needs of
5 residents in its report, “Organizations to Represent the Interests of Resident and Fellow Trainees”
6 ([CME 5-I-23](#)), which was adopted at the Interim 2023 Meeting. It also reviewed duty hour
7 standards; work conditions; the impact of private equity; and the roles of government agencies,
8 accreditors, medical staff organizations, associations, and unions. The adoption of that report
9 signifies renewed efforts to advocate for the interests of trainees.

10 *Coalition for Physician Accountability recommendations*

11
12
13 The [Coalition for Physician Accountability](#) (CPA) is comprised of representatives from national
14 organizations (including the AMA) responsible for the oversight, education, and assessment of
15 medical students and physicians throughout their medical careers. In April 2021, the CPA’s
16 Undergraduate Medical Education-Graduate Medical Education Review Committee (UGRC)
17 released 28 recommendations for comprehensive improvement of the UME-GME transition. The
18 UGRC was comprised of several workgroups, one of which focused on the mechanics of the
19 application/selection process from the graduate medical education perspective. The final
20 recommendations were categorized according to themes and refer to the residency application
21 process as well as The Match and other matching processes. Two themes of note address an
22 equitable, mission-driven application review (Recommendations #14-20) as well as optimization of
23 the application, interview, and selection processes (Recommendations #21-24). Specifically,
24 Recommendation #23 states that “Innovations to the residency application process should be
25 piloted to reduce application numbers and concentrate applicants at programs where mutual interest
26 is high, while maximizing applicant placement into residency positions. Well-designed pilots
27 should receive all available support from the medical community and be implemented as soon as
28 the 2022-2023 application cycle; successful pilots should be expanded expeditiously toward a
29 unified process.”²⁷

30 *Recent NRMP proposals*

31
32
33 The NRMP maintains that it is committed to considering ways to inform the transition to residency
34 or improve the matching process. In 2021, the NRMP issued a statement on the feasibility of an
35 early match. Specifically, NRMP was asked to pilot the Early Result and Acceptance Program
36 (ERAP) proposed for obstetrics and gynecology. This pilot program was created through a grant
37 provided by the AMA’s Reimagining Residency program. The NRMP concluded that an early
38 match would disadvantage applicants, and that changes to the process could potentially cause
39 behavior changes that could negatively affect outcomes for all participants.¹⁰

40
41 To consider the feasibility of a proposed Two-Phase Main Residency Match (that would replace
42 The Match and SOAP), the NRMP Board of Directors opened a call for comment period in
43 August-September 2022. The goal was to “alleviate some of the stressors inherent in the current
44 transition to residency based on available evidence.”²⁸ After considering the over 8,000 responses
45 to the call, the NRMP Board of Directors decided to not pursue the proposal as written, stating that
46 “Although the benefits/advantages articulated by the community are significant, the
47 risks/disadvantages are considered of greater consequence.”²⁹ The AAMC hosted several listening
48 sessions with their constituency to discuss this two-phase proposal and issued a statement
49 concluding that a long-term evaluation plan would be needed with a focus on “learners and
50 equity.”³⁰ The AAMC also noted that ERAS would still play a role in a two-phase match and
51 recommended further discussions.

1 AMA ENGAGEMENT
2

3 The AMA has been actively engaged in monitoring this process, is in regular communication with
4 the NRMP, and actively participates in the CPA. The AMA Medical Student Section (MSS) and
5 RFS each offer to their members the opportunity to apply to represent the AMA on the [NRMP](#)
6 [Board](#). Both AMA sections have solicited for or nominated members every year for at least the last
7 ten years. The NRMP board offers three seats for student directors and three seats for resident
8 physician directors. The NRMP no longer has designated AMA seats for students or residents due
9 to a change in their [bylaws](#) in 2017. To promote effective communication, fostering relationships
10 among key parties is vital. The AMA will continue to look for opportunities to collaborate with the
11 NRMP and other matching organizations.

12
13 Through the AMA's [ChangeMedEd](#) initiative, efforts are underway across the continuum with
14 visionary partners to create bold innovations. Specifically, [Reimagining Residency](#) is a grant
15 program dedicated to promoting systemic change in graduate medical education (GME). "It
16 supports bold and innovative projects that provide a meaningful and safe transition from
17 undergraduate medical education to graduate medical education."³¹ Several Reimagining Residency
18 projects directly address the transition from undergraduate medical education (UME) to GME.
19 "Right Resident, Right Program, Ready Day One," a collaboration with the Association of
20 Professors of Gynecology & Obstetrics (APGO), raises cross-specialty standards for the residency
21 application and interview process. It promotes signaling to reduce the number of applications
22 submitted by formalizing communication about true preferences. APGO has also developed an
23 Alignment Check Index (ACI). This adjunct to AMA's FREIDA platform seeks to better align
24 applicant preferences and characteristics with those being sought by specific residency programs. A
25 project at New York University (NYU), called the "Transition to Residency Advantage," builds on
26 experience with UME coaching to train a cadre of GME coaches and then effect a learner-driven
27 warm handoff from UME to GME. Two additional projects, the "California Oregon Medical
28 Partnership to Address Rural Disparities in Rural Education and Health" (COMPADRE) and the
29 University of North Carolina's "Fully Integrated Readiness for Service Training" (FIRST) are
30 creating pathways to rural practice that entail dedicated pathways from medical school to residency
31 that meet the needs of those areas. Also, the AMA helps to inform future GME advocacy by
32 addressing concerns regarding the challenges faced by the current GME system. A 2023
33 [compendium](#) of such GME advocacy initiatives is available for review.

34
35 *Council on Medical Education efforts*
36

37 Since 2012, the Council on Medical Education has offered several reports that address residency
38 and The Match as listed below. Additional Council reports can be accessed in the [AMA Council](#)
39 [Report Finder](#) database.

- 40 • [Organizations to Represent the Interests of Resident and Fellow Trainees" \(CME 5-I-23\)](#)
- 41 • [Optimizing Match Outcomes \(CME Report 3-A-21\)](#)
- 42 • [Standardizing the Residency Match System and Timeline \(CME Report 3-A-19\)](#)
- 43 • [The Transition from Undergraduate Medical Education to Graduate Medical Education](#)
44 [\(CME Report 5-I-19\)](#)
- 45 • [Options for Unmatched Medical Students \(CME Report 5-A-17\)](#)
- 46 • [Standardizing the Allopathic Residency Match System and Timeline \(CME Report 6-A-](#)
47 [17\)](#)
- 48 • [Resident and Fellow Compensation and Health Care System Value \(CME Report 4-A-16\)](#)
- 49 • [Transparency in the National Resident Matching Program Match Agreement \(CME Report](#)
50 [12-A-12\)](#)

1 *Relevant AMA Policy*

2
3 The AMA has ample policy in support of trainees that address such topics as The Match, other
4 match processes, residency application process, and graduate medical education. These policies
5 exemplify the AMA’s commitment to closely monitor these issues and engage with the NRMP and
6 others to optimize successful, equitable matching. See Appendix B for the following full policies:

- 7 • [Study of the Current Match Process and Alternatives D-310.944](#)
- 8 • [Residents and Fellows’ Bill of Rights H-310.912](#)
- 9 • [Preliminary Year Program Placement H-310.910](#)
- 10 • [Closing of Residency Programs H-310.943](#)
- 11 • [Protection of Resident and Fellow Training in the Case of Hospital or Training Program](#)
12 [Closure D-310.948](#)
- 13 • [Residency Interview Schedules H-310.998](#)

14
15 Of note, Policy [D-310.977](#) “National Resident Matching Program Reform” includes the following
16 clauses that state the AMA:

- 17 (4) will continue to review the NRMP’s policies and procedures and make
18 recommendations for improvements as the need arises, to include making the conditions of
19 the Match agreement more transparent while assuring the confidentiality of the match;
- 20 (5) will work with the Accreditation Council for Graduate Medical Education (ACGME)
21 and other appropriate agencies to assure that the terms of employment for resident
22 physicians are fair and equitable and reflect the unique and extensive amount of education
23 and experience acquired by physicians;
- 24 (6) does not support the current the “All-In” policy for the Main Residency Match to the
25 extent that it eliminates flexibility within the match process;
- 26 (7) will work with the NRMP, and other residency match programs, in revising Match
27 policy, including the secondary match or scramble process to create more standardized
28 rules for all candidates including application timelines and requirements;
- 29 (8) will work with the NRMP and other external bodies to develop mechanisms that limit
30 disparities within the residency application process and allow both flexibility and standard
31 rules for applicants;

32
33 Additional related policies, such as those listed below, can be accessed in the [AMA Policy Finder](#)
34 database:

- 35 • [Strengthening Interview Guidelines for American Indian and Alaska Native Medical](#)
36 [School, Residency, and Fellowship Applicants H-295.852](#)
- 37 • [Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship](#)
38 [Selection Process D-310.945](#)
- 39 • [Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or](#)
40 [Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion](#)
41 [During the Residency and Fellowship Application Process H-310.919](#)
- 42 • [Strategies for Enhancing Diversity in the Physician Workforce D-200.985](#)
- 43 • [US Physician Shortage H-200.954](#)
- 44 • [Collective Bargaining: Antitrust Immunity D-383.983](#)
- 45 • [AMA’s Aggressive Pursuit of Antitrust Reform D-383.990](#)
- 46 • [Antitrust Relief for Physicians Through Federal Legislation H-383.990](#)
- 47 • [Antitrust Relief H-383.992](#)

48
49 SUMMARY AND RECOMMENDATIONS

50

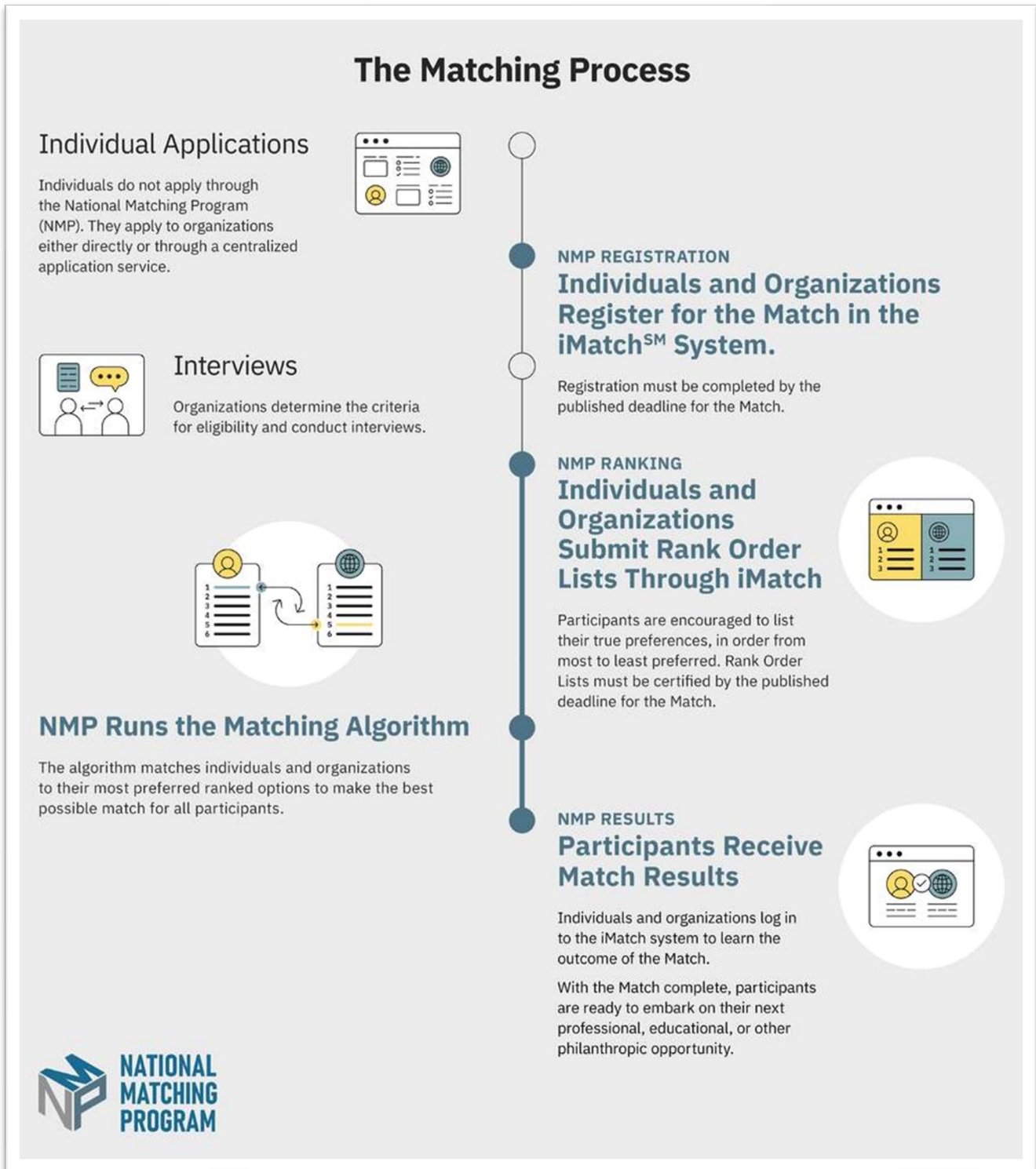
1 The Council on Medical Education understands the concerns presented by the authors of
2 Resolution 302-A-23 and their frustrations related to lack of control over their own destinies. This
3 report describes the origins of The Match and its current state as well as information about
4 independent match processes. It also clarifies the difference between the AAMC's ERAS
5 application process versus NRMP's Match process, acknowledges challenges, and summarizes
6 recent considerations and recommendations. This report illuminates the importance of ongoing
7 communication and transparency by the NRMP as well as collaboration among all invested parties.
8 Further, this report makes clear that there are no currently identified alternatives other than an
9 unstructured, open market approach, which the Council believes would be detrimental to the
10 majority of trainees in comparison to the current Match process. Accordingly, attention should be
11 focused on what can be done to improve The Match and other specialty matches rather than
12 focusing on its replacement, as a match process continues to be the best solution for trainees at this
13 time.

14
15 The Council on Medical Education therefore recommends that the following recommendations be
16 adopted and the remainder of this report be filed. That our AMA:

- 17
18 1. AMA Policy [D-310.977](#), "National Resident Matching Program Reform" be amended by
19 addition to read as follows. Our AMA:
20
21 (20) Encourages the piloting of innovations to the residency application process with aims
22 to reduce application numbers, focus applicants on programs with reciprocal interest, and
23 maximize residency placement. With support from the medical education community,
24 successful pilots should be expanded to enhance the standardized process.
25
26 (21) Continues to engage the National Resident Matching Program® (NRMP®) and other
27 matching organizations on behalf of residents and medical students to further develop
28 ongoing relationships, improve communications, and seek additional opportunities to
29 collaborate including the submission of suitable nominees for their governing bodies as
30 appropriate. (Modify Current HOD Policy)
31
32 2. Reaffirm AMA Policies [H-310.900](#) "Resident and Fellow Physicians Seeking to Transfer
33 GME Program" and [H-310.912](#) "Residents and Fellows' Bill of Rights." (Reaffirm HOD
34 Policy)
35
36 3. Rescind AMA policy [D-310.944](#), "Study of the Current Match Process and Alternatives,"
37 as having been accomplished by this report. (Rescind HOD Policy)
38
39

40 Fiscal note: \$1,000

APPENDIX A: THE MATCH PROCESS



APPENDIX B: RELEVANT AMA POLICY

[National Resident Matching Program Reform D-310.977](#)

Our AMA:

- (1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;
- (2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
- (3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
- (4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;
- (5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
- (6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
- (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
- (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;
- (9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
- (10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
- (11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
- (12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
- (13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;
- (14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;
- (15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;
- (16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;

(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine;

(18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and

(19) will work with appropriate stakeholders to study options for improving transparency in the resident application process.

[Study of the Current Match Process and Alternatives D-310.944](#)

Our American Medical Association will study alternatives to the current residency and fellowship Match process which would be less restrictive on free market competition for applicants.

[Residents and Fellows' Bill of Rights H-310.912](#)

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.

4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.

6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.

7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.

8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with

educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.

10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).

11. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.

12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

[Preliminary Year Program Placement H-310.910](#)

1. Our AMA encourages the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.

2. Our AMA encourages appropriate stakeholders to explore options to decrease the burden upon medical students who must apply to separate preliminary PGY-1 and categorical PGY-2 positions.

3. Our AMA will work with the Accreditation Council for Graduate Medical Education to encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) with insufficient availability of local PGY-1 positions to create local PGY-1 positions that will enable coordinated applications and interviews for medical students.

4. Our AMA encourages the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, including barriers to "couples matching," and to ensure that all applicants have access to robust, informative statistics to assist in decision-making.

5. Our AMA encourages the NRMP, San Francisco Match, American Urological Association, Electronic Residency Application Service, and other stakeholders to collect and publish data on a) the impact of separate matches on the personal and professional lives of medical students and b) the impact on medical students who are unable to successfully "couples match" with their significant others due to staggered entry into residency, utilization of unlinked match services, or other causes.

[Closing of Residency Programs H-310.943](#)

1. Our AMA: (a) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (b) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (c) encourages the ACGME and the various Residency Review Committees to reexamine requirements for "years of continuous training" to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (d) will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training; (e) urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; (f) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding; and (g) will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.

2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:

A. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;

B. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;

C. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and

D. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.

3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.

4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:

A. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;

B. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and

C. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.

[Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948](#)

Our AMA will:

1. ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution;

2. encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to develop a process

similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure;

3. encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger;

4. work with AAMC, AACOM, ACGME, and relevant state and specialty societies to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity;

5. encourage ACGME to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure; and

6. continue to work with ACGME, interested specialty societies, and others to monitor issues, collect data, and share information related to training programs run by nonprofit and for-profit entities and their effect on medical education.

[Residency Interview Schedules H-310.998](#)

1. Our AMA encourages residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. Our AMA encourages the ACGME and other accrediting bodies to require programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. Our AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of application and ongoing changes in the status of consideration of the application.

2. Our AMA will: (a) oppose changes to residency and fellowship application requirements unless (i) those changes have been evaluated by working groups which have students and residents as representatives, (ii) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate, (iii) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of bias that affects medical students and residents from underrepresented minority backgrounds, and (iv) the costs to medical students and residents are mitigated; and (b) continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.

REFERENCES

1. American Medical Association. Proceedings of the 2023 Annual Meeting of the House of Delegates. November 25, 2023. Accessed March 19, 2024. <https://www.ama-assn.org/house-delegates/annual-meeting/proceedings-2023-annual-meeting-house-delegates>
2. National Residency Match Program®. The Matching Algorithm. Accessed March 19, 2024. <https://www.nrmp.org/intro-to-the-match/how-matching-algorithm-works/>
3. Roth AE. The Origins, History, and Design of the Resident Match. *JAMA*. 2003. 289(7):909–912. [doi:10.1001/jama.289.7.909](https://doi.org/10.1001/jama.289.7.909).
4. Mullin FJ. A Proposal for Supplementing the Cooperative Plan for Appointment of Interns. *Journal of the Association of American Medical Colleges*. 1950. 25(6): 437-442. <https://pubmed.ncbi.nlm.nih.gov/24538917/>
5. American Medical Association. The Millis Commission Report. *Am Fam Physician* (formerly known as GP). 1966. XXXIV(6):174-188. Contact AMA for access to archived report.
6. Bhattacharjee Y. Economics Nobel Honors Perfect Match. *Science*. October 15, 2012. Accessed March 18, 2024. www.science.org/content/article/economics-nobel-honors-perfect-match
7. Brazdzionis J, Savla P, Oppenheim R, et al. Comparison of Osteopathic (DO) and Allopathic (MD) Candidates Matching Into Selected Surgical Subspecialties. *Cureus*. 2023. 15(6):e40566. [doi:10.7759/cureus.40566](https://doi.org/10.7759/cureus.40566).
8. National Residency Match Program®. Main Residency Match All in Policy. November 12, 2021. Accessed March 18, 2024. www.nrmp.org/policy/main-residency-match-all-in-policy/
9. American Medical Association. D-310.977 National Resident Matching Program Reform. *AMA Policy Finder*. Accessed March 18, 2024. <https://policysearch.ama-assn.org/policyfinder/detail/D-310.977?uri=%2FAMADoc%2Fdirectives.xml-0-987.xml>
10. National Residency Match Program®. NRMP Position Statement On The Feasibility Of An Early Match. July 2, 2021. Accessed March 18, 2024. www.nrmp.org/about/news/2021/07/nrmp-position-statement-on-the-feasibility-of-an-early-match/
11. National Residency Match Program®. I've been offered a position outside the Main Residency Match. What should I do? June 25, 2021. Accessed March 18, 2024. www.nrmp.org/help/item/offered-position-outside-the-match/
12. Wetz R, Seelig C, Khoueiry G, Weiserbs K. Out-of-Match Residency Offers: The Possible Extent and Implications of Prematching in Graduate Medical Education. *J Grad Med Educ*. 2010;2(3):327-33. [doi:10.4300/JGME-D-09-00053.1](https://doi.org/10.4300/JGME-D-09-00053.1)
13. American Medical Association. Learning about early match programs. Updated March 5, 2024. Accessed March 18, 2024. www.ama-assn.org/medical-students/preparing-residency/learning-about-early-match-programs
14. American College of Preventive Medicine. How does SAP work? Accessed March 18, 2024. www.acpm.org/SAP/How-Does-the-SAP-Work#1
15. Laughlin R, Adkins S, Baer M, et al. The Neuromuscular Portal and Match Working Toward a More Fair, Equitable, and Transparent Process. *Neurology Education*. August 23, 2023. Accessed March 18, 2024. [www.neurology.org/doi/10.1212/NE9.000000000200086](https://doi.org/10.1212/NE9.000000000200086)
16. Marks CM. Make residency - and health care - more equitable by scrapping The Match. *STAT*. March 18, 2021. Accessed March 22, 2024. www.statnews.com/2021/03/18/make-residency-more-equitable-scrap-the-match/
17. The Student Doctor Network. What are the alternatives to the Match? What do you think would happen if it were abolished? April 1, 2021. Accessed March 18, 2024. <https://forums.studentdoctor.net/threads/what-are-the-alternatives-to-the-match-what-do-you-think-would-happen-if-it-were-abolished.1439067/>
18. Weinmeyer R. Challenging the Medical Residency Matching System through Antitrust Litigation. *AMA Journal of Ethics*. February 2015. Accessed March 18, 2024. <https://journalofethics.ama-assn.org/article/challenging-medical-residency-matching-system-through-antitrust-litigation/2015-02>
19. Cornell University. 15 U.S. Code § 37b - Confirmation of antitrust status of graduate medical resident matching programs. Cornell Law School. Legal Information Institute. 2004. Accessed March 18, 2024. www.law.cornell.edu/uscode/text/15/37b

20. Bulow J, Levin J. Matching and Price Competition. *American Economic Review*. 2006. 96(3):652-668. Accessed March 18, 2024. www.aeaweb.org/articles?id=10.1257/aer.96.3.652
21. Agarwal N. An Empirical Model of the Medical Match. *American Economic Review*. 2015. 105(7):1939-1978. <https://www.aeaweb.org/articles?id=10.1257/aer.20131006>
22. Konishi H, Sapozhnikov M. Decentralized Matching Markets with Endogenous Salaries. *Games and Economic Behavior*. September 2008. 64(1):193-218. www.sciencedirect.com/science/article/abs/pii/S0899825608000298
23. Carlton D, Perloff J. *Modern Industrial Organization*, 4th edition. 2015. Accessed March 19, 2024. https://www.pearson.com/store/p/modern-industrial-organization-pdf-ebook-global-edition/GPROG_A100061457965_learnerau-availability/9781292087863
24. Baumol W, Panzar J, Willig R. Contestable Markets: An Uprising in the Theory of Industry Structure: Reply. *The American Economic Review*. 1982. 72(1):1-15. www.jstor.org/stable/1808145
25. Pindyck R, Rubinfeld D. *Microeconomics*, 9th edition. 2017. Accessed March 18, 2024. www.pearson.com/en-us/subject-catalog/p/microeconomics/P200000006021/9780134184241
26. Roth A. What Have We Learned from Market Design? *Economic Journal*. 2008. 118:285-310. <https://ideas.repec.org/a/wly/econjl/v118y2008i527p285-310.html>
27. Coalition for Physician Accountability. Undergraduate Medical Education-Graduate Medical Education Review Committee (UGRC): Recommendations for Comprehensive Improvement of the UME-GME Transition. 2021. Accessed March 18, 2024. <https://physicianaccountability.org/wp-content/uploads/2021/08/UGRC-Coalition-Report-FINAL.pdf>
28. National Residency Match Program®. NRMP Call for Public Comment Regarding Consideration of a Two-Phase Main Residency Match. 2022. Accessed March 18, 2024. www.nrmp.org/wp-content/uploads/2022/08/Two-Phase-Match-Statement-Full-FINAL.pdf
29. National Residency Match Program®. Decision of the NRMP® Board of Directors Regarding the Proposal for a Two-Phase Match. October 28, 2022. Accessed March 18, 2024. www.nrmp.org/about/news/2022/10/decision-of-the-nrmp-board-of-directors-regarding-the-proposal-for-a-two-phase-match/
30. Association of American Medical Colleges. AAMC Comments to NRMP® on Two-Phase Main Residency Match Proposal. September 19, 2022. Accessed March 18, 2024. www.aamc.org/news/press-releases/aamc-comments-nrmp-two-phase-main-residency-match-proposal
31. American Medical Association. AMA Reimagining Residency Initiative. Updated February 2, 2024. Accessed March 18, 2024. www.ama-assn.org/education/changemeded-initiative/ama-reimagining-residency-initiative

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(A-24)

Introduced by: Medical Student Section, International Medical Graduates Section

Subject: Fairness for International Medical Students

Referred to: Reference Committee C

1 Whereas, international students comprise over 10% of US graduate students but only 0.6% of
2 US medical students, indicating that the US recruits globally for academia, research, and other
3 highly educated professions, but not for medicine¹⁻³; and
4

5 Whereas, only 35% of medical schools consider international applicants, only 17% of whom are
6 admitted compared to 38% of domestic applicants⁴⁻⁷; and
7

8 Whereas, international medical students are ineligible for public loans, may be ineligible for
9 medical school scholarships, require a US cosigner for private loans, and may be required to
10 deposit up to four years of tuition upfront into an escrow account prior to matriculation⁷⁻¹⁰; and
11

12 Whereas, many common national medical student scholarships, including the AMA Physicians
13 of Tomorrow scholarship, the Tylenol Future Care scholarship, and the National Medical
14 Fellowships awards, are restricted to domestic students only¹¹⁻¹³; and
15

16 Whereas, international medical students offer valuable diversity of thought, cultural
17 perspectives, and unique life experiences that enrich medical schools, complement efforts to
18 improve physician workforce diversity, address physician shortages, and allow the US to attract
19 and retain the best and brightest future doctors from around the world^{9,14}; therefore be it
20

21 RESOLVED, that our American Medical Association encourage additional medical schools to
22 consider applications from and to admit international students to their programs alongside
23 domestic students (New HOD Policy); and be it further
24

25 RESOLVED, that our AMA amend policy H-255.968 "Advance Tuition Payment Requirements
26 for International Students Enrolled in US Medical Schools" by addition and deletion to read as
27 follows;
28

29 Advance Tuition Payment Requirements for International Students
30 Enrolled in US Medical Schools H-255.968

31 Our AMA:

- 32 1. supports the autonomy of medical schools to determine optimal tuition
33 requirements for international students;
- 34 2. encourages medical schools and undergraduate institutions to fully
35 inform international students interested in medical education in the US of
36 the limited options available to them for tuition assistance;
- 37 3. supports the Association of American Medical Colleges (AAMC) in its
38 efforts to increase transparency in the medical school application process
39 for international students by including school policy on tuition requirements
40 in the Medical School Admission Requirements (MSAR); and

- 1 4. supports efforts to re-evaluate and minimize the use of pre-payment
2 requirements specific to international medical students; and
3 5. encourages medical schools to explore alternative means of
4 prepayment, such as a letter of credit, for four years for covering the costs
5 of medical school. (Modify Current HOD Policy); and be it further
6

7 RESOLVED, that our AMA advocate for increased scholarship and funding opportunities for
8 international students accepted to or currently attending United States medical schools.
9 (Directive to Take Action)
10

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

Received: 3/28/2024

REFERENCES

1. Open Doors. IIE Open Doors / Academic Level. IIE Open Doors / Academic Level. Accessed September 22, 2022. <https://opendoorsdata.org/data/international-students/academic-level/>
2. National Center for Education Statistics. The Integrated Postsecondary Education Data System. Accessed September 22, 2022. <https://nces.ed.gov/ipeds/search/ViewTable?tableId=29448>
3. AAMC. Matriculants to U.S. MD-Granting Medical Schools by State of Legal Residence, 2012-2013 through 2021-2022. <https://www.aamc.org/media/6011/download?attachment>
4. Medical School Admission Requirements. Accessed August 30, 2022. <https://mec.aamc.org/msar-ui/#/landing>
5. American Association of Colleges of Osteopathic Medicine. Choose DO Explorer. Choose DO. Accessed September 22, 2022. <https://choosedo.org/explorer/>
6. Table A-7.2: Applicants, First-Time Applicants, Acceptees, and Matriculants to U.S. MD-Granting Medical Schools by Sex, 2012-2013 through 2021-2022.
7. Docs A. Applying to Medical School as an International Applicant. AAMC Students & Residents. Accessed August 30, 2022. <https://students-residents.aamc.org/applying-medical-school/applying-medical-school-international-applicant>
8. National Academies of Sciences E, Division H and M, Practice B on PH and PH. *Financial Barriers to Medical Education*. National Academies Press (US); 2018. Accessed August 30, 2022. <https://www.ncbi.nlm.nih.gov/books/NBK518880/>
Datta J, Miller BM. International students in United States' medical schools: does the medical community know they exist? *Med Educ Online*. 2012;17:10.3402/meo.v17i0.15748. doi:10.3402/meo.v17i0.15748
9. Virji AZ. As a non-U.S. citizen, I faced hurdles applying to U.S. medical schools. Now that I've made it, I want to help others like me. AAMC. Accessed September 22, 2022. <https://www.aamc.org/news-insights/non-us-citizen-i-faced-hurdles-applying-us-medical-schools-now-i-ve-made-it-i-want-help-others-me>
10. AMA Physicians of Tomorrow Scholarship. AMA Foundation. Accessed August 30, 2022. <https://amafoundation.org/programs/scholarships/>
11. Tylenol Future Care Scholarship FAQ. https://www.tylenol.com/sites/tylenol_us/files/22-23_tylenolr_future_care_scholarship_faq.pdf
12. National Medical Fellowships. Scholarships and Awards. Published June 28, 2021. Accessed August 30, 2022. <https://nmfonline.org/scholarships-programs/scholarships-and-awards/>
13. Krislov M. Why International Students Are Good For Colleges, Universities And America. Forbes. Accessed August 30, 2022. <https://www.forbes.com/sites/marvinkrislov/2019/03/22/why-international-students-are-good-for-colleges-universities-and-america>
14. Retaining U.S. International Student Graduates Could Help Fill Millions of Critical Job Openings. FWD.us. Accessed August 30, 2022. <https://www.fwd.us/news/us-international-students>

RELEVANT AMA POLICY

D-255.980 Impact of Immigration Barriers on the Nation's Health

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.

6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S. [Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22; Reaffirmed: Res. 210, A-23]

H-295.888 Progress in Medical Education: the Medical School Admission Process

1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.

2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school. [CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11; Reaffirmed: CME Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(A-24)

Introduced by: Private Practice Physicians Section

Subject: The Role of Maintenance of Certification

Referred to: Reference Committee C

1 Whereas, the principle of lifelong learning is fundamental to maintaining and enhancing the
2 quality of patient care delivered by physicians; and
3

4 Whereas, certified medical education (CME) already plays a pivotal role in facilitating lifelong
5 learning by offering opportunities for physicians to stay current with advances in medical
6 knowledge and technology; and
7

8 Whereas, specialty boards contend that the process of re-certification and maintenance of
9 certification (MOC) contributes to the enhancement of patient care quality by counteracting a
10 natural decline in medical knowledge and skills over time during active practice, although
11 existing evidence is at odds with this assertion and does not suggest that re-certification and
12 MOC significantly enhance the quality of care provided by physicians^(1,2); and
13

14 Whereas, the current landscape of board certification lacks sufficient competition which has
15 resulted in elevated costs for physicians seeking certification in their respective specialties,
16 competition policy experts noting the harms of consolidation in the market for certification,
17 spirited public debate amongst physicians about the value of MOC to both patients and
18 physicians, and the Department of Justice advocating for efforts to increase competition in the
19 market for physician board certification⁽³⁻⁶⁾; and
20

21 Whereas, the obligation of high-stakes testing as part of MOC is not a comprehensive or optimal
22 way to assess clinical knowledge or competence for physicians who have maintained active
23 clinical practice; and
24

25 Whereas, our American Medical Association has a responsibility to investigate issues that
26 impact physicians and their patients; therefore be it
27

28 RESOLVED, that our American Medical Association adopt a policy that states that maintenance
29 of certification requirements should not be duplicative of continuing medical education
30 requirements and not be used to determine or dictate hospital privileges, insurance network
31 credentialing, or hiring practices (New HOD Policy); and be it further
32

33 RESOLVED, that our AMA recognizes the importance of fostering competition in the market for
34 board certification, allowing physicians to have the autonomy to choose the most suitable
35 pathway for their individual learning and professional development needs (New HOD Policy);
36 and be it further
37

38 RESOLVED, that our AMA undertake a comprehensive review of the available evidence
39 concerning the impact of maintenance of certification on the quality and safety of patient care
40 and report the findings of this investigation to its members and stakeholders, including

1 policymakers and legislators, to inform future healthcare policy with a report back to the House
2 of Delegates by Annual 2025 (Directive to Take Action).

3

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

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REFERENCES

1. Gray BM, Vandergrift JL, Johnston MM, et al. Association between Imposition of a Maintenance of Certification Requirement and Ambulatory Care—Sensitive Hospitalizations and Health Care Costs. *JAMA*. 2014;312(22):2348-2357. doi:10.1001/jama.2014.12716
2. Hayes, J, Jackson JL, McNutt GM, Hertz BJ, Ryan JJ, Pawlikowski SA. Association Between Physician Time-Unlimited vs. Time-Limited Internal Medicine Board Certification and Ambulatory Patient Care Quality. *JAMA*. 2014;312(22):2358-2363. doi:10.1001/jama.2014.13992
3. T. Sandhu A, Adams Dudley R, S. Kazi D. A Cost Analysis of the American Board of Internal Medicine's Maintenance-of-Certification Program. *Ann Intern Med*. Published online September 15, 2015. doi: 10.7326/M15-1011.
4. Gilman, DJ, Miller BJ, Goldstein B. Board Certification: A Dose of Competition. *Health Aff Forefr*. doi: 10.1377/forefront.20171121.748789.
5. Healthcare Unfiltered: ABIM and MOC: The Epic Debate With Richard Baron and Aaron Goodman on Apple Podcasts. Apple Podcasts. Accessed April 4, 2024. <https://podcasts.apple.com/us/podcast/abim-and-moc-the-epic-debate-with-richard/id1534737585?i=1000623789270>
6. Comments on Maintenance of Certification Requirements for Physicians. Accessed April 4, 2024. <https://www.justice.gov/atr/page/file/1212231/download>

RELEVANT AMA POLICY

Continuing Board Certification D-275.954

Our AMA will:

1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a report regarding the CBC process at the request of the House of Delegates or when deemed necessary by the Council on Medical Education.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physician's current practice.

12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physician's decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Continue to participate in the Coalition for Physician Accountability, formerly known as the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's CBC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.
30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.
31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.
32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.
33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff

membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.

34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.

35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.

36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.

37. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.

38. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development and release of new, integrated standards for continuing certification programs that will address the Commission's recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.

39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.

40. Our AMA will continue to publicly report its work on enforcing AMA Principles on Continuing Board Certification.

Citation: CME Rep. 2, I-15; Appended: Res. 911, I-15; Appended: Res. 309, A-16; Appended: CME Rep. 02, A-16; Appended: Res. 307, I-16; Appended: Res. 310, I-16; Modified: CME Rep. 02, A-17; Reaffirmed: Res. 316, A-17; Reaffirmed in lieu of: Res. 322, A-17; Appended: CME Rep. 02, A-18; Appended: Res. 320, A-18; Appended: Res. 957, I-18; Reaffirmation: A-19; Modified: CME Rep. 02, A-19; Appended: CME Rep. 1, I-20; Appended: Res. 310, A-21; Modified: CME Rep. 2, A-22; Appended: Res. 310, I-22

MOC Provisions of Interstate Medical Licensure Compact D-275.955

Our American Medical Association will, in collaboration with the Federation of State Medical Boards and interested state medical boards, request a clarifying statement from the Interstate Medical Licensure Compact Commission that the intent of the language in the model legislation requiring that a physician "holds" specialty certification refers only to initial specialty certification recognized by the American Board of Medical Specialties or the American Osteopathic Association's (AOA's) Bureau of Osteopathic Specialists and that there is no requirement for participation in ABMS's Maintenance of Certification or AOA's Osteopathic Continuous Certification (OCC) program in order to receive initial or continued licensure under the Interstate Medical Licensure Compact.

Citation: Res. 235, A-15

An Update on Maintenance of Licensure D-275.957

Our American Medical Association will: 1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue.

2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues.

3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician workforce.

4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB's Guiding Principles for MOL.

5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and

services that may help shape and support MOL for physicians.

6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.

7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.

8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time.

Citation: CME Rep. 3, A-15; Modified: CME Rep. 2, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(A-24)

Introduced by: Young Physicians Section

Subject: Amend Policy D-275.948 Title "Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training". Creation of an AMA Task Force to Address Conflicts of Interest on Physician Boards.

Referred to: Reference Committee C

1 Whereas, physicians strive for the highest degree of patient care and professionalism¹; and

2

3 Whereas, professionalism in medicine has been achieved through self-governance and self-
4 regulation¹; and

5

6 Whereas, non-physicians serving in executive and board leadership roles in physician
7 organizations compromises the objective of self-regulation and self-governance; and

8

9 Whereas, the president and CEO of the National Resident Matching Program (NRMP) is a non-
10 physician, holds the following credentials D.H.Sc., M.B.A., B.S.N., has never participated in the
11 MATCH, never completed a residency or fellowship, and yet has held prior leadership positions
12 overseeing accreditation of physician residency and fellowship programs, was an executive
13 director at the ACGME, and held the position of designated institution official (DIO) for a
14 graduate medical education (GME) program²; and

15

16 Whereas, the newly elected vice chair of the National Board of Medical Examiners (NBME) is a
17 non-physician, holds the following credentials R.N., Ph.D., received a bachelor of science in
18 nursing, received a master of science in nursing education, received a doctor of philosophy in
19 theory development and research in nursing, has never taken any NBME examination for board
20 certification, and yet now holds the position of vice chair for the organization³; and

21

22 Whereas, the current chair of the Accreditation Council for Graduate Medical Education
23 (ACGME) is a non-physician, holds the following credentials M.A., and is co-founder of a
24 strategic human resource consulting firm⁴; and

25

26 Whereas, the recently elected President and current Vice President of the American College of
27 Cardiology (ACC) is a non-physician, holds the following credentials R.N., M.S.N., and is
28 president and CEO of Cardiovascular Management of Illinois, a cardiology physician practice
29 management company⁵; and

1 Whereas, non-physicians, who do not themselves go through physician education,
2 accreditation, certification, licensing, and credentialing, may have difficulty appreciating the
3 needs and challenges of physician trainees and practicing physicians from lack of personal
4 experience, and therefore should not be making major decisions for physicians or representing
5 physicians in the highest roles of these organizations; and
6

7 Whereas, the purpose of having non-physicians on physician boards is to have a public voice
8 on these boards, not to lead the organization itself (i.e. in the highest roles of the organizations);
9 and
10

11 Whereas, non-physicians can participate on physician boards as a public member without
12 leading these organizations in the highest roles; and
13

14 Whereas, one of the focal points of the AMA Recovery Plan is to fight scope creep, and works
15 to educate legislators about the differences in training between physicians and non-physicians⁶;
16 and
17

18 Whereas, having non-physicians lead physician boards is contradictory to the AMA message
19 about scope creep and the importance of physician-led teams; and
20

21 Whereas, our advocacy to legislators about the importance of physician education is
22 compromised by a conflict of interest if we have non-physicians in the highest roles determining
23 physician standards; and
24

25 Whereas, there are highly qualified physicians that could hold these leadership roles now held
26 by non-physicians⁶; and
27

28 Whereas, having these non-physicians lead national standard-setting organizations in our
29 physician profession undermines physician confidence in these organizations; and
30

31 Whereas, the current title of policy D-275.948 does not match the content of the policy;
32 therefore be it
33

34 RESOLVED, that our American Medical Association amend the title of policy D-275.948 by
35 substitution and deletion as follows:

36 ~~Education, Training and Credentialing of Non-Physician Health Care Professionals and Their~~
37 ~~Impact on Physician Education and Training~~ Addressing Non-physician Positions and
38 Participation on Physician Regulatory Boards and Bodies and Potential Conflicts of Interest D-
39 275.948 (Modify Current HOD Policy); and be it further
40

41 RESOLVED, that our AMA work with relevant stakeholders and regulatory bodies and boards
42 involved in physician education, accreditation, certification, licensing, and credentialing to
43 advocate for physician leadership of these regulatory bodies and boards in order to be

- 1 consistent with the AMA Recovery Plan's efforts to fight scope creep, and prevent undermining
2 physician confidence in these organizations (Directive to Take Action); and be it further
3
4 RESOLVED, that our AMA create a task force with the mission to increase physician awareness
5 of and participation in leadership positions on regulatory bodies and boards involved in
6 physician education, accreditation, certification, licensing, and credentialing through
7 mechanisms including but not limited to mentorship programs, leadership training programs,
8 board nominations, publicizing the opportunities to the membership, and creating a centralized
9 list of required qualifications and methods to apply for these positions. (Directive to Take Action)

Fiscal Note: To Be Determined

Received: 4/8/2024

REFERENCES

1. Bauchner H, Fontanarosa PB, Thompson AE. Professionalism, Governance, and Self-regulation of Medicine. *JAMA*. 2015;313(18):1831–1836. doi:10.1001/jama.2015.4569.
2. <https://www.nrmp.org/about/board-of-directors/president-and-ceo/>
3. <https://www.nbme.org/news/nbme-announces-new-officers-and-members-elected-its-board-directors>
4. <https://www.acgme.org/about-us/board-and-staff/board-of-directors/>
5. <https://www.acc.org/About-ACC/Leadership/Officers-and-Trustees>
6. <https://www.ama-assn.org/practice-management/scope-practice/advocacy-action-fighting-scope-creep>

RELEVANT AMA POLICY

Education, Training and Credentialing of Non-Physician Health Care Professionals and Their Impact on Physician Education and Training D-275.948

1. Our AMA acknowledges that a conflict of interest exists when non-physician health care professionals hold positions on physician regulatory bodies or physician boards when these individuals represent a field that either possesses or seeks to possess the ability to practice without physician supervision.
2. Our AMA will encourage key regulatory bodies involved with physician education, accreditation, certification, licensing, and credentialing to: (A) increase transparency of the process by encouraging them to openly disclose how their board is composed and members are selected; and (B) review and amend their conflict of interest and other policies related to non-physician health care professionals holding formal leadership positions (e.g., board, committee) when that non-physician professional represents a field that either possesses or seeks to possess the ability to practice without physician supervision. [CME Rep. 5, A-22; Modified: Res. 323, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(A-24)

Introduced by: Academic Physicians Section

Subject: Spirituality in Medical Education and Practice

Referred to: Reference Committee C

1 Whereas, current AMA policy recognizes the importance of spirituality concerns to many
2 patients and encourages patient access to spiritual care services (H-160.900) but does not
3 detail how the provision of spiritual care to patients would optimally involve physicians,
4 physicians-in-training, or other members of the care team; and

5
6 Whereas, the term “spiritual care” does not require, yet does not exclude, the invoking of any
7 general or specific religious beliefs; rather, spirituality is broadly defined as seeking meaning,
8 purpose, and connectedness, and is inclusive of all ways people may understand spirituality in
9 their lives; and

10
11 Whereas, our AMA’s policies on diversity, equity, and inclusion note the need to respect people
12 and their diverse backgrounds, which applies specifically to the quality and equity of patient
13 care, in that members of medical care teams should demonstrate respect for the culture and
14 spirituality of the patient (and the patient’s family); and

15
16 Whereas, many health organizations, including the World Health Organization (WHO), via its
17 Resolution on Palliative Care, have noted the need for prevention and relief of suffering by
18 means of early identification and correct assessment and treatment of pain and other problems,
19 whether physical, psychosocial, or spiritual – and in the case of WHO, have declared that the
20 treatment of all severe pain, including spiritual pain, is a human right;¹ and

21
22 Whereas, many patients value clinicians who are able to integrate inquiry about patients’
23 spirituality as related to their health, and benefit from access to specialist spiritual care services,
24 when such access is enabled for them; and

25
26 Whereas, a Delphi review of the literature found sufficient evidence to recommend education on
27 spirituality and health in the care of patients with serious and/or chronic illness;^{2,3} and

28
29 Whereas, patient referral and access to spiritual care services would be enhanced if all
30 physicians and medical students had learned how to provide generalist spiritual care through
31 the assessment and treatment of spiritual distress as a clinical symptom, with treatment options
32 to include compassionate listening and presence to patients’ suffering, reflective inquiry to
33 enable patients to fully express their spiritual distress, referral to and collaboration with spiritual
34 care specialists, and continued follow up with the patient on spiritual issues as indicated; and

35
36 Whereas, instruction in medical education regarding spiritual health as part of whole person
37 care, assessment, and treatment of spiritual distress could be expected to enhance “emotional
38 intelligence” and the recognition of opportunities for either providing spiritual care or referring
39 the patient to a spiritual care specialist; and

1 Whereas, burnout—a condition characterized by feelings of pervasive energy depletion or
2 exhaustion, negativism or cynicism about one’s occupation or occupational role, and/or a sense
3 of inadequacy or ineffectiveness in one’s occupational role, is a pervasive emotion and state
4 among clinicians and clinicians-in-training; and
5

6 Whereas, spiritual distress can contribute to burnout across the continuum of medical education
7 and practice, with an association between increased burnout and decreased meaning in work,
8 while the practice of spirituality may be a protective factor against burnout, with such
9 interventions as “reflection rounds” helping health professionals and students rekindle their
10 sense of meaning in their chosen vocation;⁴ and
11

12 Whereas, it is therefore reasonable to hope that by providing physicians and physicians-in-
13 training with opportunities to become more well-educated regarding matters of spirituality, and
14 by enabling them to implement a spiritual approach to their own life and life stresses—including
15 use of spiritual resources such as meditation, seeking professional spiritual care if needed,
16 and/or finding a spiritual community of support—that these individuals may be favorably
17 impacted and be less susceptible to burnout; and
18

19 Whereas, by extension, increased knowledge and awareness of spiritual principles may
20 enhance the abilities of caregivers to not only provide more effective care to others, but also to
21 provide more effective self-care to themselves; therefore be it
22

23 RESOLVED, that our American Medical Association amend Policy H-160.900 to read as
24 follows:
25

26 Addressing Patient Spirituality in ~~Medicine~~ Medical Education and Practice
27

28 (1) Our AMA recognizes the importance of individual patient spirituality and its impact on
29 health and encourages patient access to spiritual care services.
30

31 (2) Our AMA encourages the availability of education about spiritual health, defined as
32 meaning, purpose, and connectedness, in curricula in medical school, graduate medical
33 education, and continuing physician professional development as an integral part of
34 whole person care, which could include:

35 (a) assessing spiritual health as part of the history and physical;

36 (b) addressing treatment of spiritual distress by the clinician, with appropriate referral to
37 spiritual care professionals;

38 (c) acknowledging patients’ spiritual resources;

39 (d) developing compassionate listening skills;

40 (e) ensuring ongoing follow-up of patients’ spiritual health by clinicians as appropriate;

41 (f) describing respect for the spiritual, religious, existential, and cultural value of those
42 they serve and understanding why it is important to not impose their own personal
43 values and beliefs on those served; and

44 (g) self-reflection on one’s own spirituality within professional development courses,
45 especially as related to their vocation and wellbeing. (Modify Current HOD Policy)
46

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

Received: 4/17/2024

REFERENCES

1. World Health Organization. Strengthening of palliative care as a component of integrated treatment within the continuum of care. Adopted as a Resolution by the World Health Organization; Geneva, Switzerland: May 2014.
2. Cipta, A, Turner, B., Haupt, E. et al. Spiritual distress: symptoms, quality of life and hospital utilisation in homebased palliative care. *BMJ Supportive Palliative Care* 2021 Sep;11(3):322-328. doi: 10.1136/bmjspcare-2021-003090. Epub 2021 Jun 4.
3. Balboni, T, VanderWeele, T, Doan-Soares, et al. Spirituality in Serious Illness and Health. *JAMA* 2022;322:184-197.
4. Wachholtz A, Rogoff M. The relationship between spirituality and burnout among medical students. *J Contemp Med Educ*. 2013;1:83-91.

RELEVANT AMA POLICY

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.

Redesigning the Medicare Hospice Benefit D-330.895

Our American Medical Association advocates for:

1. A 21st century evolution of the Medicare hospice benefit that meets the quadruple aim of health care; advances health equity; and improves access, support, and outcomes for seriously ill patients across all geographies, including underserved and low-resource communities; and
2. A reformed Medicare hospice benefit that may incorporate the following components:
 - a. Hospice eligibility should not be based solely on a specified prognosis or life expectancy but rather on patients' needs.
 - b. Patients must continue to have an open choice of hospice providers.
 - c. Hospice services, including telehealth or telemedicine, should be provided by a full, physician-led interdisciplinary team.
 - d. Patients and their caregivers should receive adequate support using home- or facility-based hospice services, identified by a thorough assessment of their social determinants of health. This would incorporate 24-hour a day care for beneficiaries with very limited life expectancy who lack around the clock caregivers.
 - e. Patients should have concurrent access to disease-directed treatments along with palliative services.
 - f. Payments to hospices should be sufficient to support the quality, experience, scope, and frequency of care that beneficiaries deserve throughout the later stages of serious illness as dictated by their physical, psychological, social, spiritual, and practical needs.
 - g. The hospice benefit should be consistent, including with regard to the quality and intensity of services, regardless of which Medicare program or entity pays for services.
 - h. Metrics for health provider accountability should focus on those aspects of care and experience that matter most to patients, families, and caregivers.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(A-24)

Introduced by: Oklahoma

Subject: Public Service Loan Forgiveness Reform

Referred to: Reference Committee C

1 Whereas, there is a physician shortage across all specialties, locations, and practice types in
2 the United States¹; and
3

4 Whereas, the federal government is responsible for direct healthcare services through the
5 Veteran's Health Administration (VHA) and Indian Health Service (IHS); and
6

7 Whereas, the VHA and IHS both experience chronic, nationwide physician shortages (12.9% at
8 VHA as of 2022², 25% at IHS as of 2018³), paralleling the nation's physician shortage; and
9

10 Whereas, the VHA loan repayment program offers up to \$200,000 in relief to physicians over
11 five years, with no service commitment, while the IHS loan repayment program offers up to
12 \$50,000 in relief to physicians, with a two-year service commitment^{4,5}; and
13

14 Whereas, the VHA has bolstered physician retention and reduced physician burnout by offering
15 competitive financial relief to physicians and making improvements in workload, organizational
16 satisfaction, and psychological safety^{6,7}; and
17

18 Whereas, the VHA compensates physicians using Title 38 pay scales, which provides special
19 authority to recruit and retain employees in certain health care occupations, and also allows the
20 agency to be competitive with other healthcare facilities in the area^{8,9}; and
21

22 Whereas, the IHS compensates physicians using Title 5 pay scales, which are generally less
23 than Title 38 pay scales^{10,11}; and
24

25 Whereas, the Partnership for Public Service and Boston Consulting Group (PPS-BCG) reported
26 that the IHS ranked in the bottom-quartile of agencies within the U.S. Department of Health and
27 Human Services for employee engagement and satisfaction (332 of 432) in 2022¹²; and
28

29 Whereas, the PPS-BCG reported that nearly half of IHS physicians and other employees were
30 not satisfied with their pay and nearly a third were not satisfied with their work-life balance in
31 2022¹²; and
32

33 Whereas, the AMA recommends that compensation for IHS physicians be increased to a level
34 competitive with other federal agencies and non-governmental service (H-350.977); and
35

36 Whereas, physicians employed by the federal government may be eligible for the Public Service
37 Loan Forgiveness Program, which forgives qualifying federal loans after a standard ten-year
38 repayment plan¹³; and

1 Whereas, loan repayment can address physician retention and decrease physician burnout in
2 facilities that may not provide competitive pay or are in geographically remote locations^{14,15,16};
3 and
4

5 Whereas, the AMA has stated that reducing physician burnout should be an urgent priority¹⁷;
6 and
7

8 Whereas, the AMA already supports immediate changes in the Public Service Loan
9 Forgiveness Program to allow physicians to receive immediate loan forgiveness when they
10 practice in a Veteran's Health Administration facility (D-510.990) due to the VA physician
11 shortage; therefore be it
12

13 RESOLVED, that our American Medical Association amend Indian Health Service H-350.977 by
14 addition and deletion as follows:
15

16 Indian Health Service H-350.977

17 The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to
18 meet its obligation to bring American Indian health up to the general population level. The AMA
19 specifically recommends: (1) Indian Population: (a) In current education programs, and in the
20 expansion of educational activities suggested below, special consideration be given to involving
21 the American Indian and Alaska native population in training for the various health professions,
22 in the expectation that such professionals, if provided with adequate professional resources,
23 facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration
24 with American Indian leaders of the possibility of increased numbers of nonfederal American
25 Indian health centers, under tribal sponsorship, to expand the American Indian role in its own
26 health care; (c) Increased involvement of private practitioners and facilities in American Indian
27 care, through such mechanisms as agreements with tribal leaders or Indian Health Service
28 contracts, as well as normal private practice relationships; and (d) Improvement in
29 transportation to make access to existing private care easier for the American Indian population.
30 (2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities
31 and roads, and the availability of alternative nonfederal resources, the AMA recommends that
32 those Indian Health Service facilities currently necessary for American Indian care be identified
33 and that an immediate construction and modernization program be initiated to bring these
34 facilities up to current standards of practice and accreditation.

35 (3) Personnel Manpower: (a) Compensation scales for Indian Health Service physicians be
36 increased to a level competitive with other Federal agencies and nongovernmental service; (b)
37 Consideration should be given to increased compensation for specialty and primary care service
38 in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made
39 to establish closer ties with teaching centers and other federal health agencies, thus increasing
40 both the available staffing manpower and the level of professional expertise available for
41 consultation; (d) Allied health professional staffing of Service facilities should be maintained at a
42 level appropriate to the special needs of the population served without detracting from physician
43 compensation; (e) Continuing education opportunities should be provided for those health
44 professionals serving these communities, and especially those in remote areas, and, increased
45 peer contact, both to maintain the quality of care and to avert professional isolation and burnout;
46 and (f) Consideration should be given to a federal statement of policy supporting continuation of
47 the Public Health Service to reduce the great uncertainty now felt by many career officers of the
48 corps.

49 (4) Medical Societies: In those states where Indian Health Service facilities are located, and in
50 counties containing or adjacent to Service facilities, that the appropriate medical societies
51 should explore the possibility of increased formal liaison with local Indian Health Service
52 physicians. Increased support from organized medicine for improvement of health care provided

- 1 under their direction, including professional consultation and involvement in society activities
2 should be pursued.
- 3 (5) Our AMA also support the removal of any requirement for competitive bidding in the Indian
4 Health Service that compromises proper care for the American Indian population.
- 5 (6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic
6 Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical
7 schools and ACGME-accredited residency programs.
- 8 (7) Our AMA will encourage the development of funding streams to promote rotations and
9 learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.
- 10 (8) Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program
11 to allow physicians to receive immediate loan forgiveness when they practice in an Indian
12 Health Service, Tribal, or Urban Indian Health Program. (Modify Current HOD Policy)
13

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

Received: 4/22/2024

REFERENCES

1. AAMC. The Complexities of Physician Supply and Demand: Projections From 2019 to 2034. June 2021. Retrieved from: <https://www.aamc.org/media/54681/download?attachment>
2. Department of the Veteran Affairs Office of Inspector General. OIG Determination of Veterans Health Administration's Occupational Staffing Shortages. Report #22-00722-187. July 2022. Retrieved from: <https://www.va.gov/oig/pubs/VAOIG-22-00722-187.pdf>
3. U.S. Government Accountability Office. Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies. GAO-18-580. Aug 15, 2018. Retrieved from: <https://www.gao.gov/products/gao-18-580>
4. U.S. Department of Veteran Affairs. Pay off your school debt quickly with this VA program. November 13, 2020. Retrieved from: <https://news.va.gov/80815/pay-off-school-debt-quickly-va-program/>
5. Indian Health Service. Loan Repayment Program. Retrieved from: <https://www.ihs.gov/loanrepayment/>
6. Mohr DC, Apaydin EA, Li BM, Molloy-Paolillo BK, Rinne ST. Changes in Burnout and Moral Distress Among Veterans Health Administration (VA) Physicians Before and During the COVID-19 Pandemic. J Occup Environ Med. 2023 Jul 1;65(7):605-609. doi: 10.1097/JOM.0000000000002861. Epub 2023 Apr 11. PMID: 37043388; PMCID: PMC10332509.
7. Rinne ST, Mohr DC, Swamy L, Blok AC, Wong ES, Charns MP. National Burnout Trends Among Physicians Working in the Department of Veterans Affairs. J Gen Intern Med. 2020 May;35(5):1382-1388. doi: 10.1007/s11606-019-05582-7. Epub 2020 Feb 24. PMID: 32096080; PMCID: PMC7210363.
8. U.S. Department of Veteran Affairs. Title 38 Decision Paper. October 25, 2019. Retrieved from: https://www.va.gov/LMR/Article_55.pdf
9. U.S. Department of Veteran Affairs. Office of the Chief Human Capital Officer (OCHCO) Title 38 Pay Schedules. 2023. Retrieved from: <https://www.va.gov/ohrm/pay/>
10. Indian Health Service. Pay Systems and Tables. Retrieved from: <https://www.ihs.gov/OHR/pay-and-benefits/pay/pay-systems-pay-tables/>
11. Indian Health Service. Title 38 and Title 5 Special Salary Rate Tables Used at IHS. November 22, 2022. Retrieved from: https://www.ihs.gov/sites/ohr/themes/responsive2017/display_objects/documents/paytables/2022/IHS-2022-T38-T5-Pay-Tables.pdf
12. Partnership for Public Service. Best Places to Work in the Federal Government "Indian Health Service." 2022. Retrieved from: <https://bestplacestowork.org/rankings/detail/?c=HE37>
13. Federal Student Aid. Public Service Loan Forgiveness. Retrieved from: <https://studentaid.gov/manage-loans/forgiveness-cancellation/public-service>
14. Health and Human Services. The U.S. Surgeon General's Advisory on Building a Thriving Health Workforce: Addressing Health Worker Burnout. 2022. Retrieved from: www.hhs.gov/sites/default/files/health-worker-wellbeing-advisory.pdf
15. World Health Organization. Retention of the Health Workforce in Rural and Remote Area: A Systematic Review. 2020. Retrieved from: <https://apps.who.int/iris/bitstream/handle/10665/337187/9789240013896-eng.pdf>
16. Zhu, et. al. Behavioral Health Workforce Report to the Oregon Health Authority and State Legislature. February 1, 2022. Retrieved from: https://www.ohsu.edu/sites/default/files/2022-02/PRP_113_Behavioral_Reimbursement_Report_02.01.22_V2.pdf
17. urgent national priority." December 15, 2022. Retrieved from: <https://www.ama-assn.org/about/leadership/reducing-physician-burnout-must-be-urgent-national-priority>

RELEVANT AMA POLICY

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

(6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.

(7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs.

Fixing the VA Physician Shortage with Physicians D-510.990

1. Our AMA will work with the VA to enhance its loan forgiveness efforts to further incentivize physician recruiting and retention and improve patient access in the Veterans Administration facilities.
2. Our AMA will call for an immediate change in the Public Service Loan Forgiveness Program to allow physicians to receive immediate loan forgiveness when they practice in a Veterans Administration facility.
3. Our AMA will work with the Veterans Administration to minimize the administrative burdens that discourage or prevent non-VA physicians without compensation (WOCs) from volunteering their time to care for veterans.
4. Our AMA will: (a) continue to support the mission of the Department of Veterans Affairs Office of Academic Affiliations for expansion of graduate medical education (GME) residency positions; and (b) collaborate with appropriate stakeholder organizations to advocate for preservation of Veterans Health Administration funding for GME and support its efforts to expand GME residency positions in the federal budget and appropriations process.
5. Our AMA supports postgraduate medical education service obligations through programs where the

expectation for service, such as military service, is reasonable and explicitly delineated in the contract with the trainee.

6. Our AMA opposes the blanket imposition of service obligations through any program where physician trainees rotate through the facility as one of many sites for their training.

Physician Burnout D-405.972

Our AMA will work with: (1) Centers for Medicare and Medicaid Services (CMS), The Joint Commission, and other accrediting bodies and interested stakeholders to add an institutional focus on physician wellbeing as an accreditation standard for hospitals, focusing on system-wide interventions that do not add additional burden to physicians; and (2) hospitals and other stakeholders to determine areas of focus on physician wellbeing, to include the removal of intrusive questions regarding physician physical or mental health or related treatments on initial or renewal hospital credentialing applications.

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.

23. Continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt.

24. Encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels.

25. Support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt.

26. Support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism.

Cares Act Equity and Loan Forgiveness in the Medicare Accelerated Payment Program D-305.953

In the setting of the COVID-19 pandemic, our AMA will advocate for additional financial relief for physicians to reduce medical school educational debt.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(A-24)

Introduced by: Edmond Cabbabe, MD

Subject: Unmatched Graduating Physicians

Referred to: Reference Committee C

- 1 Whereas, the U.S. is expected to have an alarming and deeply concerning shortage of
2 physicians in primary and specialty care; and
3
- 4 Whereas, the number of practicing physicians is decreasing due to burnout, retirement,
5 pursuing non-clinical practices, and other causes; and
6
- 7 Whereas, the current number of medical students, residents, and fellows will not prevent such a
8 shortage; and
9
- 10 Whereas, the U.S. Congress has repeatedly failed to provide funding to educate the necessary
11 number of physicians to provide needed care of our aging and expanding population; and
12
- 13 Whereas, physician assistants (PAs), and advanced practice providers (APPs)/Nurse
14 Practitioners (NPs) have increasingly replaced licensed physicians in providing primary and
15 some specialty care due to geographic and economic shortage of physicians; and
16
- 17 Whereas, many states have allowed non-physician extenders to practice medicine
18 independently rather than in collaboration with licensed physicians; and
19
- 20 Whereas, a large number of physicians graduate from medical schools in the U.S. or abroad
21 take and pass USMLE part one and two, then apply for residency, but fail to get one of the
22 limited number of post graduate training spots in the U.S.; and
23
- 24 Whereas, these graduating physicians spend six to eight years in undergraduate and graduate
25 studies before graduating, and some of them serve a year of internship required to graduate.
26 They spend huge sums of money to complete their studies, sit for and pass the rigorous USMLE
27 tests, spend thousands of dollars on their applications for the matching programs and
28 interviews; and
29
- 30 Whereas, these unfortunate physicians face the very hard reality of a sudden irreversible
31 interruption of their careers, including, but not limited to large outstanding debts they cannot
32 repay, temporary to permanent interruption of their education, and the threat of never being able
33 to care for patients, while others who are less qualified, less educated, and less financially
34 burdened, such as APPs/NPs can practice medicine with or without collaborating with a
35 licensed physician; and
36
- 37 Whereas, in 2014, Missouri passed a law allowing these unfortunate graduating physicians to
38 obtain a license called Assistant Physician (AP) which allow these physicians without residency
39 to work in underserved areas in primary care, and only in collaboration with a licensed Missouri
40 physician; and

1 Whereas, many other states have passed similar or much less restrictive laws, under different
2 titles and processes such as Graduate Physician, Associate Physician, etc., some of them
3 allowing this group to gradually practice independently without a residency; and
4

5 Whereas, the number of these unfortunate graduating physicians has grown by the thousands
6 each year, yet Congress did not provide the needed funding to create enough residency slots to
7 train these physicians who would partially solve the expected shortages; and
8

9 Whereas, many of these graduating physicians, after practicing in collaboration with licensed
10 physicians, acquiring additional skills and experience, were able to match into a residency
11 program; therefore be it
12

13 RESOLVED, that our American Medical Association Board of Trustees study the role these
14 unmatched physicians can play in providing care to our patients, their impact of lessening the
15 impact of physician shortages, and provide recommendations on how to enroll these graduating
16 physicians with a uniform title, privileges, geographic restrictions, and collaboration choices, and
17 report to the House of Delegates at the next Interim meeting. (Directive to Take Action)

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

Received: 4/22/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(A-24)

Introduced by: California

Subject: Access to Reproductive Health Services When Completing Physician Certification Exams

Referred to: Reference Committee C

1 Whereas, the Supreme Court’s 2022 ruling in Dobbs. v. Jackson overturned the 1972 Roe v
2 Wade decision; and
3
4 Whereas, at least 26 states immediately enacted laws to ban or restrict abortion care in
5 response to the Supreme Court’s ruling in Dobbs v. Jackson; and
6
7 Whereas, national specialty societies host mandatory board certification exams in locations that
8 often require interstate travel for trainees completing residency and fellowship programs; and
9
10 Whereas, existing AMA policy supports encouraging American Board of Medical Specialties
11 member boards to assess whether initial board certification processes should be revised to
12 allow for testing requirements and arrangements that accommodate physicians' training and
13 employment schedules; and
14
15 Whereas, pregnant trainees may encounter health emergencies during the time frame of
16 completing mandatory board certification exam requirements that necessitate access to a full
17 spectrum of reproductive healthcare services, interventions and treatment options, including
18 abortion; therefore be it
19
20 RESOLVED, that our American Medical Association encourage national specialty boards who
21 hold in-person centralized mandatory exams for board certification to offer alternative methods
22 of taking mandatory board certification examinations, such as virtual boards examinations, or to
23 locate them outside of states that are in the process of banning or restricting or that have
24 banned or restricted abortion, gender affirming care or reproductive healthcare services. (New
25 HOD Policy)

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

Received: 4/23/2024

RELEVANT AMA POLICY

H-295.923 Medical Training and Termination of Pregnancy

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.

[Modified: Res. 317, I-22; Modified: Res. 309, I-21; Appended: Res. 957, I-17; Modified: CME Rep. 1, A-15; Modified: CME Rep. 2, A-14; Reaffirmed: CME Rep. 2, A-04; Res. 315, I-94.]

D-5.999 Preserving Access to Reproductive Health Services

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 other retaliatory efforts, including adverse medical licensing actions and the termination of medical liability coverage or clinical privileges 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. [Appended: Res. 711, A-23; Reaffirmation: A-23; Appended: Res. 317, I-22; Modified: BOT Rep. 4, I-22; Reaffirmed: Res. 224, I-22; Res. 028, A-22.]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(A-24)

Introduced by: Resident and Fellow Section

Subject: Transforming the USMLE Step 3 Examination to Alleviate Housestaff Financial Burden, Facilitate High-Quality Patient Care, and Promote Housestaff Well-Being

Referred to: Reference Committee C

- 1 Whereas, the United States Medical Licensing Examination (USMLE) Step 3 is the final
2 licensure examination in the USMLE series for physician licensure, which is taken during
3 residency training¹; and
4
5 Whereas, Step 3 is a two-day examination, with the first day (“Foundations of Independent
6 Practice,” 7 hours of testing) focused on basic science principles and the second day
7 (“Advanced Clinical Medicine,” 9 hours of testing) focused on application of clinical knowledge;
8 and
9
10 Whereas, the first testing day consists of multiple-choice questions and the second day consists
11 of a combination of multiple-choice questions and computer-based case simulations¹; and
12
13 Whereas, the cost of registering to take Step 3 was \$915 in 2023, with an increase to \$925 in
14 2024 and subsequent annual fee increases²; and
15
16 Whereas, the Step 3 test preparation question bank costs an individual resident \$429 in 2023,
17 which an increase for each renewal period³; and
18
19 Whereas, given that the computer-based simulation section utilizes software from a company
20 called *Primum*, which differs drastically from the Electronic Medical Record, trainees often
21 purchase CCS Cases to learn the software, which costs at minimum \$70; and
22
23 Whereas, therefore, the total cost of Step 3 preparation and examination is at least \$1,400 per
24 trainee, not including two missed days of work; and
25
26 Whereas, trainees may have to use their designated days off to prepare for and to sit for the
27 examination, exacerbating moral injury and burnout; and
28
29 Whereas, the objective of Step 3 is to test general medicine concepts primarily in an ambulatory
30 setting, which does not accurately reflect the sub-specialization and complexity of modern-day
31 medicine, and, therefore, does not justify a numerical score across disciplines; and
32
33 Whereas, Step 3 was designed for examination after successful completion of one’s medical
34 degree, however, USMLE recommends completion of one post-graduate year of training prior to
35 taking the exam⁴; and
36
37 Whereas, specialty choice is highly predictive of examination score; trainees in general
38 medicine fields (i.e. family medicine, emergency medicine, internal medicine, medicine-

1 pediatrics, and pediatrics) obtain significantly higher scores on Step 3 compared to more
2 specialized fields, supported by a retrospective study (n=36,805) of U.S. and Canadian medical
3 school graduates who took Step 3 for the first time between 1999 and 2002⁵; and
4

5 Whereas, the National Board of Medical Examiners (NBME) published data from 275,392
6 board-certified physicians who passed Step 3 between 2000 and 2017 indicating that a higher
7 score inversely correlated with likelihood of disciplinary action from the medical board (though
8 limitations included treating all disciplinary actions equally, which does not translate directly to
9 medical and/or surgical skills)⁶; and
10

11 Whereas, there are no published data that correlate one's numeric Step 3 score with true
12 clinical skills and beneficial patient outcomes; and
13

14 Whereas, preparing for Step 3 on top of clinical duties during residency may detract from on-
15 the-job learning and patient care, especially for trainees who pursue fellowships, as Step 3
16 scores are a component of the application process; and
17

18 Whereas, residency programs do not give residents protected study time for Step 3, thus,
19 residents must prepare for the examination on top of their 60-80+ hour work-weeks; and
20

21 Whereas, a one-day, pass/fail examination has the potential to reduce trainee costs, promote
22 trainee well-being, and encourage more learning via patient care in lieu of question banks;
23 therefore be it
24

25 RESOLVED, that our American Medical Association supports changing the United States
26 Medical Licensing Examination (USMLE) Step 3 from a numerically-scored examination to a
27 pass/fail examination (New HOD Policy); and be it further
28

29 RESOLED, that our AMA supports changing USMLE Step 3 from a two-day examination to a
30 one-day examination (New HOD Policy); and be it further
31

32 RESOLVED, that our AMA supports the option to take USMLE Step 3 after passing Step 2-
33 Clinical Knowledge (CK) during medical school (New HOD Policy); and be it further
34

35 RESOLVED, that our AMA advocates that residents taking the USMLE Step 3 exam be allowed
36 days off to take the exam without having this time counted for PTO or vacation balance.
37 (Directive to Take Action)

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

Received: 4/24/24

REFERENCES:

1. Step 3 Exam Content. United States Medical Licensing Exam. Accessed September 23, 2023. <https://www.usmle.org/step-exams/step-3/step-3-exam-content>
2. USMLE Stem 3 Critical Announcements. Federation of State Medical Boards. Accessed September 23, 2023. <https://www.fsmb.org/step-3/step-3-announcements/>
3. USMLE Step 3 QBank Pricing. USMLE Medical. Accessed April 12, 2024. https://medical.uworld.com/usmle/usmle-step-3/?gad_source=1&gclid=CjwKCAjwuJ2xBhA3EiwAMVjkVJXY2_FsIT_cBR1MP5wyz95pIDSA1GN7cC9IUpaNNJJNZvPnhR3RqRoCfJwQAvD_BwE
4. Sawhill AJ, Dillon GF, Ripkey DR, Hawkins RE, Swanson DB. The impact of postgraduate training and timing on USMLE Step 3 performance. *Acad Med.* 2003;78(10 Suppl):S10-S12. doi:10.1097/00001888-200310001-00004
5. "Eligibility." *USMLE*, www.usmle.org/bulletin-information/eligibility. Accessed 24 Sept. 2023.

6. Cuddy MM, Liu C, Ouyang W, Barone MA, Young A, Johnson DA. An Examination of the Associations Among USMLE Step 3 Scores and the Likelihood of Disciplinary Action in Practice. *Acad Med.* 2022;97(10):1504-1510. doi:10.1097/ACM.0000000000004775

RELEVANT AMA POLICY:

Proposed Single Examination for Licensure H-275.962: Our AMA: (1) endorses the concept of a single examination for medical licensure; (2) urges the NBME and the FSMB to place responsibility for developing Steps I and II of the new single examination for licensure with the faculty of U.S. medical schools working through the NBME; (3) continues its vigorous support of the LCME and its accreditation of medical schools and supports monitoring the impact of a single examination on the effectiveness of the LCME; (4) urges the NBME and the FSMB to establish a high standard for passing the examination; (5) strongly recommends and supports actively pursuing efforts to assure that the standard for passing be criterion-based; that is, that passing the examination indicate a degree of knowledge acceptable for practicing medicine; and (6) will work with the appropriate stakeholders to study the advantages, disadvantages, and practicality of combining the USMLE Step 1 and Step 2 CK exams into a single licensure exam measuring both foundational science and clinical knowledge competencies. [CME Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Modified: CME Rep. 2, A-10; Reaffirmed: BOT Rep. 3, I-14; Appended: Res. 309, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(A-24)

Introduced by: Resident and Fellow Section

Subject: Disaffiliation from the Alpha Omega Alpha Honor Medical Society due to Perpetuation of Racial Inequities in Medicine

Referred to: Reference Committee C

- 1 Whereas, founded in 1902, the Alpha Omega Alpha (AOA) Honor Medical Society consists of
2 over 200,000 medical student and physician members across 135 chapters with a mission to
3 recognize high educational achievement¹; and
4
- 5 Whereas, AOA membership is disproportionately White: a 2017 cohort study of 4,655 medical
6 students illustrated that AOA membership for White students was nearly 6 times greater than
7 that for Black students and nearly 2 times greater than that for Asian students²; and
8
- 9 Whereas, Black medical students are significantly less likely to be inducted into AOA compared
10 to other groups, according to a 2019 cohort study that examined data from 11,781 ERAS
11 applications³; and
12
- 13 Whereas, exclusion from AOA membership also disproportionately impacts Hispanic/Latino,
14 American Indian/Alaska Native, and Native Hawaiian/Pacific Islander students⁴; and
15
- 16 Whereas, these inequities are especially concerning given the differential access AOA
17 membership affords; AOA members are prioritized for interview invites and have greater odds of
18 matching into traditionally competitive specialties (i.e., dermatology, plastic surgery, orthopedic
19 surgery, urology, radiation oncology, and otolaryngology)⁵; and
20
- 21 Whereas, according to AOA’s website, 75% of medical school deans are AOA members,
22 suggesting that membership can amplify success over the course of one’s career¹; and
23
- 24 Whereas, entry into AOA relies heavily upon clerkship grades, which are subject to significant
25 biases, with studies showing students of color tend to receive lower clerkship grades compared
26 to their White counterparts, particularly those who are underrepresented in medicine (UIM),
27 even after controlling for test scores⁴; and
28
- 29 Whereas, in clinical evaluations, White medical students have a greater propensity to be
30 characterized by their professional attributes such as “knowledgeable,” while Black students are
31 more likely to be described by personal characteristics like “pleasant”⁶; and
32
- 33 Whereas, UIM students face additional burdens and energy expenditures that non-UIM students
34 do not experience, such as activation via triggers, internal dialogue, and threat response, which
35 may negatively impact their clerkship grades; and
36
- 37 Whereas, UIM students additionally face difficulty finding peer support networks, trouble
38 establishing peer-working relationships, and experiences of racism while being expected to lead

1 uncompensated diversity, equity, and inclusion efforts at their institutions, all of which can
2 detract from academic and clinical duties; and
3

4 Whereas, multiple institutions have disaffiliated from AOA due to racial inequities in
5 membership, including the University of San Francisco School of Medicine, the Yale School of
6 Medicine, and the Icahn School of Medicine at Mount Sinai⁷⁻⁹; and
7

8 Whereas, in 2020, AOA evolved eligibility criteria to promote diversity by increasing the number
9 of members per class and by allowing chapters to develop their own metrics, although this
10 change has failed to address the structural issues perpetuated by AOA^{10,11}; and
11

12 Whereas, disaffiliation from AOA entails eliminating institutional ties to the AOA national
13 organization, and residency applicants select “no AOA chapter at my school” under the ERAS
14 awards section; and
15

16 Whereas, disaffiliation from AOA is a critical step toward promoting equity in admissions and
17 medical education at large, and disaffiliation sends a compelling message that medical
18 education needs alternative, equitable mechanisms to recognize the excellence of trainees;
19 therefore be it
20

21 RESOLVED, that our American Medical Association recognizes that the Alpha Omega Alpha
22 Honor Medical Society disproportionately benefits privileged trainees (New HOD Policy); and be
23 it further
24

25 RESOLVED, that our AMA supports institutional disaffiliation from the Alpha Omega Alpha
26 Honor Medical Society due to its perpetuation of racial inequities in medicine (New HOD Policy);
27 and be it further
28

29 RESOLVED, that our AMA recognizes that the Alpha Omega Alpha Honor Medical Society
30 perpetuates and accentuates discrimination against trainees of color that is inherent in medical
31 training. (New HOD Policy)

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

Received: 4/24/2024

REFERENCES:

1. AOA's History. Alpha Omega Alpha Honor Medical Society. Accessed September 22, 2023. <https://www.alphaomegaalpha.org/about/aocas-history/>
2. Boatright D, Ross D, O'Connor P, Moore E, Nunez-Smith M. Racial disparities in medical student membership in the Alpha Omega Alpha Honor Society. *JAMA Internal Medicine*. 2017;177(5):659-665. doi:10.1001/jamainternmed.2016.9623
3. Wijesekera TP, Kim M, Moore EZ, Sorenson O, Ross DA. All other things being equal: exploring racial and gender disparities in medical school honor society induction. *Acad Med*. 2019;94(4):562-569. doi:10.1097/ACM.0000000000002463
4. Teherani A, Hauer KE, Fernandez A, King TE Jr, Lucey C. How small differences in assessed clinical performance amplify to large differences in grades and awards: a cascade with serious consequences for students underrepresented in medicine. *Acad Med*. 2018;93(9):1286-1292. doi:10.1097/ACM.0000000000002323
5. Charting outcomes in the match: senior students of U.S. MD medical schools, characteristics of U.S. MD seniors who matched to their preferred specialty in the 2022 main residency match. National Resident Matching Program. July 2022. Accessed September 22, 2023. https://www.nrmp.org/wp-content/uploads/2022/07/Charting-Outcomes-MD-Seniors-2022_Final.pdf
6. Rojek AE, Khanna R, Yim JWL, et al. Differences in narrative language in evaluations of medical students by gender and under-represented minority status. *J Gen Intern Med*. 2019;34(5):684-691. doi: 10.1007/s11606-019-04889-9
7. UCSF School of Medicine suspends affiliation with Alpha Omega Alpha (AOA) Honor Society. University of California San Francisco School of Medicine. June 5, 2022. Accessed September 22, 2023. <https://meded.ucsf.edu/news/ucsf-school-medicine-suspends-affiliation-alpha-omega-alpha-aoa-honor-society>

8. Study finds socioeconomic disparities in AOA Honor Medical Society membership. Yale School of Medicine. June 2, 2021. Accessed September 22, 2023. <https://medicine.yale.edu/news-article/study-finds-socioeconomic-disparities-in-awa-honor-medical-society-membership/>
9. Lynch G, Holloway T, Muller D, Palermo AG. Suspending student selections to Alpha Omega Alpha Honor Medical Society: how one school is navigating the intersection of equity and wellness. *Acad Med.* 2020;95(5):700-703. doi:10.1097/ACM.0000000000003087
10. Bynny RL, Martinez D, Cleary L, et al. Alpha Omega Alpha Honor Medical Society: A Commitment to Inclusion, Diversity, Equity, and Service in the Profession of Medicine. *Acad Med.* 2020 May;95(5):670-673. doi: 10.1097/ACM.0000000000003088.
11. Mabeza RM, Isaacs D. We Should Disaffiliate from the AOA Honor Medical Society. *Doximity.* Published February 1, 2024. Accessed April 22, 2024. <https://opmed.doximity.com/articles/we-should-disaffiliate-from-the-aoa-honor-medical-society>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(A-24)

Introduced by: Jill Owens, MD, Pennsylvania Chair

Subject: Accountability & Transparency in GME funding with Annual Report

Referred to: Reference Committee C

- 1 Whereas, funding for Graduate Medical Education (GME) is derived from both public and
2 private sources; and
3
4 Whereas, the federal government is by far the largest contributor to GME; and
5
6 Whereas, various programs that support physician workforce development are managed by
7 agencies within the Departments of Health and Human Services, Veterans Affairs, and Defense;
8 and
9
10 Whereas, Medicare is the largest source of federal GME funding and Medicaid, a joint federal-
11 state program, is the second largest source of support for GME; and
12
13 Whereas, the ACGME does not control and has no involvement in resident/fellow salaries; and
14
15 Whereas, each Sponsoring Institution's Graduate Medical Education Committee must approve
16 annual recommendations to administration regarding resident/fellow salaries and benefits; and
17
18 Whereas, the Institute of Medicine's (IOM) Committee on Government and Financing of
19 Graduate Medical Education (GME) put out their report "Graduate Medical Education That
20 Meets the Nation's Health Needs" in 2014; and
21
22 Whereas, it was in 2016 that CME last gave its report on Accountability and Transparency in
23 GME funding (CME Report 5-A-16); and
24
25 Whereas, it was from CME report 5 at A-16 that our American Medical Association adopted
26 policy H305.929 with provisions 3) and 4) committing to overall transparency and specifically
27 financial transparency with regard to Graduate Medical Education; and
28
29 Whereas, The Consolidated Appropriations Act of 2021 added 1000 new Medicare-funded
30 residency positions for the first time since 1997; and
31
32 Whereas, it was in 2022 that our AMA, through house policy H305.930, called for appropriate
33 increases in resident salaries; and therefore be it
34
35 RESOLVED, that our American Medical Association work with interested parties (including but
36 not limited to the CMS, VA, DOD and others) to issue an annual report detailing the quantity of
37 GME funding for each year including how those funds are allocated on a per resident or fellow
38 basis, for a minimum of the previous 5 years (Directive to Take Action); and be it further,
39
40 RESOLVED, that our AMA reaffirm policy H 305.929 (Last modified 2016). (Reaffirm HOD Policy)

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

Received: 4/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(A-24)

Introduced by: Pennsylvania Delegation

Subject: Physician Participation in Healthcare Organizations

Referred to: Reference Committee C

1 Whereas, within Pennsylvania there have been discussions of healthcare organizations
2 expanding the involvement of Advanced Care Practitioners (APP) within the healthcare
3 organization boards; and
4

5 Whereas, in the state of Pennsylvania, the Pennsylvania Medical Society has passed a
6 prophylactic policy “that all doctor’s medical and surgical societies both existing and newly
7 established should be chaired by MD’s or DO’s”; and
8

9 Whereas, our AMA supports physician participation in healthcare organizations via H 405.953
10 (2017) which says:

- 11 1. Our AMA will advocate for and promote the membership of physicians on the boards of
12 healthcare organizations including, but not limited to, acute care providers; insurance
13 entities; medical device manufacturers; and health technology service organizations.
- 14 2. Our AMA will promote educational programs on corporate governance that prepare and
15 enable physicians to participate on health organization boards.
- 16 3. Our AMA will provide physicians, the public, and health care organizations information
17 on the positive impact of physician leadership; therefore be it
18

19 RESOLVED, that our American Medical Association reaffirm H 405.953. (Reaffirm HOD Policy)
20

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

Received: 4/24/2024

RELEVANT AMA POLICY

Participation of Physicians on Healthcare Organization Boards H-405.953

1. Our AMA will advocate for and promote the membership of physicians on the boards of healthcare organizations including, but not limited to, acute care providers; insurance entities; medical device manufacturers; and health technology service organizations.
2. Our AMA will promote educational programs on corporate governance that prepare and enable physicians to participate on health organization boards.
3. Our AMA will provide physicians, the public, and health care organizations information on the positive impact of physician leadership.

Citation: Res. 001, A-17;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(A-24)

Introduced by: Georgia

Subject: AMA Collaboration with FSMB to Assist in Licensing Reentrant Physicians

Referred to: Reference Committee C

1 Whereas, physicians take time out of continuous practice for a variety of reasons, such as for
2 mental or physical health issues, family or personal life events; and
3
4 Whereas, such time off from practice raises questions about a physician's fitness to return to
5 active practice; and
6
7 Whereas, state medical boards are charged with protecting the public and must evaluate
8 physicians wishing to return to practice to determine their readiness to practice in a safe and
9 competent manner; and
10
11 Whereas, the Federation of State Medical Boards (FSMB) established the Workgroup on
12 Reentry in 2023 to evaluate and revise its existing policies on physician reentry to practice; and
13
14 Whereas, the FSMB Workgroup on Reentry found a paucity of research to support
15 development of reentry policies, procedures, and resources for state medical boards; and
16
17 Whereas, a survey of state medical boards found that only 57% have a policy or formal process
18 for the evaluation or retraining for physician reentry to practice; and
19
20 Whereas, no structured/consistent criteria or standardized processes exist across the country to
21 facilitate reentry without subjectivity, bias or possibly arbitrariness; and
22
23 Whereas, there is a need for a consistent approach to reentry to practice, informed by evidence
24 based criteria, where available; and
25
26 Whereas, the collection of relevant research and data will require multiple sources of
27 information beyond state medical boards, including specialty societies, certification boards and
28 post licensure training programs; and
29
30 Whereas, the AMA, with its broad representation within the House of Medicine has the
31 resources to support such data collection and research; therefore be it
32
33 RESOLVED, that our American Medical Association work with the FSMB, specialty and
34 subspecialty societies, and other relevant stakeholders to study and develop evidence-based
35 criteria for determining a physician's readiness to reenter practice and identify resources for the
36 evaluation and retraining of physicians seeking to reenter active practice. (Directive to Take
37 Action)

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

Received: 4/24/2024

REFERENCES

1. <https://www.fsmb.org/about-fsmb/>
2. <https://www.fsmb.org/siteassets/advocacy/policies/board-requirements-on-re-entry-to-practice.pdf>

RELEVANT AMA POLICY

Physician Reentry D-300.984

Our AMA:

1. Will continue to collaborate with other appropriate organizations on physician reentry issues including research on the need for and the effectiveness of reentry programs.
2. Will work collaboratively with the American Academy of Pediatrics and other interested groups to convene a conference on physician reentry which will bring together key stakeholders to address the development of reentry programs as well as the educational needs of physicians reentering clinical practice.
3. Will work with interested parties to establish a physician reentry program (PREP) information data base that is publicly accessible to physician applicants and which includes information pertaining to program characteristics.
4. Will support efforts to ensure the affordability and accessibility, and to address the unique liability issues related to PREPs.
5. Will make available to all interested parties the physician reentry program (PREP) system Guiding Principles for use as a basis for all reentry programs:
 - a. Accessible: The PREP system is accessible by geography, time and cost. Reentry programs are available and accessible geographically across the United States and include national and regional pools of reentry positions. Reentering physicians with families or community ties are not burdened by having to relocate to attend a program. The length of time of reentry programs is standardized and is commensurate with the assessed clinical and educational needs of reentering physicians. The cost of reentry programs is not prohibitive to the physician, health care institutions or the health care system.
 - b. Collaborative: The PREP system is designed to be collaborative to improve communication and resource sharing. Information and materials including evaluation instruments are shared across specialties, to the extent possible, to improve program and physician performance. A common nomenclature is used to maximize communication across specialties. Reentry programs share resources and create a common repository for such resources, which are easily accessible.
 - c. Comprehensive: The PREP system is comprehensive to maximize program utility. Physician reentry programs prepare physicians to return to clinical activity in the discipline in which they have been trained or certified and in the practice settings they expect to work including community-based, public health, and hospital-based or academic practice.
 - d. Ethical: The PREP system is based on accepted principles of medical ethics. Physician reentry programs will conform to physician licensure statutes. The standards of professionalism, as stated in the AMA Code of Medical Ethics, must be followed.
 - e. Flexible: The PREP system is flexible in structure in order to maximize program relevancy and usefulness. Physician reentry programs can accommodate modifications to program requirements and activities in ways that are optimal to the needs of reentering physicians.
 - f. Modular: Physician reentry programs are modularized, individualized and competency-based. They are tailored to the learning needs of reentering physicians, which prevents the need for large, expensive, and standardized programs. Physicians should only be required to take those modules that allow them to meet an identified educational need.
 - g. Innovative: Innovation is built into a PREP system allowing programs to offer state of the art learning and meet the diverse and changing needs of reentry physicians. Physician reentry programs develop and utilize learning tools including experimenting with innovative and novel curricular methodologies such as distance learning technologies and simulation.
 - h. Accountable: The PREP system has mechanisms for assessment and is open to evaluation. Physician reentry programs have an evaluation component that is comparable among all specialties. Program assessments use objective measures to evaluate physician's competence at time of entry, during the program and at time of completion. Program outcomes are measured. Reliability and validity of the measures are established. Standardization of measures exist across programs to assess whether or not national standards are being met.
 - i. Stable: A funding scheme is in place to ensure the PREP system is financially stable over the long-term. Adequate funding allows physician reentry programs to operate at sufficient and

appropriate capacity. j. Responsive: The PREP system makes refinements, updates and other changes when necessary. Physician reentry programs are equipped to address systemic changes such as changes in regulations. Additionally, the PREP system is prepared to respond efficiently to urgent health care needs within society including mobilizing clinically inactive physicians temporarily into the workforce to attend to an acute public health crisis, such as a terrorist, biological, chemical, or natural disaster.

6. Our AMA encourages each state which does not grant a full and unrestricted license to physicians undergoing reentry to develop a non-disciplinary category of licensure for physicians during their reentry process.

Citation: (CME Rep. 6, A-08; Reaffirmed: CME Rep. 11, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Appended: Res. 310, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(A-24)

Introduced by: Oklahoma

Subject: CME for Rural Preceptorship

Referred to: Reference Committee C

1 Whereas, rural Americans are more likely to die from heart disease, cancer, unintentional injury,
2 chronic lower respiratory disease, and stroke than their urban counterparts¹; and

3
4 Whereas, there are fewer health care providers per capita in nonmetropolitan areas; Although
5 nearly 20% of the U.S. population lives in rural areas, less than 10% of U.S. doctors practice in
6 rural areas²; and

7
8 Whereas, there are fewer health care providers per capita in nonmetropolitan areas; Although
9 nearly 20% of the U.S. population lives in rural areas, less than 10% of U.S. doctors practice in
10 rural areas²; and

11
12 Whereas, Continuing Medical Education (CME) credits are vital to all physicians; and

13
14 Whereas, being a “preceptor” for medical students, residents, fellows, and other allied health
15 professional students requires countless hours of preparation; and

16
17 Whereas, the American Osteopathic Association (AOA) offers category 1B credit to its members
18 for participation in the AOA Didactic and Preceptor Program⁴; and

19
20 Whereas, 60 AOA category 1B credits may be applied to the required 120 hours of CME for
21 AOA physicians⁴; and

22
23 Whereas, the American Academy of Family Physicians offers CME credits to its members for
24 teaching of medical students, residents, and other allied health professional students⁵; and

25
26 Whereas, the American Medical Association (AMA) does not recognize the AOA credits
27 awarded for teaching and being a preceptor; and

28
29 Whereas, recognizing such efforts would encourage more physicians to be involved in preceptor
30 programs especially rural, which in turn would expose more students to the practice of medicine
31 in more rural and underserved areas; therefore be it

32
33 RESOLVED, that our American Medical Association along with the Council of Medical
34 Education, formulate a “toolkit” to teach physicians who serve as preceptors, especially in rural
35 and underserved areas, how to be better preceptors and the process on claiming AMA Category
36 1 credits for preparation and teaching medical students, residents, fellows, and other allied
37 health professional students training in Liaison Committee on Medical Education/Accreditation
38 Council for Graduate Medical Education accredited institutions, thereby making them a more
39 effective preceptor (Directive to Take Action); and be it further

1 RESOLVED, that our AMA study formulating a plan, in collaboration with other interested
2 bodies, to award AMA Category 1 credits to physicians who serve as preceptors in rural and
3 underserved areas teaching medical students, residents, fellows, and other allied health
4 professional students training in Liaison Committee on Medical Education/Accreditation Council
5 for Graduate Medical Education accredited institutions thereby improving the rural healthcare
6 workforce shortage (Directive to Take Action); and be it further

7
8 RESOLVED, that our AMA devise a method of converting those credits awarded by other
9 organizations into AMA recognized credits for the purpose of CME. (Directive to Take Action)

10
Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 4/22/2024

REFERENCES

1. <https://www.cdc.gov/ruralhealth/about.html#:~:text=Rural%20Americans%20are%20more%20likely,stroke%20than%20their%20urban%20counterparts.>
2. <https://www.incrediblehealth.com/blog/8-statistics-that-explain-the-rural-doctor-shortage/#:~:text=There%20are%20fewer%20health%20care,doctors%20practice%20in%20rural%20areas.>
3. <https://meridian.allenpress.com/jgme/article/14/4/441/484914/Family-Medicine-Residencies-How-Rural-Training>
4. <https://osteopathic.org/cme/cme-faqs/>
5. <https://www.aafp.org/pubs/fpm/issues/2012/0300/p8a.html#:~:text=Learning%20hands%20on%20how%20a,rewarding%20way%20to%20earn%20CME>

RELEVANT AMA POLICY

H-300.977, Revisions to Physician's Registration Award

Our AMA has adopted the following changes in the Physician's Recognition Award:

to accept recertification by an AMA-recognized specialty board in satisfaction of requirements for a three-year PRA certificate;

(2) to allow credit for international conferences when these have been approved by the AMA prior to the event; and

(3) to allow credit for teaching to be reported for AMA PRA Category 2 Credit™ toward the award.

H-300.988, Restoring Integrity to Continuing Medical Education

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314
(A-24)

Introduced by: Women Physicians Section

Subject: Reducing the Lifetime Earnings Gap in the U.S. with Similar Educational Attainment by Employing the Gainful Employment Rule

Referred to: Reference Committee C

1 Whereas, the value of a college education was demonstrated in a 2002 Census Bureau study
2 that “estimated in 1999, the average lifetime earnings of a Bachelor’s degree holder was \$2.7
3 million, and 75 percent more than that earned by high school graduates in 1999”; and
4

5 Whereas, according to the Georgetown’s College Payoff report, those who possess “some
6 postsecondary education, even without earning a degree, add nearly one quarter of a million
7 dollars to lifetime earnings...and earnings rise substantially for those with Doctoral and
8 Professional degrees...”; and
9

10 Whereas, the Social Security Administration reports that “lifetime earnings have important
11 implications for retirement outcomes, including the level of Social Security benefits”; and
12

13 Whereas, “there are substantial differences in lifetime earnings by educational attainment”; and
14

15 Whereas, the Social Security Administration states recent research reflects that “men with
16 graduate degrees earn \$1.5 million more in median lifetime earnings than high school
17 graduates, and women with graduate degrees earn \$1.1 million more”; and
18

19 Whereas, according to the Georgetown College Payoff report, “the largest gender gap in
20 earnings is for those with professional degrees...men earn about a million dollars more over a
21 lifetime than women with these degrees”; and
22

23 Whereas, the Federal Registrar states that gainful employment reflects the “reasonable
24 relationship between the loan debt incurred by students in a training program and income from
25 employment after the training”; and
26

27 Whereas, “the Higher Education Act requires that certificate programs at all institutions and
28 degree programs at private for-profit colleges must provide training that prepares students for
29 gainful employment in a recognized occupation;” and “programs would have to show that:
30

31 a. “Graduates can afford their yearly debt payments...and the share of their annual
32 earnings needed to devote to paying their debt must be equal to or less than 8 percent,
33 or equal to or less than 20 percent of their discretionary earnings.”
34

35 b. “At least half of graduates have higher earnings than a typical high school graduate in
36 their State’s labor force who never pursued a postsecondary education”; and
37

38 Whereas, according to the U.S. Department of Education, the Biden-Harris Administration
39 “released final regulations that establish the most effective set of safeguards ever against

1 unaffordable debt or insufficient earnings for postsecondary students” and continue to seek
2 ways to reduce the student debt burden; therefore be it

3
4 RESOLVED, that our American Medical Association collaborate with higher education
5 authorities to research physician career outcomes and explore financial value transparency
6 among higher educational institutional programs that grant professional and doctoral degrees
7 beyond six years following graduation in light of the new gainful employment regulations and
8 transparency provisions that will take effect July 1, 2024 (Directive to Take Action); and be it
9 further

10
11 RESOLVED, that our AMA continue to work with key stakeholders and advocate for the
12 resolution of the student loan crisis to protect physicians from unaffordable student debt and
13 poor earning outcomes. (Directive to Take Action)

14
Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/3/2024

REFERENCES

1. Carnevale AP, Rose SJ, Cheah B. The college payoff: (Education, occupation, and lifetime earnings Report) Washington, DC: Georgetown University Center on Education and the Workforce; 2013. Retrieved from <https://cew.georgetown.edu/report/the-college-payoff>
2. "Department of Education Releases Proposed Rules on Accountability for Certificate and For-Profit Programs and Transparency into Unaffordable Student Debt." 28 February 2024. <https://www.ed.gov/news/press-releases/department-education-releases-proposed-rules-accountability-certificate-and-profit-programs-and-transparency-unaffordable-student-debt>
3. Press Office. "Biden-Harris Administration Announces Landmark Final Rules to Protect Consumers from Unaffordable Student Debt and Increase Transparency." 27 September 2023. 28 February 2024. <https://www.ed.gov/news/press-releases/biden-harris-administration-announces-landmark-final-rules-protect-consumers-unaffordable-student-debt-and-increase-transparency>
4. Social Security Administration. "Research, Statistics & Policy Analysis." 28 February 2024. <https://www.ssa.gov/policy/docs/research-summaries/education-earnings.html>

RELEVANT AMA POLICY

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with

educational debt.

7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
23. Continue to monitor opportunities to reduce additional expense burden upon medical students including reduced-cost or free programs for residency applications, virtual or hybrid interviews, and other cost-reduction initiatives aimed at reducing non-educational debt.
24. Encourage medical students, residents, fellows and physicians in practice to take advantage of available loan forgiveness programs and grants and scholarships that have been historically underutilized, as well as financial information and resources available through the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine, as required by the Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation, and resources available at the federal, state and local levels.
25. Support federal efforts to forgive debt incurred during medical school and other higher education by physicians and medical students, including educational and cost of attendance debt.

26. Support that residency and fellowship application services grant fee assistance to applicants who previously received fee assistance from medical school application services or are determined to have financial need through another formal mechanism. [CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21; Reaffirmation: A-22; Appended: CME Rep. 02, A-23; Appended: Res. 311, A-23]

Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic D-305.951

Our AMA will study the issue of medical education debt cancellation and consider the opportunities for integration of this into a broader solution addressing debt for all medical students and physicians. [Res. 301, A-22]

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. [Res. 226, I-10; Reaffirmed: BOT Rep. 04, A-20]

Medical Student Debt and Career Choice D-305.952

1. Our AMA encourages key stakeholders to collect and disseminate data on the impacts of medical education debt on career choice, especially with regard to the potentially intersecting impacts of race/ethnicity, socioeconomic status, and other key sociodemographic factors.
2. Our AMA will monitor new policies and novel approaches to influence career choice based on the key factors that affect the decision to enter a given specialty and subspecialty. [CME Rep. 4, I-21; Reaffirmed: CME Rep. 02, A-23]

Principles for Graduate Medical Education H-310.929

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.

(1) PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE. There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care. Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.

(2) RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING. Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

(3) EDUCATION IN THE BROAD FIELD OF MEDICINE. GME should provide a resident physician with broad clinical experiences that address the general competencies and professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) SCHOLARLY ACTIVITIES FOR RESIDENTS. Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

(5) FACULTY SCHOLARSHIP. All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) **INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS.** Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form housestaff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) **COMPENSATION OF RESIDENT PHYSICIANS.** All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) **LENGTH OF TRAINING.** The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) **PROVISION OF FORMAL EDUCATIONAL EXPERIENCES.** Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) **INNOVATION OF GRADUATE MEDICAL EDUCATION.** The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) **THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION.** Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) **SUPERVISION OF RESIDENT PHYSICIANS.** Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution. [CME Rep. 9, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 14, A-09; Modified: CME Rep. 06, I-18; Reaffirmed: CME Rep. 01, I-22]

Abolish Discrimination in Licensure of IMGs H-255.966

1. Our AMA supports the following principles related to medical licensure of international medical graduates (IMGs):

A. State medical boards should ensure uniformity of licensure requirements for IMGs and graduates of U.S. and Canadian medical schools, including eliminating any disparity in the years of graduate medical education (GME) required for licensure and a uniform standard for the allowed number of administrations of licensure examinations.

B. All physicians seeking licensure should be evaluated on the basis of their individual education, training, qualifications, skills, character, ethics, experience and past practice.

C. Discrimination against physicians solely on the basis of national origin and/or the country in which they completed their medical education is inappropriate.

D. U.S. states and territories retain the right and responsibility to determine the qualifications of individuals applying for licensure to practice medicine within their respective jurisdictions.

E. State medical boards should be discouraged from a) using arbitrary and non-criteria-based lists of approved or unapproved foreign medical schools for licensure decisions and b) requiring an interview or oral examination prior to licensure endorsement. More effective methods for evaluating the quality of IMGs' undergraduate medical education should be pursued with the Federation of State Medical Boards (FSMB) and other relevant organizations. When available, the results should be a part of the determination of eligibility for licensure.

2. Our AMA will continue to work with the FSMB to encourage parity in licensure requirements for all physicians, whether U.S. medical school graduates or international medical graduates.

3. Our AMA will continue to work with the Educational Commission for Foreign Medical Graduates and other appropriate organizations in developing effective methods to evaluate the clinical skills of IMGs.

4. Our AMA will work with state medical societies in states with discriminatory licensure requirements between IMGs and graduates of U.S. and Canadian medical schools to advocate for parity in licensure requirements, using the AMA International Medical Graduate Section licensure parity model resolution as a resource.

5. Our AMA will: (a) encourage states to study existing strategies to improve policies and processes to assist IMGs with credentialing and licensure to enable them to care for patients in underserved areas; and (b) encourage the FSMB and state medical boards to evaluate the progress of programs aimed at reducing barriers to licensure--including successes, failures, and barriers to implementation. [BOT Rep. 25, A-15; Appended: CME Rep. 4, A-21]

Recommendations for Future Directions for Medical Education H-295.995

Our AMA supports the following recommendations relating to the future directions for medical education:

(1) The medical profession and those responsible for medical education should strengthen the general or

broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.

(2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.

(3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.

(4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.

(5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.

(6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.

(7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.

(8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.

(9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.

(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.

(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.

(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.

(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.

(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.

(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.

(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.

(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b)

Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.

(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.

(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.

(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.

(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.

(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.

(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.

(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.

(25) Specialty boards should consider having members of the public participate in appropriate board activities.

(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.

(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US.

Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.

(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.

(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and

to develop new methods having an acceptable degree of reliability and validity should be supported.

(30) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.

(31) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.

(32) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.

(33) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.

(34) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.

(35) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.

(36) Our AMA will strongly advocate for the rights of medical students, residents, and fellows to have physician-led (MD or DO as defined by the AMA) clinical training, supervision, and evaluation while recognizing the contribution of non-physicians to medical education.

(37) Our AMA will publicize to medical students, residents, and fellows their rights, as per Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education guidelines, to physician-led education and a means to report violations without fear of retaliation. [CME Rep. B, A-82; Amended: CLRPD Rep. A, I-92; Res. 331, I-95; Reaffirmed by Res. 322, A-97; Reaffirmation I-03; Modified: CME Rep. 7, A-05; Modified: CME Rep. 2, I-05; Appended: CME Rep. 5, A-11; Reaffirmed: CME Rep. 3, A-11; Modified: CME Rep. 01, I-17; Appended: Res. 961, I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(A-24)

Introduced by: Maryland

Subject: Cease Reporting of Total Attempts of USMLE STEP1 and COMLEX-USA
Level 1 Examinations

Referred to: Reference Committee C

1 Whereas, in September 2021, the United States Medical Licensing Examination (USMLE) made
2 an official announcement regarding the implementation of a revised assessment format for
3 STEP1, wherein the conventional numeric scoring system and binary pass/fail outcomes would
4 be replaced solely with a pass/fail designation for examinations commencing in January 2022¹;
5 and
6
7 Whereas, alongside this transition, the passing threshold for STEP1 was heightened, and the
8 permissible number of attempts was reduced from six to four,¹ with the aim of alleviating the
9 psychological burden commonly associated with the examination process, while concurrently
10 fostering a more comprehensive evaluation of applicants; and
11
12 Whereas, the pass rate for all examinees in 2022 declined to 82%, compared to the previous
13 rate of 88% in 2021 prior to the introduction of the new scoring system² and
14
15 Whereas, studies have indicated significant performance disparities between men and women
16 taking STEP1, as well as variations based on the age at the time of examination;^{3,4} and
17
18 Whereas, the process of preparing for and undertaking the USMLE STEP1 exam has been
19 associated with excessive stress and social isolation⁵; and
20
21 Whereas, research has revealed that medical students encounter higher levels of burnout,
22 depressive symptoms, suicidal ideation, and substance use compared to the general
23 population;^{6,7} and
24
25 Whereas, the transition to a binary scoring system has led to heightened pressure to pass the
26 exam on the first attempt; and
27
28 Whereas, the implementation of the pass/fail scoring system has also led to an increased
29 emphasis on extracurricular activities and the STEP2 exam, a more clinically relevant exam, as
30 the primary means of distinguishing applicants and maintaining competitiveness;⁸ and
31 Whereas, in contrast to the STEP2 exam, STEP1 is considered less clinically relevant and an
32 inadequate indicator of future professional competence as a physician;⁹ and
33
34 Whereas, given that STEP1 has moved to pass/fail and is now a mere threshold to be crossed,
35 lacks clinical significance compared to STEP2, and is an inadequate indicator of future
36 professional competence as a physician, it is reasonable to move away from reporting failed
37 attempts or total number of attempts to residency and fellowship programs, as well as licensure
38 authorities; and

1 Whereas, transitioning away from reporting failed attempts on the STEP1 and Level 1
2 examinations would be another potential avenue to better support medical student mental
3 health and wellness and would align with the goal of creating a more comprehensive and
4 balanced evaluation of medical students; and

5
6 Whereas, our AMA has ample policy regarding supporting the mental health and wellness of
7 trainees in both the undergraduate and graduate medical education levels (H-345.970); and

8
9 Whereas, our AMA has expressed its support for the holistic review of medical school applicants
10 and has encouraged residency directors not to utilize ranked passing scores as a screening
11 criterion (H-275.953); therefore be it

12
13 **RESOLVED**, that our American Medical Association advocate that NBME and NBOME cease
14 reporting the total number of attempts of the STEP1 and COMLEX-USA Level 1 examinations to
15 residency and fellowship programs and licensure. (Directive to Take Action)

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

Received: 5/6/2024

REFERENCES

1. USMLE. USMLE Step 1 Transition to Pass/Fail Only Score Reporting. 2023. <https://www.usmle.org/usmle-step-1-transition-passfail-only-score-reporting>
2. USMLE. Early Release of USMLE Step 1 2022 Summary Performance. 2023. <https://www.usmle.org/early-release-usmle-step-1-2022-summary-performance>
3. Cuddy MM, Swanson DB, Clauser BE. A multilevel analysis of examinee gender and USMLE step 1 performance. *Acad Med.* Oct 2008;83(10 Suppl):S58-62. doi:10.1097/ACM.0b013e318183cd65
4. Gauer JL, Jackson JB. Relationships of demographic variables to USMLE physician licensing exam scores: a statistical analysis on five years of medical student data. *Adv Med Educ Pract.* 2018;9:39-44. doi:10.2147/amep.S152684
5. Baniadam K, Elkadi S, Towfighi P, Aminpour N, Sutariya R, Chen HC. The Impact on Medical Student Stress in Relation to a Change in USMLE Step 1 Examination Score Reporting to Pass/Fail. *Med Sci Educ.* Apr 2023;33(2):401-407. doi:10.1007/s40670-023-01749-4
6. Jackson ER, Shanafelt TD, Hasan O, Satele DV, Dyrbye LN. Burnout and Alcohol Abuse/Dependence Among U.S. Medical Students. *Academic Medicine.* 2016;91(9):1251-1256. doi:10.1097/acm.0000000000001138
7. Klein HJ, McCarthy SM. Student wellness trends and interventions in medical education: a narrative review. *Humanities and Social Sciences Communications.* 2022/03/23 2022;9(1):92. doi:10.1057/s41599-022-01105-8
8. Ehrlich H, Sutherland M, McKenney M, Elkbuli A. Implications of the United States Medical Licensing Examination Step 1 Examination Transition to Pass/Fail on Medical Students Education and Future Career Opportunities. *The American Surgeon™.* 2021;87(8):1196-1202. doi:10.1177/0003134820973382
9. Cuddy MM, Young A, Gelman A, et al. Exploring the Relationships Between USMLE Performance and Disciplinary Action in Practice: A Validity Study of Score Inferences From a Licensure Examination. *Acad Med.* Dec 2017;92(12):1780-1785. doi:10.1097/acm.0000000000001747

RELEVANT AMA POLICY

The Grading Policy for Medical Licensure Examinations H-275.953

1. Our AMA's representatives to the ACGME are instructed to promote the principle that selection of residents should be based on a broad variety of evaluative criteria, and to propose that the ACGME General Requirements state clearly that residency program directors must not use NBME or USMLE ranked passing scores as a screening criterion for residency selection.
2. Our AMA adopts the following policy on NBME or USMLE examination scoring: (a) Students receive "pass/fail" scores as soon as they are available. (If students fail the examinations, they may request their numerical scores immediately.) (b) Numerical scores are reported to the state licensing authorities upon request by the applicant for licensure. At this time, the applicant may request a copy of his or her numerical scores. (c) Scores are reported in pass/fail format for each student to the medical school. The school also receives a frequency distribution of numerical scores for the aggregate of their students.
3. Our AMA will: (a) promote equal acceptance of the USMLE and COMLEX at all United States residency programs; (b) work with appropriate stakeholders including but not limited to the National Board

of Medical Examiners, Association of American Medical Colleges, National Board of Osteopathic Medical Examiners, Accreditation Council for Graduate Medical Education and American Osteopathic Association to educate Residency Program Directors on how to interpret and use COMLEX scores; and (c) work with Residency Program Directors to promote higher COMLEX utilization with residency program matches in light of the new single accreditation system.

4. Our AMA will work with appropriate stakeholders to release guidance for residency and fellowship program directors on equitably comparing students who received 3-digit United States Medical Licensing Examination Step 1 or Comprehensive Osteopathic Medical Licensing Examination of the United States Level 1 scores and students who received Pass/Fail scores.

Improving Mental Health Services for Undergraduate and Graduate Students H-345.970

Our AMA supports: (1) strategies that emphasize de-stigmatization and enable timely and affordable access to mental health services for undergraduate and graduate students, in order to improve the provision of care and increase its use by those in need; (2) colleges and universities in emphasizing to undergraduate and graduate students and parents the importance, availability, and efficacy of mental health resources; and (3) collaborations of university mental health specialists and local public or private practices and/or health centers in order to provide a larger pool of resources, such that any student is able to access care in a timely and affordable manner

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 316
(A-24)

Introduced by: New England

Subject: Reassessment of Continuing Board Certification Process

Referred to: Reference Committee C

1 Whereas, the continuing board certification process (CBC), previously known as maintenance of
2 certification (MOC) process put forth by the American Board of Medical Specialties (ABMS) and
3 American Osteopathic Association (AOA) has been recognized by a variety of state medical
4 societies and our American Medical Association (AMA) to be expensive and burdensome for
5 physicians without providing independent studies showing benefits for physicians, patients, or
6 the general public; and
7

8 Whereas, a 2023 Survey of Clinical Oncologists ([https://connection.asco.org/magazine/asco-](https://connection.asco.org/magazine/asco-member-news/asco-members-weigh-abim-maintenance-certification-program)
9 [member-news/asco-members-weigh-abim-maintenance-certification-program](https://connection.asco.org/magazine/asco-member-news/asco-members-weigh-abim-maintenance-certification-program)) found that an
10 overwhelming majority (82%) felt that MOC was an unnecessary addition beyond typical
11 Continuing Medical Education (CME) requirements, with additional, widespread agreement
12 (74%) that MOC does not improve their clinically relevant knowledge or improve the quality of
13 patient care; and
14

15 Whereas, the National Board of Physicians and Surgeons (NBPAS), was founded in 2015
16 specifically to address the acknowledged onerous CBC process and offers a less burdensome
17 and expensive alternative; and
18

19 Whereas, item 30 of policy D-275.954 calls to “Support a recertification process based on high
20 quality, appropriate Continuing Medical Education (CME) material directed by the AMA
21 recognized specialty societies covering the physician’s practice area...to ensure lifelong
22 learning”, which, along with requiring initial ABMS board certification, is one of the mechanisms
23 utilized by NBPAS to certify physicians; and
24

25 Whereas, our AMA policy, D-275.954¹ Continuing Board Certification, limits discussion of CBC
26 to only ABMS and member boards, thus imposing its imprimatur on these boards to the
27 exclusion of alternative boards, preempting an evidenced-based, thorough, and comprehensive
28 discussion and evaluation of the current CBC opportunities available to physicians; and
29

30 Whereas, our AMA policy, H-275.926² Medical Specialty Board Certification Standards,
31 specifically excludes our AMA from considering NBPAS as an accepted alternative CBC
32 pathway because it does not provide its own certification exam nor ongoing, thus limiting
33 physician choice and autonomy and discriminating against the approximately 11,000 physicians
34 who are currently certified by NBPAS; and
35

36 Whereas, policies D-275.954 and H-275.926 do not provide evidence to support accepting
37 ABMS CBC over NBPAS CBC nor provide evidence that NBPAS CBC is inferior to ABMS CBC
38 with respect to physician competence, patient safety, patient satisfaction, malpractice rates, or
39 any other measures of physician performance; and

1 Whereas, NBPAS CBC has demonstrated their legitimacy as a widely accepted certification
2 body as they are recognized by major national accrediting bodies, including, the Joint
3 Commission, the National Committee on Quality Assurance (NCQA), the Utilization Review
4 Accreditation Commission (URAC), the Council for Affordable Quality Healthcare (CAQH),
5 Medicare and Medicaid, and Det Norske Veritas, Inc. (DNV) and many insurers also accept
6 CBC through NBPAS including Blue Cross Blue Shield (BCBS), United Healthcare (UHC),
7 Aetna, Humana, Priority, and Geisinger Health Plan; and
8

9 Whereas, the Massachusetts Medical Society convened a meeting with the Accreditation
10 Council for Continuing Medical Education (ACCME®) followed by a joint meeting with AOA,
11 ABMS, and NBPAS that included presentations by each board. The data presented and
12 discussion in those meetings failed to offer substantial evidence that ABMS CBC process
13 subsequent to initial board certification resulted in improved quality of care and better patient
14 outcomes compared to NBPAS, leading us to question if the current reliance on ABMS CBC
15 and exclusion of NBPAS CBC meets the needs of physicians, patients, and the public; therefore
16 be it
17

18 RESOLVED, that our American Medical Association undertake a thorough review and analysis
19 of the available literature, data, and evidence to re-examine and update the accepted standards
20 for continuing board certification including policy H-275.926, Medical Specialty Board
21 Certification Standards, so the standards reflect the best manner to assess physicians'
22 knowledge and skills necessary to practice medicine. (Directive to Take Action)
23

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

Received: 5/7/2024

REFERENCES

1. AMA Policy D-275.954 Continuing Board Certification
2. AMA Policy H-275.926

RELEVANT AMA POLICY

Continuing Board Certification D-275.954

Our AMA will:

1. Continue to monitor the evolution of Continuing Board Certification (CBC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for CBC, and prepare a report regarding the CBC process at the request of the House of Delegates or when deemed necessary by the Council on Medical Education.
2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Councils ongoing efforts to critically review CBC issues.
3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of CBC, and encourage the ABMS to report its research findings on the issues surrounding certification and CBC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the ability of physicians to access and apply knowledge to care for patients, and to continue to examine the evidence supporting the value of specialty board certification and CBC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III) component of CBC, including the exploration of alternative formats, in ways that effectively evaluate acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that CBC uses more than one pathway to assess accurately the competence of practicing physicians, to monitor for exam relevance and to ensure that CBC does not lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.

7. Recommend that the ABMS not introduce additional assessment modalities that have not been validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written, from CBC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the costs of preparing, administering, scoring and reporting CBC and certifying examinations.
10. Encourage the ABMS to ensure that CBC and certifying examinations do not result in substantial financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of CBC on physicians with multiple board certifications, particularly to ensure that CBC is specifically relevant to the physicians current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple and diverse physician educational and quality improvement activities to qualify for CBC; (b) support ABMS member board activities in facilitating the use of CBC quality improvement activities to count for other accountability requirements or programs, such as pay for quality/performance or PQRS reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement programs across all boards; and (d) work with specialty societies and ABMS member boards to develop tools and services that help physicians meet CBC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or discontinue their board certification.
14. Work with the ABMS to study whether CBC is an important factor in a physicians decision to retire and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from CBC to track whether physicians are maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping CBC by seeking leadership positions on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and CBC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for modification of CBC.
18. Encourage medical specialty societies leadership to work with the ABMS, and its member boards, to identify those specialty organizations that have developed an appropriate and relevant CBC process for its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the CBC requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the due dates of the multi-stage requirements of continuous professional development and performance in practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the CBC process be required to participate in CBC.
22. Continue to participate in the Coalition for Physician Accountability, formerly known as the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work together toward utilizing Consortium performance measures in Part IV of CBC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty boards CBC and associated processes.
26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the CBC program.
27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Continuing Board Certification.
28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on continuing board certification activities relevant to their practice.
29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a

secure, high-stakes recertification examination.

30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physicians practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.

32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Continuing Board Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.

34. Increase its efforts to work with the insurance industry to ensure that continuing board certification does not become a requirement for insurance panel participation.

35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for CBC Part IV.

36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.

37. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS), ABMS Committee on Continuing Certification (3C), and ABMS Stakeholder Council to pursue opportunities to implement the recommendations of the Continuing Board Certification: Vision for the Future Commission and AMA policies related to continuing board certification.

38. Our AMA, through its Council on Medical Education, will continue to work with the American Board of Medical Specialties (ABMS) and ABMS member boards to implement key recommendations outlined by the Continuing Board Certification: Vision for the Future Commission in its final report, including the development and release of new, integrated standards for continuing certification programs that will address the Commissions recommendations for flexibility in knowledge assessment and advancing practice, feedback to diplomates, and consistency.

39. Our AMA will work with the ABMS and its member boards to reduce financial burdens for physicians holding multiple certificates who are actively participating in continuing certification through an ABMS member board, by developing opportunities for reciprocity for certification requirements as well as consideration of reduced or waived fee structures.

40. Our AMA will continue to publicly report its work on enforcing AMA Principles on Continuing Board Certification.

Medical Specialty Board Certification Standards H-275.926

1. Our AMA:

(1) Opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.

(2) Opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.

(3) Continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both a) a process for defining specialty-specific standards for knowledge and skills and b) offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.

(4) Opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.

(5) Advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.

(6) Encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.

American Medical Association House of Delegates

Resolution: 317
(A-24)

Introduced by: New York

Subject: Physician Participation in the Planning and Development of Accredited Continuing Education for Physicians

Referred to: Reference Committee C

1 Whereas, Accredited Continuing Education is recognized as essential for the continuing
2 professional and personal development for physicians in order to improve the health and
3 wellbeing of patients as well as the community; and
4
5 Whereas, Accredited Continuing Medical Education (ACCME) current policies and guidelines do
6 not require an accredited provider of Continuing Education (CE) providing education for
7 physicians to be organizations for (or led) by physicians; and
8
9 Whereas, many such non-physician led accredited CE provider entities are engaged in
10 providing accredited CE to physicians; and
11
12 Whereas, accredited providers are not required to disclose to its physician learners whether any
13 physicians were engaged in the planning and development of the CE activity; and
14
15 Whereas, ACCME policies require that all accredited CE identify professional practice gaps for
16 the development of CE activities; and
17
18 Whereas, to ensure that all accredited CE for physicians addresses the needs of physician
19 learners that CE for physicians is planned and developed with physician involvement; and
20
21 Whereas, MSSNY adopted policy 50.985 Requiring Physician Participation in the Planning and
22 Development of Accredited Continuing Medical Education for Physicians; therefore be it
23
24 RESOLVED, that our American Medical Association petition the Accredited Continuing Medical
25 Education to develop policies which require physician participation in the planning and
26 development of accredited continuing education for physicians. (Directive to Take Action)

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

Received: 5/8/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 318
(A-24)

Introduced by: American Urological Association

Subject: Variation in Board Certification and Licensure Requirements for
Internationally-Trained Physicians and Access to Care

Referred to: Reference Committee C

- 1 Whereas, there exists significant variation in board certification requirements for physicians who
2 complete post-graduate training (i.e. resident/fellowship) outside of the United States,
3 “internationally trained physicians”; and
4
- 5 Whereas, while half of the American Board of Medical Specialties’ member boards allow board
6 certification from physicians accredited in other countries outside of Canada, the scope and
7 variations in board certification requirements is not well-documented and the degree to which
8 these requirements are able to ensure quality is not well understood; and
9
- 10 Whereas, according to projections published by the Association of American Medical Colleges,
11 the United States will face a physician shortage of up to 86,000 physicians by 2036; and
12
- 13 Whereas, the Health Resources and Services Administration projects a 34 percent non-metro
14 adequacy for all physician types by 2036; and
15
- 16 Whereas, two of five physicians are reaching the traditional retirement age of 65 within the next
17 10 years; and
18
- 19 Whereas, 87% of American physicians are board certified; and
20
- 21 Whereas, 25% of licensed physicians are international medical graduates; and
22
- 23 Whereas, approximately one in five U.S. physicians were born and attended medical school
24 outside of the United States and Canada (non-U.S. IMGs, as compared to Americans who
25 attend medical school abroad), totaling more than 203,500 physicians as of 2021; and
26
- 27 Whereas, the number of international medical graduates has grown by nearly 18% since 2010,
28 as compared to the 15% rise in U.S. medical graduates in the same time period; and
29
- 30 Whereas, while existing AMA and AMBS policy opposes the linkage between board certification
31 and medical licensure or staffing/clinical privileges, the true extent to which this continues to
32 occur is not well-understood and board certification may create a secondary barrier to practicing
33 and may limit the locations and types of practices available to internationally-trained physicians;
34 and
35
- 36 Whereas, licensing requirements in certain states can be an impediment to practice for
37 internationally-trained physicians, certain states, such as Tennessee, Florida, Wisconsin,
38 Virginia have begun to implement pathways for internationally-trained physicians to achieve

1 provisional licensure to practice medicine, and additional states such as Idaho and Arizona are
2 considering similar legislation; and

3
4 Whereas, board certification exceeds baseline requirements for state medical licensing,
5 assuring the public that physicians and specialists demonstrate the additional clinical skills and
6 professional behavior to provide safe and high-quality specialty care; and

7
8 Whereas, some states have begun to consider alternate pathways to licensure without
9 completion of an ACGME-accredited residency program for U.S. medical graduates under the
10 pretense that this will increase access to care particularly in rural areas, it is unclear the effects
11 these proposed pathways will actually have on rural access issues and there does not currently
12 exist a system to ensure the quality of the training they receive post medical school; and

13
14 Whereas, according to the AMA Workforce Mapper, there has not been an substantive increase
15 in non-physician providers practicing in rural and underserved areas, despite the broadening of
16 scope of practice for non-physician providers under the pretense of increasing access to care;
17 and

18
19 Whereas, advocating for increased funding for Graduate Medical Education funding continues
20 to be a major priority of our AMA, the allocation of these funds to require full re-training for a
21 fully-trained physician who has completed post-graduate training in another country may not be
22 good stewardship of limited resources; therefore be it

23
24 RESOLVED, that our American Medical Association work with the American Board of Medical
25 Specialties to study the variation in board certification requirements for internationally trained
26 physicians as well as the impact this may have on physician practices and addressing physician
27 shortages including the impact of these pathways on maintaining public assurance of a well-
28 trained physician workforce (Directive to Take Action); and be it further

29
30 RESOLVED, that our AMA study the potential effects of increasing access to board certification
31 for internationally-trained physicians on projected physician workforce shortages (Directive to
32 Take Action); and be it further

33
34 RESOLVED, that our AMA work with the Federation of State Medical Boards to study the
35 existing alternate pathways to licensure for physicians who have not completed an ACGME-
36 accredited post-graduate training program and the positive and negative impacts of these
37 pathways on addressing physician shortages. (Directive to Take Action)

38
Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/8/2024

REFERENCES

1. ABMS Affirms its Policy Regarding Use of Certification to Hospital Leaders/Chief Medical Officers. American Board of Medical Specialties. Published June 26, 2019. <https://www.abms.org/newsroom/abms-affirms-its-policy-regarding-use-of-certification-to-hospital-leaders-chief-medical-officers/>
2. ABMS Member Board Requirements for Initial Certification in a Specialty. Published 2023. <https://www.abms.org/wp-content/uploads/2023/11/abms-member-board-requirements-for-initial-certification-in-a-specialty.pdf>
3. Cassel CK, Holmboe ES. Professionalism and accountability: the role of specialty board certification. PubMed. Published online January 1, 2008. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2394686/#:~:text=About%2087%25%20of%20American%20physicians,depending%20on%20the%20different%20specialties>
4. Hospital Privileges | Physician Board Certification | ABPS. American Board of Physician Specialties. Accessed May 8, 2024. <https://www.abpsus.org/hospital-privileges/>

5. How IMGs have changed the face of American medicine. American Medical Association. Published October 19, 2021. <https://www.ama-assn.org/education/international-medical-education/how-imgs-have-changed-face-american-medicine>
6. New AAMC Report Shows Continuing Projected Physician Shortage. AAMC. Published March 21, 2024. <https://www.aamc.org/news/press-releases/new-aamc-report-shows-continuing-projected-physician-shortage>
7. Singer, JA. More States Move to Let Experienced Foreign Doctors Serve Their Patients. Cato Institute. Published March 14, 2024. <https://www.cato.org/blog/more-states-move-let-experienced-foreign-doctors-serve-their-patients>
8. Value of Board Certification. American Board of Medical Specialties. <https://www.abms.org/board-certification/value-of-board-certification/>
9. Weiner, S. 1 in 5 U.S. physicians was born and educated abroad. Who are they and what do they contribute? Published February 23, 2023. AAMC. <https://www.aamc.org/news/1-5-us-physicians-was-born-and-educated-abroad-who-are-they-and-what-do-they-contribute#:~:text=Known%20as%20non%2DU.S.%20international>
10. Workforce Projections. data.hrsa.gov. <https://data.hrsa.gov/topics/health-workforce/workforce-projections>

RELEVANT AMA POLICY

Medical Specialty Board Certification Standards H-275.926

1. Our American Medical Association opposes any action, regardless of intent, that appears likely to confuse the public about the unique credentials of American Board of Medical Specialties (ABMS) or American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) board certified physicians in any medical specialty, or take advantage of the prestige of any medical specialty for purposes contrary to the public good and safety.
2. Our AMA opposes any action, regardless of intent, by organizations providing board certification for non-physicians that appears likely to confuse the public about the unique credentials of medical specialty board certification or take advantage of the prestige of medical specialty board certification for purposes contrary to the public good and safety.
3. Our AMA continues to work with other medical organizations to educate the profession and the public about the ABMS and AOA-BOS board certification process. It is AMA policy that when the equivalency of board certification must be determined, the certification program must first meet accepted standards for certification that include both
 - a. a process for defining specialty-specific standards for knowledge and skills and
 - b. offer an independent, external assessment of knowledge and skills for both initial certification and recertification or continuous certification in the medical specialty. In addition, accepted standards, such as those adopted by state medical boards or the Essentials for Approval of Examining Boards in Medical Specialties, will be utilized for that determination.
4. Our AMA opposes discrimination against physicians based solely on lack of ABMS or equivalent AOA-BOS board certification, or where board certification is one of the criteria considered for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes. Our AMA also opposes discrimination that may occur against physicians involved in the board certification process, including those who are in a clinical practice period for the specified minimum period of time that must be completed prior to taking the board certifying examination.
5. Our AMA advocates for nomenclature to better distinguish those physicians who are in the board certification pathway from those who are not.
6. Our AMA encourages member boards of the ABMS to adopt measures aimed at mitigating the financial burden on residents related to specialty board fees and fee procedures, including shorter preregistration periods, lower fees and easier payment terms.
7. Our AMA encourages continued advocacy to federal and state legislatures, federal and state regulators, physician credentialing organizations, hospitals, and other interested parties to define physician board certification as the medical profession establishing specialty-specific standards for knowledge and skills, using an independent assessment process to determine the acquisition of knowledge and skills for initial certification and recertification.

Medical Licensure H-275.978

Our AMA: (1) urges directors of accredited residency training programs to certify the clinical competence of graduates of foreign medical schools after completion of the first year of residency training; however, program directors must not provide **certification** until they are satisfied that the resident is clinically competent;

- (2) encourages licensing boards to require a certificate of competence for full and unrestricted **licensure**;
- (3) urges licensing boards to review the details of application for initial **licensure** to assure that procedures are not unnecessarily cumbersome and that inappropriate information is not required. Accurate identification of documents and applicants is critical. It is recommended that boards continue to work cooperatively with the Federation of State Medical Boards to these ends;
- (4) will continue to provide information to licensing boards and other health organizations in an effort to prevent the use of fraudulent credentials for entry to medical practice;
- (5) urges those licensing boards that have not done so to develop regulations permitting the issuance of special purpose licenses, with the exception of special licensing pathways for "assistant physicians." It is recommended that these regulations permit special purpose **licensure** with the minimum of educational requirements consistent with protecting the health, safety and welfare of the public;
- (6) urges licensing boards, specialty boards, hospitals and their medical staffs, and other organizations that evaluate physician competence to inquire only into conditions which impair a physician's current ability to practice medicine;
- (7) urges licensing boards to maintain strict confidentiality of reported information;
- (8) urges that the evaluation of information collected by licensing boards be undertaken only by persons experienced in medical **licensure** and competent to make judgments about physician competence. It is recommended that decisions concerning medical competence and discipline be made with the participation of physician members of the board;
- (9) recommends that if confidential information is improperly released by a licensing board about a physician, the board take appropriate and immediate steps to correct any adverse consequences to the physician;
- (10) urges all physicians to participate in continuing medical education as a professional obligation;
- (11) urges licensing boards not to require mandatory reporting of continuing medical education as part of the process of reregistering the license to practice medicine;
- (12) opposes the use of written cognitive examinations of medical knowledge at the time of reregistration except when there is reason to believe that a physician's knowledge of medicine is deficient;
- (13) supports working with the Federation of State Medical Boards to develop mechanisms to evaluate the competence of physicians who do not have hospital privileges and who are not subject to peer review;
- (14) believes that licensing laws should relate only to requirements for admission to the practice of medicine and to assuring the continuing competence of physicians, and opposes efforts to achieve a variety of socioeconomic objectives through medical **licensure** regulation;
- (15) urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions; licensing jurisdictions should limit physician movement only for reasons related to protecting the health, safety and welfare of the public;
- (16) encourages the Federation of State Medical Boards and the individual medical licensing boards to continue to pursue the development of uniformity in the acceptance of examination scores on the Federation Licensing Examination and in other requirements for endorsement of medical licenses;
- (17) urges licensing boards not to place time limits on the acceptability of National Board **certification** or on scores on the United States Medical Licensing Examination for endorsement of licenses;
- (18) urges licensing boards to base endorsement on an assessment of physician competence and not on passing a written examination of cognitive ability, except in those instances when information collected by a licensing board indicates need for such an examination;
- (19) urges licensing boards to accept an initial license provided by another board to a graduate of a US medical school as proof of completion of acceptable medical education;
- (20) urges that documentation of graduation from a foreign medical school be maintained by boards providing an initial license, and that the documentation be provided on request to other licensing boards for review in connection with an application for **licensure** by endorsement;
- (21) urges licensing boards to consider the completion of specialty training and evidence of competent and honorable practice of medicine in reviewing applications for **licensure** by endorsement;
- (22) encourages national specialty boards to reconsider their practice of decertifying physicians who are capable of competently practicing medicine with a limited license;
- (23) vigorously opposes any state or other government agency plan for mandated recertification of physicians for the purpose of relicensure or reregistration;
- (24) supports the Federation of State Medical Boards' efforts to assure that organizations that use the Federation's copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards;

(25) urges that the state medical and osteopathic boards that maintain a time limit for completing licensing examination sequences for either USMLE or COMLEX to adopt a time limit of no less than 10 years for completion of the licensing exams; and

(26) urges that state medical and osteopathic licensing boards with time limits for completing the licensing examination sequence provide for exceptions that may involve personal health/family circumstances.

Licensure for International Medical Graduates Practicing in U.S. Institutions with Restricted Medical Licenses D-255.977

Our AMA will advocate that qualified international medical graduates have a pathway for **licensure** by encouraging state medical licensing boards and the member boards of the American Board of Medical Specialties to develop criteria that allow: (1) completion of medical school and residency training outside the U.S.; (2) extensive U.S. medical practice; and (3) evidence of good standing within the local medical community to serve as a substitute for U.S. graduate medical education requirement for physicians seeking full unrestricted **licensure** and board **certification**.

Credentialing Issues D-275.989

Our AMA encourages state medical licensing boards, the Federation of State Medical Boards, and other credentialing entities to accept **certification** by the Educational Commission for Foreign Medical Graduates (a member of InTealth) as proof of primary source verification of an IMG's international medical education credentials.

Mechanisms to Measure Physician Competency H-275.936

Our AMA: (1) continues to work with the American Board of Medical Specialties and other relevant organizations to explore alternative evidence-based methods of determining ongoing clinical competency; (2) reviews and proposes improvements for assuring continued physician competence, including but not limited to performance indicators, board **certification** and recertification, professional experience, continuing medical education, and teaching experience; and (3) opposes the development and/or use of "Medical Competency Examination" and establishment of oversight boards for current state medical boards as proposed in the fall 1998 Report on Professional **Licensure** of the Pew Health Professions Commission, as an additional measure of physician competency.

Physician Competence H-275.996

Our AMA: (1) urges the American Board of Medical Specialties and its constituent boards to reconsider their positions regarding recertification as a mandatory requirement rather than as a voluntarily sought and achieved validation of excellence; (2) urges the Federation of State Medical Boards and its constituent state boards to reconsider and reverse their position urging and accepting specialty board **certification** as evidence of continuing competence for the purpose of re-registration of **licensure**; and (3) favors continued efforts to improve voluntary continuing medical education programs, to maintain the peer review process within the profession, and to develop better techniques for establishing the necessary patient care data base.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 319
(A-24)

Introduced by: Minority Affairs Section

Subject: AMA Support of U.S. Pathway Programs

Referred to: Reference Committee C

1 Whereas, Association of American Medical Colleges (AAMC) defines “underrepresented in
2 medicine” as those racial and ethnic populations that are underrepresented in the medical
3 profession relative to their numbers in the general population”¹; and
4

5 Whereas, AAMC reports that across the U.S. physician workforce, American Indian and Alaska
6 Natives represent 0.3%; Black / African Americans represent 5.2%; Hispanic, Latino, or of
7 Spanish Origin represent 6.3%; and Native Hawaiian / Other Pacific Islanders represent 0.1%,
8 and comprise racial and ethnic identities that are considered underrepresented in medicine
9 despite their significantly and respectively higher percentages in the U.S. population²; and
10

11 Whereas, a U.S. Supreme Court ruling in 2023 ended affirmative action in school admissions,
12 which is expected to result in a significant impact on medical education and diversity in
13 medicine; and
14

15 Whereas, the AMA invested \$14.1 million since 2019 through the Accelerating Change in
16 Medical Education initiative, which awarded grants to 37 medical schools and resulted in the
17 creation of a community of innovation aimed at creating the medical schools of the future³; and
18

19 Whereas, the AMA Reimagining Residency grant program was devised to transform residency
20 training to best address the workplace needs of our current and future health care system³; and
21

22 Whereas, the AMA’s ChangeMedEd Innovation Grant Program has awarded \$1.5 million in
23 grants since 2018³; and
24

25 Whereas, our AMA House of Delegates adopted Council on Medical Education Report 5 (June
26 2021), “Promising Practices Among Pathway Programs to Increase Diversity in Medicine”⁴; and
27

28 Whereas, the 1910 Flexner report caused significant harm to historically Black medical schools,
29 the diversity of the physician workforce, and the outcomes of minoritized and marginalized
30 patient populations⁵; therefore be it
31

32 RESOLVED, that our American Medical Association establish a grant program to support
33 existing and new K-16 pathway, STEMM and pre-med programs whose goals include, scaling
34 organizational grantees’ ability to expand their reach among youth; increasing diversity in
35 medicine; achieving health equity; improving medical education (Directive to Take Action); and
36 be it further
37

38 RESOLVED, that our AMA establish a diverse advisory body comprised of AMA member
39 physicians and trainees, staff, and allied organization representatives in medicine and public
40 health to co-develop the grant program (i.e., administration; grantee criteria and selection;
41 periodic reporting) (Directive to Take Action); and be it further

- 1 RESOLVED, that our AMA convene a summit among pathway and STEMM programs regarding
2 best practices, collaboration and strategic planning. (Directive to Take Action)

Fiscal Note: To Be Determined

Received: 5/8/2024

REFERENCES

1. <https://www.aamc.org/what-we-do/equity-diversity-inclusion/underrepresented-in-medicine>
2. <https://www.aamc.org/data-reports/data/2023-us-physician-workforce-data-dashboard>
3. <https://www.ama-assn.org/education/changemeded-initiative/ama-reimagining-residency-initiative>
4. https://policysearch.ama-assn.org/councilreports/downloadreport?uri=/councilreports/CME_Report_05_J
5. <https://journalofethics.ama-assn.org/article/how-should-we-respond-racist-legacies-health-professions-education-originating-flexner-report/2021-03>

RELEVANT AMA POLICY

Plan for Continued Progress Toward Health Equity H-180.944

Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity. [BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, I-21; Reaffirmed: CMS Rep. 1, I-23]

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 unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population.

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; Modified: Res. 320, A-23]

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.

(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.

(3) Urging medical school and undergraduate admissions committees to proactively implement policies and procedures that operationalize race-conscious admission practices in admissions decisions, among other factors.

(4) Increasing the supply of minority health professionals.

(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.

(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.

(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.

(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

(9) Recognizing the consideration of race in admissions is a necessary safeguard in creating a pipeline to an environment within medical education that will propagate the advancement of health equity through diversification of the physician workforce. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18; Modified: Res. 320, A-23; Appended: Res. 320, A-23]

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]

Revisions to AMA Policy on the Physician Workforce H-200.955

It is AMA policy that:

- (1) any workforce planning efforts, done by the AMA or others, should utilize data on all aspects of the health care system, including projected demographics of both providers and patients, the number and roles of other health professionals in providing care, and practice environment changes. Planning should have as a goal appropriate physician numbers, specialty mix, and geographic distribution.
- (2) Our AMA encourages and collaborates in the collection of the data needed for workforce planning and in the conduct of national and regional research on physician supply and distribution. The AMA will independently and in collaboration with state and specialty societies, national medical organizations, and other public and private sector groups, compile and disseminate the results of the research.
- (3) The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.
- (4) In order to enhance access to care, our AMA collaborates with the public and private sectors to ensure an adequate supply of physicians in all specialties and to develop strategies to mitigate the current geographic maldistribution of physicians.
- (5) There is a need to enhance underrepresented minority representation in medical schools and in the physician workforce, as a means to ultimately improve access to care for minority and underserved groups.
- (6) There should be no decrease in the number of funded graduate medical education (GME) positions. Any increase in the number of funded GME positions, overall or in a given specialty, and in the number of US medical students should be based on a demonstrated regional or national need.
- (7) Our AMA will collect and disseminate information on market demands and workforce needs, so as to assist medical students and resident physicians in selecting a specialty and choosing a career.
- (8) Our AMA will encourage the Health Resources & Service Administration to collaborate with specialty societies to determine specific changes that would improve the agency's physician workforce projections process, to potentially include more detailed projection inputs, with the goal of producing more accurate and detailed projections including specialty and subspecialty workforces.
- (9) Our AMA will consider physician retraining during all its deliberations on physician workforce planning. [CME Rep. 2, I-03; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CME Rep. 15, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 324, A-17; Appended: CME Rep. 01, A-19; Reaffirmation: I-22]

Promising Practices Among Pathway Programs D-350.980

Our AMA will establish a task force to guide organizational transformation within and beyond the AMA toward restorative justice to promote truth, reconciliation, and healing in medicine and medical education. [CME Rep. 5, A-21]

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its 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; (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; (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; (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty; (8) recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts; and (9) collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure. [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; Appended: Res. 319, A-22; Modified: Res. 319, A-23]

Reference Committee D

Report(s) of the Council on Science and Public Health

- 03 Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders
- 06 Greenhouse Gas Emissions from Metered Dose Inhalers and Anesthetic Gases
- 09 Prescribing Guided Physical Activity for Depression and Anxiety
- 10 Teens and Social Media
- 11 Stand Your Ground Laws
- 13 Decreasing Youth Access to E-Cigarettes

Resolutions

- 401 Addressing Social Determinants of Health Through Closed Loop Referral Systems
- 402 Guardianship and Conservatorship Reform
- 403 Occupational Screenings for Lung Disease
- 404 Protections Against Surgical Smoke Exposure
- 405 Default Proceed Firearm Sales and Safe Storage Laws
- 406 Opposition to Pay-to-Stay Incarceration Fees
- 407 Racial Misclassification
- 408 Indian Water Rights
- 409 Toxic Heavy Metals
- 410 Access to Public Restrooms
- 411 Missing and Murdered Indigenous Persons
- 412 Lithium Battery Safety
- 413 Sexuality and Reproductive Health Education
- 414 Addressing the Health Sector's Contributions to the Climate Crisis
- 415 Building Environmental Resiliency in Health Systems and Physician Practices
- 416 Furthering Environmental Justice and Equity
- 417 Reducing Job-Related Climate Risk Factors
- 418 Early and Periodic Eye Exams for Adults
- 419 Addressing the Health Risks of Extreme Heat
- 420 Equity in Dialysis Care
- 421 Annual Conference on the State of Obesity and its Impact on Disease in America (SODA)
- 422 Immunization Registry
- 423 HPV Vaccination to Protect Healthcare Workers over Age 45
- 424 LGBTQ+ Senior Health
- 425 Perinatal Mental Health Disorders among Medical Students and Physicians
- 426 Maternal Morbidity and Mortality: The Urgent Need to Help Raise Professional and Public Awareness and Optimize Maternal Health – A Call to Action
- 427 Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals
- 428 Advocating for Education and Action Regarding the Health Hazards of PFAS Chemicals
- 429 Assessing and Protecting Local Communities from the Health Risks of Decommissioning Nuclear Power Plants
- 430 Supporting the Inclusion of Information about Lung Cancer Screening within Cigarette Packages
- 431 Combatting the Public Health Crisis of Gun Violence
- 432 Resolution to Decrease Lead Exposure in Urban Areas
- 433 Improving Healthcare of Rural Minority Populations

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-A-24

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

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee D

1 INTRODUCTION

2

3 At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates,
4 Council on Science and Medicine (CSAPH) Report 7-A-23, “Support Removal of BMI as a
5 Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of
6 Eating Disorders,” was adopted as amended, though the following recommendations were referred
7 for study:

8

9 That our AMA recognizes:

- 10 (6) that in some clinical circumstances Body Mass Index (BMI) may have utility and that BMI
11 > 35 should continue to be used for risk stratification.
12 (7) that BMI is a useful tool for population level surveillance of obesity trends due to its ease of
13 use and low risk for application inconsistencies.
14 (8) that BMI is useful as an initial screener for metabolic health risks. (New HOD Policy)

15

16 BACKGROUND

17

18 CSAPH Report 7-A-232, which evaluated the problematic history of BMI and explored other
19 alternatives to BMI, outlined the harms and benefits to using BMI and concluded that BMI is
20 inaccurate in measuring body fat in multiple groups because it does not account for the
21 heterogeneity across race/ethnic groups, sexes, and age-span. The report’s recommendations
22 recognized the issues with the use of BMI clinically and highlighted the need to use other methods.
23 This report is a follow-up to that report which will focus on studying the recommendations noted
24 above to assess if the evidence supports the inclusion of these recommendations into AMA policy.

25

26 METHODS

27

28 English language articles will be selected from searches of PubMed and Google Scholar using the
29 search terms “Body Mass Index (BMI)”, “BMI over 35 AND clinical utility”, “BMI AND obesity
30 trends”, and “BMI AND metabolic health risks”. Additional articles will be identified by manual
31 review of the reference lists of pertinent publications. Web sites managed by government agencies
32 and applicable organizations will also be reviewed for relevant information.

33

34 DISCUSSION

35

36 Ideally, an obesity classification system would be based on a practical measurement widely
37 available to clinicians regardless of their setting, would accurately predict health risk (prognosis),

1 and could be used to assign treatment strategies and goals.¹ The most accurate measures of body fat
2 adiposity such as underwater weighing, dual-energy x-ray absorptiometry (DEXA) scanning,
3 computed tomography (CT), and magnetic resonance imaging (MRI) are impractical for use in
4 everyday clinical encounters.¹ Estimates of body fat, including body mass index (BMI, calculated
5 by dividing the body weight in kilograms by height in meters squared) and waist circumference,
6 have limitations compared to these imaging methods, but still provide relevant information and are
7 easily obtained in a variety of practice settings.¹ Although BMI does not directly measure body fat,
8 its utility as a risk estimate has been demonstrated in multiple population studies.²⁻⁵ However, in
9 some instances, the use of BMI as a surrogate measure of body fat may lead to an incorrect
10 estimation of risk.^{3,6} The inherent problems with using BMI alone to estimate risk is exemplified by
11 the obesity paradox, the observed inverse correlation between BMI and mortality in patients with
12 existing chronic heart failure, coronary heart disease, and chronic kidney disease.^{3,7,8} However, it
13 should be noted that the obesity paradox is not observed among people with very low BMI (<18.5)
14 and very high (BMI >40.0). Although reasons for the obesity paradox remain uncertain, proposed
15 confounding factors include the poor sensitivity of BMI to detect excess adiposity versus lean
16 muscle mass, body fat distribution, and the independent contribution of fitness.^{3,9-11}

17
18 Further, the current BMI classification system is misleading regarding the effects of body fat mass
19 on mortality rates.^{1,12} Numerous comorbidities, lifestyle issues, gender, ethnicities, medically
20 significant familial-determined mortality effectors, duration of time one spends in certain BMI
21 categories, and the expected accumulation of fat with aging are likely to significantly affect
22 interpretation of BMI data, particularly in regard to morbidity and mortality rates.¹² Such
23 confounders as well as the known clustering of obesity in families, the strong role of genetic factors
24 in the development of obesity, the location in which excessive fat accumulates, its role in the
25 development of type 2 diabetes and hypertension, and so on, need to be considered when being
26 applied to the general population.^{12,13}

27 28 *Should BMI >35.0 be used for risk stratification?*

29
30 Currently, a BMI of 25.0 – 29.9 in the United States represents individuals who have “overweight”
31 and a BMI of 30.0 and above represents people who have “obesity.”¹⁴ Simply put, obesity is a
32 chronic, progressive, relapsing, and treatable multi-factorial, neurobehavioral disease, wherein an
33 increase in body fat promotes adipose tissue dysfunction and abnormal fat mass physical forces,
34 resulting in adverse metabolic, biomechanical, and psychosocial health consequences.¹⁵ However,
35 obesity is influenced by multiple factors. The environment influences the relationship between
36 genetics and obesity risk.^{13,14,16} Further, adverse workplace, school, social, and home environments,
37 known as “obesogenic environments,” affect physical and social structures and play a role in an
38 individual’s obesity risk.¹⁴ For example, greater availability of fast-food restaurants, poor
39 neighborhood walkability, and perceived safety risks can limit access to physical activity and
40 healthy food options.^{14,17} Additional risks for developing obesity include insufficient sleep and low
41 socioeconomic status, in part mediated by chronic stress and food insecurity, which are commonly
42 experienced by racial and ethnic minority populations.^{14,18}

43
44 The literature about the use of BMI for risk stratification is mixed. For example, in many studies
45 there is a clear empirical link between BMI and various health outcomes – especially in the case of
46 high BMIs (BMI>40.0).¹⁹ There is an observed relationship between obesity (BMI>35.0) and
47 elevated mortality risk. In examining excess deaths in the U.S. associated with individuals with a
48 BMI>35.0, some studies found that the highest number of deaths is associated with obesity, while
49 other studies noted a 22 percent reduction in longevity among men who have obesity.¹⁹⁻²¹ These

1 results were consistent across diverse data sets, with multiple meta-analyses observing a 20–30
2 percent increased risk of mortality for obese individuals.^{19,22,23}

3
4 However, in contrast to the above findings, studies have found that the association between BMI
5 and all-cause mortality is a controversial topic. Multiple studies, including several systematic
6 reviews and meta-analyses, have attempted to explain this association, and found different
7 results.^{22,24–27} The general association of BMI and all-cause mortality follows a U or J curve, with
8 very high mortality among people with very low BMI (<18.5) and very high BMI (BMI >40.0).²⁴
9 The most common unexpected finding is that people defined as having a normal or ideal weight
10 with BMI of 18.5 to 25.9 do not necessarily have the best survival.²⁴ In many cases, overweight
11 people (BMI 25.0 to 30.0), and those who have mild to moderate obesity, (BMI of 30.0 to 35.0 and
12 35.0 to 40.0), show the best survival.²⁴ This phenomenon has been described as the “obesity
13 paradox” and it is the subject of intense review due to the potential and very significant impact on
14 many aspects of routine clinical practice and healthcare in general.^{24,28–31} The obesity paradox has
15 been described not only in the general population but also in multiple cohorts of people with highly
16 prevalent medical conditions including diabetes, heart disease, kidney disease, cancer, stroke, and
17 rheumatoid and osteo arthritis, among others.^{22,24,32–37}

18
19 Further, it is worth pointing out two important caveats regarding current thresholds used to
20 diagnose overweight and obesity and risk. The first is that although there is favor for the
21 assignment of specific BMI cut-offs and increasing risk, relationships between body weight or fat
22 distribution and conditions that impair health represent a continuum.¹ For example, studies have
23 shown that increased risk for type 2 diabetes and premature mortality occurs well below a BMI of
24 30.0.^{1,38} The second is there is a complex association between BMI and all-cause mortality when
25 evaluated in the context of comorbidities and baseline mortality risk.¹ In general, comorbidities are
26 better predictors of mortality risk except at extreme BMIs (BMI <15.0, 15.0 to 18.5, and ≥45.0). In
27 patients with no or few comorbidities, BMI seems to better define mortality risk.¹ Aggressive
28 management of comorbidities may provide better survival outcomes for patients with BMI between
29 normal and moderate obesity (BMI of 18.5 to 25.0 and 35.0 to 40.0).^{1,38}

30
31 *Should BMI be used for population level surveillance of obesity trends?*

32
33 BMI is by far the simplest and most cost-effective option for tracking obesity at the population
34 level.^{19,40} Its continued use by medical professionals, health researchers, and governmental agencies
35 forms the basis of collective knowledge about the epidemiology of obesity in the U.S. and abroad.¹⁹
36 The authority afforded by its use in science and medicine is further compounded by the public’s
37 ability to quickly interpret research using BMI.^{19,41} Even at the individual level, the widespread
38 availability of BMI equations and charts across numerous forms of media and communications –
39 such as personal health-tracking applications/devices – encourages the self-evaluation of one’s
40 health relative to their weight, as the general population is empowered to freely calculate their own
41 BMI. BMI, therefore, serves as a surveillance mechanism setting a standard by which changes in
42 population health can be tracked.^{19,41–44} However, as mentioned in the previous BMI report
43 (CSAPH Report 7 A-23), the ease of calculating BMI only applies to the adult population and is
44 inaccurate in children and adolescents because of growth. In the United States, obesity in children
45 and adolescents are defined using threshold values from the 2000 CDC sex-specific body mass
46 index-for-age growth charts.

47
48 In general, most existing obesity surveillance systems in the U.S. rely on BMI. Surveillance
49 science has been slow to take advantage of research that identifies alternative anthropometric
50 measures of obesity.⁴⁵ Combining two or more different anthropometric measures, such as waist-
51 to-hip ratio and waist-circumference-to-height ratio, has been shown to work well and may be more

1 sensitive to the accumulation of abdominal fat.⁴⁵⁻⁴⁷ However, these measurements are more
2 invasive and require additional considerations such as how to track trends using other measures and
3 how to interpret those new measures on a population level. The biggest issue with current
4 surveillance systems of obesity is that most surveillance does not include the measurement of
5 policy or environmental factors that may influence obesity.^{45,48} For example, there are still gaps in
6 the availability of surveillance systems for areas such as community-level estimates of obesity-
7 related environments, policies, programs, partnerships, and social norms; community-based
8 physical activity programs; surveillance of local policies on nutrition standards for foods and
9 beverages; community-level data on exposure to food marketing; national- and community-level
10 data on worksite programs; and obesity-related policies on college campuses.^{45,48} Further, high-risk
11 populations, i.e., demographic or health status subgroups, are often not adequately represented in
12 national or state-level surveys and longitudinal BMI measure analyses are uncommon, particularly
13 among low-resource populations, which are at greater risk of having obesity.^{45,48}

14
15 *Should BMI be used as an initial screener for metabolic health risks?*

16
17 The current use of BMI as an evaluative and predictive tool is controversial.⁴⁹ Originally conceived
18 as a practical index of relative body weight, BMI is now wielded in medicine as a measure for
19 disease and health risk, despite studies showing that BMI can be an inaccurate proxy for
20 cardiometabolic markers of health (i.e., blood pressure, cholesterol levels) and imprecise in its
21 prediction of health risks when applied to the diversity of human bodies.⁴⁹⁻⁵² The use of BMI as an
22 initial screener for metabolic health risks is controversial. An example of why it is controversial
23 can be examined in a subgroup of individuals that has been identified within the obese population,
24 who do not display the typical metabolic disorders associated with higher BMI's and are
25 hypothesized to have lower risk of obesity-related complications. Metabolically healthy obesity
26 (MHO) has been previously defined as a subgroup of obese (which is measured by having a BMI
27 ≥ 30) individuals who do not have insulin resistance, lipid disorders, or hypertension.^{53,54} Multiple
28 studies indicate 10-25 percent of individuals who have obesity, according to their BMI, can be
29 categorized as MHO.⁵³⁻⁵⁵ A study which used the National Health and Nutrition Examination
30 Survey, a nationally representative sample of adults living in the U.S., to examine the MHO
31 phenotype, found a prevalence of 32 percent among obese adults over the age of 20.^{53,56} Further,
32 studies examining cardiovascular disease (CVD) outcomes or all-cause mortality, were not able to
33 demonstrate a significant association between MHO and increased risk of CVD and morbidity and
34 mortality.⁵³

35
36 Further, when thinking about screening tools, specificity should be factored in. Research has shown
37 that BMI does not appropriately represent racial and ethnic minorities. For example, a longitudinal
38 study of healthy women found that at the same BMI, Asians had more than double the risk of
39 developing type 2 diabetes than Whites; Hispanics and Blacks also had higher risks of diabetes
40 than Whites, but to a lesser degree.⁵⁷ Studies have found that Blacks have lower body fat and
41 higher lean muscle mass than Whites at the same BMI, and therefore, at the same BMI, may be at
42 lower risk of obesity-related diseases.^{57,58} Finally, as mentioned in the previous BMI report
43 (CSAPH Report 7 A-23) BMI has the following limitations: older adults tend to have more body
44 fat than younger adults at an equivalent BMI; women have greater amounts of total body fat than
45 men with an equivalent BMI; muscular individuals, or highly-trained athletes, may have a high
46 BMI because of increased muscle mass; and BMI also does not account for the life cycle and
47 location of accumulated fat caused by hormones.⁵⁹⁻⁶¹ Given these limitations, certain groups of
48 people are [?] more likely to be misclassified if BMI alone is used, and therefore these individuals
49 may be subject to more unnecessary diagnostic testing/evaluation, unnecessary anxiety, and higher
50 health care spending leading to inequities.

1 EXISTING AMA POLICY

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

13
14 Further, under AMA Policy H-440.797, “Support Removal of BMI as a Standard Measure in
15 Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders,” the
16 AMA recognizes: (1) the issues with using BMI as a measurement because: (a) of the historical
17 harm of BMI, (b) of the use of BMI for racist exclusion, and (c) BMI cutoffs are based primarily on
18 data collected from previous generations of non-Hispanic White populations and does not consider
19 a person's gender or ethnicity; (2) the significant limitations associated with the widespread use of
20 BMI in clinical settings and suggests its use be in a conjunction with other valid measures of risk
21 such as, but not limited to, measurements of: (a) visceral fat, (b) body adiposity index, (c) body
22 composition, (d) relative fat mass, (e) waist circumference and (f) genetic/metabolic factors; (3)
23 that BMI is significantly correlated with the amount of fat mass in the general population but loses
24 predictability when applied on the individual level; and (4) that relative body shape and
25 composition heterogeneity across race/ethnic groups, sexes, genders, and age-span is essential to
26 consider when applying BMI as a measure of adiposity.

27
28 CONCLUSION

29
30 BMI is an imperfect measure of body fat and may be influenced by many factors, including body
31 composition of muscle mass, fat distribution, visceral vs. subcutaneous fat, and ectopic fat.²⁴
32 Physical fitness and nutritional status may play a more important role than BMI in predicting
33 overall health and risk of mortality.^{24,53} Current use of BMI as an evaluative and predictive tool is
34 troubling. Originally conceived as a practical index of relative body weight, BMI is now wielded in
35 medicine as a measure for disease and health risk, despite studies showing that BMI can be an
36 inaccurate proxy for cardiometabolic markers of health (i.e., blood pressure, cholesterol levels) or
37 lifestyle factors (i.e., physical activity, eating habits) and imprecise in its prediction of health risks
38 when applied to the diversity of human bodies.⁴⁹⁻⁵² There is a complex association between BMI
39 and all-cause mortality when evaluated in the context of comorbidities and baseline mortality
40 risk.²⁴ Obesity is an important risk factor for many chronic and common clinical conditions.
41 However, comorbidities are better predictors of mortality risk except at extreme BMIs.²⁴ In patients
42 with no or few comorbidities, BMI seems to better define mortality risk.²⁴

43
44 The U.S. currently conducts population level surveillance of obesity and individual obesity-related
45 behaviors. However, to fully understand the etiology of obesity and the effects of prevention
46 efforts, current surveillance systems must be expanded in terms of settings, measures, periodicity,
47 and populations.⁴⁵ Increases in funding and infrastructure for local surveillance would assist in
48 obtaining data on underserved populations to better understand health disparities in obesity and
49 prevention efforts.⁴⁵ Also critical is the addition of environmental and policy measures to
50 surveillance systems to allow for a better understanding of the global obesity epidemic and the
51 effects of obesity prevention initiatives on the population.⁴⁵

1 An accurate diagnosis of obesity prevents patients at risk due to excess adiposity from being
2 erroneously labeled as “normal” and avoids labeling patients with no excess fat as overweight or
3 obese.¹⁴ As a result, this report supports the need to screen for secondary causes of obesity such as
4 environmental factors, hormonal abnormalities (i.e., hypothyroidism, hypercortisolism), psychiatric
5 diagnoses (i.e., binge eating disorder), iatrogenic obesity (i.e., medications), and genetic syndromes
6 (i.e., proopiomelanocortin deficiency).^{14,62} Further, assessment for weight-related comorbidities
7 such as nonalcoholic fatty liver disease or obstructive sleep apnea is important to understand the
8 complexity of obesity in patients and guide treatment.^{14,62}

9
10 RECOMMENDATION

11
12 The Council on Science and Public Health recommends that the following be adopted, and the
13 remainder of the report be filed.

14
15 1. That AMA Policy H-440.797, “Support Removal of BMI as a Standard Measure in Medicine
16 and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders,” be amended by
17 addition to read as follows:

18
19 1. Our AMA recognizes:

- 20 1. the issues with using body mass index (BMI) as a measurement because: (a) the
21 eugenics behind the history of BMI, (b) the use of BMI for racist exclusion, and (c)
22 BMI cutoffs are based on the imagined ideal Caucasian and does not consider a
23 person’s gender or ethnicity.
- 24 2. the significant limitations associated with the widespread use of BMI in clinical
25 settings and suggests its use be in a conjunction with other valid measures of risk such
26 as, but not limited to, measurements of: (a) visceral fat, (b) body adiposity index, (c)
27 body composition, (d) relative fat mass, (e) waist circumference and (f)
28 genetic/metabolic factors.
- 29 3. that BMI is significantly correlated with the amount of fat mass in the general
30 population but loses predictability when applied on the individual level.
- 31 4. that relative body shape and composition heterogeneity across race/ethnic groups,
32 sexes, and age-span is essential to consider when applying BMI as a measure of
33 adiposity.
- 34 5. that in some diagnostic circumstances, the use of BMI should not be used as a sole
35 criterion for appropriate insurance reimbursement.
- 36 6. the use of BMI within the context of comorbidities, baseline mortality risk, and
37 environmental factors such as chronic stressors, poor nutrition, and low physical
38 activity may be used for risk stratification.
- 39 7. BMI is a widely used tool for population level surveillance of obesity trends due to its
40 ease of use and low risk for application inconsistencies, but BMI does not fully capture
41 the complexity of the obesity epidemic.
- 42 8. that BMI, in combination with other anthropometric measures and environmental
43 factors, may be useful as an initial screener to identify individuals for further
44 investigation of metabolic health risks.

45
46 2. Our AMA supports further research on the application of the extended BMI percentiles and z-
47 scores and its association with other anthropometric measurements, risk factors, and health
48 outcomes.

49 3. Our AMA supports efforts to educate physicians on the issues with BMI and alternative
50 measures for diagnosing obesity. (Amend HOD Policy)

Fiscal Note: less than \$1,000

REFERENCES

1. Purnell JQ. Definitions, Classification, and Epidemiology of Obesity. In: Feingold KR, Anawalt B, Blackman MR, et al., eds. *Endotext*. MDText.com, Inc.; 2000. Accessed January 30, 2024. <http://www.ncbi.nlm.nih.gov/books/NBK279167/>
2. Green MA. Do we need to think beyond BMI for estimating population-level health risks? *J Public Health (Oxf)*. 2016;38(1):192-193. doi:10.1093/pubmed/fdv007
3. Kushner RF. Clinical assessment and management of adult obesity. *Circulation*. 2012;126(24):2870-2877. doi:10.1161/CIRCULATIONAHA.111.075424
4. Berrington De Gonzalez A, Hartge P, Cerhan JR, et al. Body-Mass Index and Mortality among 1.46 Million White Adults. *N Engl J Med*. 2010;363(23):2211-2219. doi:10.1056/NEJMoa1000367
5. Prospective Studies Collaboration. Body-mass index and cause-specific mortality in 900 000 adults: collaborative analyses of 57 prospective studies. *The Lancet*. 2009;373(9669):1083-1096. doi:10.1016/S0140-6736(09)60318-4
6. Romero-Corral A, Somers VK, Sierra-Johnson J, et al. Accuracy of body mass index in diagnosing obesity in the adult general population. *Int J Obes*. 2008;32(6):959-966. doi:10.1038/ijo.2008.11
7. Ades PA, Savage PD. The Obesity Paradox: Perception vs Knowledge. *Mayo Clinic Proceedings*. 2010;85(2):112-114. doi:10.4065/mcp.2009.0777
8. Romero-Corral A, Montori VM, Somers VK, et al. Association of bodyweight with total mortality and with cardiovascular events in coronary artery disease: a systematic review of cohort studies. *The Lancet*. 2006;368(9536):666-678. doi:10.1016/S0140-6736(06)69251-9
9. Lavie CJ, Milani RV, Ventura HO, Romero-Corral A. Body Composition and Heart Failure Prevalence and Prognosis: Getting to the Fat of the Matter in the "Obesity Paradox." *Mayo Clinic Proceedings*. 2010;85(7):605-608. doi:10.4065/mcp.2010.0333
10. Oreopoulos A, Ezekowitz JA, McAlister FA, et al. Association Between Direct Measures of Body Composition and Prognostic Factors in Chronic Heart Failure. *Mayo Clinic Proceedings*. 2010;85(7):609-617. doi:10.4065/mcp.2010.0103
11. McAuley PA, Kokkinos PF, Oliveira RB, Emerson BT, Myers JN. Obesity Paradox and Cardiorespiratory Fitness in 12,417 Male Veterans Aged 40 to 70 Years. *Mayo Clinic Proceedings*. 2010;85(2):115-121. doi:10.4065/mcp.2009.0562
12. Nuttall FQ. Body Mass Index: Obesity, BMI, and Health A Critical Review. *Nutrition Today*. 2015;50(3):117-128. doi:10.1097/NT.0000000000000092
13. Loos RJF, Yeo GSH. The genetics of obesity: from discovery to biology. *Nat Rev Genet*. 2022;23(2):120-133. doi:10.1038/s41576-021-00414-z
14. Elmaleh-Sachs A, Schwartz JL, Bramante CT, Nicklas JM, Gudzone KA, Jay M. Obesity Management in Adults: A Review. *JAMA*. 2023;330(20):2000. doi:10.1001/jama.2023.19897

15. Obesity Medicine. What Is Obesity? Published July 31, 2023.
<https://obesitymedicine.org/blog/what-is-obesity/>
16. Oussaada SM, Van Galen KA, Coومان MI, et al. The pathogenesis of obesity. *Metabolism*. 2019;92:26-36. doi:10.1016/j.metabol.2018.12.012
17. Lovasi GS, Hutson MA, Guerra M, Neckerman KM. Built Environments and Obesity in Disadvantaged Populations. *Epidemiologic Reviews*. 2009;31(1):7-20.
doi:10.1093/epirev/mxp005
18. Anekwe CV, Jarrell AR, Townsend MJ, Gaudier GI, Hiserodt JM, Stanford FC. Socioeconomics of Obesity. *Curr Obes Rep*. 2020;9(3):272-279. doi:10.1007/s13679-020-00398-7
19. Gutin I. In BMI we trust: reframing the body mass index as a measure of health. *Soc Theory Health*. 2018;16(3):256-271. doi:10.1057/s41285-017-0055-0
20. Flegal KM. Excess Deaths Associated With Underweight, Overweight, and Obesity. *JAMA*. 2005;293(15):1861. doi:10.1001/jama.293.15.1861
21. Fontaine KR, Redden DT, Wang C, Westfall AO, Allison DB. Years of Life Lost Due to Obesity. *JAMA*. 2003;289(2):187. doi:10.1001/jama.289.2.187
22. Flegal KM, Kit BK, Orpana H, Graubard BI. Association of All-Cause Mortality With Overweight and Obesity Using Standard Body Mass Index Categories: A Systematic Review and Meta-analysis. *JAMA*. 2013;309(1):71. doi:10.1001/jama.2012.113905
23. McGee DL. Body mass index and mortality: a meta-analysis based on person-level data from twenty-six observational studies. *Annals of Epidemiology*. 2005;15(2):87-97.
doi:10.1016/j.annepidem.2004.05.012
24. Li J, Simon G, Castro MR, Kumar V, Steinbach MS, Caraballo PJ. Association of BMI, comorbidities and all-cause mortality by using a baseline mortality risk model. Rohrmann S, ed. *PLoS ONE*. 2021;16(7):e0253696. doi:10.1371/journal.pone.0253696
25. Global BMI Mortality Collaboration null, Di Angelantonio E, Bhupathiraju S, et al. Body-mass index and all-cause mortality: individual-participant-data meta-analysis of 239 prospective studies in four continents. *Lancet*. 2016;388(10046):776-786. doi:10.1016/S0140-6736(16)30175-1
26. Zhang J, Begley A, Jackson R, et al. Body mass index and all-cause mortality in heart failure patients with normal and reduced ventricular ejection fraction: a dose-response meta-analysis. *Clin Res Cardiol*. 2019;108(2):119-132. doi:10.1007/s00392-018-1302-7
27. Winter JE, MacInnis RJ, Nowson CA. The Influence of Age the BMI and All-Cause Mortality Association: A Meta-Analysis. *J Nutr Health Aging*. 2017;21(10):1254-1258.
doi:10.1007/s12603-016-0837-4
28. Liu X, Guo L, Xiao K, et al. The obesity paradox for outcomes in atrial fibrillation: Evidence from an exposure-effect analysis of prospective studies. *Obes Rev*. 2020;21(3):e12970.
doi:10.1111/obr.12970

29. Hidvegi R, Puelacher C, Gualandro DM, et al. Obesity paradox and perioperative myocardial infarction/injury in non-cardiac surgery. *Clin Res Cardiol.* 2020;109(9):1140-1147. doi:10.1007/s00392-020-01605-0
30. Tojek K, Wustrau B, Czerniak B, et al. Body mass index as a biomarker for the evaluation of the “Obesity Paradox” among inpatients. *Clin Nutr.* 2019;38(1):412-421. doi:10.1016/j.clnu.2017.12.005
31. Iyer AS, Dransfield MT. The “Obesity Paradox” in Chronic Obstructive Pulmonary Disease: Can It Be Resolved? *Ann Am Thorac Soc.* 2018;15(2):158-159. doi:10.1513/AnnalsATS.201711-901ED
32. Costanzo P, Cleland JGF, Pellicori P, et al. The obesity paradox in type 2 diabetes mellitus: relationship of body mass index to prognosis: a cohort study. *Ann Intern Med.* 2015;162(9):610-618. doi:10.7326/M14-1551
33. Xia JY, Lloyd-Jones DM, Khan SS. Association of body mass index with mortality in cardiovascular disease: New insights into the obesity paradox from multiple perspectives. *Trends Cardiovasc Med.* 2019;29(4):220-225. doi:10.1016/j.tcm.2018.08.006
34. Mohebi R, Simforoosh A, Tohidi M, Azizi F, Hadaegh F. Obesity Paradox and Risk of Mortality Events in Chronic Kidney Disease Patients: A Decade of Follow-up in Tehran Lipid and Glucose Study. *J Ren Nutr.* 2015;25(4):345-350. doi:10.1053/j.jrn.2014.12.006
35. Ujvari B, Jacqueline C, Misse D, et al. Obesity paradox in cancer: Is bigger really better? *Evol Appl.* 2019;12(6):1092-1095. doi:10.1111/eva.12790
36. Hoffman H, Jalal MS, Furst T, Chin LS. The Obesity Paradox in Spontaneous Intracerebral Hemorrhage: Results from a Retrospective Analysis of the Nationwide Inpatient Sample. *Neurocrit Care.* 2020;32(3):765-774. doi:10.1007/s12028-019-00796-3
37. Baker JF, Billig E, Michaud K, et al. Weight Loss, the Obesity Paradox, and the Risk of Death in Rheumatoid Arthritis. *Arthritis Rheumatol.* 2015;67(7):1711-1717. doi:10.1002/art.39136
38. Willett WC, Dietz WH, Colditz GA. Guidelines for Healthy Weight. *N Engl J Med.* 1999;341(6):427-434. doi:10.1056/NEJM199908053410607
39. Mozaffarian D, Benjamin EJ, Go AS, et al. Heart Disease and Stroke Statistics—2016 Update: A Report From the American Heart Association. *Circulation.* 2016;133(4). doi:10.1161/CIR.0000000000000350
40. Prentice AM, Jebb SA. Beyond body mass index. *Obesity Reviews.* 2001;2(3):141-147. doi:10.1046/j.1467-789x.2001.00031.x
41. Fletcher I. Defining an epidemic: the body mass index in British and US obesity research 1960–2000. *Sociology Health & Illness.* 2014;36(3):338-353. doi:10.1111/1467-9566.12050
42. Jutel A. Sociology of diagnosis: a preliminary review. *Sociology Health & Illness.* 2009;31(2):278-299. doi:10.1111/j.1467-9566.2008.01152.x

43. Rich E, Evans J. 'Fat Ethics' – The Obesity Discourse and Body Politics. *Soc Theory Health*. 2005;3(4):341-358. doi:10.1057/palgrave.sth.8700057
44. Nicholls SG. Standards and classification: A perspective on the 'obesity epidemic.' *Social Science & Medicine*. 2013;87:9-15. doi:10.1016/j.socscimed.2013.03.009
45. Hoelscher DM, Ranjit N, Pérez A. Surveillance Systems to Track and Evaluate Obesity Prevention Efforts. *Annu Rev Public Health*. 2017;38(1):187-214. doi:10.1146/annurev-publhealth-031816-044537
46. Blundell JE, Dulloo AG, Salvador J, Frühbeck G, On Behalf Of The Easo Sab Working Group On Bmi G. Beyond BMI - Phenotyping the Obesities. *Obes Facts*. 2014;7(5):322-328. doi:10.1159/000368783
47. Carmienke S, Freitag MH, Pischon T, et al. General and abdominal obesity parameters and their combination in relation to mortality: a systematic review and meta-regression analysis. *Eur J Clin Nutr*. 2013;67(6):573-585. doi:10.1038/ejcn.2013.61
48. The National Academies Press. *Evaluating Obesity Prevention Efforts.*; 2013. <https://nap.nationalacademies.org/read/18334/chapter/1>
49. Mishra K, Floegel-Shetty A. What's Wrong With Overreliance on BMI? *AMA Journal of Ethics*. 2023;25(7):E469-471. doi:10.1001/amajethics.2023.469
50. Eknoyan G. Adolphe Quetelet (1796 1874) the average man and indices of obesity. *Nephrology Dialysis Transplantation*. 2007;23(1):47-51. doi:10.1093/ndt/gfm517
51. Tomiyama AJ, Hunger JM, Nguyen-Cuu J, Wells C. Misclassification of cardiometabolic health when using body mass index categories in NHANES 2005–2012. *Int J Obes*. 2016;40(5):883-886. doi:10.1038/ijo.2016.17
52. Elagizi A, Kachur S, Lavie CJ, et al. An Overview and Update on Obesity and the Obesity Paradox in Cardiovascular Diseases. *Progress in Cardiovascular Diseases*. 2018;61(2):142-150. doi:10.1016/j.pcad.2018.07.003
53. Roberson LL, Aneni EC, Maziak W, et al. Beyond BMI: The "Metabolically healthy obese" phenotype & its association with clinical/subclinical cardiovascular disease and all-cause mortality -- a systematic review. *BMC Public Health*. 2014;14:14. doi:10.1186/1471-2458-14-14
54. Blüher M. The distinction of metabolically 'healthy' from 'unhealthy' obese individuals. *Current Opinion in Lipidology*. 2010;21(1):38-43. doi:10.1097/MOL.0b013e3283346ccc
55. Karelis AD. To be obese—does it matter if you are metabolically healthy? *Nat Rev Endocrinol*. 2011;7(12):699-700. doi:10.1038/nrendo.2011.181
56. Wildman RP. The Obese Without Cardiometabolic Risk Factor Clustering and the Normal Weight With Cardiometabolic Risk Factor Clustering: Prevalence and Correlates of 2 Phenotypes Among the US Population (NHANES 1999-2004). *Arch Intern Med*. 2008;168(15):1617. doi:10.1001/archinte.168.15.1617

57. Shai I, Jiang R, Manson JE, et al. Ethnicity, Obesity, and Risk of Type 2 Diabetes in Women. *Diabetes Care*. 2006;29(7):1585-1590. doi:10.2337/dc06-0057
58. Pan WH, Flegal KM, Chang HY, Yeh WT, Yeh CJ, Lee WC. Body mass index and obesity-related metabolic disorders in Taiwanese and US whites and blacks: implications for definitions of overweight and obesity for Asians. *The American Journal of Clinical Nutrition*. 2004;79(1):31-39. doi:10.1093/ajcn/79.1.31
59. Wagner DR, Heyward VH. Measures of body composition in blacks and whites: a comparative review. *The American Journal of Clinical Nutrition*. 2000;71(6):1392-1402. doi:10.1093/ajcn/71.6.1392
60. Flegal KM, Ogden CL, Yanovski JA, et al. High adiposity and high body mass index-for-age in US children and adolescents overall and by race-ethnic group. *The American Journal of Clinical Nutrition*. 2010;91(4):1020-1026. doi:10.3945/ajcn.2009.28589
61. Appropriate body-mass index for Asian populations and its implications for policy and intervention strategies. *The Lancet*. 2004;363(9403):157-163. doi:10.1016/S0140-6736(03)15268-3
62. Garvey WT, Mechanick JI, Brett EM, et al. American Association of Clinical Endocrinologists and American College of Endocrinology Comprehensive Clinical Practice Guidelines For Medical Care of Patients with Obesity. *Endocrine Practice*. 2016;22:1-203. doi:10.4158/EP161365.GL

REPORT 6 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-24)
Greenhouse Gas Emissions from Metered Dose Inhalers and Anesthetic Gases
(Reference Committee D)

EXECUTIVE SUMMARY

INTRODUCTION. American Medical Association (AMA) Policy H-135.913, “Metered Dose Inhalers and Greenhouse Gas Emissions,” as adopted by the House of Delegates (HOD) at the 2023 Annual Meeting asked that our AMA study options for reducing hydrofluorocarbon use in the medical sector.

METHODS. English language articles were selected from searches of PubMed and Google Scholar using the search terms “metered dose inhalers” AND “dry powder inhalers” AND “sustainability” as well as “anesthetics” AND “sustainability.” Supplementary searches were performed on both effectiveness and cost differences between metered dose inhalers and dry powder inhalers. Additional articles were identified by manual review of the reference lists of relevant publications.

BACKGROUND. Metered-dose inhalers (MDIs) are medical devices used to deliver inhaled medication for individuals with asthma and chronic obstructive pulmonary disease. MDIs rely on a liquified-gas propellant to atomize medication for inhalation delivery. These propellants were first chlorofluorocarbons (CFCs) but then later transitioned to hydrofluorocarbons (HFCs) after it was found that CFCs were depleting the stratospheric ozone layer.¹ HFCs, while not causing ozone depletion, are potent greenhouse gases (GHG) and represent substantial proportions of the health care sector’s carbon footprint.²⁻⁴ Besides MDIs, alternative types of inhalers include dry powder inhalers (DPIs) and soft mist inhalers (SMIs), which both have significantly lower GHG emission profiles compared to MDIs.^{4,6} Currently, there is no DPI or SMI combined preventer and reliever regimen for asthma that is easy to use and affordable in the U.S., despite being more widely available in Europe.⁷

RESULTS. Except in circumstances where the patient cannot generate sufficient inspiratory airflow, such as with very young children (under the age of 5) or frail, older adults,⁸ research has demonstrated that DPIs are as effective and safe as MDIs for most patients.^{9,10} There is also evidence demonstrating that DPIs are easier to use and result in lower error rates compared to MDIs.¹¹⁻¹³ One potential reason for the lack of competitive, low-cost alternatives to MDIs has been pharmaceutical companies’ ability to maintain patent protections on their brand name products through secondary patents after the primary patent has expired.^{14,15} In addition to the use of HFCs in MDIs, the other major source of HFC/CFC use in health care comes from anesthetic gases, which includes the HFCs sevoflurane and desflurane and the CFC isoflurane.^{16,17} Clinical care recommendations by the American Society of Anesthesiologists Committee on Environmental Sustainability to reduce the negative environmental impact of anesthetic gases focus on delivery performance improvements, removing or avoiding the “worst” GHG offenders from hospital drug formularies, and substituting non-inhaled anesthetic gases when clinically appropriate.¹⁸

CONCLUSION. Switching to low carbon footprint inhalers is an opportunity to not only reduce GHG emissions from the health care sector, but also to improve chronic asthma management and health outcomes through the broader usage of DPI preventer inhalers containing an inhaled corticosteroid. With inhaled anesthetics, there are several relatively easy and well documented strategies to improve environmental sustainability which could be more widely adopted through expanded educational efforts and result in cost savings for health systems.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 6-A-24

Subject: Greenhouse Gas Emissions from Metered Dose Inhalers and Anesthetic Gases

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee D

1 INTRODUCTION

2
3 American Medical Association (AMA) Policy H-135.913, “Metered Dose Inhalers and Greenhouse
4 Gas Emissions,” as adopted by the House of Delegates (HOD) at the 2023 Annual Meeting asked
5 that our AMA study options for reducing hydrofluorocarbon use in the medical sector.

6 7 BACKGROUND

8
9 Asthma is a chronic respiratory disease that reversibly impacts the ability of air to move in and out
10 of the lungs due, usually to inflammation of the airways, and requires ongoing medical
11 management.^{19,20} The potential factors that cause asthma are both environmental and genetic,
12 including family history, allergies, viral respiratory infections, occupational exposures, smoking, air
13 pollution, and/or obesity.²¹ According to data from the National Health Interview Survey, during
14 2016 to 2018 approximately 8 percent of the U.S. population reported having asthma, with a higher
15 prevalence among Black persons (10.7 percent) compared to White persons (8 percent).²⁰ Chronic
16 obstructive pulmonary disease (COPD) refers to a group of respiratory diseases that cause airflow
17 blockage and make breathing more difficult, including emphysema and chronic bronchitis.²² About
18 16 million Americans have COPD and in 2018 it was the fourth leading cause of death in the
19 U.S.^{22,23} Exposure to tobacco smoke is a key contributor to the development and progression of
20 COPD, but environmental exposures to air pollutants, genetic factors, and respiratory infections
21 also play an important role.²³

22
23 Metered-dose inhalers (MDIs) are medical devices used to deliver inhaled medication, typically for
24 individuals with asthma and COPD. MDIs are pressurized and rely on liquefied-gas propellants to
25 atomize medication for inhalation delivery. The pharmaceutical industry historically used
26 chlorofluorocarbons (CFCs), specifically CFC-11, CFC-12, and CFC-114, as propellants. CFCs are
27 synthetic, nontoxic, and nonflammable chemicals that contain atoms of carbon, chlorine, and
28 fluorine. They were first developed in the late 1920s to replace toxic refrigerants that were being
29 used at the time.¹ Following their initial development, CFCs were widely adopted and used in foam
30 insulation, refrigeration, and aerosols (including MDIs).

31
32 While CFCs were found to be safe in their applications, they undergo significant chemical changes
33 in the upper atmosphere and by the early 1970s, chemists from the University of California
34 demonstrated that CFCs could be destroying the stratospheric ozone layer that helps shield the
35 Earth from the sun’s ultraviolet radiation.¹ By the 1980s, it was clear that stratospheric ozone loss
36 was getting worse every year and CFCs were a major contributor. The global environmental
37 response came in the late 1980s and resulted in the signing of the Montreal Protocol in 1987, which
38 phased out the use of CFCs. MDIs and other medical uses of CFCs were exempted under the

1 Montreal Protocol until safer alternatives could be identified. The pharmaceutical industry
2 introduced hydrofluorocarbon (HFC) (also known as hydrofluoroalkanes - HFA) propellants for
3 MDIs as replacements for CFCs in the mid-1990s, specifically HFC-134a in 1996 followed by
4 HFC-227ea in 2006. However, it took over 20 years, until 2016, for all CFCs to be phased out of
5 MDI applications.²
6

7 In addition to the use of HFCs in MDIs, modern anesthetic gases include the HFCs sevoflurane and
8 desflurane, the CFC isoflurane, and nitrous oxide.²⁴ Anesthetic gases have been excluded from
9 international protocols due to their medical necessity but measured concentrations of desflurane, the
10 most damaging in terms of GHG warming potential, in the atmosphere have increased over the last
11 few decades.²⁴ Therefore, exploring alternatives to the usage of these anesthetic gases is another
12 way health care systems can reduce their carbon footprint and improve sustainability.
13

14 This report outlines the greenhouse gas (GHG) emissions and climate impacts of the use of CFCs
15 and HFCs in the medical sector, with a focus primarily on MDIs and secondarily on anesthetic
16 gases, followed by a discussion of potential alternatives and how they compare in terms of their
17 carbon footprint, effectiveness, and cost.
18

19 METHODS

20

21 English language articles were selected from searches of PubMed and Google Scholar using the
22 search terms “metered dose inhalers” AND “dry powder inhalers” AND “sustainability” as well as
23 “anesthetics” AND “sustainability.” Supplementary searches were performed on both effectiveness
24 and cost differences between metered dose inhalers and dry powder inhalers. Additional articles
25 were identified by manual review of the reference lists of relevant publications. Data regarding
26 available asthma/COPD medications presented in Table 2 were extracted from FDA’s approved
27 drug website and individual medication prescribing sheets.²⁵
28

29 DISCUSSION

30

31 *Climate Impact of CFCs and HFCs*

32

33 Despite improvements to the ozone layer after the Montreal Protocol, HFCs are powerful GHG that
34 contribute to climate change. HFCs can be up to 3800 times more powerful of a GHG than carbon
35 dioxide (see Table 1) and there is now increasing attention on the environmental impacts of HFCs.²⁶
36 Atmospheric concentrations of common HFCs used in medical sector have been found to be
37 increasing since the early 1990s while CFCs previously used in MDIs have plateaued and decreased
38 (see Figure 1).²⁷ Reducing the use of MDIs is consistently noted among the top high-priority and
39 effective measures for reducing GHGs within the health care sector, as GHG emissions from the
40 use of MDIs are substantial. MDIs are the most used inhalers in the world.^{2,26} “In 2020, MDIs made
41 up 75 percent of inhalers in use in the United States, with the equivalent emissions impact of
42 driving half a million cars for a year.”²³ Due to their wide usage, MDI prescriptions can account for
43 about three percent of a health system’s carbon footprint.⁴
44

45 As such, there is an unfortunate feedback loop between ongoing climate change impacts and
46 treating asthma/COPD with MDI inhalers, as increased global warming will likely exacerbate
47 existing asthma and respiratory issues, potentially requiring more acute treatment options which
48 MDIs currently provide.²⁸ Recognizing the climate change impacts of HFCs, the Kigali
49 Amendment to the Montreal Protocol calls for the phasing out of HFCs due to their climate
50 warming potential, but medical uses for HFCs are currently exempted. Additionally, the American
51 Innovation and Manufacturing Act of 2020, enacted by the U.S. Congress, directs the

1 Environmental Protection Agency (EPA) to phase down the production and use of HFCs in
2 consumer products, such as aerosols, refrigerants, etc., by 2036 but the rule also does not apply to
3 MDIs.²⁹

4
5 Additionally, direct emissions of anesthetic gases have been estimated to represent about three
6 percent of the health care-related GHGs in high-income nations.³⁰ As noted in Table 1, desflurane
7 has a GHG warming potential around 5-20 times higher than sevoflurane and isoflurane over a 100-
8 year period and it is also generally more expensive.³¹ While nitrous oxide is not a HFC, it also has
9 deleterious climate impacts. Even though it has a lower global warming potential, it is also less
10 potent than other inhalable anesthetics so is typically used in higher concentrations and has a long
11 atmospheric lifetime, thus making it problematic from a sustainability perspective.

12 *Metered Dose Inhalers - What are the alternatives?*

13
14
15 Inhaled therapy is the primary pharmacological therapy for obstructive lung diseases such as COPD
16 and asthma.³² Obstructive lung disease management and control has two components, symptom
17 control and risk reduction.⁵ Inhalers are generally categorized as either reliever or preventer
18 inhalers, with recent formulations combining these different types into one inhaler that is
19 recommended for daily usage. Preventer inhalers contain an inhaled corticosteroid (ICS), and
20 the Global Initiative for Asthma (GINA) and the Expert Panel Working Group of the National
21 Asthma Education and Prevention Program Coordinating Committee (NAEPPCC) recommend
22 most patients with asthma receive an ICS treatment.^{5,33} Reliever inhalers include a short-acting β -
23 agonist (SABA) which is intended to be utilized during asthma exacerbation events. GINA does not
24 recommend treatment of asthma with SABA inhalers alone. Recent developments in asthma
25 treatment recommend combined therapy, including anti-inflammatory reliever (AIR), which
26 consists of ICS with a short-acting β -agonist reliever and maintenance and reliever therapy
27 (MART) (ICS-formoterol), also called SMART in some places (single inhaler maintenance and
28 reliever therapy), which combines ICS and long-acting beta-agonist (LABA) therapy together.⁵

29
30 In addition to different therapeutic approaches, there are different types of inhalers available:
31 pressurized metered dose inhalers (pMDI), dry powder inhalers (DPI), and soft mist inhalers
32 (SMIs). DPIs rely on delivering medication in the form of a fine powder that is activated by a
33 person's breathing and SMIs use a spring action mechanism to deliver the medication in a fine mist.
34 pMDIs and DPIs are the two most commonly prescribed and manufactured inhalers globally.⁶ Table
35 2 provides a list of U.S. Food and Drug Administration (FDA) approved asthma/COPD
36 medications, their therapy approach, and the type of inhalation device.

37
38 As shown in Table 2, SABA inhalers available in the U.S. are predominantly pMDIs while the ICS
39 and combination therapy treatments are available as both DPI and pMDI inhalers. There is only one
40 DPI reliever inhaler, the ProAir Respiclick/Digihaler, and only four inhalers are available as an
41 SMI; these are only approved for the treatment of COPD. Currently, there is no DPI anti-
42 inflammatory reliever (AIR) regimen, which combines ICS-SABA that is easy to use and
43 affordable in the U.S., despite being more widely available in Europe (more on cost considerations
44 below).⁷

45
46 Life cycle assessments comparing pMDIs to DPIs have overwhelmingly and consistently found that
47 DPIs have a much lower carbon footprint due to their lack of an HFC propellant.^{4,6} Estimates from
48 the U.K. have projected a 96 percent reduction in the existing carbon footprint of asthma treatment
49 if all pMDIs were switched to DPIs.⁶ Similar life cycle assessments comparing SMI versus pMDIs
50 in terms of overall carbon footprint found comparable reductions in GHG emissions.⁶ Additionally,
51 climate model estimates have demonstrated that the phasing out of HFCs, as proposed by the Kigali

1 Amendment to the Montreal Protocol, could deliver 0.3 to 0.5°C degrees of climate benefit by
2 2100.³⁴ As the Kigali Amendment exempts HFCs for medical uses, it is possible that the
3 elimination of HFCs in both medical uses and other commercial applications could deliver even
4 greater climate benefit.

5
6 *Safety and Effectiveness of MDIs*
7

8 A barrier to switching from MDIs to DPIs has been the concern that DPIs are not as effective or are
9 more difficult to use than MDIs. Except in circumstances where the patient cannot generate
10 sufficient inspiratory airflow, such as with very young children (under the age of 5) or frail, older
11 adults, research has demonstrated that DPIs are as effective and safe as MDIs for a majority of
12 patients.⁸⁻¹⁰ For example, a randomized controlled trial (RCT) of patients with COPD comparing
13 the efficacy of a DPI versus a pMDI pharmaceutical formulation, found that the different inhaler
14 types demonstrated similar efficacy and a similar proportion of patients in the different inhaler
15 groups experienced any adverse effects from treatment.⁹ In another study, researchers did a post-
16 hoc analysis of patients from the Salford Lung Study in Asthma (a 12 month, multi-site RCT study
17 conducted in the UK on patients with asthma and COPD) who switched from a pMDI to DPI during
18 the study.³⁵ Patients that switched to DPIs halved their inhaler carbon footprint without loss of
19 asthma control, and in fact, asthma control was consistently superior over the 12 months in the DPI
20 group compared to the control group.³⁶

21
22 Despite the popularity and widespread usage of MDIs, studies have shown that many patients use
23 MDIs incorrectly, despite educational trainings on usage, resulting in improper inhalation
24 techniques and poor asthma control and management.^{11,12} DPIs have been found to be easier to
25 correctly use compared to MDIs, which requires some level of coordination between inhaler
26 actuation and patient inspiration to ensure correct inhalation and treatment.^{11,13} Additionally, in a
27 recent survey of asthma and COPD patients' inhaler preferences done in the U.K., "environmental
28 sustainability" was found to be one of the more important characteristics, indicating that patients
29 may be inclined to switch inhalers from an MDI to a DPI if the environmental impacts were
30 discussed.³⁷

31
32 While MDIs are the most used inhaler in the U.S., the U.K. has recently designated DPIs as the
33 default treatment for patients 12 and older and removed two carbon-intensive inhalers from
34 formularies.³⁸ Additionally, DPIs are the primary inhaler used in several other European countries.³
35 For example, Sweden has a higher prevalence of asthma to the U.S. (11.6 percent of individuals in
36 2022 in Sweden compared to 7.7 percent in 2021 in the U.S.) and DPIs account for 90 percent of
37 inhalers used.^{39,40} Although there is no available evidence on the role of inhaler types to account for
38 health outcome differences, Sweden has demonstrated better asthma-related mortality outcomes
39 compared to the U.S.; in 2012 the age-standardized asthma mortality for the 5–34-year age group in
40 Sweden was 0.00 compared to 0.37 in the U.S.⁴¹

41
42 Additionally, Finland in the early 1990s launched a national ten year program intended to improve
43 asthma care and limit the projected increases in costs.⁴² As part of this national program, the
44 importance of preventative ICS versus reliever medications was emphasized and a shift was
45 promoted from MDIs to DPIs. As a result of this initiative, the number of patients using daily ICS
46 went from around 33 percent in 1987 to over 85 percent in 2004 and while DPIs only accounted for
47 29 percent of inhalers sold in 1993, by 2003 they accounted for 84 percent.⁴² These changes were
48 concurrent with improved health outcomes, including a reduction in asthma related deaths and
49 emergency room visits, and decreased direct annual costs associated with asthma.⁴²

1 With the manufacturing of HFC propellant inhalers being an important component of their GHG
 2 emissions, several pharmaceutical companies have made promises to replace existing pMDIs with
 3 new HFC propellant that have a lower carbon footprint.⁶ There are several new HFC inhaler
 4 formulations that have a much lower GHG warming potential (see Table 1), with at least one set to
 5 be released in 2025. This would help pharmaceutical companies meet their sustainability goals
 6 while also reducing GHG emissions from the overall healthcare sector, but these new HFC inhalers
 7 may be more costly than currently available low-GHG alternatives.

8
 9 *Cost considerations*

10
 11 Increased costs are another challenge of switching to DPIs from MDIs, which is partly driven by a
 12 lack of competitive DPIs/SMIs that have been approved and made available in the U.S. (as
 13 compared to Canada and European countries). At the start of 2019, there were no generic inhalers
 14 on the U.S. market. While there are multiple low-cost DPI inhalers available in Europe, there are
 15 few low-cost alternatives in the U.S.⁷ Researchers estimate that a global inhaler transition where
 16 DPIs are the prevailing inhaler used could take a decade to implement and may lead to increased
 17 patient costs.^{26,43} Currently, SABA relievers as DPIs compared to MDIs tend to be more expensive
 18 but the cost of HFC propellants is expected to rise due to global policy trends in phasing out the use
 19 of HFCs in products.²

20
 21 One potential reason for the lack of competitive, low-cost alternatives to the prevailing MDIs on the
 22 market has been pharmaceutical companies’ ability to maintain patent protections on their brand
 23 name products through secondary patents after the primary patent has expired.¹⁴ Primary patents on
 24 pharmaceuticals cover the active ingredients within the medication while secondary patents can be
 25 claimed for peripheral aspects of the product, such as the propellants and delivery devices.
 26 Research on revenue earned on brand-name inhaler products in the U.S. found that manufacturers
 27 earned \$67.2 billion while primary patents were active and \$110.3 billion (62 percent) after primary
 28 patents had expired but when secondary patents were active, reflecting the importance of these
 29 secondary patents for maintaining high revenues while limiting potential competition.¹⁴ The
 30 persistent high cost of inhalers in the U.S. has caught the attention of U.S. lawmakers. In January
 31 2024, U.S. Senator Tammy Baldwin (D-WI) and colleagues launched an investigation into four
 32 pharmaceutical companies in regard to their high prices for inhalers.⁴⁴

33
 34 Despite the increased costs of switching to DPIs from MDIs, improved asthma management could
 35 help balance existing cost differentials. The overreliance on SABA (relief) inhalers alone in asthma
 36 treatment results in poor asthma management and health outcomes, which can lead to greater health
 37 care costs.² As one study notes, “[a]ny increase in low-cost salbutamol MDIs can potentially be
 38 offset by improving care to drive down their use ... and by using more cost-effective controller
 39 medication. For patients with poor asthma control, escalating controller therapy is a cost-effective,
 40 but underused strategy.”² Evidence from other countries demonstrate that a concerted effort to
 41 increase the use of ICS medication and reduce reliance on relief (SABA) medication, can improve
 42 asthma outcomes and lower costs.^{42,45}

43
 44 Policy recommendations to reduce the negative economic impacts of switching to lower carbon
 45 footprint inhalers are severalfold. Lawmakers could incentivize early entry of greener generic
 46 inhalers by extending the 180-day exclusivity period awarded to the first generic manufacturers to
 47 successfully challenge patents on a particular drug-device combination. The U.S Patent and
 48 Trademark Office could also pursue reforms to further examine drug-device combination patents
 49 and ensure the quality of patents issued on new inhalers. Lastly, the Centers for Medicare and
 50 Medicaid Services could determine a favorable reimbursement rate that is applicable for any

1 greener inhalers when they gain approval, considering their overall environmental benefits, that
2 would make them more favorable to include on insurance formularies.¹⁵

3
4 *Other advantages to switching from MDIs to DPIs*

5
6 There are a few other advantages to switching from pMDIs to non-propellant inhalers, like DPIs.
7 First, because pMDIs can be challenging to use and less critical errors are made while using DPIs,
8 overall asthma care could improve.⁴⁵ Also, because not all pMDIs have a counter that shows how
9 many doses are left, sometimes they are used when empty, also leading to poor disease control.
10 Lastly, pMDIs are sometimes used with a spacer – which allows patients, particularly young
11 children who may have difficulty using the inhaler, to deliver the medication in a slower, more
12 controlled way – and these are supposed to be replaced every year.⁴⁶ However, a Dutch study found
13 that only 60 percent of pMDI users received a new spacer annually, which may imply suboptimal
14 quality of care. As DPIs do not require a spacer, their use eliminates these possible issues while also
15 reducing the generation of non-reusable plastics.⁴⁵

16
17 *Equity considerations*

18
19 There are important health equity considerations regarding asthma prevalence, management, and
20 related health outcomes in the U.S. that make following current GINA and NAEPPCC care
21 recommendations challenging.⁴⁷ Asthma disproportionality impacts Black, non-Hispanic, American
22 Indian/Alaska Native, and Puerto Rican populations.^{40,48,49} Additionally, individuals living below
23 100 percent of the poverty threshold have a higher asthma prevalence compared to other socio-
24 economic groups (10.4 percent compared to 6.8 percent among individuals at 450 percent of
25 poverty threshold or higher).⁴⁰ In terms of asthma management, racial and ethnic minority children
26 are more likely to rely on SABA rather than ICS therapies, which, as noted above, can result in
27 poorer asthma control and management.⁴⁹ Lastly, Black, non-Hispanics have a much higher asthma
28 mortality rate compared to other racial and ethnic groups (24.4 per million for Black, non-Hispanics
29 compared to 9.8 per million for white, non-Hispanic populations).⁴⁰ Financial barriers for those who
30 lack insurance coverage for recommended combined therapies and working through authorizations
31 and referrals for those with public health insurance also pose equity challenges.⁴⁷ Considering these
32 existing health disparities and equity challenges, increased costs associated with new asthma
33 medications could disproportionately impact low-income communities of color who are already
34 burdened by asthma and has the potential to increase existing health disparities if asthma
35 medication becomes more costly and inaccessible.

36
37 *Prevention as a primary strategy and alternative*

38
39 As noted above, two of the key risk factors for both asthma and COPD are tobacco smoke and air
40 pollution.^{21,23} Public health policy and educational campaigns over the last 50 years have been
41 remarkably successful at lowering the prevalence of smoking and limiting indoor exposure to
42 tobacco smoke, thus reducing this exposure pathway.⁵⁰⁻⁵² However, tobacco use still remains the
43 leading cause of preventable disease and death in the U.S.⁵⁰ The introduction of e-cigarettes and
44 vape pens in the past decade has led to an increase in e-cigarette usage, particularly among young
45 adults, which may reverse the decades long downward trend in tobacco usage.⁵³ As such, there is
46 still a critical need for continued public health efforts to reduce smoking and tobacco use, which
47 would reduce the prevalence of asthma and COPD. Common outdoor air pollutants, including
48 particulate matter, ozone, carbon monoxide, lead, sulfur dioxide, and nitrogen dioxide, are in part
49 anthropogenic (human-caused) and result from the burning of fossil fuels for electricity generation,
50 industrial uses, and motor vehicle use.^{54,55} Federal and state policy to reduce air pollution has
51 resulted in substantially better air quality over the last several decades, but high pollution levels are

1 still a concern in many urban areas and for those living close to major sources of pollution, with
2 low income communities of color experiencing disproportionately high exposure to air
3 pollution.^{56,57} Efforts to reduce fossil fuel emissions would thus have multiple co-benefits, including
4 minimizing anthropogenic climate change by reducing GHG emissions, building more resilient
5 communities, improving health equity, and reducing outdoor air pollutants resulting in improved
6 respiratory outcomes.^{55,58,59}

7 *Anesthetic gases – Solutions and alternatives*

9
10 Life cycle assessments of anesthetic gases have found that more than 95 percent of emissions occur
11 in their waste phase, in that they are emitted freely to the outdoor atmosphere during use through
12 medical gas evacuation systems or through unscavenged gas exhaled into the indoor environment
13 that then flows outdoors.^{18,30} To mitigate the negative environmental impact of anesthetic gases,
14 clinical care recommendations, including those in the *Greening the Operating Room* report by the
15 American Society of Anesthesiologists Committee on Environmental Sustainability, focus on
16 delivery performance improvements, removing or avoiding the “worst” GHG offenders from
17 hospital drug formularies, and substituting non-inhaled anesthetic gases when clinically
18 appropriate.¹⁸

19
20 Delivery performance improvements are aimed at lowering the volume of anesthetic gases
21 unnecessarily wasted or lost during usage. A simple way to minimize gas waste is to lower fresh
22 gas flows during the maintenance phase of the anesthetic, but continuous oxygen concentration
23 monitoring is critical to prevent the possibility of hypoxemia.^{16,18,31} Additional strategies to reduce
24 gas flow and minimize environmental contamination of anesthetic gases have been outlined by the
25 American Society of Anesthesiologists *Greening the Operating Room* report.

26
27 Another strategy to reduce wasted gas is through improved delivery infrastructure. In older hospital
28 buildings, nitrous oxide has been delivered through central piping systems, which over time have
29 leaked nitrous oxide into the atmosphere. It is estimated that most nitrous oxide loss happens prior
30 to its usage with the patient and it has been recommended that these piping systems should be
31 decommissioned in existing infrastructure and avoided in new construction.³¹ As an alternative, it is
32 recommended that portable canisters should be substituted and should be closed between uses to
33 avert continuous leaks.³¹ Lastly, in terms of performance improvement, innovative methods for
34 collecting and reusing anesthesia, thus preventing them from being released directly into the
35 atmosphere, are currently being researched and evaluated.¹⁸ However, these devices have not been
36 widely used or evaluated on their efficacy, safety, benefit, or cost.²⁴

37
38 When evaluating choice of inhaled anesthesia gases, two important considerations include GHG
39 warming potential and the gas flowrate.^{16,18} Desflurane has the highest GHG warming potential
40 compared to other inhaled anesthetic gases and while nitrous oxide has a lower GHG warming
41 potential, it requires greater quantities to meet similar clinical effectiveness. Nitrous oxide also
42 persists in the atmosphere for more than 100 years, making its impacts felt over a much longer
43 period of time compared to other anesthetic gases.¹⁶ The larger quantities needed, and longer
44 persistence in the atmosphere, makes nitrous oxide’s environmental impact substantially greater
45 than isoflurane or sevoflurane.³⁰ With these considerations, eliminating desflurane and nitrous
46 oxide to the greatest extent possible in clinical practice, is recommended for improving the climate
47 impact of anesthetic gases.⁶⁰ However, nitrous oxide continues to be useful for elimination of pain
48 with no real alternative and therefore the use of portable cannisters with nitrous oxide is
49 recommended versus using older building piping systems.^{24,61} With desflurane, there is limited
50 evidence of clinically meaningful differences over other anesthetic gases, except minor differences
51 in faster mean wake up times following surgery.³¹ However, desflurane is also more expensive than

1 other anesthetic gases, therefore it's elimination or reduction in usage could result in cost savings
2 for health care systems.³¹

3
4 A final practice consideration to improve sustainability and reduce GHG emissions is to use total
5 intravenous anesthesia and/or regional anesthesia to eliminate volatile anesthetic emissions
6 whenever possible. It is important to note that this recommendation is not a carbon-neutral strategy,
7 as considerations must be made for minimizing single use plastics and unnecessary use of drugs and
8 supplies, which also contribute to overall hospital waste streams that have their own carbon
9 footprint. That being said, this alternative has been found to be associated with substantially less
10 emissions, even considering their full life cycle.^{17,31} To offset environmental impacts from
11 intravenous anesthesia, there are several strategies to reduce anesthesia equipment waste generation
12 overall, including: using prefilled syringes and appropriate sized vials for an individual patient, only
13 opening equipment intended for immediate use, considering purchase of reusable or reprocessed
14 equipment over disposable, reprocessing or recycling suitable disposable equipment, adjusting
15 stock levels to minimize discarding expired items, reformulating prefabricated kits to eliminate
16 unnecessary items, reformulating anesthesia supply carts to eliminate unnecessary items, and
17 donating expired or unused open equipment.^{16,62}

18 19 *Challenges and barriers*

20
21 Efforts to make anesthesia care more environmentally friendly have met several barriers. These
22 include the need for more education among anesthesiologists on the environmental impacts of
23 different anesthesia options as well as a lack of support from hospital leadership to implement
24 sustainability efforts.⁶³ In a qualitative study of anesthesiologists, several participants reported a
25 lack of knowledge and feedback as impediments to sustainable practices.⁶⁴ An educational
26 intervention with this aim at the University of Wisconsin was found to be effective at reducing
27 GHG emissions through changes in anesthetic practices and resulted in cost savings for the
28 hospital.⁶⁵ Interestingly, the environmental impact of physician decisions was a greater motivational
29 impact than monetary savings.⁶⁵ Thus, further advocacy and education is warranted to guide and
30 encourage more sustainable anesthetic practices.¹⁷

31
32 Beyond increased education, efforts to bring practice changes to scale could include the integration
33 of sustainability metrics into the Quality Payment Program established by the Medicare Access and
34 Children's Health Insurance Program Reauthorization Act of 2015. If environmental costs,
35 including GHG emissions associated with clinical practices, were to be incorporated into the cost
36 component of the program, it could serve to reward waste reduction strategies and programs within
37 healthcare systems.⁶⁶

38 39 RELEVANT AMA POLICY

40
41 Current AMA policy recognizes that climate change is a public health crisis and supports action on
42 reducing greenhouse gas emissions and reducing global warming.⁶⁷ AMA policy recognizes that
43 minoritized and marginalized populations, children, pregnant people, the elderly, rural
44 communities, and those who are economically disadvantaged will suffer disproportionate harm
45 from climate change and the health care sector has an important role to play in reducing its
46 greenhouse gas emissions.^{67,68} Lastly, AMA policy on asthma control encourages physicians to
47 make appropriate use of evidence-based guidelines, to provide self-management education tailored
48 to the literacy level of the patient by teaching and reinforcing appropriate self-monitoring, the use
49 of a written asthma action plan, taking medication correctly, and avoiding environmental factors
50 that worsen asthma; and encourages physicians to incorporate the four components of care

1 (assessment and monitoring; education; control of environmental factors and comorbid conditions;
2 and appropriate medication selection and use).⁶⁹

3
4 CONCLUSIONS

5
6 Asthma and chronic obstructive pulmonary disease (COPD) are two respiratory diseases with a
7 large burden of disease in the U.S. and treatment options primarily consist of inhalation therapy,
8 particularly using metered dose inhalers (MDIs).^{20,22} MDIs rely on liquefied-gas propellants to
9 atomize medication for inhalation delivery and represent the most used inhalers in the world.^{2,3}
10 Propellants in MDIs were historically chlorofluorocarbons (CFCs) but following evidence of their
11 deleterious impact on the Earth's ozone layer, were switched to hydrofluorocarbons (HFCs). While
12 HFCs do not negatively affect the ozone layer, they are potent greenhouse gases (GHG) and
13 contribute a significant portion of overall emissions in the health care sector.²

14
15 Switching to low carbon footprint inhalers is an opportunity to not only reduce GHG emissions
16 from the health care sector, but also to improve chronic asthma management and health outcomes
17 through the broader usage of dry powder inhalers (DPI) or soft mist inhalers (SMI) containing an
18 inhaled corticosteroid. Other countries, particularly in Europe, have either made commitments to
19 switch primarily to using DPIs for asthma treatment or made the transition years ago and now an
20 overwhelming majority of asthma patients use DPIs.^{3,38,42} However, there are several barriers to
21 switching to low carbon footprint inhalers in the U.S., including a common perception among
22 physicians that DPIs are more difficult to use as well as cost and access barriers to more affordable
23 and environmentally friendly options available. While there are perceptions among physicians that
24 DPIs are more difficult to use for some vulnerable populations, research has demonstrated that a
25 relatively small proportion of asthma patients have insufficient respiratory capacity to use DPIs
26 effectively and that DPIs are just as clinically effective as MDIs.¹¹⁻¹³ The cost and access barriers
27 could be addressed through policy changes that incentivize the introduction of greener, generic
28 inhalers on the U.S. market and the inclusion of more environmentally friendly options on
29 insurance formularies.

30
31 In addition to the use of HFCs in MDIs, the other major source of HFC/CFC use in health care
32 comes from anesthetic gases, which includes the HFCs sevoflurane and desflurane and the CFC
33 isoflurane. With anesthetic gases, there are several well documented strategies to improve
34 environmental sustainability, including the removal or avoidance of the "worst" GHG offender
35 from hospital drug formularies (desflurane), substituting non-inhaled anesthetic gases when
36 clinically appropriate, and minimizing gas waste by lowering fresh gas flows during the
37 maintenance phase of the anesthesia.¹⁸ The switch to more environmentally friendly anesthesia
38 options presents an opportunity for health care systems to lower their carbon footprint and could
39 result in cost savings.

40
41 RECOMMENDATIONS

42
43 The Council on Science and Public Health recommends that the following be adopted, and the
44 remainder of the report be filed.

- 45
46 1. That Policy H-160.932, "Asthma Control" be amended by addition and deletion to read as
47 follows:

48
49 The AMA: (1) encourages physicians to make appropriate use of evidence-based
50 guidelines, including those contained in ~~Expert Panel Report III: Guidelines for the~~
51 ~~Diagnosis and Management of Asthma~~ released by the National Heart, Lung and Blood

1 ~~Institute and the National Asthma Education and Prevention Program Coordinating~~
 2 ~~Committee Expert Panel Working Group 2020 Focused Updates to the Asthma~~
 3 ~~Management Guidelines;~~ (2) encourages physicians to provide self-management education
 4 tailored to the literacy level of the patient by teaching and reinforcing appropriate self-
 5 monitoring, the use of a written asthma action plan, taking medication correctly, and
 6 avoiding environmental factors that worsen asthma; ~~and~~ (3) encourages physicians to
 7 incorporate the four components of care (assessment and monitoring; education; control of
 8 environmental factors and comorbid conditions; and appropriate medication selection and
 9 use); ~~and~~ (4) will, in collaboration with interested parties and organizations, develop
 10 content to help physicians talk through the different asthma control options and their known
 11 economic costs and environmental impacts. (Modify Current AMA Policy)

- 12
- 13 2. That Policy H-135.913, “Metered Dose Inhalers and Greenhouse Gas Emissions” be
 14 amended by addition and deletion to read as follows:
 15
- 16 1. Our AMA will advocate to reduce the climate effects of hydrofluorocarbon propellants
 17 in metered-dose inhalers and encourage strategies ~~for encouraging supporting~~
 18 the development and use of alternative inhalers and propellants with equal and or
 19 higher efficacy and less adverse effect on our climate.
 - 20 2. Our AMA ~~will advocate for~~ supports legislative and regulatory reforms; that increase
 21 access to affordable ~~to keep inhalers medications affordable and accessible, will urge~~
 22 FDA to consider metered dose inhaler propellant substitutions for the purposes
 23 of climate protection as drug reclassifications, with lower greenhouse gas emissions
 24 that align with current recommended standards of care. Reforms should aim to ensure
 25 the quality of patents issued on new drug-device combinations, prevent new patents for
 26 minor changes made to delivery systems, and remove barriers to market entry for
 27 generic inhalers.
 - 28 3. Our AMA supports consideration of the environmental impacts of inhalers when
 29 creating prescription drug formularies and for the federal government to factor
 30 environmental impact into price negotiations with pharmaceutical manufacturers.
 31 ~~without new patent or exclusivity privileges, and not allow these substitutions to~~
 32 ~~classify as new drug applications.~~
 - 33
 - 34 ~~3. Our AMA will study options for reducing hydrofluorocarbon use in the medical sector.~~
 35 ~~(Modify Current AMA Policy)~~

36

37 3. That the following new policy be adopted.
 38

39 **REDUCING ENVIRONMENTAL IMPACTS OF ANESTHETIC GASES**

40

41 The AMA, in collaboration with interested parties and organizations, will disseminate
 42 evidence-based content and recommended strategies to reduce the global warming impact
 43 of anesthetic gases and encourage the phasing out of desflurane as an anesthetic gas. (New
 44 HOD Policy)

Fiscal Note: \$5,000

Table 1: Global warming potential of CFC/HFCs used in current and possibly future MDIs as well as common anesthetic gases¹

	Name	Global Warming Potential
	Carbon dioxide – reference	1
MDI Propellants	HFO 1234ze (potential new propellant in future MDIs)	<1
	HFA152a (potential new propellant in future MDIs)	138
	HFA-134a (used in most current MDIs)	1300
	HFA-227ea (used in some current MDIs)	3350
	CFC-11 (previously used in MDIs)	4660
	CFC-12 (previously used in MDIs)	10200
Anesthetic Gases	Nitrous oxide ² (N ₂ O)	273
	Isoflurane (CF ₃ CHClOCHF ₂)	539
	Desflurane (CF ₃ CHFOCHF ₂)	2590
	Sevoflurane ((CF ₃) ₂ CHOCH ₂ F)	144
	Methoxyflurane (CHCl ₂ CF ₂ OCH ₃)	4

Table 2: FDA Approved Asthma and COPD Medications^a

Drug name (active ingredient)	Company ^b	Method of Inhalation	Type of Treatment ^c	Target Disease
Aerospan (flunisolide)	Meda pharmaceuticals	pMDI	ICS	Asthma
Alvesco (ciclesonide)	Covis Pharma US	pMDI	ICS	Asthma
ArmonAir (fluticasone)	Teva	DPI	ICS	Asthma
Arnuity Ellipta (fluticasone furoate)	GlaxoSmithKline	DPI	ICS	Asthma
Asmanex (mometasone)	Organon	pMDI	ICS	Asthma
Asmanex Twisthaler (mometasone)	Organon	DPI	ICS	Asthma
Flovent HFA (fluticasone) ³	GlaxoSmithKline	pMDI	ICS	Asthma
Flovent Diskus (fluticasone)	GlaxoSmithKline	DPI	ICS	Asthma
Pulmicort (budesonide)	AstraZeneca	DPI	ICS	Asthma
Qvar RediHaler (beclomethasone dipropionate)	Teva	pMDI	ICS	Asthma
Serevent Diskus (salmeterol xinafoate)	GlaxoSmithKline	DPI	ICS	Asthma/ COPD
Advair HFA (fluticasone propionate and salmeterol)	GlaxoSmithKline	pMDI	ICS/LABA	Asthma

¹ Table adopted from Table 1 from this article: <https://bpspubs.onlinelibrary.wiley.com/doi/10.1111/bcp.15135> and Table 1 from this article: [https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196\(23\)00084-0/fulltext](https://www.thelancet.com/journals/lanplh/article/PIIS2542-5196(23)00084-0/fulltext)

² While nitrous oxide is not a hydrofluorocarbon, it is often discussed in tandem with hydrofluorocarbons in terms of climate impacts from anesthetic gases.

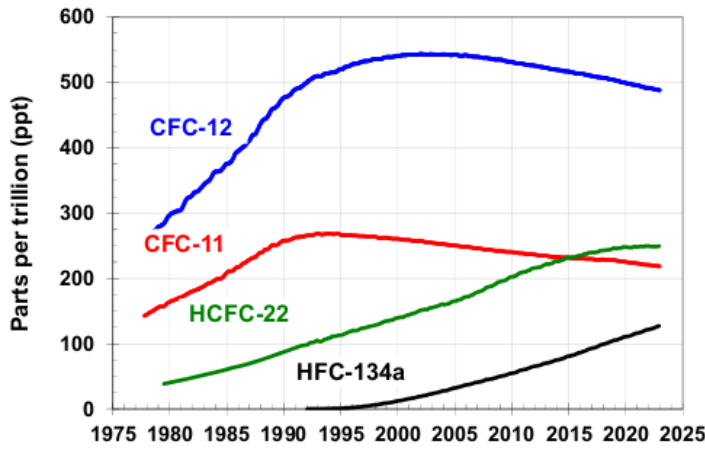
³ GlaxoSmithKline recently pulled Flovent HFA and Flovent Diskus from the market and it will now only be made available as a generic. <https://www.cnn.com/2023/12/28/health/asthma-inhaler-generic-switch/index.html>

Advair Diskus (fluticasone propionate and salmeterol)	GlaxoSmithKline	DPI	ICS/LABA	Asthma
Breo Ellipta (fluticasone furoate and vilanterol)	GlaxoSmithKline	DPI	ICS/LABA	Asthma/ COPD
Dulera (mometasone furoate and formoterol fumarate dihydrate)	Organon	pMDI	ICS/LABA	Asthma
Symbicort (budesonide and formoterol)	AstraZeneca	pMDI	ICS/LABA	Asthma/COPD
Trelegy Ellipta (fluticasone furoate, umeclidinium, and vilanterol)	GlaxoSmithKline	DPI	ICS/LAMA/ LABA	Asthma/COPD
Bretzi (budesonide, glycopyrrolate, and formoterol)	AstraZeneca	pMDI	ICS/LAMA/ LABA	COPD
Airsupra (albuterol and budesonide)	AstraZeneca	pMDI	ICS/SABA	Asthma
Arcapta (indacaterol)	Sunovion	DPI	LABA	Asthma
Foradil Aerolizer (formoterol fumarate)	Novartis	DPI	LABA	Asthma/COPD
Striverdi (olodaterol)	Boehringer Ingelheim	SMI	LABA	COPD
Incruse (umeclidinium)	GlaxoSmithKline	DPI	LAMA	COPD
Seebri (glycopyrrolate and formoterol)	Novartis	DPI	LAMA	COPD
Spiriva Respimat (tiotropium)	Boehringer Ingelheim	SMI	LAMA	Asthma/COPD
Spiriva HandiHaler (tiotropium)	Boehringer Ingelheim	DPI	LAMA	Asthma/COPD
Tudorza (aclidinium)	AstraZeneca	DPI	LAMA	COPD
Bevespi (glycopyrrolate and formoterol)	AstraZeneca	pMDI	LAMA/LABA	COPD
Anoro (umeclidinium and vilanterol)	GlaxoSmithKline	DPI	LAMA/LABA	COPD
Duaklir (aclidinium and formoterol)	AstraZeneca	DPI	LAMA/LABA	COPD
Stiolto Respimat (tiotropium and olodaterol)	Boehringer Ingelheim	SMI	LAMA/LABA	COPD
Utibron (glycopyrrolate and formoterol)	Sunovion	DPI	LAMA/LABA	COPD
ProAir (albuterol)	Teva	pMDI	SABA	Asthma
ProAir Respiclick/Digihaler (albuterol sulfate)	Teva	DPI	SABA	Asthma
Proventil HFA (albuterol sulfate)	Merck	pMDI	SABA	Asthma
Ventolin HFA (albuterol sulfate)	GlaxoSmithKline	pMDI	SABA	Asthma/COPD
Xopenex (levalbuterol)	Sunovion	pMDI	SABA	Asthma
Atrovent (ipratropium)	Boehringer Ingelheim	pMDI	SAMA	COPD
Combivent Respimat (ipratropium and albuterol)	Boehringer Ingelheim	SMI	SAMA/SABA	COPD

a: This list does not represent an exhaustive list of all FDA approved drugs for asthma and COPD but is intended to provide a snapshot of currently available inhalation therapies.
 b: The company listed represents the pharmaceutical company that originally manufactured the drug. Several of these brand-name medications have been discontinued as generic formulations are available, while five have independent generics.

c: ICS: Inhaled corticosteroid; LAMA: long-acting muscarinic antagonist; LABA: Long-acting β -agonist; SABA: Short-acting β -agonist; SAMA: Short-acting muscarinic antagonist

Figure 1: Global average abundances of common CFCs and HFCs, from the NOAA global air sampling network since the beginning of 1979.²⁷ [To note: HCFC-22 is primarily used as a refrigerant in air conditioning units and is therefore not included in Table 1 as it is not healthcare related]



REFERENCES

1. US Department of Commerce N. NOAA Global Monitoring Laboratory - Halocarbons and other Atmospheric Trace Species. Accessed September 25, 2023. <https://gml.noaa.gov/hats/publicn/elkins/cfcs.html>
2. Wilkinson A, Woodcock A. The environmental impact of inhalers for asthma: A green challenge and a golden opportunity. *Br J Clin Pharmacol*. 2022;88(7):3016-3022. doi:10.1111/bcp.15135
3. Huffman P, Hough E. A Hidden Contributor to Climate Change — Asthma Inhalers. *The Commonwealth Fund*. doi:10.26099/3yxy-5t89
4. Starup-Hansen J, Dunne H, Sadler J, Jones A, Okorie M. Climate change in healthcare: Exploring the potential role of inhaler prescribing. *Pharmacol Res Perspect*. 2020;8(6):e00675. doi:10.1002/prp2.675
5. Global Initiative for Asthma. *Global Strategy for Asthma Management and Prevention*; 2023:https://ginasthma.org/wp-content/uploads/2023/07/GINA-2023-Full-report-23_07_06-WMS.pdf.
6. Woodcock A, Beeh KM, Sagara H, et al. The environmental impact of inhaled therapy: making informed treatment choices. *Eur Respir J*. 2022;60(1):2102106. doi:10.1183/13993003.02106-2021
7. Furie GL, Feldman WB. Improving respiratory care for patients and the planet: Addressing the environmental impact of metered-dose inhalers. Presented at: Council on Science and Public Health meeting; January 31, 2024; American Medical Association webinar.
8. Clark AR, Weers JG, Dhand R. The Confusing World of Dry Powder Inhalers: It Is All About Inspiratory Pressures, Not Inspiratory Flow Rates. *J Aerosol Med Pulm Drug Deliv*. 2020;33(1):1-11. doi:10.1089/jamp.2019.1556
9. Beeh KM, Kuna P, Corradi M, Viaud I, Guasconi A, Georges G. Comparison of Dry-Powder Inhaler and Pressurized Metered-Dose Inhaler Formulations of Extrafine Beclomethasone Dipropionate/Formoterol Fumarate/Glycopyrronium in Patients with COPD: The TRI-D Randomized Controlled Trial. *Int J Chron Obstruct Pulmon Dis*. 2021;16:79-89. doi:10.2147/COPD.S291030
10. Borgström L, Asking L, Thorsson L. Idehalers or realhalers? A comparison of Diskus and Turbuhaler. *Int J Clin Pract*. 2005;59(12):1488-1495. doi:10.1111/j.1368-5031.2005.00747.x
11. Lavorini F, Pistolesi M, Usmani OS. Recent advances in capsule-based dry powder inhaler technology. *Multidiscip Respir Med*. 2017;12(1):11. doi:10.1186/s40248-017-0092-5
12. Ramadan WH, Sarkis A, Aderian SS, Milane A. Asthma and COPD Patients' Perception of Appropriate Metered-Dose Inhaler Technique. *Dose-Response*. 2020;18(2):1559325820917832. doi:10.1177/1559325820917832
13. Ramadan WH, Sarkis AT. Patterns of use of dry powder inhalers versus pressurized metered-dose inhalers devices in adult patients with chronic obstructive pulmonary disease or asthma: An observational comparative study. *Chron Respir Dis*. 2017;14(3):309-320. doi:10.1177/1479972316687209
14. Feldman WB, Tu SS, Alhiary R, Kesselheim AS, Wouters OJ. Manufacturer Revenue on Inhalers After Expiration of Primary Patents, 2000-2021. *JAMA*. 2023;329(1):87-89. doi:10.1001/jama.2022.19691
15. Wouters OJ, Feldman WB, Tu SS. Product Hopping in the Drug Industry — Lessons from Albuterol. *N Engl J Med*. 2022;387(13):1153-1156. doi:10.1056/NEJMp2208613
16. Gordon D. Sustainability in the Operating Room. *Anesthesiol Clin*. 2020;38(3):679-692. doi:10.1016/j.anclin.2020.06.006
17. Yates EF, Bowder AN, Roa L, et al. Empowering Surgeons, Anesthesiologists, and Obstetricians to Incorporate Environmental Sustainability in the Operating Room. *Ann Surg*. 2021;273(6):1108-1114. doi:10.1097/SLA.0000000000004755

18. Axelrod, D, Feldman J, Bell C, et al. Greening the Operating Room and Perioperative Arena: Environmental Sustainability for Anesthesia Practice. American Society of Anesthesiologists. Accessed December 11, 2023. <https://www.asahq.org/about-asa/governance-and-committees/asa-committees/environmental-sustainability/greening-the-operating-room>
19. American Lung Association. What Is Asthma? Accessed January 30, 2024. <https://www.lung.org/lung-health-diseases/lung-disease-lookup/asthma/learn-about-asthma/what-is-asthma>
20. Pate CA. Asthma Surveillance — United States, 2006–2018. *MMWR Surveill Summ*. 2021;70. doi:10.15585/mmwr.ss7005a1
21. American Lung Association. What Causes Asthma? Accessed January 30, 2024. <https://www.lung.org/lung-health-diseases/lung-disease-lookup/asthma/learn-about-asthma/what-causes-asthma>
22. Chronic Obstructive Pulmonary Disease (COPD) | CDC. Published June 30, 2023. Accessed October 23, 2023. <https://www.cdc.gov/copd/index.html>
23. CDC. Basics About COPD. Centers for Disease Control and Prevention. Published June 30, 2023. Accessed January 30, 2024. <https://www.cdc.gov/copd/basics-about.html>
24. Charlesworth M, Swinton F. Anaesthetic gases, climate change, and sustainable practice. *Lancet Planet Health*. 2017;1(6):e216-e217. doi:10.1016/S2542-5196(17)30040-2
25. Drugs@FDA: FDA-Approved Drugs. Accessed February 1, 2024. <https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm>
26. Woodcock A. Hydrofluorocarbons, Climate, and Health — Moving the Montreal Protocol beyond Ozone-Layer Recovery. *N Engl J Med*. 2023;388(26):2404-2406. doi:10.1056/NEJMp2302197
27. US Department of Commerce N. NOAA Global Monitoring Laboratory - THE NOAA ANNUAL GREENHOUSE GAS INDEX (AGGI). Accessed December 14, 2023. <https://gml.noaa.gov/aggi/aggi.html>
28. Asthma. C-CHANGE | Harvard T.H. Chan School of Public Health. Published August 20, 2019. Accessed January 31, 2024. <https://www.hsph.harvard.edu/c-change/subtopics/climate-change-and-asthma/>
29. U.S. House of Representatives Ways and Means Committee, Minority Staff. *Health Care and the Climate Crisis: Inhalers & the Environment*. U.S. House of Representatives; 2023. https://democrats-waysandmeans.house.gov/sites/evo-subsites/democrats-waysandmeans.house.gov/files/evo-media-document/20231218-climate-crisis_inhaler-fact-sheet_final_0.pdf
30. Andersen MPS, Nielsen OJ, Sherman JD. Assessing the potential climate impact of anaesthetic gases. *Lancet Planet Health*. 2023;7(7):e622-e629. doi:10.1016/S2542-5196(23)00084-0
31. Devlin-Hegedus JA, McGain F, Harris RD, Sherman JD. Action guidance for addressing pollution from inhalational anaesthetics. *Anaesthesia*. 2022;77(9):1023-1029. doi:10.1111/anae.15785
32. Çakmaklı S, Özdemir A, Firat H, Aypak C. An evaluation of the use of inhalers in asthma and chronic obstructive pulmonary disease. *J Taibah Univ Med Sci*. 2023;18(4):860-867. doi:10.1016/j.jtumed.2023.01.001
33. 2020 Focused Updates to the Asthma Management Guidelines: A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group | NHLBI, NIH. Published December 3, 2020. Accessed December 14, 2023. <https://www.nhlbi.nih.gov/resources/2020-focused-updates-asthma-management-guidelines>
34. Laboratory (CSL) NCS. Scientific Assessment of Ozone Depletion 2022: Executive Summary. Accessed February 26, 2024. <https://csf.noaa.gov/assessments/ozone/2022/executivesummary/>
35. Albertson TE, Murin S, Sutter ME, Chenoweth JA. The Salford Lung Study: a pioneering comparative effectiveness approach to COPD and asthma in clinical trials. *Pragmatic Obs Res*. 2017;8:175-181. doi:10.2147/POR.S144157

36. Woodcock A, Janson C, Rees J, et al. Effects of switching from a metered dose inhaler to a dry powder inhaler on climate emissions and asthma control: post-hoc analysis. *Thorax*. 2022;77(12):1187-1192. doi:10.1136/thoraxjnl-2021-218088
37. Metting EI, Dijk LV, Messlaki HE, Luers J, Kock J. Development of a shared decision-making tool to support patients and their healthcare provider in choosing the best inhaler device. *Eur Respir J*. 2018;52(suppl 62). doi:10.1183/13993003.congress-2018.OA1643
38. National Health Service - England. Greener NHS » Improving health outcomes for respiratory patients while reducing carbon emissions. Accessed January 30, 2024. <https://www.england.nhs.uk/greenernhs/whats-already-happening/improving-health-outcomes-for-respiratory-patients-while-reducing-carbon-emissions/>
39. Sweden: share of individuals with asthma 2022, by type. Statista. Accessed December 18, 2023. <https://www.statista.com/statistics/974393/share-of-individuals-with-asthma-in-sweden-by-type/>
40. Most Recent National Asthma Data | CDC. Published June 23, 2023. Accessed December 18, 2023. https://www.cdc.gov/asthma/most_recent_national_asthma_data.htm
41. Ebmeier S, Thayabaran D, Braithwaite I, Bénamara C, Weatherall M, Beasley R. Trends in international asthma mortality: analysis of data from the WHO Mortality Database from 46 countries (1993–2012). *The Lancet*. 2017;390(10098):935-945. doi:10.1016/S0140-6736(17)31448-4
42. Haahtela T, Tuomisto LE, Pietinalho A, et al. A 10 year asthma programme in Finland: major change for the better. *Thorax*. 2006;61(8):663-670. doi:10.1136/thx.2005.055699
43. Pritchard JN. The Climate is Changing for Metered-Dose Inhalers and Action is Needed. *Drug Des Devel Ther*. 2020;14:3043-3055. doi:10.2147/DDDT.S262141
44. Baldwin T. Senator Baldwin, Colleagues Launch Investigation into Pharmaceutical Companies' High Price of Asthma Inhalers | U.S. Senator Tammy Baldwin of Wisconsin. Published January 8, 2024. Accessed February 5, 2024. <https://www.baldwin.senate.gov/news/press-releases/senators-baldwin-colleagues-launch-investigation-into-pharmaceutical-companies-high-price-of-asthma-inhalers>
45. Have P ten, Hal P van, Wichers I, et al. Turning green: the impact of changing to more eco-friendly respiratory healthcare – a carbon and cost analysis of Dutch prescription data. *BMJ Open*. 2022;12(6):e055546. doi:10.1136/bmjopen-2021-055546
46. Using an inhaler with a spacer: How to use, benefits, and tips. Published June 14, 2019. Accessed January 9, 2024. <https://www.medicalnewstoday.com/articles/325472>
47. Nanda A, Siles R, Park H, et al. Ensuring equitable access to guideline-based asthma care across the lifespan: Tips and future directions to the successful implementation of the new NAEPP 2020 guidelines, a Work Group Report of the AAAAI Asthma, Cough, Diagnosis, and Treatment Committee. *J Allergy Clin Immunol*. 2023;151(4):869-880. doi:10.1016/j.jaci.2023.01.017
48. Perez MF, Coutinho MT. An Overview of Health Disparities in Asthma. *Yale J Biol Med*. 2021;94(3):497-507.
49. Holsey CN, Collins P, Zahran H. Disparities in Asthma Care, Management, and Education Among Children With Asthma. *Clin Pulm Med*. 2013;20(4):172-177. doi:10.1097/CPM.0b013e3182991146
50. Cornelius ME. Tobacco Product Use Among Adults – United States, 2021. *MMWR Morb Mortal Wkly Rep*. 2023;72. doi:10.15585/mmwr.mm7218a1
51. Health and Economic Benefits of Tobacco Use Interventions | Power of Prevention. Published February 1, 2023. Accessed February 1, 2024. <https://www.cdc.gov/chronicdisease/programs-impact/pop/tobacco.htm>
52. Levy DT, Chaloupka F, Gitchell J. The Effects of Tobacco Control Policies on Smoking Rates: A Tobacco Control Scorecard. *J Public Health Manag Pract*. 2004;10(4):338.

53. Ali FRM. E-cigarette Unit Sales by Product and Flavor Type, and Top-Selling Brands, United States, 2020–2022. *MMWR Morb Mortal Wkly Rep.* 2023;72. doi:10.15585/mmwr.mm7225a1
54. US EPA O. Criteria Air Pollutants. Published April 9, 2014. Accessed February 1, 2024. <https://www.epa.gov/criteria-air-pollutants>
55. Lancet Policy Brief for the United States of America. LANCET COUNTDOWN: Accessed February 1, 2024. <https://www.lancetcountdownus.org/2022-lancet-countdown-u-s-brief/>
56. US EPA O. Outdoor Air Quality. Published November 2, 2017. Accessed February 1, 2024. <https://www.epa.gov/report-environment/outdoor-air-quality>
57. American Lung Association. Disparities in the Impact of Air Pollution. Accessed February 1, 2024. <https://www.lung.org/clean-air/outdoors/who-is-at-risk/disparities>
58. How Climate Change Impacts Health. Accessed February 1, 2024. <https://www.apha.org/Topics-and-Issues/Climate-Health-and-Equity/Health-Impacts>
59. Haines A. Health co-benefits of climate action. *Lancet Planet Health.* 2017;1(1):e4-e5. doi:10.1016/S2542-5196(17)30003-7
60. Lopes R, Shelton C, Charlesworth M. Inhalational anaesthetics, ozone depletion, and greenhouse warming: the basics and status of our efforts in environmental mitigation. *Curr Opin Anaesthesiol.* 2021;34(4):415-420. doi:10.1097/ACO.0000000000001009
61. Reduce Carbon Footprint from Inhaled Anesthesia with New Guidance Published. Accessed September 14, 2023. <https://www.asahq.org/about-asa/newsroom/news-releases/2022/06/reduce-carbon-footprint-from-inhaled-anesthesia-with-new-guidance-published>
62. Inhaled Anesthesia Climate Initiative | Yale School Of Public Health. Accessed September 14, 2023. <https://ysph.yale.edu/yale-center-on-climate-change-and-health/healthcare-sustainability-and-public-health/inhaled-anesthesia-climate-initiative/>
63. Petre MA, Bahrey L, Levine M, van Rensburg A, Crawford M, Matava C. A national survey on attitudes and barriers on recycling and environmental sustainability efforts among Canadian anesthesiologists: an opportunity for knowledge translation. *Can J Anaesth J Can Anesth.* 2019;66(3):272-286. doi:10.1007/s12630-018-01273-9
64. Zaw MWW, Leong KM, Xin X, Lin S, Ho C, Lie SA. The perceptions and adoption of environmentally sustainable practices among anesthesiologists-a qualitative study. *Can J Anaesth J Can Anesth.* 2023;70(3):313-326. doi:10.1007/s12630-022-02392-0
65. Zuegge KL, Bunsen SK, Volz LM, et al. Provider Education and Vaporizer Labeling Lead to Reduced Anesthetic Agent Purchasing With Cost Savings and Reduced Greenhouse Gas Emissions. *Anesth Analg.* 2019;128(6):e97. doi:10.1213/ANE.0000000000003771
66. Sherman JD, Berkow L. Scaling Up Inhaled Anesthetic Practice Improvement: The Role of Environmental Sustainability Metrics. *Anesth Analg.* 2019;128(6):1060. doi:10.1213/ANE.0000000000004095
67. D-135.966 Declaring Climate Change a Public Health Crisis | AMA. Accessed February 26, 2024. <https://policysearch.ama-assn.org/policyfinder/detail/climate%20change?uri=%2FAMADoc%2Fdirectives.xml-D-135.966.xml>
68. H-135.938 Global Climate Change and Human Health | AMA. Accessed February 26, 2024. <https://policysearch.ama-assn.org/policyfinder/detail/Global%20Climate%20Change%20and%20Human%20Health%20?uri=%2FAMADoc%2FHOD.xml-0-309.xml>
69. H-160.932 Asthma Control | AMA. Accessed February 26, 2024. <https://policysearch.ama-assn.org/policyfinder/detail/asthma%20control?uri=%2FAMADoc%2FHOD.xml-0-747.xml>

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-24)
Prescribing Guided Physical Activity for Depression and Anxiety (Reference Committee D)

EXECUTIVE SUMMARY

INTRODUCTION. Resolution 421-A-23 modified existing American Medical Association (AMA) policy and asked that our AMA study the evidence of the efficacy of physical activity interventions (i.e., group fitness, personal training, or physical therapy) on behavioral activation and outcomes on depressive and anxiety symptoms and report its findings to the AMA House of Delegates by the 2024 Annual Meeting.

METHODS. English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: “physical activity prescribing” AND “depression”, “anxiety,” “park prescription programs,” “insurance reimbursement,” “minoritized communities,” “older (pregnant, minoritized, adolescent) individuals”. Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies and applicable professional and advocacy organizations, including the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, the National Institute of Mental Health, and the American Council on Exercise were also reviewed for relevant information.

BACKGROUND. Approximately one in eight people (970 million) worldwide are affected by a mental health disorder and almost one in two (44 percent) will experience a mental health disorder in their lifetime.^{1,2} Depression is the leading cause of mental health-related disease burden, while anxiety is the most prevalent mental health disorders.^{1,3} Interventions for treatment of depression and anxiety often include medication and/or psychotherapy.⁴ However, one promising alternative to psychotherapy or pharmacotherapy to treat depression and anxiety is the prescription of physical activity. Research trials examining the effects of physical activity on depression and anxiety suggest that physical activity may have similar effects to the combination treatment of psychotherapy and pharmacotherapy. However, physical activity prescriptions have not been widely adopted therapeutically. The limited availability of evidence on the efficacy of physical activity prescriptions for various populations, patient resistance, and the difficulty of prescribing and monitoring physical activity in clinical settings remain major barriers to wider adoption.⁵⁻⁷ Further, a successful physical activity program is multi-faceted and needs to consider what an effective program will look like depending on the patient’s individual circumstances (i.e., current level of activity, age, access to facilities or safe outdoor spaces, existing chronic conditions, etc.).¹

CONCLUSION. This report outlines the biological mechanisms that contribute to the antidepressant effects of exercise, the current physical activity guidelines for specific age groups, what different levels of physical activity intensity entail, and what counts for the different types of activity (i.e., aerobic versus strength training). The report also evaluates the current clinical evidence on the efficacy of physical activity on mental health disorders in different populations, evidence on the efficacy of physical activity prescription programs, and the current challenges and barriers to implementing physical activity as a standard of care for mental health. The recommendations recognize the limitations in existing data on developing effective physical activity prescriptions, the need for education of health care professionals on the mental health benefits of physical activity, and a potential first step to incorporating physical activity into current standards of care.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 9-A-24

Subject: Prescribing Guided Physical Activity for Depression and Anxiety

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee D

1 Resolution 421-A-23, as adopted by the American Medical Association’s (AMA) House of
2 Delegates. That policy (H-470.997, “Exercise and Physical Fitness”) directs the AMA to:

3
4 “study evidence of the efficacy of physical activity interventions (i.e., group fitness, personal
5 training, or physical therapy) on behavioral activation and outcomes on depressive and anxiety
6 symptoms.”

7 8 BACKGROUND

9
10 In the U.S., five percent adults aged 18 and over experience regular feelings of depression and 12.5
11 percent have regular feelings of worry, nervousness, or anxiety.⁸ Feelings of depression, in this
12 case, is defined as feeling depressed daily and describing the level of depression as “somewhere in
13 between a little and a lot” or “a lot” or feeling depressed weekly and describing the level of
14 depression as “a lot.” There are several different types of depressive disorders but, in general,
15 depression is a mood disorder that affects how a person feels, thinks, and handles daily activities.
16 Individuals may experience symptoms of persistent sadness or hopelessness, loss of motivation,
17 low self-attitude, decreased energy, changes in sleep, appetite and concentration, anhedonia, and
18 sometimes suicidal ideation.⁹ According to the National Institute of Mental Health, major
19 depression is one of the most common mental health diagnoses in the U.S. and an estimated 21.0
20 million U.S. adults (a little over eight percent) have had at least one major depressive episode over
21 their lifetime.⁹ There are a variety of etiologies involved in depression, including genetic,
22 environmental, psychological, and biochemical factors.¹⁰ An individual has an increased risk of
23 depression if they have a family history of depression, they have experienced trauma, major life
24 changes, stress, chronic pain, certain physical illnesses (such as diabetes, cancer, or Parkinson’s),
25 or as a side effect to certain medication.¹⁰

26
27 Anxiety is a normal physiologic reaction and oftentimes can be positive. When anxiety is
28 excessive, including somatic anxiety and impacts day-to-day functioning, it is considered an
29 anxiety disorder.¹¹ Anxiety disorders are a spectrum of anxiety-related illnesses including but not
30 limited to Obsessive Compulsive Disorder (OCD), Panic Disorder, Agoraphobia, and Generalized
31 Anxiety Disorder (GAD).¹¹ Symptoms of generalized anxiety disorder may include feeling restless,
32 on-edge, difficulty concentrating, increased irritability, and sleep disruption.¹¹ Anxiety comes from
33 a complex interaction between biology and environment. Some factors may include genetics, brain
34 function and chemistry, individual temperament, development, and one’s perception of threats.¹¹
35 Anxiety disorders are often comorbid with other mental health conditions, including depressive
36 disorders.

1 Interventions for treatment of depression and anxiety often include medication and/or
2 psychotherapy, with the greatest evidence of effectiveness often including a combination of both
3 medication and psychotherapy.⁴ However, evidence has demonstrated a beneficial effect of
4 exercise interventions on the prevention of depression. A recent meta-analysis found that people
5 with high levels of exercise had lower odds of developing depression.¹² In other countries such as
6 Australia, lifestyle management is recommended as the first-line treatment approach, though in
7 practice, pharmacotherapy is often provided first.^{13,14} While the many physical and mental health
8 benefits of regular physical activity are well documented, as of 2019, only 23 percent of adults in
9 the U.S. were meeting recommended levels of physical activity.^{15,16,17} Many people in the U.S.
10 could benefit from increased physical activity to help prevent, better manage, and improve mental
11 health issues like depression and anxiety.

12 13 METHODS

14
15 English language reports were selected from searches of the PubMed and Google Scholar databases
16 using the search terms: “physical activity prescribing” AND “depression”, “physical activity
17 prescribing”, AND “anxiety”, “park prescription programs”, “prescribing physical activity”, AND
18 “insurance reimbursement,” “minoritized communities” AND “prescribing physical activity,” and
19 “physical activity for mental health” AND “older (pregnant, minoritized, adolescent) individuals”.
20 Additional articles were identified by manual review of the reference lists of pertinent publications.
21 Web sites managed by federal agencies and applicable professional and advocacy organizations,
22 including the U.S. Department of Health and Human Services (HHS), Centers for Disease Control
23 and Prevention (CDC), the National Institute of Mental Health, and the American Council on
24 Exercise were also reviewed for relevant information.

25 26 DISCUSSION

27
28 Physical activity is defined as bodily movement produced by movement of skeletal muscles that
29 results in energy expenditure.^{18,19} Exercise is a type of physical activity that involves planned,
30 structured, and repetitive bodily movement, performed to maintain or improve one’s physical
31 fitness.¹⁸ Numerous guidelines exist to promote recommended amounts of physical activity. HHS
32 has developed general guidelines for physical activity for different age groups and populations with
33 specific health concerns.²⁰ Specific recommendations for each group are summarized in Table 1,
34 but for adults, the general recommendation is at least 150 minutes to 300 minutes of moderate-
35 intensity physical activity each week (e.g., walking or biking at a leisurely to moderate-pace, and
36 slow swimming) or 75 to 150 minutes of vigorous-intensity aerobic physical activity per week
37 (e.g., fast-pace walking or biking, jogging, or sports play).

38
39 Physical activity intensity is based on the energy expenditure incurred during the activity, as
40 expressed by multiples of 1 MET, which is the ratio of the metabolic rate for an activity divided by
41 a standardized expression of the resting metabolic rate (RMR).²⁰ It has been noted that different
42 populations, based on gender, age, etc., have different RMRs and correction factors have been
43 applied to adjust for these individual differences.²⁰ However, in general, physical activity is
44 categorized into three intensity levels, based on expended energy: light-intensity (1.6-2.9 METs),
45 moderate-intensity (3-5.9 METs), and vigorous-intensity (≥ 6 METs).²⁰ It is important to note that
46 energy expenditure is also determined by an individual’s physical fitness. In other words, an
47 individual who regularly exercises may find fast-paced walking to be a moderate intensity exercise
48 versus someone who has historically been physically inactive may find it to be of vigorous
49 intensity. Lastly, different types of physical activity are based on the type of movement and the
50 way in which different components of the body are engaged. Table 2 defines several common types
51 of movement. To note, many physical activities combine more than one type of movement.

Biological Mechanisms Underlying the Role of Physical Activity on Depression and Anxiety

It has been demonstrated that exercise has beneficial effects in reducing symptoms of depression such as low mood, anhedonia, and loss of interest and on body functions such as cardiorespiratory system and cognitive function.²¹ However, more research is needed into the mechanisms underlying the antidepressant effects of exercise. Most studies on the mechanisms of the antidepressant effect of exercise are mouse/rodent model studies, with some clinical studies in humans when feasible.^{21,22} The biological pathways whereby regular physical activity might confer resilience include promoting an anti-inflammatory state, reducing the negative effects of oxidative stress, serving as a buffer against stress and stress-related disorders/chronic diseases, and enhancing neuroplasticity and neurogenesis.²¹⁻²⁵ In addition, exercise causes an increase in neurotransmitters associated with increased activity of dopamine, 5-hydroxytryptamine, and noradrenaline in the central nervous system.

Anti-inflammatory and Antioxidant Factors

A mechanism in which regular exercise and/or physical fitness may confer resilience is through minimizing inflammation. Psychological stress and physical inactivity/low aerobic fitness have all been associated with persistent, systemic, low-grade inflammation, and are associated with adverse effects on mental and physical health.^{21,26,27} Systemic markers of inflammation include tumor necrosis factor alpha (TNF α), interleukin (IL)-1, IL-6, IL-8 and C-reactive protein (CRP), with elevated basal IL-6 and CRP levels being closely associated with persistent depressive symptomatology and cognitive dysfunction.²⁸ A randomized control trial (RCT) designed to assess the relative efficacy of aerobic exercise to augment selective serotonin reuptake inhibitor (SSRI) treatment of major depressive disorder (MDD) in treatment-resistant patients, found those who had high basal levels of serum TNF α were found to have a greater decrease in depressive symptoms over the 12-week aerobic exercise intervention.^{28,29} These results suggest that high serum TNF α levels may differentially predict better outcomes with exercise and antidepressant medication as treatment as opposed to antidepressant medications alone, wherein high serum TNF α levels are linked to a poor treatment response.^{28,29}

Oxidative Stress (OS)

Oxidative and nitrosative stress occurs when excess reactive oxygen species and reactive nitrogen species are produced as a byproduct of metabolic processing and have harmful effects on the body.²¹ Organs such as the brain are particularly vulnerable to this damage because it has a high metabolic rate and lower antioxidant levels.^{21,30} As a result, oxidative stress pathways may contribute towards the pathophysiology of psychiatric disorders, such as depression. Over time, the resulting damage may counteract neuroplasticity and contribute some of the structural abnormalities in people with depression.²¹ Moderate aerobic exercise has been shown to reduce OS and inflammation.²¹ It also reduces the concentration of several inflammatory biomarkers, such as IL-6, homocysteine, and TNF- α , and restrains the activity of nicotinamide adenine dinucleotide (NADH) oxidase, which results in metabolic oxidative stress.²¹ One study illustrated that voluntary wheel running alleviated depression-like symptoms in male rats with prenatal ethanol exposure and that the positive effects of exercise were linked to increased levels of antioxidants.^{21,31} In clinical studies, a 12-week aquatic exercise program in older adults with depression (n = 92) was shown to reduce depression and anxiety and decrease OS.^{21,32}

Neurogenesis and Neuroplasticity

1 The beneficial effects of physical activity and increased cardiorespiratory fitness on brain health
2 are well recognized. Chronic stress, exemplified by high level glucocorticoid exposure, decreases
3 neurotrophic factor expression/signaling, neurogenesis and gliogenesis in the brain; this appears to
4 be associated with reduced volumes of stress-sensitive brain regions as well as depression and
5 cognitive dysfunction.^{28,33,34} By contrast, regular exercise has been shown to enhance positive
6 mood, decrease depression and anxiety, and increase cognitive function such as learning and
7 memory in both animal and human studies.^{28,29,35} Possible biological mechanisms mediating these
8 effects include structural (i.e., increased neurogenesis, synaptogenesis, gliogenesis and
9 angiogenesis) and cellular/molecular changes in the brain.^{28,35,36} Together, they can promote
10 enhanced neuroplasticity and may be capable of blocking and/or reversing the detrimental effects
11 of chronic stress on the brain.

12
13 One important growth factor that has received much attention is brain-derived neurotrophic factor
14 (BDNF).^{28,37} BDNF plays a critical role in integrating behavioral and metabolic responses to
15 various challenging environments, including exercise.^{28,37} Studies of outpatients with MDD and
16 persistent depressive disorder demonstrated that both acute and regular exercise caused an increase
17 in BDNF.²¹ A study of elderly women with major depression showed that a single exercise session
18 significantly increased serum BDNF levels; however, it showed a significant secondary decrease in
19 BDNF serum levels after 30 min of rest. This suggests that acute exercise might be beneficial for
20 MDD treatment, but further studies are needed.^{21,38}

21 22 EFFICACY OF PHYSICAL ACTIVITY ON DEPRESSION AND ANXIETY IN DIFFERENT 23 POPULATIONS

24
25 The sections below examine current evidence in the literature about the efficacy of physical
26 activity on anxiety and depression in children and adolescents, older adults, adults with chronic
27 health conditions and/or disability, pregnancy, and minoritized communities. There are many
28 limitations in current literature surrounding the benefits of physical activity on anxiety and
29 depression which includes, but are not limited to, the nature of the patient sample; the methods
30 used to document anxiety and depression in the patient sample; the lack of inclusion of
31 symptomology to describe anxiety disorders and depressive disorders in the patient sample;
32 heterogeneity within the group of individuals who have similar depressive disorders or anxiety
33 disorders; and the lack of objective measures of either functional or quality of life impairment.
34 Further, it should be acknowledged that depression and anxiety are complex disorders that are
35 influenced by many factors and are often comorbid with other mental health conditions.

36 37 *Children and Adolescents*

38
39 A systematic review and meta-analysis which included studies involving 2441 participants aged
40 less than 19 years old, aimed to understand if physical activity interventions were associated with
41 significant reductions in depressive symptoms compared with the control condition in children and
42 adolescents.³⁹⁻⁴⁴ This meta-analysis showed that physical activity interventions produced greater
43 reductions in depressive symptoms compared with the control conditions.³⁹⁻⁴⁴ However, these
44 differences were not detected after a mean follow-up of 21 weeks, possibly due to the limited
45 number of studies with follow-up outcomes.³⁹⁻⁴⁴ Previous studies have shown that physical activity
46 had greater benefits in participants aged 13 years or older than in younger participants.⁴⁵ It also has
47 been demonstrated that three physical activity sessions per week and interventions that were shorter
48 than 12 weeks induced greater benefits on depressive symptoms compared with other frequencies
49 and durations.⁴⁵ These findings were reflected in the results of previous meta-analyses on the
50 association between physical activity and depression, suggesting that increasing amounts of
51 physical activity may not translate into greater reductions in depressive symptoms.^{39,46,47} A recent

1 cross-sectional study found a U-shaped association between physical activity frequency and mental
2 health, such that 10 to 15 sessions per month induced the greatest mental health improvements.^{39,48}
3 In contrast, there is other evidence that greater than 10 to 15 sessions per month of physical activity
4 have increasingly beneficial effects on mental health.^{39,49} These discrepancies in the literature
5 highlight the need for more comprehensive studies in this population to better understand the
6 benefits of physical activity on depressive symptoms.

7 8 *Older Adults*

9
10 Regular physical activity can help older adults, aged 50 years and older, maintain and improve their
11 mental health and cognitive ability, and reduce symptoms of depression and anxiety.⁵⁰⁻⁵² It can also
12 improve other functional abilities, including physical function and balance, thereby preventing falls
13 and fall-related injuries.^{50,51,53} In addition to serving as an important pathway for improved mental
14 health, physical activity brings social benefits, as being active offers the chance to build
15 relationships and strengthen social networks around an older person.⁵⁰

16
17 One study examined the minimal dose of moderate to vigorous physical activity (MVPA)
18 associated with a reduced risk of depression and depressive symptoms in 4016 older adults, over a
19 10-year period.⁵⁰ Depression and depressive symptoms were measured using the short form of the
20 Centre for Epidemiological Studies Depression scale along with the Composite International
21 Diagnostic Interview for diagnosis of a major depressive episode during the past 12 months. Older
22 adults performing between 400 to 600 MET minutes per week had a 16 percent lower rate of
23 depressive symptoms and 43 percent lower odds of major depression.⁵⁰ These findings were
24 consistent with meta-analytic data suggesting that mental health benefits among adults can be
25 achieved with physical activity below public health recommendations (600 MET-min/wk).
26 Specifically, an activity volume equivalent to 2.5 hours per week of brisk walking was associated
27 with a 25 percent lower risk of depression, and half that activity volume was associated with an 18
28 percent lower risk compared with no activity.^{46,50} Minimally sufficient activity doses for depressive
29 symptoms and major depressive disorder vary based on chronic disease status.⁵⁰ For depressive
30 symptoms, older adults with chronic disease showed a significantly reduced risk (seven percent) at
31 the WHO guideline threshold of 600 MET-min/wk, although the greatest decreases occurred with
32 increasing physical activity dose, with a similar outcome observed for major depression.^{50,54}
33 Further, previous meta-analytic evidence that suggested significantly larger antidepressant effects
34 of exercise training among adults with chronic illness who were meeting WHO guidelines for
35 physical activity.^{50,54-56}

36 37 *Adults With Chronic Health Conditions and/or Disability*

38
39 Regular physical activity is recommended for adults with chronic health conditions and/or a
40 disability and can provide both physical and cognitive benefits.^{20,54} For many chronic conditions,
41 physical activity provides therapeutic benefits and is part of recommended treatment for the
42 condition.⁵⁷ The benefits of physical activity for people with disabilities have been studied in
43 diverse groups with disabilities related to traumatic events or to chronic health conditions. These
44 groups include people with previous stroke, spinal cord injury, multiple sclerosis, Parkinson
45 disease, muscular dystrophy, cerebral palsy, traumatic brain injury, limb amputations, mental
46 illness, intellectual disability, and dementias including Alzheimer.^{20,57} Studies have shown there
47 was moderate-certainty to high-certainty evidence that physical activity decreased symptoms of
48 anxiety and depression in people with chronic conditions.^{20,57,58}
49 It should be noted that data assessing the benefits of physical activity in individuals with a
50 disability is very limited. In individuals who are disabled and with schizophrenia or major
51 depressive disorder, there is moderate-certainty evidence for the beneficial effects of physical

1 activity on quality of life.^{20,54,59} There is also moderate-certainty evidence that physical activity can
2 have beneficial effects on cognition in people who are disabled with multiple sclerosis, Parkinson's
3 disease, a history of stroke, ADHD and major clinical depression.^{20,54,59}

4 5 *Pregnancy*

6
7 There is limited evidence on the efficacy of physical activity in reducing symptoms of anxiety and
8 depression in people who are pregnant. Most studies focus on pregnant women, and this highlights
9 a gap in current literature. Depression in pregnancy is a significant public health problem; both
10 pregnancy and childbirth are some of the factors that contribute to the development of
11 depression.^{60,61} The incidence of depression in pregnancy ranges from 6–25 percent.^{60,62–64} The
12 incidence of depression during pregnancy, also varies depending on trimester.⁶⁰ It is estimated that
13 the onset of depression occurs in 7.4 percent (2.2–12.6 percent) of pregnant women in the first
14 trimester, in 12.8 percent (10.7–14.8 percent) of pregnant women in the second trimester, and in
15 12.0 percent (7.4–16.7 percent) of pregnant women in the third trimester.^{60,65} In addition, according
16 to WHO data, depression during pregnancy is a strong risk factor for the development of
17 postpartum depression, which may affect 10–15 percent of pregnant women in the period of up to
18 12 months after delivery.^{54,60} Moreover, prior studies have shown that a lack of proper treatment of
19 depression in people who are pregnant and may have a negative impact on the fetus (i.e., premature
20 delivery, reduced birth weight, as well as an increase in the concentration of stress hormones in the
21 child).^{60,66} Early and correct diagnosis can minimize the negative effects of depression on the birth
22 parent's, fetus's, and child's health.^{60,67}

23
24 Even a small amount of physical activity during pregnancy may reduce the severity of depressive
25 symptoms, as well as the occurrence of depression.⁶⁰ The best forms of activity during pregnancy
26 include walking, yoga, swimming and general exercises (i.e., breathing, posture, and Kegel
27 exercises).⁶⁸ However, it should be noted that the physical capacity of pregnant women varies in
28 terms of their baseline physical activity levels and individual trimesters.⁶⁸ Research on the
29 influence of supervised training on depressive disorders shows that aerobic exercises performed
30 three times a week for about 60 minutes can significantly reduce the symptoms of depression in
31 pregnant women.^{60,69–71} However, there are also reports indicating that physical activity already at
32 the level of 1–2 sessions a week may also be beneficial in reducing the frequency and severity of
33 depressive symptoms in pregnant women.⁷² Being physically active in pregnancy not only has
34 benefits of lowering the risk of developing depression in pregnancy, but also has the benefits of
35 lowering the risk of developing depression in early and late postpartum.^{60,70} In addition, evidence
36 suggests that women who do not exercise are more at risk of developing depressive disorders, both
37 during pregnancy and postpartum compared to women who exercise.^{60,70}

38 39 *Minoritized Communities*

40
41 Data on the benefits of physical activity on mental health in minoritized communities is limited,
42 and many barriers exist for these communities. However, it has been noted that minority
43 populations are more likely to seek care for mental health concerns from their primary care
44 providers versus behavioral health professionals, underscoring an important opportunity for
45 primary care physicians to engage with their patients on this issue.⁷³ Strategies to reduce depressive
46 symptoms and improve emotional well-being in older Hispanic/Latinx adults are largely absent
47 from the scientific literature. One study suggests that older Hispanic/Latinx adults displayed
48 improvements in depressive symptoms at the 24-month follow up period following an exercise

1 intervention that included four weekly one-hour group-based exercise classes targeting strength
2 training, endurance, balance and flexibility.⁷⁴ The results of this study were consistent with
3 previous research documenting the therapeutic health effects of structured exercise in older adults
4 using Latin dance.^{74,75} Culturally appropriate and cost-effective intervention modalities to reduce
5 depression in Hispanics/Latinxs are both needed and critical given the stigma associated with
6 mental health disorders in this population and reluctance in taking antidepressant medication.^{74,76}

7
8 Multiple studies have found a significant inverse relationship between physical activity and
9 depressive symptoms in Black adults.⁷⁷⁻⁸⁰ In a mixed-methods study on aspects of depression
10 among low-income black youth, life challenges faced by participants diminished the potential anti-
11 depressant effects of exercise – highlighting the importance of the social determinants of health
12 role as a moderator in the effectiveness of exercise as a therapy.⁸¹ The available research has
13 limitations and further studies are needed in this population to assess the benefits of physical
14 activity on mental health.

15 16 *Anxiety Studies*

17
18 Studies assessing the impact of physical activity on anxiety disorders are limited. One study
19 investigated cross-sectional and longitudinal associations between different amounts of moderate-
20 to-vigorous physical activity and anxiety symptoms in older adults (50 years of age and older) in
21 Ireland.⁸² Compared with the inactive group, the minimally- and very-active groups were
22 associated with an 8.4 percent and 18.8 percent lower odds of anxiety, respectively.⁸² However,
23 following adjustment, only high volumes of physical activity were significantly associated with
24 lower prevalence of anxiety.⁸²

25
26 Another study aimed to document the effect of add-on treatment with structured physical exercise
27 in a clinical population of adolescents hospitalized for depression and anxiety in a psychiatric
28 hospital in Belgium.⁸³ A group of 52 adolescent inpatients were randomly assigned to a physical
29 exercise or control social relaxation program three to four times per week over a six-week period
30 (20 hours in total).⁸³ The results showed a reduction in anxiety symptoms over time in both groups.
31 Therefore, it was concluded that there was no benefit of sufficient effect size to attain
32 significance.⁸³ To date, there is a significant lack of evidence for a reduction in symptoms of
33 anxiety with exercise in young ambulatory patients.

34
35 Finally, a study in Sweden investigated the effects of an exercise intervention on symptoms of
36 anxiety and to evaluate the benefit of moderate/high intensity exercise vs low intensity exercise, in
37 primary care patients diagnosed with anxiety disorder.⁸⁴ Included in the study were patients aged
38 18 to 65 years of age and were diagnosed with anxiety disorders using Diagnostic and Statistical
39 manual of Mental disorders (DSM-IV and V), including panic disorder (PD; DSM 300.01),
40 generalized anxiety disorder (GAD; DSM 300.02) and anxiety not otherwise specified (NOS; DSM
41 300.00).⁸⁴ This study shows that both low- and moderate/high intensity exercise interventions
42 improved anxiety symptoms at follow-up.⁸⁴ This was done using self-assessed severity of
43 perceived anxiety symptoms using the clinically well-established psychiatric assessment scale
44 Beck Anxiety Inventory.⁸⁴ These effects were independent of depressive symptoms, which is
45 important to assess given the well-known benefits of exercise for patients with MDD.⁸⁴⁻⁸⁶ Severity
46 of ongoing symptoms of depression was self-assessed using the Montgomery Åsberg Depression
47 Rating Scale (MADRS-S).⁸⁴ Although no clear dose-response effect of exercise intensity was
48 observed, there was a significant trend in the proportion of patients with improved anxiety
49 symptoms with increased exercise intensity.⁸⁴

50 51 PHYSICAL ACTIVITY PRESCRIPTIONS

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What is a Physical Activity Prescription?

Physicians may recognize the therapeutic benefit of physical activity and may have even counseled their patients to “exercise more,” as part of their treatment. In fact, in a cross-sectional survey among faculty and staff from a large academic tertiary care medical center in the southeastern U.S. with nearly 200 respondents, more than half (58 percent) said they recommended exercise as part of treatment but roughly only a quarter offered specific exercise instructions (24 percent) or followed national guidelines (30 percent).⁸⁷ This type of general clinical advice to exercise is not what is referred to as a physical activity prescription.

A physical activity prescription is one that dictates a specific regimen of physical activity and, like any other medical prescription, includes details on the type, dose, frequency, duration, and therapeutic goal.⁸⁸ Another key component of the physical activity prescription is connecting patients with appropriate, supportive physical activity resources.⁸⁹ A critical component of counseling or prescribing physical activity to patients is understanding what different levels of physical activity intensity entail and what counts for the different types of activity (i.e., aerobic activities versus muscle strengthening).

It is also important to distinguish between physical therapy and a physical activity prescription. Physical therapy’s universal aim is “to identify and maximize human movement potential within the spheres of promotion, prevention, treatment and rehabilitation,” and has the potential to be an effective promotion of physical activity.⁹⁰ However, physical therapy has generally been employed as a means for restoration and maintenance of physical functioning in individuals who have experienced a disabling condition, loss of movement, or injury, as opposed to a method to improve physical activity in general.⁹⁰ Part of this is due to the insurance industry’s payment system, which does not generally pay for physical activity programming.

Effectiveness of Physical Activity Prescriptions for Depression and Anxiety

While there have been numerous studies assessing the relationship (causal or otherwise) between physical activity and mental health disorders, there are fewer available studies evaluating the effectiveness of physical activity prescription-type interventions designed specifically for the treatment of depression and/or anxiety. A 2014 meta-analysis evaluating exercise as a treatment for depression identified five RCTs where exercise was found to be beneficial in the treatment of depression.⁹¹ Specifically, treatment programs with exercise done at least three times a week, for a minimum of nine weeks, at moderate intensity were shown to be an effective for treatment of depression.⁹¹

A 2018 meta-analysis of RCTs evaluating the effects of Baduanjin (a traditional Chinese mind-body exercise) in adults diagnosed with any mental (depression, anxiety or mood) or physical illness (e.g., fatigue, diabetic mellitus, cancer, drug addiction, heart disease, stroke, and musculoskeletal disorder) found that despite wide heterogeneity among treatment interventions, in terms of frequency, length, intensity, etc., the Baduanjin intervention was effective in reducing both anxiety and depression among the patients.⁹² A more recent RCT assessed the impact of Baduanjin on patients diagnosed with lung cancer who were experiencing depression and anxiety. After an eight-week intervention, the treatment group had statistically significant lower self-reported depression and anxiety scores compared to baseline.⁹³ Despite the positive and consistent findings on the impact of Baduanjin on depression and anxiety, the cultural context of these studies and focus on Baduanjin specifically may reduce the generalizability to the U.S. population.

1 There is also qualitative evidence from general practitioners in New Zealand on a physical activity
 2 prescription program, the Green Prescription, for treating depression. The Green Prescription
 3 program involved a prescription for physical activity provided by a general practitioner or nurse
 4 and lasted for a three-month period. Within those three months, individuals received monthly
 5 phone calls from patient support counselors to help set realistic physical activity goals and identify
 6 solutions for barriers encountered. All general practitioners interviewed in the study emphasized
 7 the importance of physical activity to improve mood and treat depression and noted its usefulness
 8 in helping lessen the need for pharmacotherapy.⁹⁴

9
 10 *Making Physical Activity Assessment and Prescription a Medical Standard of Care*

11
 12 In April 2015, the American College of Sports Medicine and Kaiser Permanente convened a joint
 13 consensus meeting to discuss the development and implementation of a physical activity vital sign
 14 (PAVS) to be obtained and recorded regularly.^{95,96} PAVS was documented based on the answers
 15 from two questions: 1. On average, how many days per week do you engage in moderate to
 16 vigorous physical activity (like a brisk walk) and 2. On average, how many minutes do you engage
 17 in physical activity at this level? It resulted in a “call to action” for current and future clinicians
 18 and the health care community to implement a PAVS in daily practice with every patient.^{95,96} The
 19 health care team is uniquely positioned to address the importance of a healthy lifestyle, including
 20 physical activity, in the prevention and treatment of disease and disability.

21
 22 As a result, Kaiser Permanente, Greenville Health System in South Carolina, and Intermountain
 23 Healthcare System in Utah successfully integrated the use of PAVS.^{95,97} These organizations have
 24 been able to manage workflows and include the measure in their electronic health record alongside
 25 other vital signs. They have accomplished this goal working alongside different health record
 26 vendors, including Epic, HELP2, and iCentra.^{95,97} Further, a study of 2.1 million adult patients from
 27 Kaiser Permanente in Southern California demonstrated that within the first year of
 28 implementation, they were able to capture a PAVS on 85 percent of eligible patients.^{95,97}
 29 Importantly, the PAVS showed similar results to the reported number of minutes of exercise
 30 compared with other self-reported physical activity questionnaires, such as Behavioral Risk Factor
 31 Surveillance System (BRFSS) (50 percent) and the National Health and Nutrition Examination
 32 Survey (NHANES) (59.6 percent).^{95,97}

33
 34 Best practices to implement a uniform PAVS and physical activity prescription include increased
 35 education on benefits of physical activity on health, collaboration with large medical associations,
 36 alignment with current initiatives (i.e. Physical Activity Guidelines for Americans), and
 37 collaboration with local community groups, organizations, or facilities for counseling and
 38 assistance with culturally appropriate, basic physical activity information.⁹⁵ Due to its successful
 39 implementation, there are readily accessible resources (professionals, patient materials, and access
 40 to adequate facilities/equipment) to implement the recommendations for integrating PAVS and
 41 avenues to re-educate practicing clinicians and health care team members.⁹⁵ Further, at the level of
 42 the individual physician, medical practice, and health care system, there are a variety of incentives
 43 tied to quality measures or metrics.^{95,98}

44
 45 *When prescribing physical activity, what has been demonstrated to work well?*

46
 47 Treatment programs that incorporate aerobic activities at a moderate level of intensity either in a
 48 group or individual setting have been shown to be effective.⁹¹ Programs that included some level of
 49 supervision by an individual trained in physical activity were recommended to achieve beneficial
 50 treatment.⁹¹ Physicians should consider the following when developing a physical activity
 51 prescription for their patients. First and foremost, the prescription must be tailored to the individual

1 and incorporate the following four steps: (1) take an exercise history, (2) identify any
2 contraindications and refer those who require medical clearance to a sports/exercise specialist, (3)
3 develop an effective but realistic program, and (4) provide advice on how to reduce sedentary
4 behavior.⁶ These considerations are critical, as developing an effective and specific physical
5 activity program will depend on the patient's current level of activity and must be considerate of
6 age and existing chronic conditions.⁹⁹ Another component of an effective physical activity
7 prescription is considering exercise that integrates physical activity into an individual's daily life or
8 habits, rather than making it an extra chore.^{6,100}

9
10 A critical component of implementing physical activity prescriptions is the integration of PAVS in
11 electronic health records.^{97,100} Additionally, it has been recommended that a successful physical
12 activity prescription intervention must engage the larger health care team, not just the clinician.^{89,100}
13 For the Green Prescription program in New Zealand, the health care team responsible for providing
14 the physical activity prescription included patient support counsellors and nurses, who helped carry
15 out more of the time-consuming tasks and administration of the program.⁸⁹ For additional guidance
16 and resources on prescribing physical activity, the American College of Sports Medicine's Exercise
17 site has a step-by-step guide for clinicians to utilize in their practice.¹⁰¹

18 19 CHALLENGES AND BARRIERS

20
21 A challenge for physicians in prescribing physical activity is the heterogenous nature of exercise
22 activities and programs (as outlined above, there are many ways to exercise and at different levels
23 of intensity, frequency, etc.) and knowing what is most appropriate for the patient. Another major
24 barrier for physicians is the amount of need time to spend with patients to talk through a physical
25 activity prescription, including, but not limited to, doing a baseline assessment, creating an
26 individually tailored plan, and connecting the patient with appropriate resources.^{94,100} Additionally,
27 there is no standard of practice in the U.S. (like nutritional counseling) for physical activity
28 counseling and prescription within a clinical setting.⁸⁹ However, the global health initiative,
29 Exercise is Medicine®, is working to make physical activity assessment and promotion a standard
30 within clinical care.¹⁰²

31
32 Barriers that will be further discussed below also include inadequate provider reimbursement,
33 training, and self-efficacy, insufficient health care system support, and scarcity of certified
34 community resources to refer for evidence-based physical activity programming.¹⁰³⁻¹⁰⁵ Poor care
35 coordination and the inability to follow the progress of a referred patient are also important barriers
36 to consider when establishing sustainable clinical-community linkages for physical activity-related
37 care.^{103,106}

38 39 *Billing and Reimbursement for Prescribing Physical Activity*

40
41 Billing rules set by the Centers for Medicare and Medicaid Services (CMS) and private insurers
42 prohibit most allied health professionals from receiving reimbursement for providing exercise
43 programming in mental health settings.¹⁰⁷⁻¹⁰⁹ It should also be noted that some private insurance
44 companies offer their members a variety of incentives to engage in exercise, such as reimbursement
45 for gym memberships, cash rebates for selecting healthy food at the grocery store, and reduced
46 premiums for people who engage in regular exercise.^{107,113,114} A number of health insurance
47 companies offer their members incentives for engagement in exercise.¹⁰⁷ Large corporations also
48 offer incentives for engagement in exercise, such as on-site fitness equipment.^{107,115} However, this
49 creates an inequitable barrier for individuals who do not have access to private insurance
50 companies or work for large corporations.

51

Logistical and Workflow Barriers for Physical Activity Assessment and Referrals

Despite the availability of evidence-based programs to improve physical health and wellness behaviors among people with mental health conditions, there are multiple policies and funding barriers that make it difficult for community mental health programs to offer these programs to consumers.^{107,116} Health care policies typically “carve out” mental health funds from physical health funds, denying community mental health programs the financial ability to offer exercise programming.^{107,116} Few funds are set aside for community mental health programs to train staff to deliver preventive health services like exercise programs.^{107,108,116}

These barriers are perpetuated by fragmentation of preventive care in the U.S. and may explain the lack of standardized physical activity community-referral programs.¹⁰³ The national health promotion objectives have included a specific target to increase the proportion of primary care clinicians who routinely assess and counsel their patients on physical activity.¹⁰³ Occasional surveys of primary care practitioners and patients suggest that there has been little improvement over the last decade in physical activity assessment and promotion in clinical visits. The rates of clinician-initiated physical activity counseling continue to be low (<35 percent), particularly among women and racial minorities.^{103,117} Rates for physical activity counseling among patients with CVD (41.2 percent), hypertension, (44.2 percent), obesity (46.9 percent), and diabetes mellitus (56.3 percent) are also suboptimal.^{103,117}

Further, even though patients can be referred to either self-managed or community-based physical activity professionals/programs, health care systems are often unwilling to refer patients outside their system unless the professional/program referred to is part of a network where quality can be ensured and controlled.^{95,103} The development of a database of local physical activity programming and other health resources (e.g., medical fitness centers, gyms with certified programming and personnel, parks, trails, community centers) classified by age, clinical conditions, insurance benefits, and other factors (such as cost, activities offered) can enable the provision of a robust, personalized list of potential places and programs when integrating into the clinical workflow, electronic health record (EHR), and patient portals.^{103,118}

Education of the Health Care Workforce

To provide beneficial patient education, our nation’s health care professionals must be educated in the vital role physical activity and/or structured exercise plays in preventing, treating, and managing disease and the need to screen, motivate, and educate patients about physical activity.^{95,119} At the medical school level, there are innovative curricula, including those at the University of South Carolina School of Medicine Greenville and the University of Wisconsin, where exercise and lifestyle medicine are integrated into all four years of the students’ undergraduate medical education.^{95,120,121} The Accreditation Council for Graduate Medical Education sets the program requirements for residency and fellowship programs.^{95,122} However, despite specific curricula to which a resident must be exposed during graduate medical training, in most specialties there are no current requirements that residents receive education and training in physical activity.

Electronic Health Record

A recommendation by the National Academies highlights the value of EHR to provide information to the health care team related to health and treatment.^{103,123} Providing information pertaining to physical activity in the EHR creates an opportunity for the HCP to discuss patients’ or clients’

1 physical activity habits.^{103,123} Discussion about physical activity will be easier if these measures are
2 collected in a similar method across time and can be used between health record systems.

3
4 Two suggested methods for capturing physical activity for the EHR are self-reports and wearable
5 devices such as pedometers or accelerometers.^{103,124} An example of a self-report questionnaire that
6 can ascertain compliance with the physical activity guidelines is called the Exercise Vital Sign
7 (EVS), modified from the Behavioral Risk Factor Surveillance System.^{97,103} The EVS consists of 2
8 questions that take approximately ≤ 1 minute to administer. Wearable activity monitoring (WAM)
9 devices provide information on activity such as accelerometers counts, steps, and estimated
10 minutes of physical activity at various intensity levels.^{97,103} These devices can be worn on clothing
11 or the waist, wrist, or ankle to measure physical activity. Comparisons of findings based on
12 behavior questionnaires versus wearable devices find a remarkably similar relationship between
13 physical activity and health outcomes, buttressing older data from questionnaire studies that
14 underpin current physical activity guidelines.¹²⁵

15
16 There are numerous devices available, with many wrist-based devices or smartwatches now also
17 tracking heart rate to enhance physical activity intensity estimation. However, to date, there is no
18 widespread integration of patient-generated data from wearable devices into the EHR.^{103,126} No
19 matter which method is used, self-report or wearable devices, linking physical activity data to the
20 EHR provides a forum for health care professionals to initiate discussion and counseling on
21 increasing physical activity. However, uniform access to wearable devices presents logistical and
22 equity issues. There are also data privacy, integrity, provenance, and quality considerations that
23 should be addressed. Integrating information into an EHR from external third-party sources can be
24 a challenge and requires planning and preparation.

25 26 *Environmental Equity Considerations*

27
28 Another potential barrier for successful implementation of physical activity prescription programs
29 is the community setting in which patients are expected to return and fulfill their physical activity
30 regimen. For example, in a study assessing the level of physical activity among adolescent girls in
31 relation to their proximity to parks, researchers found that girls who live near more parks,
32 particularly near those with amenities conducive to walking and with active features (i.e.,
33 playgrounds, multipurpose fields, etc.), engaged in more physical activity compared to those who
34 with access to fewer parks.¹²⁷ CDC's Active People, Healthy Nation campaign aims to get more
35 Americans physically active using a number of evidence-based strategies to increase physical
36 activity. As part of this campaign, CDC has noted "providing equitable and inclusive access to safe
37 places for physical activity is foundational to each strategy."¹²⁸ However, inclusive and safe places
38 to exercise are not equitably distributed among U.S. communities, with notable disparities in low
39 income, minority communities.^{128,129} Low income, minority communities face a number of societal,
40 institutional, and environmental barriers to meeting physical activity recommendations, including
41 lack of access to appropriate facilities (i.e., parks, recreation or fitness centers), perceived
42 unattractiveness or cleanliness of one's neighborhood, and perceived safety and concerns of
43 violence.¹²⁹ As such, the patient's neighborhood and socio-environmental conditions should be
44 considered when developing a patient's physical activity prescription.

45 46 *Evidence from other types of prescriptions for 'healthy behaviors'*

47
48 The topic of physical activity prescriptions raises a larger question on whether physician
49 prescriptions, which have historically been focused on pharmacological treatment, can be an
50 effective intervention to motivate behavior changes that improve health. Similar prescription
51 interventions include park prescription and healthy food prescription programs. Park Prescriptions

1 are programs or interventions that include a health or social service provider, encourages
2 patients/clients to spend time in nature, and have a goal of improving their health and well-being.¹³⁰
3 There are a few studies that have been conducted or are ongoing that aim to evaluate the
4 effectiveness of park prescription interventions on physical activity and mental health
5 outcomes.^{131,132} In one RCT study evaluating a park prescription program intended to increase
6 physical activity in parks, the intervention group demonstrated improved park use, physical activity
7 in parks, recreational physical activity, and psychological quality of life.¹³² However, one challenge
8 in evaluating these types of programs is the ability to discern the independent effect of the
9 ‘physical activity’ and ‘park/nature’ components of the program. Parks prescription interventions
10 often have overlapping goals of improving access to nature and increasing physical activity. Thus,
11 if one is trying to discern which component is helping with improved mental health outcomes, it is
12 unclear which aspect of the program is “doing the work.” This is a useful distinction to understand
13 as there may be different biological mechanisms involved that connect access to nature/green space
14 and mental health.

15
16 Similar to a lack of physical activity, a poor-quality diet is a leading risk factor for non-
17 communicable diseases and has been implicated in the growing prevalence of chronic diseases,
18 such as obesity and diabetes.¹³³ As a result, there has been a growing interest in incorporating “food
19 as medicine” interventions within health care systems, one of which is the “produce prescription”
20 program.¹³⁴ With this type of intervention, a physician or health care worker identifies patients who
21 may be eligible to receive free or discounted healthy produce and patients are provided subsidized
22 or free healthy foods, with options to redeem prescribed coupons at local food stores, farmers
23 markets, or the direct provision of fresh produce at a community based organization, healthcare
24 center, or delivered directly to their home.¹³⁴ A 2021 systematic review of literature evaluating the
25 effectiveness of these types of interventions found there were statistically significant increases in
26 fruit and vegetable consumption and decreases in body mass index and glycated hemoglobin
27 (HbA1c) levels among program participants.¹³⁴ Whether either of these prescription-type programs
28 demonstrate long-term improvements in health outcomes has yet to be studied, but the current
29 evidence suggests they are effective at improving the adoption of healthy behaviors in the short
30 term. Generally positive evidence from these other types of prescription programs provides
31 credence to explore physician prescription programs as a worthwhile intervention to promote
32 healthy behavior change in individual patients.

33 34 RELEVANT AMA POLICY

35
36 Under existing AMA Policy H-440.859 “American's Health” the AMA supports improving health
37 through increased activity and proper diet a priority and calling on the federal government and state
38 governments to develop new and innovative programs in partnership with the private sector that
39 encourage personal responsibility for proper dietary habits and physical activity of individual
40 Americans.

41
42 Policy H-150.965, “Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses
43 H-345.984” encourages medical schools, primary care residencies, and other training programs as
44 appropriate to include the appropriate knowledge and skills to enable graduates to recognize,
45 diagnose, and treat depression and other mental illnesses, either as the chief complaint or with
46 another general medical condition, and supports additional research into the course and outcomes
47 of patients with depression and other mental illnesses who are seen in general medical settings and
48 into the development of clinical and systems approaches designed to improve patient outcomes.
49 The policy also recognizes the impact of violence and social determinants on women’s mental
50 health. Further, the policy states that the AMA will work with the National Institute on Mental
51 Health and appropriate medical specialty and mental health advocacy groups to increase public

1 awareness about depression and other mental illnesses, to reduce the stigma associated with
2 depression and other mental illnesses, and to increase patient access to quality care for depression
3 and other mental illnesses.

4 5 CONCLUSIONS

6
7 Mental health disorders are among the leading causes of global health-related burden, with
8 substantial individual and societal costs.^{1,2} Depression is the leading cause of mental health-related
9 disease burden, while anxiety is the most prevalent mental health disorder.¹ The role of lifestyle
10 management approaches, such as exercise, sleep hygiene and a healthy diet, varies between clinical
11 practice guidelines in different countries. In U.S. clinical guidelines, psychotherapy or
12 pharmacotherapy is recommended as the initial treatment approaches, with lifestyle approaches
13 considered as ‘complementary alternative treatments’ where psychotherapy and pharmacotherapy
14 are ‘ineffective or unacceptable.’^{1,13}

15
16 One potential alternative to psychotherapy or pharmacotherapy to treat depression and anxiety is
17 the prescription of physical activity. There have been hundreds of research trials examining the
18 effects of physical activity on depression, with more limited studies examining the effects of
19 physical activity on anxiety. Many of these studies suggest that physical activity may have similar
20 effects to psychotherapy and pharmacotherapy (and with numerous advantages over psychotherapy
21 and pharmacotherapy, in terms of cost, side-effects and ancillary health benefits).^{1,135,136} Despite the
22 evidence for the benefits of physical activity, it has not been widely adopted therapeutically as a
23 prescribed alternate to psychotherapy or pharmacotherapy. The limited availability of evidence on
24 the efficacy of physical activity prescriptions for various populations, patient resistance, the
25 difficulty of prescribing and monitoring physical activity in clinical settings, as well as the huge
26 volume of largely incommensurable studies, have impeded wider adoption.⁵⁻⁷

27
28 Further, a critical component of counseling or prescribing physical activity to patients is
29 understanding what different levels of physical activity intensity entail and what counts for the
30 different types of activity (i.e., aerobic activities versus muscle strengthening).¹ Physicians have
31 expressed that insufficient knowledge or training is the most common potential barrier to
32 prescribing exercise for patients with mental health conditions.¹³⁷ There are also many
33 environmental equity considerations that need to be addressed before a physical activity
34 prescription program can be applied broadly.

35
36 Despite these barriers, there are promising practices that can be implemented to begin
37 incorporating physical activity prescriptions as a standard of care. One of these practices include
38 the introduction of physical activity vital sign (PAVS).^{95,96} PAVS is reliable and feasible and has
39 been validated against established survey tools to quantify physical activity engagement. It has also
40 been successfully implemented in large-scale demonstration projects.^{97,103} Other practices include
41 integrating the benefits of prescribing physical activity into undergraduate, graduate, and
42 continuing medical education, establishing partnerships and community links to sustain and
43 support equitable physical activity programs, and continued research into the efficacy of
44 prescribing physical activity to treat depression and anxiety.

45 46 RECOMMENDATIONS

47
48 The Council on Science and Public Health recommends that the following be adopted, and the
49 remainder of the report be filed.

50

1 1. That our AMA amend policy H-470.997, "Exercise and Physical Fitness" by addition and
2 deletion to read as follows:

3
4 Exercise and Physical Fitness H-470.997

5 1. Our AMA encourages all physicians to utilize the health potentialities of exercise for their
6 patients as a most important part of health promotion and rehabilitation and urges state and local
7 medical societies to emphasize through all available channels the need for physical activity for all
8 age groups and both sexes. The AMA encourages other organizations and agencies to join with the
9 Association in promoting physical fitness through all appropriate means.

10 ~~Our AMA will study evidence of the efficacy of physical activity interventions (i.e., group fitness,~~
11 ~~personal training, or physical therapy) on behavioral activation and outcomes on depressive and~~
12 ~~anxiety symptoms.~~

13
14
15 2. Our AMA advocates for continued research towards development of structured physical activity
16 treatment plans for the specific diagnoses of anxiety and depression, as well as longitudinal studies
17 to examine the effects of physical activity on health outcomes, particularly later in life.

18
19 3. Our AMA encourages:

- 20 1. education of health care professionals on the role of physical activity and/or structured
21 exercise in treating and managing anxiety and depression and the need to screen, motivate,
22 and educate patients of all ages about the benefits of physical activity, including positive
23 mental health benefits.
24 2. health care payers and employers to provide coverage for gym memberships and access to
25 other physical activity programs.
26 3. the implementation, trending, and utilization of physical activity measures, such as
27 physical activity vital signs (PAVS), in the medical record for treatment prescription,
28 counseling, coaching, and follow up of physical activity for therapeutic use. (Modify HOD
29 Policy)

Fiscal note: less than \$1,000

Table 1 – Key Guidelines for Physical Activity, adopted from the U.S. Department of Health and Human Services Physical Activity Guidelines for Americans, 2nd edition.²⁰

Age group/Population	Guidelines
Preschool-Aged Children (ages 3 through 5 years)	<ul style="list-style-type: none"> • Should be physically active throughout the day to enhance growth and development. • Active play that includes a variety of activity types is encouraged.
Children and Adolescents (ages 6 through 17 years)	<ul style="list-style-type: none"> • Should do 60 minutes (1 hour) or more of moderate-to-vigorous physical activity daily. Most of the 60 minutes or more per day should be either moderate- or vigorous intensity aerobic physical activity and should include vigorous-intensity physical activity on at least 3 days a week. • Should include muscle-strengthening physical activity on at least 3 days a week. • Should include bone-strengthening physical activity on at least 3 days a week.
Adults (ages 18 through 64 years)	<ul style="list-style-type: none"> • Should do at least 150 minutes (2 hours and 30 minutes) to 300 minutes (5 hours) a week of moderate-intensity, or 75 minutes (1 hour and 15 minutes) to 150 minutes (2 hours and 30 minutes) a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic activity. • Should also do muscle-strengthening activities of moderate or greater intensity and that involve all major muscle groups on 2 or more days a week, as these activities provide additional health benefits.
Older Adults (aged 65+ years)	<ul style="list-style-type: none"> • For those who are able, recommended physical activity is the same as healthy adults. • As part of their weekly physical activity, should do multicomponent physical activity that includes balance training as well as aerobic and muscle-strengthening activities. • If unable to meet the above guidelines, they should be as physically active as their abilities and conditions allow.
Women During Pregnancy and the Postpartum Period	<ul style="list-style-type: none"> • Should do at least 150 minutes (2 hours and 30 minutes) of moderate-intensity aerobic activity a week during pregnancy and the postpartum period. • Should consult with their health care provider to monitor progress of pregnancy and whether or how to adjust their physical activity during pregnancy and after the baby is born.
Adults With Chronic Health Conditions and Adults with Disabilities	<ul style="list-style-type: none"> • For those who are able, recommended physical activity is the same as healthy adults. • If unable to meet the above guidelines, should engage in regular physical activity according to their abilities and should avoid inactivity. • Should be under the care of a health care provider and can consult with a health care professional or physical activity

	specialist about the types and amounts of activity appropriate for their abilities and chronic conditions.
--	--

Table 2 – Different forms of physical activity and bodily movements ²⁰

Activity Type	Definition and examples
Endurance (or aerobic) activities	Increases breathing and heart rate. Examples include brisk walking or jogging, biking, dancing, swimming.
Strength training or resistance training	Causes your muscles to contract against outside resistance. Examples include lifting weights or using resistance bands.
Bone-strengthening activity	Also referred to as weight-bearing or weight-loading activity, produces force on your bones that promotes bone growth and strength. Examples include jumping jacks, running, brisk walking, and weightlifting.
Balance activities	Activities aimed at improving postural control. They are particularly helpful for older adults as they help prevent falls. Examples include yoga, lower body strength training, and targeted exercises to improve balance.
Flexibility activities	Stretches muscles and helps individuals stay limber, improving range of motion and circulation. Examples include yoga and everyday stretching.

REFERENCES

1. Ben Singh, Timothy Olds, Rachel Curtis, et al. Effectiveness of physical activity interventions for improving depression, anxiety and distress: an overview of systematic reviews. *Br J Sports Med.* 2023;57(18):1203. doi:10.1136/bjsports-2022-106195
2. Australian Bureau of Statistics. National Study of Mental Health and Wellbeing. Published online 2022 2020. <https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release#cite-window1>
3. Patel V, Chisholm D, Parikh R, et al. Addressing the burden of mental, neurological, and substance use disorders: key messages from Disease Control Priorities, 3rd edition. *The Lancet.* 2016;387(10028):1672-1685. doi:10.1016/S0140-6736(15)00390-6
4. CDC Tobacco Free. Depression and Anxiety. Centers for Disease Control and Prevention. Published March 14, 2023. Accessed January 4, 2024. [https://www.cdc.gov/tobacco/campaign/tips/diseases/Depression is more than just feeling down or having a bad day. When a sad mood lasts for a long time and interferes with normal, everyday functioning, you may be depressed.](https://www.cdc.gov/tobacco/campaign/tips/diseases/Depression%20is%20more%20than%20just%20feeling%20down%20or%20having%20a%20bad%20day.%20When%20a%20sad%20mood%20lasts%20for%20a%20long%20time%20and%20interferes%20with%20normal,%20everyday%20functioning,%20you%20may%20be%20depressed.)
5. Thompson PD, Arena R, Riebe D, Pescatello LS, American College of Sports Medicine. ACSM's new preparticipation health screening recommendations from ACSM's guidelines for exercise testing and prescription, ninth edition. *Curr Sports Med Rep.* 2013;12(4):215-217. doi:10.1249/JSR.0b013e31829a68cf
6. Rooney D, Gilmartin E, Heron N. Prescribing exercise and physical activity to treat and manage health conditions. *Ulster Med J.* 2023;92(1):9-15.
7. Melzer K, Kayser B, Pichard C. Physical activity: the health benefits outweigh the risks. *Curr Opin Clin Nutr Metab Care.* 2004;7(6):641-647. doi:10.1097/00075197-200411000-00009
8. Centers for Disease Control and Prevention National Center for Health Statistics. FastStats - Mental Health. Published December 29, 2023. Accessed January 4, 2024. <https://www.cdc.gov/nchs/fastats/mental-health.htm>
9. Major Depression - National Institute of Mental Health (NIMH). Accessed January 4, 2024. <https://www.nimh.nih.gov/health/statistics/major-depression>
10. Substance Abuse and Mental Health Services Administration. Depression. Published February 7, 2023. Accessed January 4, 2024. <https://www.samhsa.gov/mental-health/depression>
11. Anxiety Disorders - National Institute of Mental Health (NIMH). Accessed January 4, 2024. <https://www.nimh.nih.gov/health/topics/anxiety-disorders>
12. Schuch FB, Vancampfort D, Firth J, et al. Physical Activity and Incident Depression: A Meta-Analysis of Prospective Cohort Studies. *Am J Psychiatry.* 2018;175(7):631-648. doi:10.1176/appi.ajp.2018.17111194
13. Malhi GS, Bell E, Bassett D, et al. The 2020 Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for mood disorders. *Aust N Z J Psychiatry.* 2021;55(1):7-117. doi:10.1177/0004867420979353
14. Ben Singh, Timothy Olds, Rachel Curtis, et al. Effectiveness of physical activity interventions for improving depression, anxiety and distress: an overview of systematic reviews. *Br J Sports Med.* 2023;57(18):1203. doi:10.1136/bjsports-2022-106195
15. McKeon G, Curtis J, Rosenbaum S. Promoting physical activity for mental health: an updated evidence review and practical guide. *Curr Opin Psychiatry.* 2022;35(4):270-276. doi:10.1097/YCO.0000000000000796
16. CDC. Benefits of Physical Activity. Centers for Disease Control and Prevention. Published August 1, 2023. Accessed January 4, 2024. <https://www.cdc.gov/physicalactivity/basics/physical-activity/index.htm>

17. DNPAO Data, Trends and Maps: Explore by Topic | CDC. Accessed January 4, 2024. https://nccd.cdc.gov/dnpao_dtm/rdPage.aspx?rdReport=DNPAO_DTM.ExploreByTopic&islClass=PA&islTopic=PA1&go=GO
18. NHIS - Adult Physical Activity - Glossary. Published May 10, 2019. Accessed February 26, 2024. https://www.cdc.gov/nchs/nhis/physical_activity/pa_glossary.htm
19. Caspersen CJ, Powell KE, Christenson GM. Physical activity, exercise, and physical fitness: definitions and distinctions for health-related research. *Public Health Rep.* 1985;100(2):126-131.
20. U.S. Department of Health and Human Services. Physical Activity Guidelines for Americans. 2018;2nd edition.
21. Xie Y, Wu Z, Sun L, et al. The Effects and Mechanisms of Exercise on the Treatment of Depression. *Front Psychiatry.* 2021;12:705559. doi:10.3389/fpsyt.2021.705559
22. Ma CL, Ma XT, Wang JJ, Liu H, Chen YF, Yang Y. Physical exercise induces hippocampal neurogenesis and prevents cognitive decline. *Behav Brain Res.* 2017;317:332-339. doi:10.1016/j.bbr.2016.09.067
23. Abdollahi A, LeBouthillier DM, Najafi M, et al. Effect of exercise augmentation of cognitive behavioural therapy for the treatment of suicidal ideation and depression. *J Affect Disord.* 2017;219:58-63. doi:10.1016/j.jad.2017.05.012
24. Laske C, Banschbach S, Stransky E, et al. Exercise-induced normalization of decreased BDNF serum concentration in elderly women with remitted major depression. *Int J Neuropsychopharmacol.* 2010;13(05):595-602. doi:10.1017/S1461145709991234
25. Imboden C, Gerber M, Beck J, et al. Effects of Aerobic Exercise as Add-On Treatment for Inpatients With Moderate to Severe Depression on Depression Severity, Sleep, Cognition, Psychological Well-Being, and Biomarkers: Study Protocol, Description of Study Population, and Manipulation Check. *Front Psychiatry.* 2019;10:262. doi:10.3389/fpsyt.2019.00262
26. Ventura J, McEwen S, Subotnik KL, et al. Changes in inflammation are related to depression and amount of aerobic exercise in first episode schizophrenia. *Early Interv Psychiatry.* 2021;15(1):213-216. doi:10.1111/eip.12946
27. Euteneuer F, Dannehl K, Del Rey A, Engler H, Schedlowski M, Rief W. Immunological effects of behavioral activation with exercise in major depression: an exploratory randomized controlled trial. *Transl Psychiatry.* 2017;7(5):e1132-e1132. doi:10.1038/tp.2017.76
28. Silverman MN, Deuster PA. Biological mechanisms underlying the role of physical fitness in health and resilience. *Interface Focus.* 2014;4(5):20140040. doi:10.1098/rsfs.2014.0040
29. Rethorst CD, Toups MS, Greer TL, et al. Pro-inflammatory cytokines as predictors of antidepressant effects of exercise in major depressive disorder. *Mol Psychiatry.* 2013;18(10):1119-1124. doi:10.1038/mp.2012.125
30. Luca M, Luca A. Oxidative Stress-Related Endothelial Damage in Vascular Depression and Vascular Cognitive Impairment: Beneficial Effects of Aerobic Physical Exercise. *Oxid Med Cell Longev.* 2019;2019:1-6. doi:10.1155/2019/8067045
31. Brocardo PS, Boehme F, Patten A, Cox A, Gil-Mohapel J, Christie BR. Anxiety- and depression-like behaviors are accompanied by an increase in oxidative stress in a rat model of fetal alcohol spectrum disorders: Protective effects of voluntary physical exercise. *Neuropharmacology.* 2012;62(4):1607-1618. doi:10.1016/j.neuropharm.2011.10.006
32. Da Silva LA, Tortelli L, Motta J, et al. Effects of aquatic exercise on mental health, functional autonomy and oxidative stress in depressed elderly individuals: A randomized clinical trial. *Clinics.* 2019;74:e322. doi:10.6061/clinics/2019/e322
33. Banasr M, Duman R. Regulation of Neurogenesis and Gliogenesis by Stress and Antidepressant Treatment. *CNS Neurol Disord - Drug Targets.* 2007;6(5):311-320. doi:10.2174/187152707783220929
34. McEwen BS, Morrison JH. The Brain on Stress: Vulnerability and Plasticity of the Prefrontal Cortex over the Life Course. *Neuron.* 2013;79(1):16-29. doi:10.1016/j.neuron.2013.06.028

35. Greenwood BN, Fleshner M. Exercise, Learned Helplessness, and the Stress-Resistant Brain. *NeuroMolecular Med.* 2008;10(2):81-98. doi:10.1007/s12017-008-8029-y
36. Gligoroska J, Manchevska S. The Effect of Physical Activity on Cognition - Physiological Mechanisms. *Mater Socio Medica.* 2012;24(3):198. doi:10.5455/msm.2012.24.198-202
37. Rothman SM, Griffioen KJ, Wan R, Mattson MP. Brain-derived neurotrophic factor as a regulator of systemic and brain energy metabolism and cardiovascular health. *Ann N Y Acad Sci.* 2012;1264(1):49-63. doi:10.1111/j.1749-6632.2012.06525.x
38. Szuhany KL, Otto MW. Assessing BDNF as a mediator of the effects of exercise on depression. *J Psychiatr Res.* 2020;123:114-118. doi:10.1016/j.jpsychires.2020.02.003
39. Recchia F, Bernal JD, Fong DY, et al. Physical Activity Interventions to Alleviate Depressive Symptoms in Children and Adolescents: A Systematic Review and Meta-analysis. *JAMA Pediatr.* 2023;177(2):132-140. doi:10.1001/jamapediatrics.2022.5090
40. Hughes CW, Barnes S, Barnes C, DeFina LF, Nakonezny P, Emslie GJ. Depressed Adolescents Treated with Exercise (DATE): A pilot randomized controlled trial to test feasibility and establish preliminary effect sizes. *Ment Health Phys Act.* 2013;6(2):119-131. doi:10.1016/j.mhpa.2013.06.006
41. Lin K, Stubbs B, Zou W, et al. Aerobic exercise impacts the anterior cingulate cortex in adolescents with subthreshold mood syndromes: a randomized controlled trial study. *Transl Psychiatry.* 2020;10(1):155. doi:10.1038/s41398-020-0840-8
42. Nabkasorn C, Miyai N, Sootmongkol A, et al. Effects of physical exercise on depression, neuroendocrine stress hormones and physiological fitness in adolescent females with depressive symptoms. *Eur J Public Health.* 2006;16(2):179-184. doi:10.1093/eurpub/cki159
43. Norris R, Carroll D, Cochrane R. The effects of physical activity and exercise training on psychological stress and well-being in an adolescent population. *J Psychosom Res.* 1992;36(1):55-65. doi:10.1016/0022-3999(92)90114-H
44. Olive LS, Byrne D, Cunningham RB, Telford RM, Telford RD. Can physical education improve the mental health of children? The LOOK study cluster-randomized controlled trial. *J Educ Psychol.* 2019;111(7):1331-1340. doi:10.1037/edu0000338
45. Kandola A, Ashdown-Franks G, Hendrikse J, Sabiston CM, Stubbs B. Physical activity and depression: Towards understanding the antidepressant mechanisms of physical activity. *Neurosci Biobehav Rev.* 2019;107:525-539. doi:10.1016/j.neubiorev.2019.09.040
46. Pearce M, Garcia L, Abbas A, et al. Association Between Physical Activity and Risk of Depression: A Systematic Review and Meta-analysis. *JAMA Psychiatry.* 2022;79(6):550. doi:10.1001/jamapsychiatry.2022.0609
47. Kim SY, Jeon SW, Shin DW, Oh KS, Shin YC, Lim SW. Association between physical activity and depressive symptoms in general adult populations: An analysis of the dose-response relationship. *Psychiatry Res.* 2018;269:258-263. doi:10.1016/j.psychres.2018.08.076
48. Xu P, Huang Y, Hou Q, et al. Relationship between physical activity and mental health in a national representative cross-section study: Its variations according to obesity and comorbidity. *J Affect Disord.* 2022;308:484-493. doi:10.1016/j.jad.2022.04.037
49. Hamer M, Stamatakis E, Steptoe A. Dose-response relationship between physical activity and mental health: the Scottish Health Survey. *Br J Sports Med.* 2009;43(14):1111-1114. doi:10.1136/bjism.2008.046243
50. Laird E, Rasmussen CL, Kenny RA, Herring MP. Physical Activity Dose and Depression in a Cohort of Older Adults in The Irish Longitudinal Study on Ageing. *JAMA Netw Open.* 2023;6(7):e2322489. doi:10.1001/jamanetworkopen.2023.22489
51. Baldwin RC, Gallagley A, Gourlay M, Jackson A, Burns A. Prognosis of late life depression: a three-year cohort study of outcome and potential predictors. *Int J Geriatr Psychiatry.* 2006;21(1):57-63. doi:10.1002/gps.1424

52. Lenze EJ, Schulz R, Martire LM, et al. The Course of Functional Decline in Older People with Persistently Elevated Depressive Symptoms: Longitudinal Findings from the Cardiovascular Health Study. *J Am Geriatr Soc.* 2005;53(4):569-575. doi:10.1111/j.1532-5415.2005.53202.x
53. Briggs R, Carey D, O'Halloran AM, Kenny RA, Kennelly SP. Validation of the 8-item Centre for Epidemiological Studies Depression Scale in a cohort of community-dwelling older people: data from The Irish Longitudinal Study on Ageing (TILDA). *Eur Geriatr Med.* 2018;9(1):121-126. doi:10.1007/s41999-017-0016-0
54. World Health Organization. Global recommendations on physical activity for health. *Recomm Mond Sur Act Phys Pour Santé.* Published online 2010:58.
55. Chu IH, Buckworth J, Kirby TE, Emery CF. Effect of exercise intensity on depressive symptoms in women. *Ment Health Phys Act.* 2009;2(1):37-43. doi:10.1016/j.mhpa.2009.01.001
56. Herring MP. Effect of Exercise Training on Depressive Symptoms Among Patients With a Chronic Illness: A Systematic Review and Meta-analysis of Randomized Controlled Trials. *Arch Intern Med.* 2012;172(2):101. doi:10.1001/archinternmed.2011.696
57. Dempsey PC, Friedenreich CM, Leitzmann MF, et al. Global Public Health Guidelines on Physical Activity and Sedentary Behavior for People Living With Chronic Conditions: A Call to Action. *J Phys Act Health.* 2021;18(1):76-85. doi:10.1123/jpah.2020-0525
58. Lee IM, Shiroma EJ, Lobelo F, Puska P, Blair SN, Katzmarzyk PT. Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy. *The Lancet.* 2012;380(9838):219-229. doi:10.1016/S0140-6736(12)61031-9
59. Schuch FB, Vancampfort D. Physical activity, exercise, and mental disorders: it is time to move on. *Trends Psychiatry Psychother.* Published online 2021. doi:10.47626/2237-6089-2021-0237
60. Kołomańska D, Zarawski M, Mazur-Bialy A. Physical Activity and Depressive Disorders in Pregnant Women—A Systematic Review. *Medicina (Mex).* 2019;55(5):212. doi:10.3390/medicina55050212
61. Albert PR. Why is depression more prevalent in women? *J Psychiatry Neurosci.* 2015;40(4):219-221. doi:10.1503/jpn.150205
62. Josefsson A, Berg G, Nordin C, Sydsjö G. Prevalence of depressive symptoms in late pregnancy and postpartum. *Acta Obstet Gynecol Scand.* 2001;80(3):251-255. doi:10.1034/j.1600-0412.2001.080003251.x
63. Johanson R, Chapman G, Murray D, Johnson I, Cox J. The north staffordshire maternity hospital prospective study of pregnancy-associated depression. *J Psychosom Obstet Gynecol.* 2000;21(2):93-97. doi:10.3109/01674820009075614
64. Rich-Edwards JW. Sociodemographic predictors of antenatal and postpartum depressive symptoms among women in a medical group practice. *J Epidemiol Community Health.* 2006;60(3):221-227. doi:10.1136/jech.2005.039370
65. Bennett HA, Einarson A, Taddio A, Koren G, Einarson TR. Prevalence of Depression During Pregnancy: Systematic Review. *Obstet Gynecol.* 2004;103(4):698-709. doi:10.1097/01.AOG.0000116689.75396.5f
66. Perales M, Refoyo I, Coteron J, Bacchi M, Barakat R. Exercise During Pregnancy Attenuates Prenatal Depression: A Randomized Controlled Trial. *Eval Health Prof.* 2015;38(1):59-72. doi:10.1177/0163278714533566
67. Khafagy G, Gamal M, El-Rafie M. Effect of aerobic exercise during pregnancy on antenatal depression. *Int J Womens Health.* Published online February 2016:53. doi:10.2147/IJWH.S94112
68. Berghella V, Saccone G. Exercise in pregnancy! *Am J Obstet Gynecol.* 2017;216(4):335-337. doi:10.1016/j.ajog.2017.01.023
69. Robledo-Colonia AF, Sandoval-Restrepo N, Mosquera-Valderrama YF, Escobar-Hurtado C, Ramírez-Vélez R. Aerobic exercise training during pregnancy reduces depressive symptoms in

- nulliparous women: a randomised trial. *J Physiother.* 2012;58(1):9-15. doi:10.1016/S1836-9553(12)70067-X
70. Vargas-Terrones M, Barakat R, Santacruz B, Fernandez-Buhigas I, Mottola MF. Physical exercise programme during pregnancy decreases perinatal depression risk: a randomised controlled trial. *Br J Sports Med.* 2019;53(6):348-353. doi:10.1136/bjsports-2017-098926
71. Petrovic D, Perovic M, Lazovic B, Pantic I. Association between walking, dysphoric mood and anxiety in late pregnancy: A cross-sectional study. *Psychiatry Res.* 2016;246:360-363. doi:10.1016/j.psychres.2016.10.009
72. Gjestland K, Bø K, Owe KM, Eberhard-Gran M. Do pregnant women follow exercise guidelines? Prevalence data among 3482 women, and prediction of low-back pain, pelvic girdle pain and depression. *Br J Sports Med.* 2013;47(8):515-520. doi:10.1136/bjsports-2012-091344
73. Dejesus SA, Diaz VA, Gonsalves WC, Carek PJ. Identification and Treatment of Depression in Minority Populations. *Int J Psychiatry Med.* 2011;42(1):69-83. doi:10.2190/PM.42.1.e
74. Hernandez R, Andrade FCD, Piedra LM, Tabb KM, Xu S, Sarkisian C. The impact of exercise on depressive symptoms in older Hispanic/Latino adults: results from the “¡Caminemos!” study. *Aging Ment Health.* 2019;23(6):680-685. doi:10.1080/13607863.2018.1450833
75. Marquez DX, Bustamante EE, Aguiñaga S, Hernandez R. BAILAMOS[®]: Development, Pilot Testing, and Future Directions of a Latin Dance Program for Older Latinos. *Health Educ Behav.* 2015;42(5):604-610. doi:10.1177/1090198114543006
76. Lewis-Fernandez R, Das AK, Alfonso C, Weissman MM, Olfson M. Depression in US Hispanics: Diagnostic and Management Considerations in Family Practice. *J Am Board Fam Med.* 2005;18(4):282-296. doi:10.3122/jabfm.18.4.282
77. Torres ER, Sampsel CM, Gretebeck KA, Ronis DL, Neighbors HW. Physical Activity Effects on Depressive Symptoms in Black Adults. *J Health Disparities Res Pract.* 2010;4(2):70-87.
78. Knox S, Barnes A, Kiefe C, et al. History of depression, race, and cardiovascular risk in cardia. *Int J Behav Med.* 2006;13(1):44-50. doi:10.1207/s15327558ijbm1301_6
79. Orr ST, James SA, Garry J, Newton E. Exercise participation before and during pregnancy among low-income, urban, Black women: the Baltimore Preterm Birth Study. *Ethn Dis.* 2006;16(4):909-913.
80. Patil SK, Johnson AS, Lichtenberg PA. The relation of pain and depression with various health-promoting behaviors in African American elders. *Rehabil Psychol.* 2008;53(1):85-92. doi:10.1037/0090-5550.53.1.85
81. Kosma M, Buchanan DR. Aspects of Depression Among Socioeconomically Disadvantaged African American Young Adults. *Int Q Community Health Educ.* 2019;39(4):199-207. doi:10.1177/0272684X19829612
82. McDowell CP, Gordon BR, Andrews KL, MacDonncha C, Herring MP. Associations of physical activity with anxiety symptoms and status: results from The Irish longitudinal study on ageing. *Epidemiol Psychiatr Sci.* 2019;28(04):436-445. doi:10.1017/S204579601800001X
83. Philippot A, Dubois V, Lambrechts K, et al. Impact of physical exercise on depression and anxiety in adolescent inpatients: A randomized controlled trial. *J Affect Disord.* 2022;301:145-153. doi:10.1016/j.jad.2022.01.011
84. Henriksson M, Wall A, Nyberg J, et al. Effects of exercise on symptoms of anxiety in primary care patients: A randomized controlled trial. *J Affect Disord.* 2022;297:26-34. doi:10.1016/j.jad.2021.10.006
85. Kvam S, Kleppe CL, Nordhus IH, Hovland A. Exercise as a treatment for depression: A meta-analysis. *J Affect Disord.* 2016;202:67-86. doi:10.1016/j.jad.2016.03.063
86. Rimer J, Dwan K, Lawlor DA, et al. Exercise for depression. In: The Cochrane Collaboration, ed. *Cochrane Database of Systematic Reviews.* John Wiley & Sons, Ltd; 2012:CD004366.pub5. doi:10.1002/14651858.CD004366.pub5
87. Escobar-Roldan ID, Babyak MA, Blumenthal JA. Exercise Prescription Practices to Improve Mental Health. *J Psychiatr Pract.* 2021;27(4):273-282. doi:10.1097/PRA.0000000000000554

88. Seth A. Exercise prescription: what does it mean for primary care? *Br J Gen Pract.* 2014;64(618):12-13. doi:10.3399/bjgp14X676294
89. Whitsel LP, Bantham A, Jarrin R, Sanders L, Stoutenberg M. Physical activity assessment, prescription and referral in US healthcare: How do we make this a standard of clinical practice? *Prog Cardiovasc Dis.* 2021;64:88-95. doi:10.1016/j.pcad.2020.12.006
90. Verhagen E, Engbers L. The physical therapist's role in physical activity promotion. *Br J Sports Med.* 2009;43(2):99-101. doi:10.1136/bjsm.2008.053801
91. Stanton R, Reaburn P. Exercise and the treatment of depression: A review of the exercise program variables. *J Sci Med Sport.* 2014;17(2):177-182. doi:10.1016/j.jsams.2013.03.010
92. Zou L, Yeung A, Quan X, et al. Mindfulness-Based Baduanjin Exercise for Depression and Anxiety in People with Physical or Mental Illnesses: A Systematic Review and Meta-Analysis. *Int J Environ Res Public Health.* 2018;15(2):321. doi:10.3390/ijerph15020321
93. Lei J, Yang J, Dong L, et al. An exercise prescription for patients with lung cancer improves the quality of life, depression, and anxiety. *Front Public Health.* 2022;10:1050471. doi:10.3389/fpubh.2022.1050471
94. Patel A, Schofield GM, Kolt GS, Keogh JW. General practitioners' views and experiences of counselling for physical activity through the New Zealand Green Prescription program. *BMC Fam Pract.* 2011;12(1):119. doi:10.1186/1471-2296-12-119
95. Sallis RE, Matuszak JM, Baggish AL, et al. Call to Action on Making Physical Activity Assessment and Prescription a Medical Standard of Care: *Curr Sports Med Rep.* 2016;15(3):207-214. doi:10.1249/JSR.0000000000000249
96. Garber CE, Blissmer B, Deschenes MR, et al. American College of Sports Medicine position stand. Quantity and quality of exercise for developing and maintaining cardiorespiratory, musculoskeletal, and neuromotor fitness in apparently healthy adults: guidance for prescribing exercise. *Med Sci Sports Exerc.* 2011;43(7):1334-1359. doi:10.1249/MSS.0b013e318213febf
97. Coleman KJ, Ngor E, Reynolds K, et al. Initial validation of an exercise "vital sign" in electronic medical records. *Med Sci Sports Exerc.* 2012;44(11):2071-2076. doi:10.1249/MSS.0b013e3182630ec1
98. HEDIS Measures and Technical Resources. NCQA. <https://www.ncqa.org/hedis/measures/>
99. Warburton DE, Nicol CW, Bredin SS. Prescribing exercise as preventive therapy. *Can Med Assoc J.* 2006;174(7):961-974. doi:10.1503/cmaj.1040750
100. Sallis R, Franklin B, Joy L, Ross R, Sabgir D, Stone J. Strategies for promoting physical activity in clinical practice. *Prog Cardiovasc Dis.* 2015;57(4):375-386. doi:10.1016/j.pcad.2014.10.003
101. ACSM's Guidelines for Exercise Testing and Prescription. ACSM_CMS. Accessed January 30, 2024. <https://www.acsm.org/education-resources/books/guidelines-exercise-testing-prescription>
102. Home - Exercise is Medicine. Published January 20, 2021. Accessed September 18, 2023. <https://www.exerciseismedicine.org/>, <https://www.exerciseismedicine.org/home/>
103. Lobelo F, Rohm Young D, Sallis R, et al. Routine Assessment and Promotion of Physical Activity in Healthcare Settings: A Scientific Statement From the American Heart Association. *Circulation.* 2018;137(18). doi:10.1161/CIR.0000000000000559
104. Horner-Johnson W, Krahn G, Andresen E, Hall T, RRTC Expert Panel on Health Status Measurement. Developing Summary Scores of Health-Related Quality of Life for a Population-Based Survey. *Public Health Rep.* 2009;124(1):103-110. doi:10.1177/003335490912400113
105. Hébert ET, Caughy MO, Shuval K. Primary care providers' perceptions of physical activity counselling in a clinical setting: a systematic review. *Br J Sports Med.* 2012;46(9):625-631. doi:10.1136/bjsports-2011-090734
106. Holtrop JS, Dosh SA, Torres T, Thum YM. The Community Health Educator Referral Liaison (CHERL). *Am J Prev Med.* 2008;35(5):S365-S372. doi:10.1016/j.amepre.2008.08.012

107. Pratt SI, Jerome GJ, Schneider KL, et al. Increasing US health plan coverage for exercise programming in community mental health settings for people with serious mental illness: a position statement from the Society of Behavior Medicine and the American College of Sports Medicine. *Transl Behav Med.* 2016;6(3):478-481. doi:10.1007/s13142-016-0407-7
108. O'Donnell AN, Williams M, Kilbourne AM. Overcoming Roadblocks: Current and Emerging Reimbursement Strategies for Integrated Mental Health Services in Primary Care. *J Gen Intern Med.* 2013;28(12):1667-1672. doi:10.1007/s11606-013-2496-z
109. Pronk NP, Remington PL, on behalf of the Community Preventive Services Task Force*. Combined Diet and Physical Activity Promotion Programs for Prevention of Diabetes: Community Preventive Services Task Force Recommendation Statement. *Ann Intern Med.* 2015;163(6):465-468. doi:10.7326/M15-1029
110. Exercise is Medicine. The Challenge of Reimbursement – Coding and Billing Tips. <https://www.exerciseismedicine.org/wp-content/uploads/2021/04/EIM-Provider-Coding-Tip-Sheet.pdf>
111. American Medical Association. CPT® overview and code approval. <https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval#:~:text=Code%20applications%20%26%20criteria-,What%20is%20a%20CPT%20code%3F,reporting%2C%20increase%20accuracy%20and%20efficiency.>
112. American Medical Association. Evaluation and Management (E/M) Coding. <https://www.ama-assn.org/topics/evaluation-and-management-em-coding#:~:text=medical%20practice%20today-,E%26M%20coding%20involves%20use%20of%20CPT%20codes%20ranging%20from%2099202,or%20managing%20a%20patient's%20health.>
113. Ackermann RT, Williams B, Nguyen HQ, Berke EM, Maciejewski ML, LoGerfo JP. Healthcare Cost Differences with Participation in a Community-Based Group Physical Activity Benefit for Medicare Managed Care Health Plan Members. *J Am Geriatr Soc.* 2008;56(8):1459-1465. doi:10.1111/j.1532-5415.2008.01804.x
114. Mitchell MS, Goodman JM, Alter DA, et al. Financial Incentives for Exercise Adherence in Adults. *Am J Prev Med.* 2013;45(5):658-667. doi:10.1016/j.amepre.2013.06.017
115. U.S. News and World Report. Employees Get Paid to Exercise, While Some Pay to Sit Out. <https://money.usnews.com/money/personal-finance/articles/2012/02/14/employees-get-paid-to-exercise-while-some-pay-to-sit-out>
116. Chwastiak L. Making Evidence-Based Lifestyle Modification Programs Available in Community Mental Health Centers: Why So Slow?: (Commentary). *J Clin Psychiatry.* 2015;76(04):e519-e520. doi:10.4088/JCP.14com09503
117. Barnes PM, Schoenborn CA. Trends in adults receiving a recommendation for exercise or other physical activity from a physician or other health professional. *NCHS Data Brief.* 2012;(86):1-8.
118. Exercise is Medicine. Atlanta Community fitness program relational database. <https://www.eimsc.eimconnection.com/>
119. Joy E (Liz), Blair SN, McBride P, Sallis R. Physical activity counselling in sports medicine: a call to action. *Br J Sports Med.* 2013;47(1):49-53. doi:10.1136/bjsports-2012-091620
120. USC School of Medicine Greenville. Lifestyle Medicine. https://sc.edu/study/colleges_schools/medicine_greenville/medical_education/lifestyle_medicine/index.php#:~:text=The%20USC%20School%20of%20Medicine,of%20the%20medical%20school%20curriculum.
121. University of Wisconsin. Osher Center for Integrative Health at University of Wisconsin–Madison. <https://www.fammed.wisc.edu/integrative/>

122. Accreditation Council for Graduate Medical Education. Guide to the Common Program Requirements. <https://www.acgme.org/meetings-and-educational-activities/program-directors-guide-to-the-common-program-requirements/>
123. National Academies Press. Capturing Social and Behavioral Domains and Measures in Electronic Health Records. Published 2014. <https://nap.nationalacademies.org/catalog/18951/capturing-social-and-behavioral-domains-and-measures-in-electronic-health-records>
124. Ball TJ, Joy EA, Goh TL, Hannon JC, Gren LH, Shaw JM. Validity of two brief primary care physical activity questionnaires with accelerometry in clinic staff. *Prim Health Care Res Dev.* 2015;16(01):100-108. doi:10.1017/S1463423613000479
125. Lee IM, Keadle SK, Matthews CE. Fitness Trackers to Guide Advice on Activity Prescription. *JAMA.* 2023;330(18):1733-1734. doi:10.1001/jama.2023.19332
126. Lobelo F, Kelli HM, Tejedor SC, et al. The Wild Wild West: A Framework to Integrate mHealth Software Applications and Wearables to Support Physical Activity Assessment, Counseling and Interventions for Cardiovascular Disease Risk Reduction. *Prog Cardiovasc Dis.* 2016;58(6):584-594. doi:10.1016/j.pcad.2016.02.007
127. Cohen DA, Ashwood JS, Scott MM, et al. Public Parks and Physical Activity Among Adolescent Girls. *Pediatrics.* Published online December 31, 2005. Accessed January 22, 2024. https://www.rand.org/pubs/external_publications/EP20061101.html
128. CDC. Creating an Active America Together. Centers for Disease Control and Prevention. Published March 23, 2023. Accessed September 18, 2023. <https://www.cdc.gov/physicalactivity/activepeoplehealthynation/index.html>
129. Bantham A, Taverno Ross SE, Sebastião E, Hall G. Overcoming barriers to physical activity in underserved populations. *Prog Cardiovasc Dis.* 2021;64:64-71. doi:10.1016/j.pcad.2020.11.002
130. About. Parkrx. Published September 9, 2014. Accessed January 16, 2024. <https://www.parkrx.org/about>
131. Zarr R, Han B, Estrada E, Cohen DA. The Park Rx trial to increase physical activity among low-income youth. *Contemp Clin Trials.* 2022;122:106930. doi:10.1016/j.cct.2022.106930
132. Müller-Riemenschneider F, Petrunoff N, Yao J, et al. Effectiveness of prescribing physical activity in parks to improve health and wellbeing - the park prescription randomized controlled trial. *Int J Behav Nutr Phys Act.* 2020;17(1):42. doi:10.1186/s12966-020-00941-8
133. CDC. Good Nutrition. Centers for Disease Control and Prevention. Published July 13, 2022. Accessed January 22, 2024. <https://www.cdc.gov/nutrition/about-nutrition/index.html>
134. Bhat S, Coyle DH, Trieu K, et al. Healthy Food Prescription Programs and their Impact on Dietary Behavior and Cardiometabolic Risk Factors: A Systematic Review and Meta-Analysis. *Adv Nutr Bethesda Md.* 2021;12(5):1944-1956. doi:10.1093/advances/nmab039
135. Rebar AL, Stanton R, Geard D, Short C, Duncan MJ, Vandelanotte C. A meta-meta-analysis of the effect of physical activity on depression and anxiety in non-clinical adult populations. *Health Psychol Rev.* 2015;9(3):366-378. doi:10.1080/17437199.2015.1022901
136. Gianfredi V, Blandi L, Cacitti S, et al. Depression and Objectively Measured Physical Activity: A Systematic Review and Meta-Analysis. *Int J Environ Res Public Health.* 2020;17(10):3738. doi:10.3390/ijerph17103738
137. Tulloch H, Fortier M, Hogg W. Physical activity counseling in primary care: Who has and who should be counseling? *Patient Educ Couns.* 2006;64(1-3):6-20. doi:10.1016/j.pec.2005.10.010

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-24)
Teens and Social Media (Resolution 430-A-23)
(Reference Committee D)

EXECUTIVE SUMMARY

OBJECTIVE: This report examines the available evidence regarding the impacts of social media on the health of youth as well as the potential actions and interventions for government, policy makers, technology companies, researchers, parents, and children.

METHODS: English language reports were selected from searches of the PubMed and Google Scholar databases using the search terms: “teens” AND “social media” as well as “adolescents” AND “social media.” Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies and applicable professional and advocacy organizations were also reviewed for relevant information.

RESULTS: There is a pervasive presence of digital media, smartphones, and social media in nearly all aspects of youth and adolescent life. Despite substantial research efforts, the evidence is too weak to promote a uniform interpretation of the impact of social media on adolescent health at the population level. There are several factors contributing to the weak evidence including: (1) the reciprocal associations between social media use and health; (2) the lack of consistent and comparable methodologies; (3) entanglement of impact and exposure as a byproduct of social media’s ubiquity; (4) different dynamics and trends depending on level of analysis; (5) the wide variety of interactions, behaviors, and health impacts engendered by social media; and (6) reliance on cross-sectional studies with high heterogeneity. Although the evidence is too weak to provide a uniform interpretation, there are clear positive and negative trends. There is some evidence of potential benefit in the form of improved social support, identity development, civic engagement, and self-directed learning. There is also some evidence of potential harm including negative impacts on sleep, physical activity, and mental health, as well as exposure to inappropriate content, and data privacy issues. Furthermore, it is apparent that the relative risks and benefits of social media likely depend on individual differences in: (1) engagement with social media (e.g., what kids see and do online, who they talk to, when they use social media, and how they use social media); (2) pre-existing strengths and weaknesses; and (3) the cultural, social, and physical environment.

CONCLUSION: Even though the evidence of harm is limited there is an urgent need for action for two reasons. First, the lack of algorithmic transparency, privacy protections, and accountability and redress for online harassment on most platforms is concerning given the power, reach, and ubiquity of social media. Second, the potential harms are serious particularly during sensitive developmental periods, therefore, proactively creating digital environments that protect and enrich children’s and adolescents’ health and well-being is beneficial regardless of the evidence of harm. There are two key approaches that would likely facilitate the creation of safer, developmentally appropriate environments: (1) federal and state legislative action (e.g., expansion of the Children’s Online Privacy Protection Act (COPPA), implementation of age-appropriate design, and mechanisms to address online harassment, and (2) development and widespread adoption of industry standards to benchmark platform operations, transparency, and data use. In addition to improving the digital environment, it is imperative that there are simultaneous efforts to address harms that still arise including: (1) education and training on digital media literacy and the potential harms posed by social media; (2) improved screening and support for those who experience harms (e.g., problematic internet use and online harassment); and (3) continued research of the health impacts of social media.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 10-A-24

Subject: Teens and Social Media

Presented by: David J. Welsh MD, MBA, Chair

Referred to: Reference Committee D

1 INTRODUCTION

2
3 At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates
4 (HOD), Resolution 430, “Teens and Social Media” was adopted. The policy (H-478.976, “Teens
5 and Social Media,”) as adopted, asked that our AMA “study and make recommendations for
6 teenage use of social media, including proposing model state and federal legislation as needed,
7 with a report back at the 2024 Annual Meeting.”

8
9 At the 2023 Interim Meeting of the AMA HOD, Resolution 915, “Social Media Impact on Youth
10 Mental Health,” was referred. The resolution asked that our AMA:

- 11
12 (1) work with relevant parties to develop guidelines for age-appropriate content and access and
13 to develop age-appropriate digital literacy training to precede social media engagement
14 among children and adolescents;
15
16 (2) amend policy D-478.965 by insertion as follows: (4) advocates for and support media and
17 social networking services addressing and developing safeguards for users,
18 including protections for youth online privacy, effective controls allowing youth and
19 caregivers to manage screentime content and access, and to develop age-appropriate digital
20 literacy training; and
21
22 (3) advocate that the federal government requires social media companies to share relevant
23 data for further independent research on social media’s effect on youth mental health and
24 fund future federal research on the potential benefits and harms of social media use on
25 youth mental health.

26
27 METHODS

28
29 English language reports were selected from searches of the PubMed and Google Scholar databases
30 using the search terms: “teens” AND “social media” as well as “adolescents” AND “social media.”
31 Additional articles were identified by manual review of the reference lists of pertinent publications.
32 Web sites managed by federal agencies and applicable professional and advocacy organizations
33 were also reviewed for relevant information.

34
35 BACKGROUND

36
37 The co-occurrence of the growing ubiquity of social media use by adolescents and teens and the
38 increase in poor mental health, among these same age groups, is alarming. These trends have

1 prompted calls for action and research around adolescents and teens and their use of social media.
2 A common theme in the research is that social media is not inherently beneficial or harmful.
3 Instead, the effects of social media likely depend on what kids see, their pre-existing strengths and
4 weaknesses, and their environment.¹⁻⁴ In particular, child-social media interactions may be
5 bidirectional as users shape their experience which in turn shapes them and vice versa.^{5,6} Further,
6 many argue that it is important to move away from the false dichotomy of whether social media is
7 hurting or helping adolescents -- instead researchers, parents, and policy makers should consider
8 who is using social media, what are they using it for, when are they using it, and how are they
9 using it.⁷⁻⁹ The focus of this report will be on adolescents and teens aged 10-17.

10 *Social Media Privacy, Transparency and Accountability*

11 The American Psychological Association (APA) defines social media as, “interactive technologies
12 that facilitate the creation and sharing of information, ideas, interests, and other forms of
13 expression through virtual communities and networks.”¹⁰ This can include social networking,
14 gaming, virtual worlds, video sharing sites, and blogs.³ Social media, internet use, and screentime
15 all fall under the umbrella of digital media - the parent category of all interactive media consumed
16 through screens.¹ These terms are used interchangeably throughout the rest of the report, unless
17 noted otherwise.
18
19
20

21 The different forms of social media have different possibilities for action and engagement, known
22 as affordances. Affordances, include things like visibility, editability, persistence, replicability,
23 searchability, scalability, and reachability and they manifest as the capacity for public posting,
24 sharing functions, auto-scroll, gamified interaction, push notifications, private messaging,
25 affiliations, and running counts of feedback on posts.¹¹⁻¹³
26

27 Affordances can have meaningful influence on the actions of the user; therefore, many researchers
28 advocate for an affordances approach to understanding and evaluating social media.¹⁴ This is
29 important because affordances are powered by and interact with computational algorithms. These
30 algorithms moderate content by generating recommendations, ranking and removing content, and
31 targeting ads.³ A challenge with content moderation is that it is intrinsically subjective. The value
32 and appropriateness of content depends on the context – the who, what, why, how, and when of the
33 information being shared may determine if it is elevated, downplayed, or removed.
34

35 Most platforms use a mix of artificial intelligence and human editing to enforce content
36 moderation.³ This can create intentional manipulation of information on the part of individuals. For
37 instance, Facebook allowed advertisers to choose to exclude whole racial, ethnic, and age groups
38 from seeing their ads.^{3,15,16} Similarly, TikTok issues separate content moderation approaches for
39 different countries depending on the degree of social conservatism.^{3,17} Many platforms can and do
40 selectively reduce or increase the prominence of content from certain users without violating the
41 terms of use.^{3,18} There is also unintentional, or at a minimum unexplained, manipulation of
42 information, caused by using machine learning algorithms for content modification. Machine
43 learning algorithms are black box mechanisms that learn without explicitly being programmed.
44 Companies know the inputs, outputs, and training data that go into their algorithms, but the internal
45 processes by which most machine learning algorithms work are less clear. Additionally, algorithms
46 are proprietary, so companies are reluctant to share the details they do have.^{3,19,20} Consequently, the
47 intrinsic subjectivity of content moderation is made more opaque by machine learning algorithms
48 as well as the platforms’ lack of transparency about them.^{3,21}
49

50 Relying on machine learning for content modification is not inherently harmful, but it can create
51 recursive feedback loops that exacerbate problems with harmful content and misinformation. The

1 algorithms send users more of the content that they engage with, thereby creating the impression
 2 that theories and behaviors they are seeing are potentially more prominent than they are. Moreover,
 3 many users do not realize that social media platforms are designed to show them content that is
 4 most likely to keep them engaged and on the platform rather than providing a comprehensive view
 5 of the content of friends and family.^{3,22} There is some evidence that recursive feedback loops and
 6 echo chambers exacerbate vaccine hesitancy.^{3,23–25} Similarly, content modification, and the echo
 7 chambers it creates had a significant impact on behavior during the 2016 Election.^{3,26–28}

8
 9 Ultimately, the current processes for content moderation introduce bias on both the front end (e.g.,
 10 the training data that informs the algorithms and intentional modification of information) and on
 11 the back end (e.g., recursive feedback loops and echo chambers). Content moderation also
 12 leverages user data, often in ways the user is unaware of, which raises ethical and privacy concerns.

13
 14 Furthermore, there is concern among users that companies like Facebook (now Meta) both
 15 overlook the risks posed by their product and misrepresent their internal findings when necessary
 16 to benefit the company.^{3,29,30} It is for these reasons that many criticize platforms and call for
 17 evaluation of algorithm bias, transparency, justice, and accountability.^{3,20}

18 19 *Adolescence as a sensitive period*

20
 21 One of the reasons parents, clinicians, researchers, and policy makers have raised alarm about
 22 social media use among adolescents is that adolescence is a developmentally sensitive period.
 23 There are three key features of adolescent brain development that may impact how youth engage
 24 with social media: (1) heightened sensitivity to rewards and dynamic changes in the dopaminergic
 25 system;^{3,31–33} (2) protracted maturation of brain networks that support cognitive function;³⁴ and (3)
 26 neural sensitivity to specific types of social information.^{3,35} As a result, adolescence is a time of
 27 tremendous cognitive, social, emotional, and physical change that involves both opportunity for
 28 maturation and vulnerability to environmental stressors.^{3,36} Evidence from developmental
 29 neuroscience illustrates that adolescence is a time of heightened risk taking, impulsivity, and
 30 sensitivity to social stimuli.^{4,37} Consequently, adolescents are particularly susceptible to
 31 environmental influences like drugs, social stress, cognitive training, and likely social media.^{3,4,38–41}
 32 There is some concern that constant engagement in social media in early adolescence may alter
 33 neural sensitivity to rewards and punishment.^{3,42} Furthermore, changes in the reward circuit may be
 34 a factor in excessive and problematic internet and social media use.^{3,43}

35
 36 At the same time, self-presentation and identity exploration is an important part of adolescence that
 37 social media can support.^{3,14,44,45} It is a critical time for building relationships and developing a
 38 social support system.³ Adolescents demonstrate an increased ability to consider other perspectives,
 39 which drives empathetic and prosocial behaviors on the one hand, as well as increased social
 40 comparison on the other.^{3,46} The strong desire for social connectedness demonstrated by
 41 adolescents suggests that they may be relaxed regarding privacy settings and connecting with
 42 strangers.^{35,47} Online environments and social media interactions may also lower inhibitions and
 43 accelerate intimacy.⁴⁸ In this way, online environments create both benefits and risks to
 44 development of identity and social connectedness.⁴⁸ Adolescence is also a time of increased
 45 flexibility and plasticity so researchers and public health practitioners advocate leveraging the
 46 plasticity of adolescent brain for health promotion.³⁷

47
 48 Ultimately, the power of social media to influence well-being likely depends on developmental
 49 stage.⁴⁹ There is some evidence that the concept of adolescence should be expanded to include
 50 individuals aged 10 to 24.⁴⁰ An expanded definition of adolescence is essential for developmentally

1 appropriate framing of laws, social policies, and service systems. There are ethical reasons to limit
2 marketing to children and teens as they may struggle to resist advertising.⁵⁰

4 YOUTH PREVALENCE, MOTIVATIONS, AND EXPERIENCES ON SOCIAL MEDIA

6 According to a 2022 Pew survey, 95 percent of teens in the U.S. have a smartphone and 97 percent
7 use the internet daily, which represents a 22 percent increase over the last eight years.⁵¹ The
8 omnipresence of both internet and mobile devices in how youth engage in relationships, learn, and
9 experience milestones reflects a massive cultural shift since the early 2000s.⁵² Smartphone use
10 starts in early adolescence, with 40 percent of children ages 8 to 12 owning a smartphone and 18
11 percent reporting social media use every day.⁵³

13 The 2022 Pew survey also found that 35 percent of teens report using YouTube, Instagram,
14 TikTok, Snapchat, and Facebook almost constantly.⁵¹ Fifty-five percent of teens thought they used
15 social media the right amount, 36 percent thought they use social media too much, and eight
16 percent thought they used it too little.⁵¹ Additionally, 54 percent thought it would be somewhat
17 hard to give up social media.⁵¹ Findings from the Pew study mirror older studies reporting that 50
18 percent of teens describe themselves as constantly connected and feel that they are addicted.^{1,2}
19 There are slight demographic differences as well. Black and Hispanic teens may use online media
20 more than their White peers.⁵¹ Girls use social media more than boys and also report that they
21 would have a harder time giving up social media.⁵¹ Finally, teens over 15 use social media more
22 than teens under 15.⁵¹

24 The most popular platform is YouTube, used every day by 95 percent of teens.⁵¹ YouTube is
25 followed by TikTok at 67 percent, Instagram and Snapchat at 60 percent, Facebook at 32 percent,
26 and then Twitter, Twitch, WhatsApp, Reddit, and Tumbler.⁵¹

28 Despite widespread use among children and adolescents, robust independent safety analyses on the
29 impact of social media on youth have not yet been conducted.⁴ Currently, we do not yet have
30 enough evidence to determine if social media is sufficiently safe for children and adolescents. Yet,
31 the body of research about potential harm evidences the importance of understanding the possible
32 risks and proactively creating digital environments that safeguard children's and adolescents'
33 mental health and well-being during critical stages of development.⁴

35 *MOTIVATIONS FOR USE*

37 Motivations for social media use among teens include social interaction, connection, curiosity-
38 driven learning, information sharing, entertainment, relaxation, stress relief, escapism, novelty
39 seeking, social capital, and appearance feedback.^{3,54-56} Moreover, there is evidence that the ways in
40 which youth engage with social media can improve and enrich their lives through social support,
41 connection, community building, identity development, civic engagement, and exposure to new
42 ideas.⁵⁷

44 *Friendship, social support, and connection*

46 Social media plays a vital role in the development and maintenance of friendships and social
47 connectedness.^{54,57,58} Communication with friends and family is often reported as the most
48 important function of social media,^{59,60} particularly when family and friends are far away.⁶¹ Fifty-
49 seven percent of teens have met a new friend online.^{60,62} There appear to be some gender
50 differences in how boys and girls interact with friends on social media. Sixty-one percent of boys
51 and 52 percent of girls made friends online, and video games play a critical role in boys' friendship

1 development.⁶² In contrast, one study found that on average, teen girls spend over two hours a day
 2 on TikTok, Snapchat, and YouTube and over 90 minutes a day on Instagram and messaging apps.⁶³
 3 Roughly, 69 percent of teens feel better connected to their friends' feelings, 83 percent better
 4 connected to their friends' lives, and 68 percent receive social support during tough times from
 5 friends through social media.⁶² In this way, social media may be helpful in combating social
 6 isolation and building social capital.^{3,64}

7
 8 There is some evidence that social media can both reduce stigma and be a venue for sharing coping
 9 strategies.³ Social media provides a way for youth to connect with people in the same position,
 10 which can be particularly valuable to adolescents who feel excluded or otherwise lack offline
 11 support, including patients with rare diseases, individuals with disabilities, those who struggle with
 12 mental illness and/or obesity, and marginalized groups (e.g., LGTBQ+ youth).^{1,4} For instance,
 13 through social media, teens who are neurodivergent can connect socially with others in a way that
 14 is manageable for them, thereby reducing loneliness.^{3,65} Social media may also help teens and
 15 youth coping with grief,⁶⁶ navigating foster care,⁶⁷ dealing with cancer, diabetes, rare diseases,^{68,69}
 16 and mental illness.^{3,70} Sharing on social media about losses and stressors can provide a sense of
 17 connection, support, and understanding.⁷¹ Similarly, social media can provide support and
 18 connection for young people who live in communities where sexual and gender diversity are not
 19 accepted, which may buffer them from stigma and loneliness.^{3,72-74} This is particularly true for
 20 LGTBQ teens in rural areas that are able to find support they do not have offline by connecting
 21 with other queer youth.^{3,72,75-77}

22
 23 It is not clear if online and in-person relationships are equivalent; however, friendship and social
 24 connection facilitate a sense of belonging.^{3,78} Moreover, friendship can reduce anxiety and improve
 25 life satisfaction in its own right.^{3,79} Cross-sectional studies among undergrads provide some
 26 evidence that people who use social media to connect with a diverse friend group tend to have
 27 higher social self-efficacy.^{3,80} Yet, the relative support provided by online social connection may be
 28 influenced by the individual and how they engage with social media.^{3,81}

29 *Self-expression, Identity exploration, and Independence*

30
 31
 32 There is some evidence that social media can support self-expression, identity exploration, and
 33 independence.^{3,14,44,45,57,60,82,83} Adolescents who communicated more with friends online had a
 34 greater self-concept clarity.⁶⁰ One systematic review found that LGBTQ youth negotiated and
 35 explored identity using social media to manage identities through anonymity, censoring locations
 36 and content, restricting audiences, and using multiple accounts.⁷² This suggests social media may
 37 support the mental health and well-being of LGTBQ youth through identity management.⁷² In
 38 particular, the online environment of social media creates a space to reveal and express
 39 differences.⁸⁴ Similarly, many cis girls are meticulous about which platforms and accounts they use
 40 for specific tasks, because it allows them to experiment with different forms of expression and
 41 ways of presenting themselves to their peers.^{3,85} Self-disclosure, a key process in asserting personal
 42 agency, may be facilitated through digital platforms.^{3,81}

43 *Self-directed learning, Creative expression, and Civic engagement*

44
 45
 46 Social media can also facilitate exposure to new ideas, raise awareness about current events,
 47 increase community participation and civic engagement, and allow collaboration on schoolwork.²
 48 A study of teens in western countries found that social media use predicts greater ability for both
 49 reading and navigating information online.^{3,86} There is also some evidence that when social media
 50 is used for classroom writing exercises, students demonstrate less writing anxiety and increased
 51 agency.⁸⁷ Similarly, online fanfiction communities facilitate informal learning by creating a space

1 for youth to build literary skills and support the same skills in others.⁸⁷ The same can be said for
 2 other hobbies, interests, and activities that have a social media component and roughly 70 percent
 3 of teens use social media to express their creative side.⁵⁴ The informal learning environment of
 4 social media facilitates empowerment and agency among some young people.^{3,88} It has also been
 5 associated with increases in self-motivation among adolescents.^{3,88}

6
 7 About two-thirds of teens ages 13-18 reported using social media to learn about different points of
 8 view or show support,⁵⁴ and 64 percent of teens look for news online.^{3,89} Furthermore, evidence
 9 suggests youth who engage in online political discussions also engage in offline political
 10 discussions.^{3,89,90} Therefore, social media may be a vehicle to engage and utilize the social and
 11 political power of young people through civic engagement.^{3,90-92} Social media can facilitate
 12 political democracy, cultural democracy, and spread of knowledge.⁹³ Finally, there is some
 13 evidence that adolescents both seek out and share health information on social media.^{53,54}
 14 Therefore, it may be an effective tool for health interventions and health promotion.^{1,94,95} On the
 15 other hand, health misinformation can exacerbate adoption of harmful behaviors.⁹⁶

16 17 *ONLINE HARASSMENT AND EXPOSURE TO INAPPROPRIATE CONTENT*

18 19 *Cyberbullying and online harassment*

20
 21 There is evidence that social media increases risk of cyberbullying among youth.^{1-3,60,83,97}
 22 According to a recent Pew survey, 46 percent of U.S. teens ages 13 to 17 report ever experiencing
 23 at least one of six cyberbullying behaviors.⁵¹ Name-calling was most common, with 32 percent of
 24 teens reporting they have been called an offensive name online or on their cellphone.⁵¹ False
 25 rumors (22 percent), receipt of explicit images (17 percent), pervasive questions about location (15
 26 percent), physical threats (10 percent), and the sharing of explicit images of them without their
 27 consent (7 percent) were also reported.⁵¹ There appear to be slight demographic differences in who
 28 experiences cyberbullying. Specifically, studies have shown that black teens experience more
 29 cyberbullying than their white peers,^{51,98} LGBTQ youth experience more cyberbullying than their
 30 cisgender and heterosexual peers,^{51,98} and adolescent girls experience more cyberbullying than
 31 adolescent boys.^{51,63,99,100} Evidence also suggests that relationship issues (e.g., feeling left out and
 32 interpersonal drama) were the most common reason for cyberbullying among adolescent girls.^{63,100}

33
 34 Studies suggest that the size and type of the network as well as anonymity of those on the network
 35 impact the likelihood of harassment, but it is not easily predicted.^{3,101,102} For instance, online
 36 harassment occurs often among video game users, particularly female gamers who commonly
 37 report sexual harassment.^{3,103,104} One study found that indiscreet posting, time spent on social
 38 media, and personality traits were all predictors of cyberbullying.¹⁰⁵ There is some evidence of a
 39 relationship across studies between cyberbullying and depression among children and adolescents;
 40 however, the evidence of the effect of cyberbullying on other mental health conditions is
 41 inconsistent.¹⁰⁰ Adolescents' self-view and interpersonal relationships may be affected through
 42 social comparison and negative interactions, like cyberbullying and exposure to inappropriate
 43 content.⁹⁷

44
 45 Responses to cyberbullying are most often passive, with a pervasive lack of awareness or
 46 confidence that anything can be done.¹⁰⁰ Despite the prevalence of cyberbullying, some evidence
 47 suggests that in-person bullying is more common.^{3,106}

48 49 *Exposure to inappropriate content and misinformation*

50

1 One major concern of parents, clinicians, researchers, and policy makers is that poorly regulated
 2 and moderated social media can result in youth exposure to inappropriate content (e.g., alcohol,
 3 tobacco, risky sexual behaviors, cyberflashing, porn, and self-harm).^{1-3,107} A survey of more than
 4 1,300 teens aged 13 to 17 found nearly three-fourths had seen pornography online, with social
 5 media being the point of access for about 18 percent.^{3,108} Moreover, average first exposure was at
 6 12 years old and accidental exposure accounted for 40 percent of cases.^{3,108} Cyberflashing – the
 7 electronic transmission of sexually explicit photos without the recipients’ consent – is a particularly
 8 troubling form of online harassment.^{3,109} One survey found that 37 percent of girls and 20 percent
 9 of boys aged 12 to 18 had received sexual photos online, often from strangers,^{3,110} and another
 10 study found more than 6 percent reporting the first flashing incident occurred between the ages of
 11 12 and 14.^{3,111} It is difficult to evaluate brief and limited exposures; however, there is evidence that
 12 repeated exposure to inappropriate content in childhood was associated with risky sexual behavior
 13 later in life.¹⁰⁷ Similarly, exposure to alcohol, tobacco, or risky sexual behaviors may be associated
 14 with initiation of those behaviors.¹

15
 16 Teens and adolescents may also be uniquely vulnerable to misinformation and disinformation
 17 because their maturity and cognitive capacities are still evolving.^{3,112} Misinformation and
 18 disinformation can take a variety of forms including clickbait, hoax, rumor, satire, propaganda, and
 19 conspiracy theories.^{113,114} Examples include things like foreign interference, political deceit, and
 20 claims for ineffective and unproven natural remedies and medical advice.¹¹² Concerningly, many
 21 people lack the ability to identify misinformation and disinformation as evidenced by one study
 22 which found that the percentage of people who share fake news without the intention to mislead is
 23 five times higher than intentional spreaders.¹¹⁵ A 2018–2019 survey of 3,446 U.S. high-school
 24 students demonstrated that 52 percent believed that a grainy video claiming to show ballot-stuffing
 25 in the 2016 Democratic primaries constituted ‘strong evidence’ of voter fraud in the US, and only
 26 0.1 percent were able to track down the original video even though a quick search showed that it
 27 was actually shot in Russia.^{112,116} Similarly, two-thirds could not tell the difference between news
 28 stories and ‘sponsored content’ (i.e. adverts) on a website.^{112,116} Although teens and adolescents
 29 may be particularly vulnerable to misinformation and disinformation, there is currently very little
 30 data available to provide a clear picture of how misinformation and disinformation may affect their
 31 development, well-being, and rights.¹¹²

32 33 IMPACTS OF SOCIAL MEDIA ON ADOLESCENT HEALTH

34
 35 To understand the impacts of social media on adolescent health, the conflicting and often reciprocal
 36 mechanisms through which online experience and health (physical and mental) influence each
 37 other must be disentangled.³ However, there are several factors that make this extremely
 38 challenging, including:

- 39
 40 (1) the direction of the relationship between social media and health is difficult to determine -
 41 social media use influences health and health influences social media use;
- 42 (2) the research lacks uniform, consistent, and comparable methodologies;
- 43 (3) social media is so ubiquitous it is difficult to separate the impact of exposure;
- 44 (4) different levels of analysis may reveal different dynamics – with large scale studies
 45 showing population level trends and psychological studies showing mixed, small, or no
 46 associations;
- 47 (5) social media is not a monolith, the affordances of different platforms and types of social
 48 media engender a wide variety of interactions, behaviors, and health impacts; and
- 49 (6) the heterogeneity of the literature and the primary reliance on cross-sectional studies (or
 50 meta-analysis of cross-sectional studies) make definitive conclusions and causal

1 relationships limited. Most of the associations are qualified or limited to certain
2 populations.³

3 *Social Media and Physical Health: Sleep, Physical Activity, and Obesity.*

4
5 There is evidence that social media use can disrupt sleep.^{1-3,97,107,117,118} Specifically, increased
6 duration of computer, internet, and social media exposure,^{3,118} and the presence of a tv, computer,
7 or mobile device in the bedroom in childhood were associated with fewer minutes of sleep, greater
8 risk of sleep disturbances, longer sleep latency, worse sleep quality, and daytime dysfunction.^{1,119}
9 Gaming predicted delayed bedtimes and reduced attention the following day.^{3,120} One study found
10 that screen-based digital media use is closely associated with sleep duration and sleep quality in
11 teens; however, they cautioned that more research was needed to determine the direction of the
12 effect.^{3,121} Another study found that smartphone use at night can delay sleep among adolescents.^{3,122}
13 In a nationally representative sample, one-third of parents of teens 12-17 had rules about
14 smartphone use at bedtime and those kids had less daytime sleepiness.^{3,123}

15
16 However, it is not clear if social media or devices more broadly are driving the relationship. There
17 are three likely ways in which digital media use may disrupt sleep.^{3,124} First, social media displaces
18 sleep thereby delaying bedtime, disrupting sleep, and reducing sleep duration.^{3,121,124} Second,
19 devices can disrupt circadian rhythms through light emissions which heighten arousal and decrease
20 sleepiness.^{3,122,124} Third, social media may be psychologically stimulating in such a way that makes
21 sleep difficult.^{3,124,125} Determining which mechanism(s) are driving the association between digital
22 media and poor sleep is necessary given that the cascading impacts of poor sleep and the potential
23 harms of social media overlap significantly.

24
25 Observational studies suggest a significant association between poor sleep quality and excess social
26 media use and negative mental health outcomes.^{3,126} Therefore, the interplay between social media
27 and sleep quality may impact mental health outcomes. Sleep loss is a risk factor for depression,
28 mood disturbances, injuries, attention problems, and excessive weight gain.^{3,127-129} Additionally,
29 teens with restricted sleep have more problems with emotion regulation, anxiety, hostility, and
30 fatigue.^{3,130} One study also found that sleep-deprived participants showed worse mood, more social
31 media use, and problems with concentration.^{3,131} Moreover, findings from the Youth Risk Behavior
32 Survey illustrated that teens who sleep four or fewer hours a night have 5.9 times higher odds of
33 having a serious suicide attempt.^{3,132} Some studies showed sleep quality mediating the relationship
34 between social media use and negative mental health outcomes in youth.¹²⁶ In particular, if social
35 media displaces sleep and hobbies, it can be predictive of anxiety and depression.^{3,133} Similarly,
36 when screen time displaces sleep and exercise it is predictive of problematic use.^{3,134,135} However,
37 the current body of evidence on the directionality and relationships between social media use,
38 mental health, and sleep is inconclusive.^{3,126}

39
40 There is some evidence that social media use may correlate to non-adequate nutrition, non-
41 physiologic postures, weight gain, and obesity.^{1,2,107,117} Excessive TV viewing in early childhood is
42 associated with an increased risk of obesity.¹ Social media could be displacing physical activity,
43 sleep, studying, and other hobbies, resulting in a more sedentary lifestyle and an increased risk of
44 obesity.^{3,107,136} In support of this, another study found that increased digital media use was
45 associated with a sedentary lifestyle.^{3,137} Social media use is also associated with consumption of
46 fast food, sugary drinks, snacks, and mindless eating.^{3,138} One study theorizes that this may be
47 occurring because social media is displacing regular meals.^{3,138}

48 *Social Media and Mental Health: Anxiety, Depression, and Loneliness*

49
50

1 The findings on the association between social media and adolescent mental health are small,
2 inconsistent, or non-existent. Moreover, the differences in findings appear to be explained by
3 bidirectional interactions, methodological weaknesses and differences, and/or individual rather than
4 population differences.

5
6 Several meta-analyses, systematic reviews, and other studies have found small negative
7 associations between social media use and depression, anxiety, psychological distress,¹³⁹
8 loneliness, internalizing problems, and low offline social support.^{3,139-147} At the same time,
9 numerous other studies found the relationship between social media and adolescent mental health is
10 non-existent, mixed, or inconsistent.¹⁴⁸⁻¹⁵¹ Specifically, there was no significant association
11 between social media use and depression, anxiety, and life satisfaction.^{148,150,152} Additionally, there
12 is inconsistent evidence that social media makes social comparison, envy, and well-being worse.¹⁴⁹
13 Importantly, many of these studies note that predictive relationships between social media use and
14 well-being are reciprocal, as well as present only in certain populations, developmental windows,
15 or among certain patterns of use.^{49,141-143,151-155}

16
17 For instance, one review found that early studies show comparison and envy are common on social
18 media and linked to ill-being, whereas recent studies find positive, person-specific, conditional, and
19 reciprocal effects.¹⁴⁹ Similarly, one study found that social media use in and of itself is not a
20 predictor of life satisfaction; rather the relationship between self-reported estimates of social media
21 use and life satisfaction is more nuanced, reciprocal over time, gender specific, and likely
22 dependent on analytic methods.¹⁵² Another study found that life satisfaction is most negatively
23 associated with social media use in younger adolescents, but also noted possible developmental
24 windows of sensitivity -- at ages 14-15 and 19 for boys and at ages 11-13 and 19 for girls.⁴⁹ A
25 longitudinal study that characterized subgroups based on type of social media use found that the
26 high social media use subgroup predicted higher depressive symptoms, panic disorder, delinquent
27 behaviors, family conflict, and lower family and friend support than the high Instagram/Snapchat
28 and low social media subgroup.¹⁵⁴ Similarly, in a study of U.S. undergrads, social media use was
29 not predictive of impaired mental health; however, “vaguebooking” -- the practice of making a post
30 on social media that is intentionally vague but highly personal and emotional -- was predictive of
31 suicidal ideation.¹⁵¹ This suggests how individuals use social media is more important than the
32 amount of time they spend on social media, particularly considering that perceived parent-child
33 conflict was a stronger predictor of mental health issues than social media use.¹⁵¹

34
35 There is also some evidence that young people who report symptoms of depression are using
36 digital tools to learn about and help their mental health problems.¹⁵⁵ One study found that girls and
37 LGBTQ teens were more likely to seek out online resources for mental health and showed interest
38 in stories of others with similar experiences.¹⁵⁵ Those who benefit most from social media appear
39 to be those who are marginalized as well as those with chaotic home lives, suggesting the benefits
40 of online social support are most salient when offline social support is lacking.^{51,54} These findings
41 highlight the importance of researching patterns, quality, and type of use in addition to amount of
42 use.

43
44 Additionally, there are methodological issues that further complicate definitive conclusions.
45 Several studies note that wide variation in methods and rigor make it difficult to synthesize
46 findings.^{139,143,154,156,157} For instance, one systematic review found a small association between self-
47 reported social media use and depressive symptoms, but noted that the studies had high
48 heterogeneity, which suggests that other factors are likely moderating the relationship.¹⁴³ Another
49 systematic review argued that small associations and inconsistent results may be influenced by
50 choice of mental health indication (e.g., presence of well-being is not necessarily the absence of ill-
51 being and vice versa).¹⁴⁹ Furthermore, the research on social media and adolescent well-being

1 primarily comes from cross-sectional studies, therefore causal associations may be
2 unwarranted.^{49,140,152,156-158} Finally, this research should consider a person-specific approach as
3 individual differences may explain the mixed and inconsistent results.¹⁵⁶

4
5 Ultimately, the presence of small associations as well as inconsistent and conflicting results
6 highlights that the evidence is still too weak to promote a uniform interpretation or to support the
7 conclusion that social media causes changes in adolescent mental health at the population level.^{3,159}
8 Moreover, the fact that social media use is linked in complex and ubiquitous ways with other
9 aspects of life means it is unclear what such a small effect demonstrates.¹⁵⁹ Ultimately, more
10 research is needed along with improved transparency and greater appreciation for individual
11 differences.^{4,159}

12 *Problematic Internet Use and Internet Gaming Disorder*

13
14
15 Internet gaming disorder is defined as persistent and recurrent use of the internet to engage in
16 games, leading to clinically significant impairment or distress.⁴¹ Problematic internet use is defined
17 as internet use that creates psychological, social, school and/or work difficulties in a person's
18 life.¹⁶⁰ This can include video gaming, social media use, web-streaming, and buying; however,
19 those activities are characterized as excessive or poorly controlled preoccupations, urges, or
20 behaviors regarding computer use and internet access that lead to impairment or distress. The key
21 factor is that internet use becomes problematic when it causes dysfunction in daily life activities
22 (e.g., school, sleep, exercise).^{3,26,161} There appears to be significant overlap in internet gaming
23 disorder, problematic social media use, and problematic internet use.^{3,162,163} At this point it is
24 unclear whether problematic social media use and gaming disorder are distinct or different
25 manifestations of disordered tech use.³

26
27 There is some evidence that internet gaming disorder predicts depression, anxiety, social phobia,
28 poor school performance, sleep disruption, and poor relationships with parents and peers.^{3,164-167}
29 There is also some evidence that problematic internet use is associated with depression,
30 disturbances in sleep and mood, upward social comparisons, cybervictimization, and poor
31 academic performance.^{3,4,58,72,168-172} Problematic social media use is most common among older age
32 groups and may be associated with irritability, nervousness, loneliness, and morning tiredness.¹⁶⁹
33 There are gender differences in internet gaming disorder, as it affects males 5 times more than
34 females.¹⁷³ Moreover, there is some evidence that boys are more addicted to games whereas girls
35 are more addicted to social media.^{3,174}

36
37 Some researchers suggest that problematic internet use could explain the small negative
38 associations between social media and youth mental health. For instance, problematic social media
39 use mediated the association between depressive symptoms and cyberbullying.¹⁴² Additionally, one
40 study found that teens with problematic internet use reported more difficulty identifying and
41 describing emotions, and there is some evidence that emotion regulation is a significant mediator in
42 quality of parent-adolescent relationship.¹⁷⁵ Some researchers theorize that problematic internet use
43 might be a coping strategy to compensate for emotion regulation deficits, which might explain why
44 a good relationship with parents reduces problematic internet use.¹⁷⁵ However, problematic use is
45 more complex than simply the amount of time spent on social media. It includes enduring
46 preoccupation with social media, inability to stop, neglect of one's health and other areas of one's
47 life.¹⁵⁶ Therefore, more research is needed to better understand the relationships between
48 problematic internet use, social media, and adolescent mental health.

49 *Attention and Learning*

50

1 There is limited evidence that social media use negatively impacts attention and learning. One
2 study found that time spent on social media predicts concentration problems in adolescent girls.^{3,176}
3 Additionally, there are small associations between both frequency of social media use and number
4 of platforms and attention deficit hyperactivity disorder (ADHD).^{3,177-179} However, it is not clear
5 what is driving the association between social media use and decreased attention.¹
6

7 There is some evidence that reading on screens is fundamentally distracting.^{3,180} Others have
8 suggested that multitasking is the root of the problem. High proportions of youth engage in heavy
9 smartphone use and media multitasking.⁹⁷ Moreover, a recent meta-analysis found associations
10 between multitasking and problems with attention, behavior regulation, impulsiveness, and
11 memory.^{3,181} Specifically, media multitasking is associated with negative effects on cognitive
12 control, academic performance, and socioeconomic functioning.^{3,97,181,182} One study found that in
13 three hours of studying, adolescents experienced an average of 35 social media distractions that
14 diverted attention.^{3,183} Additionally, another study found that the number of social media accounts
15 correlated with parent reports of symptoms of inattention, hyperactivity, impulsivity, oppositional
16 defiant disorder, anxiety, and depressive symptoms, and adolescent reports of fear of missing out
17 and loneliness.¹⁷⁹ Therefore, it has been suggested that the amount of time spent online can have
18 bidirectional effects on depressive symptoms and ADHD; this risk is particularly heightened in
19 those with pre-existing poor mental health.¹²⁶
20

21 *Body Image and Eating Disorders*

22

23 Significant research exists on the association between social media use and body image, but the
24 findings are limited, and causal factors are difficult to differentiate. There is some evidence that
25 social media use and consequent exposure to appearance-focused content may be weakly
26 associated with poorer body image.^{3,4,184,185} A cross-sectional study found that greater levels of self-
27 objectifying social media use predicted greater body shame among youth, and the association was
28 mediated by an associated increase in body surveillance.^{3,186} Specifically, the role of body
29 surveillance was stronger among girls and adolescents who are particularly focused on others for
30 approval.¹⁸⁶ Body image concerns may be a key mechanism underlying the associations between
31 adolescent girls' social media use and mental health.¹⁸⁷
32

33 A scoping review found that social media use may have a variety of impacts on diet, exercise, and
34 body image.¹⁰⁷ Similarly, another study found that the same platform that helped some patients find
35 recovery support was also a source of body shaming and rumination for others.^{3,188} Another review
36 found that peer influences on social media span from healthy eating and exercise to disordered
37 eating, and that dietary information shared on social media often misaligns with national dietary
38 standards.¹⁸⁹ Similarly, one study found youth had an increased ability to recall unhealthy food,
39 beverages, and brands particularly when celebrities and influencers are promoting them.¹⁹⁰
40

41 PRIVACY

42

43 Researchers have found that the growing use of social networks has led to the emergence of ethical
44 and privacy concerns regarding the management of user data and how social networks train
45 algorithms for economic purposes to organize the content shown to users.^{1,191} The new privacy
46 paradox is that these sites have become so ubiquitous that users feel they must disclose information
47 on them even though these sites do not provide adequate privacy controls.^{3,192} Specifically, the
48 privacy policies used by platforms either require or allow users to review and consent to their data
49 collection and data use practices; however, most respondents agreed to the terms without reviewing
50 them.^{3,193,194} This could be because the policies themselves are long and technical, they do not

1 provide consumers with meaningful choices, and people are skeptical of whether policies achieve
2 their goals.¹⁹⁴ Concern over what platforms do with user data coupled with a sense of futility over
3 having the agency to change anything may explain why a recent Pew survey found overall strong
4 bipartisan support for more regulation of what companies can do with people's data, with 72
5 percent of Americans reporting that there should be more regulation than there is now.¹⁹⁴

6
7 These issues may be even more salient for children. A recent Pew study found that Americans
8 worry about kids' online privacy, with 89 percent of respondents reporting that they are very or
9 somewhat concerned about social media platforms knowing personal information about kids.¹⁹⁴
10 Similar concern arises over how advertisers, online games, and gaming apps collect and use
11 children's data.¹⁹⁴ However, respondent expectations regarding responsibility for protecting kids is
12 placed primarily on parents at 85 percent, followed by technology companies at 59 percent and the
13 government at 46 percent.¹⁹⁴

14
15 The Children's Online Privacy Protection Act (COPPA), which was enacted in 1998, recognizes
16 that young children cannot consent to the terms of use for data collection, and thus prohibits
17 enticing personal disclosures through games and restricts advertising to children. Yet, COPPA only
18 applies to kids under 13. Consequently, recent legislation has focused on age-appropriate design
19 and proposed additional protections for adolescents.

20
21 There is mixed evidence on how adolescents and adults feel about online privacy. There is some
22 evidence that older users are more concerned about privacy than youth.¹⁹⁵ Additionally, a strong
23 desire among adolescents for social connectedness suggests that youth may be more inclined to
24 have relaxed privacy settings and show a greater willingness to connect with strangers.^{3,35,196}
25 However, a different study found a negative relationship between age and privacy; noting that
26 young people are more likely to have taken action to protect their privacy than older people.¹⁹²
27 Therefore, it is possible that the studies finding that young people are not concerned about their
28 privacy may be because they are taking more precautions.

29 30 POTENTIAL APPROACHES TO PROTECT CHILDREN ON SOCIAL MEDIA

31
32 Despite widespread use among children and adolescents, the evidence on the potential harms and
33 benefits is too weak to promote a uniform interpretation of the impact of social media on
34 adolescent health at the population level. Nonetheless, the current body of research does highlight
35 the importance of understanding the risks and benefits and proactively creating digital
36 environments that protect and enrich children's and adolescents' health and well-being during
37 critical stages of development.^{1-4,41}

38 39 *Recommendations for Industry*

40
41 The most common recommendation for the social media industry is improved privacy protections,
42 improved transparency, and a better system of reporting inappropriate content and ill-actors. Yet
43 aside from internal efforts, like Facebook's Oversight Board, there has been little voluntary
44 governance action on the part of industry.¹⁹⁷ Highlighting the success of the Global Internet Forum
45 to Counterterrorism, the National Academy of Science, Engineering, and Medicine (NASSEM)
46 argues that the International Organization for Standardization (ISO) should convene an ongoing
47 technical working group comprised of industry, academic, and civil stakeholders to develop
48 standards for social media platform design, transparency, and data use.^{3,198} Other researchers,
49 professional organizations, and policy makers also advocate for development of industry
50 standards.^{4,197}

1 Specifically, the goals of the work group would be to develop standards that: (1) limit the personal
2 information companies collect, the types of content available, and the prompts to extend time on a
3 platform; and (2) develop easy to use, universal, transparent systems for reporting, follow-up, and
4 adjudication for cases of online harassment and abuse.^{3,4,197} Specifically, efforts should be made to
5 move to a functional privacy system that emphasizes transparency of and access to inputs and
6 outputs. On the front-end inputs would include: (1) a clear process for content moderation and use;
7 (2) contents of privacy agreements; and (3) mandatory disclosures to users.³ On the back-end,
8 standard outputs might include: (1) platform health measures (e.g., content moderation and take
9 down policies and data at the community, group level to evaluate platform toxicity); (2)
10 algorithmic transparency standards and summaries at the user level; and (3) reports on efforts to
11 remediate youth mental health problems on the platform.^{3,4} This would improve privacy protections
12 and transparency by making it clear what data is collected from minors, how it is collected and
13 used, and what the consequences of use are. Furthermore, this would give companies and
14 researchers more straightforward guidelines for measuring data collection risks that children
15 encounter online, as well as technical standards to benchmark platform operations, transparency,
16 and data use.³ Arguably social media platforms would benefit from a standard guide of assessment
17 to evaluate how their products influence youth well-being.

18
19 However, developing standards is insufficient unless social media companies adopt the standards
20 both as their policy and as provisions in their terms of service.³ There is a precedent of self-
21 regulation in media (e.g., tv, movies, videogames, music) using industry standards, as well as early
22 efforts at self-regulation evidenced by Facebook's Oversight Board.^{3,197,199-201} However, given that
23 the success of social media is contingent on engaging as many people for as long as possible,
24 implementing standards aimed to reduce controversial, emotional, and inflammatory content might
25 not be in their best interest. This is evidenced by the pending lawsuit to enjoin the California Age-
26 Appropriate Design Code Act on first amendment violation claims.^{202,203} Enacting a regulatory
27 framework across jurisdictions on global companies is not always legally or logistically viable;
28 however, voluntarily adopting standards now could reduce the likelihood of more sweeping
29 regulatory action later.^{3,197,204,205} Furthermore, evidence from political science literature on
30 transnational governance shows that multistakeholder regulatory standards setting schemes can be
31 a vital part of the corporate regulatory toolbox.¹⁹⁷ However, more research is needed to see how
32 and if they can be implemented to protect adolescent social media users.¹⁹⁷

33
34 A public statement of compliance with standards and a commitment to uphold those standards in
35 the terms of service would be a meaningful step towards an enforceable legal structure.³
36 Specifically, the Federal Trade Commission (FTC) can penalize firms that engage in unfair or
37 deceptive business practices and has used this authority against companies that have failed to honor
38 commitments made in their privacy policies and similar agreements.²⁰⁶⁻²⁰⁸ Audit and systemic risk
39 reports of compliance with the standards should be available to the FTC, researchers, and the
40 public. Social media companies should make a good faith effort to ensure access to data that
41 facilitates research on the effects of social media on child and adolescent health possibly including
42 removal of the prohibition on researchers' use of publicly available data.³ More transparency would
43 allow for comparisons across platforms and over time, which would provide a better insight for the
44 companies, the public, and the FTC. Creation of a standard would also support and inform the
45 FTC's use of consent decrees as a regulatory tool.^{3,209} Once a company agrees to a consent decree –
46 terms of the decree determine obligations to remediate regardless of whether the terms are within
47 the FTC's authority.^{3,210} Creation of an industry standard could support the FTC's governance by
48 consent decree, even for providers who do not explicitly adopt the standard.³

1 Once standards have been created and adopted, it would be much easier to assess and remedy
2 harms posed by social media. For instance, standards could be used to evaluate whether the
3 platform has age-verification processes, data encryption, and privacy policies.³ Similarly, they
4 could be used to determine whether a platform's content is suitable for children by evaluating the
5 likelihood of exposure to illegal and maladaptive behavior.⁴¹ The first step towards benchmarking
6 is transparency and more fair competition in an opaque market.³ For instance, ethical artificial
7 intelligence (AI) tool kits could help facilitate more open communication among technology
8 developers, researchers, policy makers, and civil society.^{3,211} Additionally, public documentation of
9 the provenance of the dataset used to calibrate machine learning models is gaining traction as way
10 to mitigate harms from biased models.^{3,212}

11
12 NASEM makes a persuasive case that an ongoing technical workgroup to develop industry
13 standards, ideally facilitated by ISO, as well as near uniform industry adoption of the standards in
14 their policies and terms of service would improve privacy protections, improve algorithmic and
15 other transparency, and facilitate a better system of reporting inappropriate content and ill-actors.
16 However, this is new territory and despite the ISO's strong track record of developing complex
17 technical international standards (e.g., information security management and data protection), it is
18 difficult to fully assess if something similar would be an effective tool to regulate social media.^{3,198}

19 20 *Recommendations for the Federal Government*

21
22 In addition to developing and adopting industry standards, another approach is to improve privacy
23 protections and age-appropriate design at the federal and state level through legislation. This is
24 further supported by the Surgeon General's Advisory on the effects of social media on youth
25 mental health, which urges action to ensure social media environments are healthy and safe.⁴ As
26 noted earlier, COPPA recognizes that young children cannot consent to the terms of use for data
27 collection, and thus prohibits enticing personal disclosures through games and restricts advertising
28 to children.²¹³ Currently, when companies violate COPPA by collecting data for children under the
29 age of 13, the FTC can and has issued fines. Specifically, in 2019, the FTC required Google to pay
30 \$170 million for data collection in violation of COPPA.²¹⁴ However, COPPA only protects children
31 under the age of 13 so arguably one way to improve privacy protections for children would be to
32 expand COPPA to include all minors. In 2021, legislation to extend COPPA protections to kids
33 through age 16 was proposed with the Children and Teens' Online Privacy Protection Act, which
34 would also require platforms and providers to report on foreseeable risks of harm.²¹⁵ However,
35 there has been no action on the proposed legislation. The FTC also has authority over unfair and
36 deceptive practices in commerce. Therefore, in response to concerns about the erosion of consumer
37 privacy, in particular with data collection and use practices, the FTC has issued guidance
38 documents on internet advertising.^{3,216-218} Moreover, there is proposed rulemaking on commercial
39 surveillance and data security.^{3,219} Additional guidance and/or revisions from the FTC regarding
40 how to make systems for reporting cases of online harassment and abuse that comply with COPPA
41 would be beneficial.³

42
43 In addition to improving children's privacy and better regulating social media providers through
44 the FTC and COPPA, it may be beneficial to develop support programs for children and
45 adolescents who experience digital abuse and evaluate the effectiveness of such programs, and the
46 US Substance Abuse and Mental Health Services Administration is well positioned to do this.³
47 Finally, assuming industry leaders do not voluntarily remove the prohibitions in their terms of
48 service on the use of publicly available data for research, Congress could pass legislation to ensure
49 researchers can access data to examine the effects of social media on child and adolescent health.³

50 *Recommendations for State and Local Agencies*

1
2 One potential way of making technology safer for kids is through age-appropriate design.^{3,4} Some
3 of the goals of age-appropriate design include: (1) centering the rights and developmental needs of
4 children and (2) improving privacy protections by addressing and modifying what data is collected
5 from minors, how it is collected, and how it is used. In practice this might look like collecting the
6 minimum information necessary and prohibiting the use of that information in commerce. It might
7 also include shifting the burden to establish users' age to the producers of the technology as was
8 done in the United Kingdom.^{3,220} It would also likely discourage developmentally inappropriate
9 persuasive design features (e.g., push notifications, like buttons, tones for new content, and endless
10 scrolling).⁴¹

11
12 The increasing concerns about social media use and adolescent health has prompted federal, state,
13 and local legislators to propose age-appropriate design measures to protect children while using the
14 internet and internet-based forms of communication, including social media.^{221,222} In 2023, 35
15 states and Puerto Rico introduced legislation around social media and youth, and 12 states enacted
16 bills or adopted resolutions.²²¹ By and large, the goals of the legislation are to: (1) create study
17 commissions and task forces to evaluate the relationship between social media and adolescent
18 health; (2) require age verification and/or parental consent to open social media accounts; and (3)
19 adding digital and media literacy to K-12 curriculums.

20
21 For instance, Utah enacted the Utah Social Media Regulation Act, which requires age verification
22 of state residents and parental consent for those under the age of 18 to open an account.²²³ It also
23 limits the hours of access for certain users, subject to parental or guardian direction, and provides
24 for a private right of action. Similarly, Arkansas created the Social Media Safety Act which
25 requires age verification and parental consent for use of social media. It also establishes a
26 mechanism for liability for failure to perform age verification for use of social media and for illegal
27 retention of data.²²⁴ In 2022, California passed the Age-Appropriate Design Code Act (AADC).²⁰²
28 The law was modeled after the United Kingdom's Age-Appropriate Design Code which advocates
29 for businesses to consider the best interests of children when designing, developing, and providing
30 online services, products, or features likely to be accessed by children. Notable obligations under
31 the Age-Appropriate Design Code Act include requiring providers to: (1) configure a high level of
32 default privacy settings; (2) assess whether algorithms, data collection, or targeted advertising
33 systems could harm children; and (3) use clear, age-appropriate language for user-facing
34 information and documents.²²² In 2023 a lawsuit to invalidate the AADC on first amendment free
35 speech grounds was filed in federal court by NetChoice, a coalition representing the country's tech
36 companies.²⁰³ The District for the Northern District of California granted a preliminary injunction
37 against the AADC, the California Attorney General appealed, and a decision by the Ninth Circuit
38 Court of Appeals is anticipated in Spring 2024.^{202,203,225}

39
40 Efforts around age-appropriate design legislation are relatively new so the overall impacts are
41 unclear. However, age verification, digital media literacy, and continued research appear beneficial
42 and do not have obvious risks. Likewise, expansion of COPPA and provision of resources and
43 support for those who experience online harassment have little formal evidence of effectiveness but
44 are rationally grounded.

45 46 *Recommendations for Parents and Kids*

47
48 Parents and children are encouraged to use social media functions that facilitate social support,
49 online companionship, emotional intimacy, and healthy socialization; particularly during periods of
50 isolation, during stress, mental health crisis, and for marginalized groups.⁴¹ To achieve this, it is
51 recommended that families should collectively develop, review, and follow a family media use

1 plan, which should outline developmentally appropriate types, times, methods, places for, and
2 amounts of acceptable media use.^{1,2,4,41} For instance, there is evidence of the impact of excessive
3 digital technology use (e.g., screentime, tv, and social media) by adolescents on negative health
4 impacts.^{1,2,226} However, there has been a push among researchers to move away from focusing on
5 screentime and instead to consider how, why, when, and with whom youth are engaging online.
6 Despite this, the American Association of Pediatrics, American Psychological Association, and
7 many other organizations and policy makers advocate for screen time limits and media-free time.^{1,2}
8 Specifically, it is recommended that adolescents abstain from using screens 1 hour before bed and
9 that adolescents should not sleep with digital devices in their bedrooms.^{7,52} Additionally, there is
10 some evidence supporting open, non-judgmental communication between caregivers and children
11 and some degree of parental monitoring of social media use.^{1,2,41,97} Recent surveys suggest roughly
12 63 percent of adolescents and 70.8 percent of parents reported parental monitoring, and 74.3
13 percent of adolescents reporting being friends with their parents online.¹⁷⁹ Open communication is
14 helpful for teaching digital literacy, which is necessary for children to understand the limits of “free
15 digital products” that process access in exchange for data on user demographics, politics, mental
16 health, and sexuality generated through engagement and viewing behavior.⁵⁰

17 18 *Recommendations for Clinicians*

19
20 It is recommended that clinicians be aware of and talk with children and families about the risks
21 and benefits of social media use.^{1-3,107,227} Specifically, communication with adolescents is the most
22 effective in the context of a therapeutic alliance that is open and non-judgmental.⁹⁷ Physicians
23 should encourage: (1) setting boundaries for screentime and social media use; (2) discuss the risks
24 and benefits of social media, including impact of smartphones on learning and the importance of
25 digital media literacy; and (3) encourage communication between caregivers and children and
26 advocate use of the Family Media Toolkit and Family Media Use Plan.^{1,2,58,60,97}

27 28 *Recommendations for Training and Education*

29
30 One way to reduce potential harm to adolescents using social media is through improved digital
31 media literacy. Specifically, it is important to train adolescents and those teaching and advising
32 them skills for assessing and validating information on social media and the internet more
33 broadly.^{41,50,60,97,227} Moreover, the approach to digital media literacy needs to be multi-tiered and
34 tailored to children, parents, educators, and clinicians. Specifically, comprehensive digital media
35 literacy should be integrated into the standards set by state boards of education. Moreover, the U.S.
36 Department of Education should draw national attention to the importance of comprehensive
37 digital media literacy.³ This is necessary to create both an online environment that protects youth
38 and social media consumers who are empowered to protect themselves. Furthermore, educators and
39 clinicians need to be trained in digital media literacy so they can adequately teach and advise
40 adolescents on the risks and benefits of social media.¹⁻⁴ This could include incorporation of digital
41 media literacy requirements for licensure as well as ongoing professional development training and
42 resources for both educators and clinicians.³ In addition to incorporating digital media literacy into
43 training and licensure, additional efforts to improve dissemination of health-related digital media
44 literacy is suggested.²²⁷

45 46 *Recommendations for Research*

47
48 Currently, the research on social media and adolescent health is limited.^{3,4} Therefore, federal and
49 non-profit research funders should support a research agenda that prioritizes: (1) the health
50 consequences of social media use and the mechanisms of harm, (2) the epidemiology of
51 problematic use, (3) interventions and other efforts to reduce and remediate harms arising from

1 social media, (4) the role of parents and other adults in influencing positive use, and (5) algorithmic
2 audits.^{3,4} There is a need for validated tools to measure exposure to social media affordances, data
3 sharing, and the establishment of long-term cohort studies. Special emphasis should be given to
4 interdisciplinary approaches and study designs that attempt to understand causal directions.

5 6 RELEVANT AMA POLICY

7
8 The AMA has existing policy that addresses social media and mental health, gun violence, internet
9 pornography, online streaming of sexual encounters, the effects of video game and internet
10 overuse, disinformation, cannabis marketing, and online human subjects' research. In general,
11 these policies advocate the use of education and legislation to: (1) increase awareness about
12 potential risks associated with social media and internet use; and (2) reduce exposure to harmful
13 content (e.g., gun violence, pornography, disinformation, etc.) particularly for children,
14 adolescents, and young adults. Current policy also supports development and implementation of
15 clinical tools for identification and treatment of harms that arise from exposure as well as continued
16 research into potential harms and the effectiveness of screening and treatment. Detailed
17 information on the current AMA policies can be found in the appendix.

18 19 CONCLUSION

20
21 Digital media, smartphones, and social media have a pervasive presence in nearly all aspects of
22 youth and adolescent life. Despite substantial research efforts, the evidence is too weak to promote
23 a uniform interpretation of the impact of social media on adolescent health at the population level.
24 There are several factors contributing to the weak evidence including: (1) the reciprocal
25 associations between social media use and health; (2) the lack of consistent and comparable
26 methodologies; (3) entanglement of impact and exposure as a byproduct of social media's ubiquity;
27 (4) different dynamics and trends depending on level of analysis; (5) the wide variety of
28 interactions, behaviors, and health impacts engendered by social media; and (6) reliance on cross-
29 sectional studies with high heterogeneity.

30
31 Although the evidence is too weak to provide a uniform interpretation, there are clear positive and
32 negative trends. There is some evidence of potential benefit in the form of improved social support,
33 identity development, civic engagement, and self-directed learning. There is also some evidence of
34 potential harm including negative impacts on sleep, physical activity, and mental health, as well as
35 exposure to inappropriate content, and data privacy issues. Furthermore, it is apparent that the
36 relative risks and benefits of social media likely depend on individual differences in: (1)
37 engagement with social media (e.g., what kids see and do online, who they talk to, when they use
38 social media, and how they use social media); (2) pre-existing strengths and weaknesses; and (3) the
39 cultural, social, and physical environment.

40
41 Even though the evidence of harm is limited there is an urgent need for action for two reasons.
42 First, the lack of algorithmic transparency, privacy protections, and accountability and redress for
43 online harassment on most platforms is concerning given the power, reach, and ubiquity of social
44 media. Second, the potential harms are serious, particularly during sensitive developmental
45 periods; therefore, proactively creating digital environments that protect and enrich children's and
46 adolescents' health and well-being is beneficial regardless of the evidence of harm. There are two
47 key approaches that would likely facilitate the creation of safer, developmentally appropriate
48 environments. First, federal and state legislative action (e.g., expansion of COPPA, implementation
49 of age-appropriate design, and mechanisms to address online harassment), and second,
50 development and widespread adoption of industry standards to benchmark platform operations,
51 transparency, and data use. In addition to improving the digital environment, it is imperative that

1 there are simultaneous efforts to address harms that still arise including: (1) education and training
2 on digital media literacy and the potential harms posed by social media; (2) improved screening
3 and support for those who experience harms (e.g., problematic internet use and online harassment);
4 and (3) continued research of the health impacts of social media.

5
6 RECOMMENDATION

7
8 The Council on Science and Public Health recommends that the following be adopted, and the
9 remainder of the report be filed:

10
11 1. That our AMA:

- 12
13 (1) urges physicians to: (a) educate themselves about social media; (b) be prepared to
14 counsel patients and/or their guardians about the potential risks and harms of social media;
15 and (c) consider expanding clinical interviews to inquire about social media use.
16 (2) encourages further clinical, epidemiological, and interdisciplinary research on the
17 impact of social media on health.
18 (3) supports education of clinicians, educators, and the public on digital media literacy and
19 the health effects of social media.
20 (4) recognizes that the relative risks and benefits of social media may depend on individual
21 differences (e.g., social media engagement, pre-existing traits, and environment).
22 (5) supports legislative, regulatory, and associated initiatives (e.g., development of industry
23 standards, age-appropriate design, and funding programs that support those harmed by
24 online harassment).
25 (6) will collaborate with professional societies, industry, and other stakeholders to improve
26 social media platform privacy protections, transparency (e.g., algorithmic, data, and
27 process), data sharing processes, and systems for accountability and redress in response to
28 online harassment. (New HOD Policy)

29
30 2. That current AMA policy D-478.965, "Addressing Social Media and Social Networking
31 Usage and its Impacts on Mental Health D-478.965" be amended by addition and deletion
32 to read as follows:

33
34 Our AMA: (1) will collaborate with relevant professional organizations to: (a) support the
35 development of continuing education programs to enhance physicians' knowledge of the
36 health impacts of social media and social networking usage; and (b) support the
37 development of effective clinical tools and protocols for the identification, treatment, and
38 referral of children, adolescents, and adults at risk for and experiencing health sequelae of
39 social media and social networking usage; (2) advocates for schools to provide safe and
40 effective educational programs by which so that (a) all students can learn to identify and
41 mitigate the onset of mental health sequelae of social media and social networking usage,
42 (b) all students develop skills in digital literacy to serve as an individual protective
43 foundation for interaction with various types of digital media (including social media), and
44 (c) at risk students' access to social media can be limited and/or closely monitored as
45 individually appropriate; (3) affirms that use of social media and social networking has the
46 potential to positively or negatively impact the physical and mental health of individuals,
47 especially adolescents and those with preexisting psychosocial conditions; (4) advocates
48 for and support media and social networking services addressing and developing
49 safeguards for users, including protections for youth online privacy, effective controls
50 allowing youth and caregivers to manage screentime content and access, and development
51 and dissemination of age-appropriate digital literacy training; and (5) advocates for the

- 1 study of the positive and negative biological, psychological, and social effects of social
- 2 media and social networking services use. (Modify Current HOD Policy)

Fiscal Note: \$5,000 - \$10,000

APPENDIX: Relevant AMA Policy

Addressing Social Media and Social Networking Usage and its Impacts on Mental Health D-478.965

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

Minimizing the Influence of Social Media on Gun Violence H-478.977

1. Our American Medical Association calls upon all social media sites that allow posting of videos, photographs, and written online comments encouraging and glorifying the use of guns and gun violence to vigorously and aggressively remove such postings.
2. Our AMA strongly recommends social media sites continuously update and monitor their algorithms in order to detect and eliminate any information that discusses and displays guns and gun violence in a way that encourages viewers to act violently.
3. Our AMA will work with social media sites to provide educational content on the use of guns, inherent dangers, and gun safety in an effort to end the ongoing and devastating effects of gun violence in our communities.

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

Our AMA:

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

Addressing Public Health Disinformation Disseminated by Health Professionals D-440.914

Our AMA will collaborate with relevant health professional societies and other stakeholders:

- (a) on efforts to combat public health disinformation disseminated by health professionals in all forms of media,
- (b) address disinformation that undermines public health initiatives, and

(c) implement a comprehensive strategy to address health-related disinformation disseminated by health professionals that includes:

- (1) Maintaining AMA as a trusted source of evidence-based information for physicians and patients.
- (2) Ensuring that evidence-based medical and public health information is accessible by engaging with publishers, research institutions and media organizations to develop best practices around paywalls and preprints to improve access to evidence-based information and analysis.
- (3) Addressing disinformation disseminated by health professionals via social media platforms and addressing the monetization of spreading disinformation on social media platforms.
- (4) Educating health professionals and the public on how to recognize disinformation as well as how it spreads.
- (5) Considering the role of health professional societies in serving as appropriate fact-checking entities for health-related information disseminated by various media platforms.
- (6) Encouraging continuing education to be available for health professionals who serve as fact-checker to help prevent the dissemination of health-related disinformation.
- (7) Ensuring licensing boards have the authority to take disciplinary action against health professionals for spreading health-related disinformation and affirms that all speech in which a health professional is utilizing their credentials is professional conduct and can be scrutinized by their licensing entity.
- (8) Ensuring specialty boards have the authority to take action against board certification for health professionals spreading health-related disinformation.
- (9) Encouraging state and local medical societies to engage in dispelling disinformation in their jurisdictions.

Television Broadcast and Online Streaming of Sexual Encounters and Public Health Awareness on Social Media Platforms H-485.994

Our AMA urges television broadcasters and online streaming services, producers, sponsors, and any associated social media outlets to encourage education about 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.

Medical and Public Health Misinformation 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.

Marketing Guardrails for the "Over-Medicalization" of Cannabis Use D-95.958

Our AMA will: (1) send a formal letter to the Food and Drug Administration and Federal Trade Commission requesting more direct oversight of the marketing of cannabis for medical use; (2)

generate a formal letter for use by state medical societies requesting more direct oversight by state government of the marketing of cannabis; (3) support and encourage federal, state, and private sector research on the effects of cannabis marketing to identify best practices in protecting vulnerable populations, as well as the benefits of safety campaigns such as preventing impaired driving or dangerous use; (4) encourage state regulatory bodies to enforce cannabis-related marketing laws and to publicize and make publicly available the results of such enforcement activities; (5) encourage social media platforms to set a threshold age of 21 years for exposure to cannabis advertising and marketing and improve age verification practices on social media platforms; (6) encourage regulatory agencies to research how marketing best practices learned from tobacco and alcohol policies can be adopted or applied to cannabis marketing; and (7) support using existing AMA channels to educate physicians and the public on the health risks of cannabis to children and potential health risks of cannabis to people who are pregnant or lactating.

Principles of Human Subjects Research Shall Apply to Online Medical Research Projects H-460.898

Our American Medical Association declares social media sites' terms of service as an insufficient proxy for informed consent prior to being enrolled in any medical experiment and recommends that online social networks provide users with specific informed consent outlining the aims, risks and possible benefits of any medical experimental study prior to study enrollment.

Emotional and Behavioral Effects of Video Game and Internet Overuse H-60.915

Our AMA supports increased awareness of the need for parents to monitor and restrict use of video games and the Internet and encourage increased vigilance in monitoring the content of games purchased and played for children 17 years old and younger.

REFERENCES

1. Reid Chassiakos Y (Linda), Radesky J, Christakis D, et al. Children and Adolescents and Digital Media. *Pediatrics*. 2016;138(5):e20162593. doi:10.1542/peds.2016-2593
2. AAP Council on Communication and Media. Media Use in School-Aged Children and Adolescents. *Pediatrics*. 2016;138(5):e20162592. doi:10.1542/peds.2016-2592
3. Committee on the Impact of Social Media on Adolescent Health, Board on Population Health and Public Health Practice, Health and Medicine Division, National Academies of Sciences, Engineering, and Medicine. *Social Media and Adolescent Health*. (Galea S, Buckley GJ, Wojtowicz A, eds.). National Academies Press; 2023:27396. doi:10.17226/27396
4. *Social Media and Youth Mental Health*. U.S. Surgeon General’s Advisory; 2023. <https://www.hhs.gov/sites/default/files/sg-youth-mental-health-social-media-advisory.pdf>
5. American Psychological Association Health Advisory on Social Media Use in Adolescence.
6. Prinstein MJ, Nesi J, Telzer EH. Commentary: An updated agenda for the study of digital media use and adolescent development – future directions following Odgers & Jensen (2020). *J Child Psychol Psychiatry*. 2020;61(3):349-352. doi:10.1111/jcpp.13219
7. Weinstein E. The social media see-saw: Positive and negative influences on adolescents’ affective well-being. *New Media Soc*. 2018;20(10):3597-3623. doi:10.1177/1461444818755634
8. George M. The Importance of Social Media Content for Teens’ Risks for Self-harm. *J Adolesc Health*. 2019;65(1):9-10. doi:10.1016/j.jadohealth.2019.04.022
9. Hamilton JL, Nesi J, Choukas-Bradley S. Reexamining Social Media and Socioemotional Well-Being Among Adolescents Through the Lens of the COVID-19 Pandemic: A Theoretical Review and Directions for Future Research. *Perspect Psychol Sci*. 2022;17(3):662-679. doi:10.1177/17456916211014189
10. Social media and the internet. <https://www.apa.org>. Accessed February 14, 2024. <https://www.apa.org/topics/social-media-internet>
11. Treem JW, Leonardi PM. Social Media Use in Organizations: Exploring the Affordances of Visibility, Editability, Persistence, and Association. *Ann Int Commun Assoc*. 2013;36(1):143-189. doi:10.1080/23808985.2013.11679130
12. Boyd D. Social network sites as networked publics: Affordances, dynamics, and implications. In: *A Networked Self*. Routledge; 2010:47-66.
13. Sharma D, Saha B, Sarkar UK. Affordance Lost, Affordance Regained, and Affordance Surrendered. In: Introna L, Kavanagh D, Kelly S, Orlikowski W, Scott S, eds. *Beyond Interpretivism? New Encounters with Technology and Organization*. IFIP Advances in Information and Communication Technology. Springer International Publishing; 2016:73-89. doi:10.1007/978-3-319-49733-4_5
14. Moreno MA, Uhls YT. Applying an affordances approach and a developmental lens to approach adolescent social media use. *Digit Health*. 2019;5:205520761982667. doi:10.1177/2055207619826678
15. Angwin J, Parris T. Facebook Lets Advertisers Exclude Users by Race. ProPublica. Published October 28, 2016. Accessed February 13, 2024. <https://www.propublica.org/article/facebook-lets-advertisers-exclude-users-by-race>
16. Angwin J, Tobin A, Varner M. Facebook (Still) Letting Housing Advertisers Exclude Users by Race. ProPublica. Published November 21, 2017. Accessed February 14, 2024. <https://www.propublica.org/article/facebook-advertising-discrimination-housing-race-sex-national-origin>
17. Hern A, editor AHT. TikTok’s local moderation guidelines ban pro-LGBT content. *The Guardian*. <https://www.theguardian.com/technology/2019/sep/26/tiktoks-local-moderation-guidelines-ban-pro-lgbt-content>. Published September 26, 2019. Accessed February 13, 2024.
18. Gillespie T. Do not recommend? Reduction as a form of content moderation. *Soc Media Soc*. 2022;8(3):20563051221117552.

19. Foss-Solbrekk K. Three routes to protecting AI systems and their algorithms under IP law: The good, the bad and the ugly. *J Intellect Prop Law Pract.* 2021;16(3):247-258. doi:10.1093/jiplp/jpab033
20. Waddell K. Tech Companies Too Secretive About Algorithms That Curate Feeds, Study Says. Consumer Reports. Published February 24, 2021. Accessed February 13, 2024. <https://www.consumerreports.org/consumer-protection/tech-companies-too-secretive-about-algorithms-that-curate-feeds-a8134259964/>
21. Gorwa R, Binns R, Katzenbach C. Algorithmic content moderation: Technical and political challenges in the automation of platform governance. *Big Data Soc.* 2020;7(1):2053951719897945. doi:10.1177/2053951719897945
22. Eslami M, Rickman A, Vaccaro K, et al. “I always assumed that I wasn’t really that close to [her]”: Reasoning about Invisible Algorithms in News Feeds. In: *Proceedings of the 33rd Annual ACM Conference on Human Factors in Computing Systems*. CHI ’15. Association for Computing Machinery; 2015:153-162. doi:10.1145/2702123.2702556
23. Brugnoli E, Cinelli M, Quattrociocchi W, Scala A. Recursive patterns in online echo chambers. *Sci Rep.* 2019;9(1):20118. doi:10.1038/s41598-019-56191-7
24. Dow BJ, Johnson AL, Wang CS, Whitson J, Menon T. The COVID-19 pandemic and the search for structure: Social media and conspiracy theories. *Soc Personal Psychol Compass.* 2021;15(9):e12636. doi:10.1111/spc3.12636
25. Robins-Early N. There’s a reason thousands of people take quack cures for Covid. *The Guardian.* <https://www.theguardian.com/commentisfree/2022/feb/17/quacks-cashed-in-world-quick-fix-covid-ivermectin-social-media-conspiracy-theories>. Published February 17, 2022. Accessed February 13, 2024.
26. Caplan SE. Theory and measurement of generalized problematic Internet use: A two-step approach. *Comput Hum Behav.* 2010;26(5):1089-1097. doi:10.1016/j.chb.2010.03.012
27. McSherry C. Content Moderation and the U.S. Election: What to Ask, What to Demand. Electronic Frontier Foundation. Published October 26, 2020. Accessed February 13, 2024. <https://www.eff.org/deeplinks/2020/10/content-moderation-and-us-election-what-ask-what-demand>
28. Edelman G. Better Than Nothing: A Look at Content Moderation in 2020 | WIRED. WIRED. Published October 27, 2020. Accessed February 13, 2024. <https://www.wired.com/story/content-moderation-2020-better-than-nothing/>
29. Lima-Strong C. A whistleblower’s power: Key takeaways from the Facebook Papers. *The Washington Post.* <https://www.washingtonpost.com/technology/2021/10/25/what-are-the-facebook-papers/>. Published October 25, 2021. Accessed February 13, 2024.
30. Dwoskin E, Newmyer T, Mahtani S. The case against Mark Zuckerberg: Insiders say Facebook’s CEO chose growth over safety. *The Washington Post.* <https://www.washingtonpost.com/technology/2021/10/25/mark-zuckerberg-facebook-whistleblower/>. Published October 25, 2021. Accessed February 13, 2024.
31. Silverman MH, Jedd K, Luciana M. Neural networks involved in adolescent reward processing: An activation likelihood estimation meta-analysis of functional neuroimaging studies. *NeuroImage.* 2015;122:427-439. doi:10.1016/j.neuroimage.2015.07.083
32. Spear LP. Rewards, aversions and affect in adolescence: Emerging convergences across laboratory animal and human data. *Dev Cogn Neurosci.* 2011;1(4):390-403. doi:10.1016/j.dcn.2011.08.001
33. Wahlstrom D, Collins P, White T, Luciana M. Developmental changes in dopamine neurotransmission in adolescence: Behavioral implications and issues in assessment. *Brain Cogn.* 2010;72(1):146-159. doi:10.1016/j.bandc.2009.10.013
34. Giedd JN. Adolescent brain and the natural allure of digital media. *Dialogues Clin Neurosci.* 2020;22(2):127-133. doi:10.31887/DCNS.2020.22.2/jgiedd
35. Nelson EE, Jarcho JM, Guyer AE. Social re-orientation and brain development: An expanded and updated view. *Dev Cogn Neurosci.* 2016;17:118-127. doi:10.1016/j.dcn.2015.12.008

36. Committee on the Neurobiological and Socio-behavioral Science of Adolescent Development and Its Applications, Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education, Health and Medicine Division, National Academies of Sciences, Engineering, and Medicine. *The Promise of Adolescence: Realizing Opportunity for All Youth*. (Bonnie RJ, Backes EP, eds.). National Academies Press; 2019:25388. doi:10.17226/25388
37. Giovanelli A, Ozer EM, Dahl RE. Leveraging Technology to Improve Health in Adolescence: A Developmental Science Perspective. *J Adolesc Health*. 2020;67(2):S7-S13. doi:10.1016/j.jadohealth.2020.02.020
38. Fuhrmann D, Knoll LJ, Blakemore SJ. Adolescence as a Sensitive Period of Brain Development. *Trends Cogn Sci*. 2015;19(10):558-566. doi:10.1016/j.tics.2015.07.008
39. Crone EA, Konijn EA. Media use and brain development during adolescence. *Nat Commun*. 2018;9(1):588. doi:10.1038/s41467-018-03126-x
40. Sawyer SM, Azzopardi PS, Wickremarathne D, Patton GC. The age of adolescence. *Lancet Child Adolesc Health*. 2018;2(3):223-228. doi:10.1016/S2352-4642(18)30022-1
41. *Health Advisory on Social Media Use in Adolescence*. American Psychological Association; 2023. Accessed February 18, 2024. <https://www.apa.org/topics/social-media-internet/health-advisory-adolescent-social-media-use.pdf>
42. Maza MT, Fox KA, Kwon SJ, et al. Association of Habitual Checking Behaviors on Social Media With Longitudinal Functional Brain Development. *JAMA Pediatr*. 2023;177(2):160. doi:10.1001/jamapediatrics.2022.4924
43. Wadsley M, Ihssen N. A Systematic Review of Structural and Functional MRI Studies Investigating Social Networking Site Use. *Brain Sci*. 2023;13(5):787. doi:10.3390/brainsci13050787
44. Subrahmanyam K, Šmahel D. Adolescents' Digital Worlds: An Introduction. In: Subrahmanyam K, Šmahel D, eds. *Digital Youth: The Role of Media in Development*. Advancing Responsible Adolescent Development. Springer; 2011:1-25. doi:10.1007/978-1-4419-6278-2_1
45. Valkenburg PM, Schouten AP, Peter J. Adolescents' identity experiments on the internet. *New Media Soc*. 2005;7(3):383-402. doi:10.1177/1461444805052282
46. Hollarek M, Lee NC. Current understanding of developmental changes in adolescent perspective taking. *Curr Opin Psychol*. 2022;45:101308. doi:10.1016/j.copsyc.2022.101308
47. Sherman LE, Greenfield PM. Forging friendship, soliciting support: A mixed-method examination of message boards for pregnant teens and teen mothers. *Comput Hum Behav*. 2013;29(1):75-85. doi:10.1016/j.chb.2012.07.018
48. Eleuteri S, Saladino V, Verrastro V. Identity, relationships, sexuality, and risky behaviors of adolescents in the context of social media. *Sex Relatsh Ther*. 2017;32(3-4):354-365. doi:10.1080/14681994.2017.1397953
49. Orben A, Przybylski AK, Blakemore SJ, Kievit RA. Windows of developmental sensitivity to social media. *Nat Commun*. 2022;13(1):1649. doi:10.1038/s41467-022-29296-3
50. Radesky J, Chassiakos Y (Linda) R, Ameenuddin N, Navsaria D, COUNCIL ON COMMUNICATION AND MEDIA. Digital Advertising to Children. *Pediatrics*. 2020;146(1):e20201681. doi:10.1542/peds.2020-1681
51. Vogels EA, Rainie L, Nolan H. *Teens, Social Media and Technology 2022*. Pew Research Center Accessed February 17, 2024. <https://www.pewresearch.org/internet/2022/08/10/teens-social-media-and-technology-2022/>
52. Lenhart A. *Teens and Social Media: An Overview*. Pew Research Center: Internet, Science & Tech. Published April 10, 2009. Accessed February 13, 2024. <https://www.pewresearch.org/internet/2009/04/10/teens-and-social-media-an-overview/>
53. Rideout V, Peebles A, Mann S, Robb M. *The Common Sense Census: Media Use by Tweens and Teens*. Common Sense Media; 2021. Accessed February 13, 2024. <https://apo.org.au/node/58360>

54. Anderson M, Vogels EA, Perrin A, Rainie L. *Connection, Creativity and Drama: Teen Life on Social Media in 2022*. Pew Research Center; 2022. Accessed February 13, 2024. <https://www.pewresearch.org/internet/2022/11/16/connection-creativity-and-drama-teen-life-on-social-media-in-2022/>
55. Hancock JT, Liu SX, Luo M, Mieczkowski H. Social media and psychological well-being. In: *The Psychology of Technology: Social Science Research in the Age of Big Data*. American Psychological Association; 2022:195-238. doi:10.1037/0000290-007
56. Jarman HK, Marques MD, McLean SA, Slater A, Paxton SJ. Motivations for Social Media Use: Associations with Social Media Engagement and Body Satisfaction and Well-Being among Adolescents. *J Youth Adolesc*. 2021;50(12):2279-2293. doi:10.1007/s10964-020-01390-z
57. Shankleman M, Hammond L, Jones FW. Adolescent Social Media Use and Well-Being: A Systematic Review and Thematic Meta-synthesis. *Adolesc Res Rev*. 2021;6(4):471-492. doi:10.1007/s40894-021-00154-5
58. O'Reilly M. Social media and adolescent mental health: the good, the bad and the ugly. *J Ment Health*. 2020;29(2):200-206. doi:10.1080/09638237.2020.1714007
59. Allen KA, Ryan T, Gray DL, McInerney DM, Waters L. Social Media Use and Social Connectedness in Adolescents: The Positives and the Potential Pitfalls. *Aust Educ Dev Psychol*. 2014;31(1):18-31. doi:10.1017/edp.2014.2
60. Uhls YT, Ellison NB, Subrahmanyam K. Benefits and Costs of Social Media in Adolescence. *Pediatrics*. 2017;140(Supplement_2):S67-S70. doi:10.1542/peds.2016-1758E
61. Scott RA, Stuart J, Barber BL. Connecting with close friends online: A qualitative analysis of young adults' perceptions of online and offline social interactions with friends. *Comput Hum Behav Rep*. 2022;7:100217. doi:10.1016/j.chbr.2022.100217
62. Lenhart A, Smith A, Anderson M, Duggan M, Perrin A. *Teens, Technology & Friendships*. Pew Research Center; 2015. Accessed February 17, 2024. <https://www.pewresearch.org/internet/2015/08/06/teens-technology-and-friendships/>
63. Nesi J, Mann S, Robb MB. *Teens and Mental Health: How Girls Really Feel about Social Media*. Common Sense; 2023. https://www.common sense media.org/sites/default/files/research/report/how-girls-really-feel-about-social-media-researchreport_final_1.pdf
64. Liu D, Ainsworth SE, Baumeister RF. A meta-analysis of social networking online and social capital. *Rev Gen Psychol*. 2016;20(4):369-391.
65. Sallafranque-St-Louis F, Normand CL. From solitude to solicitation: How people with intellectual disability or autism spectrum disorder use the internet. *Cyberpsychology J Psychosoc Res Cyberspace*. 2017;11(1). doi:10.5817/CP2017-1-7
66. Sofka C. Grief, Adolescents, and Social Media. In: *Understanding Child and Adolescent Grief*. Routledge; 2017.
67. Sage M, Jackson S. A Systematic Review of Internet Communication Technology Use by Youth in Foster Care. *Child Adolesc Soc Work J*. 2022;39(4):375-390. doi:10.1007/s10560-021-00738-z
68. Chou W ying S, Moskowitz M. Social media use in adolescent and young adult (AYA) cancer survivors. *Curr Opin Psychol*. 2016;9:88-91. doi:10.1016/j.copsyc.2016.01.003
69. Daniels SR, Yang CC, Toohey SJ, Willard VW. Perspectives on Social Media from Adolescents and Young Adults with Cancer. *J Pediatr Oncol Nurs*. 2021;38(4):225-232. doi:10.1177/1043454221992319
70. Naslund JA, Aschbrenner KA, Marsch LA, Bartels SJ. The future of mental health care: peer-to-peer support and social media. *Epidemiol Psychiatr Sci*. 2016;25(2):113-122. doi:10.1017/S2045796015001067
71. Hoffner CA, Bond BJ. Parasocial relationships, social media, & well-being. *Curr Opin Psychol*. 2022;45:101306. doi:10.1016/j.copsyc.2022.101306

72. Berger MN, Taba M, Marino JL, Lim MSC, Skinner SR. Social Media Use and Health and Well-being of Lesbian, Gay, Bisexual, Transgender, and Queer Youth: Systematic Review. *J Med Internet Res*. 2022;24(9):e38449. doi:10.2196/38449
73. Jenzen O. LGBTQ Youth Cultures and Social Media. In: *Oxford Research Encyclopedia of Communication*. ; 2022. doi:10.1093/acrefore/9780190228613.013.1363
74. Kaniuka A, Pugh KC, Jordan M, et al. Stigma and suicide risk among the LGBTQ population: Are anxiety and depression to blame and can connectedness to the LGBTQ community help? *J Gay Lesbian Ment Health*. 2019;23(2):205-220. doi:10.1080/19359705.2018.1560385
75. Han X, Han W, Qu J, Li B, Zhu Q. What happens online stays online? — Social media dependency, online support behavior and offline effects for LGBT. *Comput Hum Behav*. 2019;93:91-98. doi:10.1016/j.chb.2018.12.011
76. Selkie E, Adkins V, Masters E, Bajpai A, Shumer D. Transgender Adolescents' Uses of Social Media for Social Support. *J Adolesc Health*. 2020;66(3):275-280. doi:10.1016/j.jadohealth.2019.08.011
77. Escobar-Viera CG, Choukas-Bradley S, Sidani J, Maheux AJ, Roberts SR, Rollman BL. Examining Social Media Experiences and Attitudes Toward Technology-Based Interventions for Reducing Social Isolation Among LGBTQ Youth Living in Rural United States: An Online Qualitative Study. *Front Digit Health*. 2022;4. Accessed February 13, 2024. <https://www.frontiersin.org/journals/digital-health/articles/10.3389/fdgth.2022.900695>
78. Bowins B. Social connectedness. *States Process Ment Health*. Published online 2021:41-48.
79. Zhou Z, Cheng Q. Relationship between online social support and adolescents' mental health: A systematic review and meta-analysis. *J Adolesc*. 2022;94(3):281-292. doi:10.1002/jad.12031
80. Kim Y, Kim B, Hwang HS, Lee D. Social media and life satisfaction among college students: A moderated mediation model of SNS communication network heterogeneity and social self-efficacy on satisfaction with campus life. *Soc Sci J*. 2020;57(1):85-100. doi:10.1016/j.soscij.2018.12.001
81. Nesi J. The Impact of Social Media on Youth Mental Health: Challenges and Opportunities. *N C Med J*. 2020;81(2):116-121. doi:10.18043/ncm.81.2.116
82. Spies Shapiro LA, Margolin G. Growing Up Wired: Social Networking Sites and Adolescent Psychosocial Development. *Clin Child Fam Psychol Rev*. 2014;17(1):1-18. doi:10.1007/s10567-013-0135-1
83. Dennen VP, Choi H, Word K. Social media, teenagers, and the school context: a scoping review of research in education and related fields. *Educ Technol Res Dev*. 2020;68(4):1635-1658. doi:10.1007/s11423-020-09796-z
84. Michikyan M, Suárez-Orozco C. Adolescent Media and Social Media Use: Implications for Development. *J Adolesc Res*. 2016;31(4):411-414. doi:10.1177/0743558416643801
85. Bell BT. "You take fifty photos, delete forty nine and use one": A qualitative study of adolescent image-sharing practices on social media. *Int J Child-Comput Interact*. 2019;20:64-71. doi:10.1016/j.ijcci.2019.03.002
86. Chen J, Lin CH, Chen G. A cross-cultural perspective on the relationships among social media use, self-regulated learning and adolescents' digital reading literacy. *Comput Educ*. 2021;175:104322. doi:10.1016/j.compedu.2021.104322
87. Galvin S, Greenhow C. Writing on Social Media: a Review of Research in the High School Classroom. *TechTrends*. 2020;64(1):57-69. doi:10.1007/s11528-019-00428-9
88. Gil Quintana J, Osuna-Acedo S. Transmedia Practices and Collaborative Strategies in Informal Learning of Adolescents. *Soc Sci*. 2020;9(6):92. doi:10.3390/socsci9060092
89. Cho A, Byrne J, Pelter Z. *Digital Civic Engagement by Young People*. UNICEF Office of Global Insight and Policy
90. Boulianne S, Theocharis Y. Young People, Digital Media, and Engagement: A Meta-Analysis of Research. *Soc Sci Comput Rev*. 2020;38(2):111-127. doi:10.1177/0894439318814190

91. Baskin-Sommers A, Simmons C, Conley M, et al. Adolescent civic engagement: Lessons from Black Lives Matter. *Proc Natl Acad Sci.* 2021;118(41):e2109860118. doi:10.1073/pnas.2109860118
92. Daiute C. Adolescent civic engagement in contemporary political and technological realities. *Handb Adolesc Dev Res Its Impact Glob Policy.* Published online 2018:84.
93. Balkin JM. How to Regulate (and Not Regulate) Social Media.
94. Hamm MP, Shulhan J, Williams G, Milne A, Scott SD, Hartling L. A systematic review of the use and effectiveness of social media in child health. *BMC Pediatr.* 2014;14(1):138. doi:10.1186/1471-2431-14-138
95. Plaisime M, Robertson-James C, Mejia L, Núñez A, Wolf J, Reels S. Social Media and Teens: A Needs Assessment Exploring the Potential Role of Social Media in Promoting Health. *Soc Media Soc.* 2020;6(1):205630511988602. doi:10.1177/2056305119886025
96. Wang ML, Togher K. Health Misinformation on Social Media and Adolescent Health. *JAMA Pediatr.* 2024;178(2):109-110. doi:10.1001/jamapediatrics.2023.5282
97. Abi-Jaoude E, Naylor KT, Pignatiello A. Smartphones, social media use and youth mental health. *Can Med Assoc J.* 2020;192(6):E136-E141. doi:10.1503/cmaj.190434
98. Park J, Hallman J, Liu XS, Hancock J. Black representation in social media well-being research: A scoping review of social media experience and psychological well-being among Black users in the United States. *New Media Soc.* Published online August 28, 2023:14614448231191542. doi:10.1177/14614448231191542
99. Alhajji M, Bass S, Dai T. Cyberbullying, Mental Health, and Violence in Adolescents and Associations With Sex and Race: Data From the 2015 Youth Risk Behavior Survey. *Glob Pediatr Health.* 2019;6:2333794X19868887. doi:10.1177/2333794X19868887
100. Hamm MP, Newton AS, Chisholm A, et al. Prevalence and Effect of Cyberbullying on Children and Young People: A Scoping Review of Social Media Studies. *JAMA Pediatr.* 2015;169(8):770-777. doi:10.1001/jamapediatrics.2015.0944
101. Machackova H. Bystander reactions to cyberbullying and cyberaggression: individual, contextual, and social factors. *Curr Opin Psychol.* 2020;36:130-134. doi:10.1016/j.copsyc.2020.06.003
102. You L, Lee YH. The bystander effect in cyberbullying on social network sites: Anonymity, group size, and intervention intentions. *Telemat Inform.* 2019;45:101284. doi:10.1016/j.tele.2019.101284
103. Kuss DJ, Kristensen AM, Williams AJ, Lopez-Fernandez O. To Be or Not to Be a Female Gamer: A Qualitative Exploration of Female Gamer Identity. *Int J Environ Res Public Health.* 2022;19(3):1169. doi:10.3390/ijerph19031169
104. McLean L, Griffiths MD. Female Gamers' Experience of Online Harassment and Social Support in Online Gaming: A Qualitative Study. *Int J Ment Health Addict.* 2019;17(4):970-994. doi:10.1007/s11469-018-9962-0
105. Giumetti GW, Kowalski RM. Cyberbullying via social media and well-being. *Curr Opin Psychol.* 2022;45:101314. doi:10.1016/j.copsyc.2022.101314
106. Przybylski AK, Bowes L. Cyberbullying and adolescent well-being in England: a population-based cross-sectional study. *Lancet Child Adolesc Health.* 2017;1(1):19-26. doi:10.1016/S2352-4642(17)30011-1
107. Bozzola E, Spina G, Agostiniani R, et al. The Use of Social Media in Children and Adolescents: Scoping Review on the Potential Risks. *Int J Environ Res Public Health.* 2022;19(16):9960. doi:10.3390/ijerph19169960
108. Robb M, Mann S. *2022 Teens and Pornography.* Common Sense Media
109. Miller BC. Fact or Phallus? Considering the Constitutionality of Texas's Cyber-Flashing Law under the True Threat Doctrine. *Tex AM Law Rev.* 2020;8:423.

110. Ringrose J, Regehr K, Whitehead S. Teen Girls' Experiences Negotiating the Ubiquitous Dick Pic: Sexual Double Standards and the Normalization of Image Based Sexual Harassment. *Sex Roles*. 2021;85(9):558-576. doi:10.1007/s11199-021-01236-3
111. Salerno-Ferraro AC, Erentzen C, Schuller RA. Young Women's Experiences With Technology-Facilitated Sexual Violence From Male Strangers. *J Interpers Violence*. 2022;37(19-20):NP17860-NP17885. doi:10.1177/08862605211030018
112. Howard PN, Neudert LM, Prakash N, Vosloo S. Digital misinformation / disinformation and children.
113. Aïmeur E, Amri S, Brassard G. Fake news, disinformation and misinformation in social media: a review. *Soc Netw Anal Min*. 2023;13(1):30. doi:10.1007/s13278-023-01028-5
114. Shu K, Bhattacharjee A, Alatawi F, et al. Combating disinformation in a social media age. *WIREs Data Min Knowl Discov*. 2020;10(6):e1385. doi:10.1002/widm.1385
115. Fake news shared on social media U.S. Statista. Accessed March 18, 2024. <https://www.statista.com/statistics/657111/fake-news-sharing-online/>
116. Breakstone J, Smith M, Wineburg S, et al. Students' Civic Online Reasoning: A National Portrait. Accessed March 19, 2024. <https://purl.stanford.edu/gf151tb4868>
117. Nagata JM, Abdel Magid HS, Pettee Gabriel K. Screen Time for Children and Adolescents During the Coronavirus Disease 2019 Pandemic. *Obesity*. 2020;28(9):1582-1583. doi:10.1002/oby.22917
118. Brautsch LAS, Lund L, Andersen MM, Jennum PJ, Folker AP, Andersen S. Digital media use and sleep in late adolescence and young adulthood: A systematic review. *Sleep Med Rev*. 2023;68:101742. doi:10.1016/j.smrv.2022.101742
119. Exelmans L, Van den Bulck J. Bedtime mobile phone use and sleep in adults. *Soc Sci Med*. 2016;148:93-101. doi:10.1016/j.socscimed.2015.11.037
120. Peracchia S, Curcio G. Exposure to video games: effects on sleep and on post-sleep cognitive abilities. A systematic review of experimental evidences. *Sleep Sci*. 2018;11(4):302-314. doi:10.5935/1984-0063.20180046
121. Hale L, Li X, Hartstein LE, LeBourgeois MK. Media Use and Sleep in Teenagers: What Do We Know? *Curr Sleep Med Rep*. 2019;5(3):128-134. doi:10.1007/s40675-019-00146-x
122. Chang AM, Aeschbach D, Duffy JF, Czeisler CA. Evening use of light-emitting eReaders negatively affects sleep, circadian timing, and next-morning alertness. *Proc Natl Acad Sci*. 2015;112(4):1232-1237. doi:10.1073/pnas.1418490112
123. Hamilton JL, Lee W. Associations Between Social Media, Bedtime Technology Use Rules, and Daytime Sleepiness Among Adolescents: Cross-sectional Findings From a Nationally Representative Sample. *JMIR Ment Health*. 2021;8(9):e26273. doi:10.2196/26273
124. LeBourgeois MK, Hale L, Chang AM, Akacem LD, Montgomery-Downs HE, Buxton OM. Digital Media and Sleep in Childhood and Adolescence. *Pediatrics*. 2017;140(Supplement 2):S92-S96. doi:10.1542/peds.2016-1758J
125. Cain N, Gradisar M. Electronic media use and sleep in school-aged children and adolescents: A review. *Sleep Med*. 2010;11(8):735-742. doi:10.1016/j.sleep.2010.02.006
126. Alonzo R, Hussain J, Stranges S, Anderson KK. Interplay between social media use, sleep quality, and mental health in youth: A systematic review. *Sleep Med Rev*. 2021;56:101414. doi:10.1016/j.smrv.2020.101414
127. Lowry R, Eaton DK, Foti K, McKnight-Eily L, Perry G, Galuska DA. Association of Sleep Duration with Obesity among US High School Students. *J Obes*. 2012;2012:e476914. doi:10.1155/2012/476914
128. Owens JA, Weiss MR. Insufficient sleep in adolescents: causes and consequences. *Minerva Pediatr*. 2017;69(4):326-336. doi:10.23736/s0026-4946.17.04914-3
129. Paruthi S, Brooks LJ, D'Ambrosio C, et al. Consensus Statement of the American Academy of Sleep Medicine on the Recommended Amount of Sleep for Healthy Children: Methodology and Discussion. *J Clin Sleep Med*. 2016;12(11):1549-1561. doi:10.5664/jcsm.6288

130. Baum KT, Desai A, Field J, Miller LE, Rausch J, Beebe DW. Sleep restriction worsens mood and emotion regulation in adolescents. *J Child Psychol Psychiatry*. 2014;55(2):180-190. doi:10.1111/jcpp.12125
131. Mark G, Wang YDOI, Niiya M, Reich S. Sleep Debt in Student Life: Online Attention Focus, Facebook, and Mood. In: *Proceedings of the 2016 CHI Conference on Human Factors in Computing Systems*. ACM; 2016:5517-5528. doi:10.1145/2858036.2858437
132. Fitzgerald CT, Messias E, Buysse DJ. Teen Sleep and Suicidality: Results from the Youth Risk Behavior Surveys of 2007 and 2009. *J Clin Sleep Med*. 2011;07(04):351-356. doi:10.5664/JCSM.1188
133. Hökby S, Hadlaczky G, Westerlund J, et al. Are Mental Health Effects of Internet Use Attributable to the Web-Based Content or Perceived Consequences of Usage? A Longitudinal Study of European Adolescents. *JMIR Ment Health*. 2016;3(3):e31. doi:10.2196/mental.5925
134. Gentile DA, Berch ON, Choo H, Khoo A, Walsh DA. Bedroom media: One risk factor for development. *Dev Psychol*. 2017;53(12):2340-2355. doi:10.1037/dev0000399
135. Lua VYQ, Chua TBK, Chia MYH. A Narrative Review of Screen Time and Wellbeing among Adolescents before and during the COVID-19 Pandemic: Implications for the Future. *Sports*. 2023;11(2):38. doi:10.3390/sports11020038
136. Twenge JM, Joiner TE, Martin G, Rogers ML. Amount of time online is problematic if it displaces face-to-face social interaction and sleep. *Clin Psychol Sci*. 2018;6(4):456-457. doi:10.1177/2167702618778562
137. Oh C, Carducci B, Vaivada T, Bhutta ZA. Interventions to Promote Physical Activity and Healthy Digital Media Use in Children and Adolescents: A Systematic Review. *Pediatrics*. 2022;149(Supplement 6):e2021053852I. doi:10.1542/peds.2021-053852I
138. Sina E, Boakye D, Christianson L, Ahrens W, Hebestreit A. Social Media and Children's and Adolescents' Diets: A Systematic Review of the Underlying Social and Physiological Mechanisms. *Adv Nutr*. 2022;13(3):913-937.
139. Keles B, McCrae N, Grealish A. A systematic review: the influence of social media on depression, anxiety and psychological distress in adolescents. *Int J Adolesc Youth*. 2020;25(1):79-93. doi:10.1080/02673843.2019.1590851
140. Karim F, Oyewande A, Abdalla LF, Chaudhry Ehsanullah R, Khan S. Social Media Use and Its Connection to Mental Health: A Systematic Review. *Cureus*. Published online June 15, 2020. doi:10.7759/cureus.8627
141. Cataldo I, Lepri B, Neoh MJY, Esposito G. Social Media Usage and Development of Psychiatric Disorders in Childhood and Adolescence: A Review. *Front Psychiatry*. 2021;11. Accessed February 13, 2024. <https://www.frontiersin.org/journals/psychiatry/articles/10.3389/fpsy.2020.508595>
142. Vidal C, Lhaksampa T, Miller L, Platt R. Social media use and depression in adolescents: a scoping review. *Int Rev Psychiatry*. 2020;32(3):235-253. doi:10.1080/09540261.2020.1720623
143. Ivie EJ, Pettitt A, Moses LJ, Allen NB. A meta-analysis of the association between adolescent social media use and depressive symptoms. *J Affect Disord*. 2020;275:165-174. doi:10.1016/j.jad.2020.06.014
144. Cunningham S, Hudson CC, Harkness K. Social Media and Depression Symptoms: a Meta-Analysis. *Res Child Adolesc Psychopathol*. 2021;49(2):241-253. doi:10.1007/s10802-020-00715-7
145. Hancock J, Liu SX, Luo M, Mieczkowski H. Psychological Well-Being and Social Media Use: A Meta-Analysis of Associations between Social Media Use and Depression, Anxiety, Loneliness, Eudaimonic, Hedonic and Social Well-Being. Published online March 9, 2022. doi:10.2139/ssrn.4053961
146. Zhang L, Li C, Zhou T, Li Q, Gu C. Social Networking Site Use and Loneliness: A Meta-Analysis. *J Psychol*. 2022;156(7):492-511. doi:10.1080/00223980.2022.2101420

147. Riehm KE, Feder KA, Tormohlen KN, et al. Associations Between Time Spent Using Social Media and Internalizing and Externalizing Problems Among US Youth. *JAMA Psychiatry*. 2019;76(12):1266. doi:10.1001/jamapsychiatry.2019.2325
148. Coyne SM, Rogers AA, Zurcher JD, Stockdale L, Booth M. Does time spent using social media impact mental health?: An eight year longitudinal study. *Comput Hum Behav*. 2020;104:106160. doi:10.1016/j.chb.2019.106160
149. Meier A, Johnson BK. Social comparison and envy on social media: A critical review. *Curr Opin Psychol*. 2022;45:101302. doi:10.1016/j.copsyc.2022.101302
150. Kreski N, Platt J, Rutherford C, et al. Social Media Use and Depressive Symptoms Among United States Adolescents. *J Adolesc Health*. 2021;68(3):572-579. doi:10.1016/j.jadohealth.2020.07.006
151. Berryman C, Ferguson CJ, Negy C. Social Media Use and Mental Health among Young Adults. *Psychiatr Q*. 2018;89(2):307-314. doi:10.1007/s11126-017-9535-6
152. Orben A, Dienlin T, Przybylski AK. Social media's enduring effect on adolescent life satisfaction. *Proc Natl Acad Sci*. 2019;116(21):10226-10228. doi:10.1073/pnas.1902058116
153. Bonsaksen T, Ruffolo M, Leung J, et al. Loneliness and Its Association With Social Media Use During the COVID-19 Outbreak. *Soc Media Soc*. 2021;7(3):20563051211033821. doi:10.1177/20563051211033821
154. Vannucci A, McCauley Ohannessian C. Social Media Use Subgroups Differentially Predict Psychosocial Well-Being During Early Adolescence. *J Youth Adolesc*. 2019;48(8):1469-1493. doi:10.1007/s10964-019-01060-9
155. Rideout V, Fox S, Trust WB. Digital Health Practices, Social Media Use, and Mental Well-Being Among Teens and Young Adults in the U.S. Published online 2018.
156. Valkenburg PM, Meier A, Beyens I. Social media use and its impact on adolescent mental health: An umbrella review of the evidence. *Curr Opin Psychol*. 2022;44:58-68. doi:10.1016/j.copsyc.2021.08.017
157. Valkenburg PM, Beyens I, Pouwels JL, van Driel II, Keijsers L. Social Media Browsing and Adolescent Well-Being: Challenging the "Passive Social Media Use Hypothesis." Published online 2021.
158. Valkenburg PM, van Driel II, Beyens I. The associations of active and passive social media use with well-being: A critical scoping review. *New Media Soc*. 2022;24(2):530-549. doi:10.1177/14614448211065425
159. Orben A. Teenagers, screens and social media: a narrative review of reviews and key studies. *Soc Psychiatry Psychiatr Epidemiol*. 2020;55(4):407-414. doi:10.1007/s00127-019-01825-4
160. Beard KW, Wolf EM. Modification in the Proposed Diagnostic Criteria for Internet Addiction. *Cyberpsychol Behav*. 2001;4(3):377-383. doi:10.1089/109493101300210286
161. Casale S, Banchi V. Narcissism and problematic social media use: A systematic literature review. *Addict Behav Rep*. 2020;11:100252. doi:10.1016/j.abrep.2020.100252
162. Moreno M, Riddle K, Jenkins MC, Singh AP, Zhao Q, Eickhoff J. Measuring Problematic Internet Use, Internet Gaming Disorder, and Social Media Addiction in Young Adults: Cross-sectional Survey Study. *JMIR Public Health Surveill*. 2022;8(1):e27719. doi:10.2196/27719
163. Kim HS, Son G, Roh EB, et al. Prevalence of gaming disorder: A meta-analysis. *Addict Behav*. 2022;126:107183. doi:10.1016/j.addbeh.2021.107183
164. Ahmed GK, Abdalla AA, Mohamed AM, Mohamed LA, Shamaa HA. Relationship between time spent playing internet gaming apps and behavioral problems, sleep problems, alexithymia, and emotion dysregulations in children: a multicentre study. *Child Adolesc Psychiatry Ment Health*. 2022;16(1):67. doi:10.1186/s13034-022-00502-w
165. Gentile DA, Anderson CA, Yukawa S, et al. The Effects of Prosocial Video Games on Prosocial Behaviors: International Evidence From Correlational, Longitudinal, and Experimental Studies. *Pers Soc Psychol Bull*. 2009;35(6):752-763. doi:10.1177/0146167209333045

166. Gentile DA, Choo H, Liau A, et al. Pathological Video Game Use Among Youths: A Two-Year Longitudinal Study. *Pediatrics*. 2011;127(2):e319-e329. doi:10.1542/peds.2010-1353
167. Teng Z, Griffiths MD, Nie Q, Xiang G, Guo C. Parent–adolescent attachment and peer attachment associated with Internet Gaming Disorder: A longitudinal study of first-year undergraduate students. *J Behav Addict*. 2020;9(1):116-128.
168. Buda G, Lukoševičiūtė J, Šalčiūnaitė L, Šmigelskas K. Possible Effects of Social Media Use on Adolescent Health Behaviors and Perceptions. *Psychol Rep*. 2021;124(3):1031-1048. doi:10.1177/0033294120922481
169. Paakkari L, Tynjälä J, Lahti H, Ojala K, Lyyra N. Problematic Social Media Use and Health among Adolescents. *Int J Environ Res Public Health*. 2021;18(4):1885. doi:10.3390/ijerph18041885
170. Boer M, Stevens GWJM, Finkenauer C, De Looze ME, Van Den Eijnden RJJM. Social media use intensity, social media use problems, and mental health among adolescents: Investigating directionality and mediating processes. *Comput Hum Behav*. 2021;116:106645. doi:10.1016/j.chb.2020.106645
171. Huang C. A meta-analysis of the problematic social media use and mental health. *Int J Soc Psychiatry*. 2022;68(1):12-33. doi:10.1177/0020764020978434
172. Bányai F, Zsila Á, Király O, et al. Problematic Social Media Use: Results from a Large-Scale Nationally Representative Adolescent Sample. Jiménez-Murcia S, ed. *PLOS ONE*. 2017;12(1):e0169839. doi:10.1371/journal.pone.0169839
173. Fam JY. Prevalence of internet gaming disorder in adolescents: A meta-analysis across three decades. *Scand J Psychol*. 2018;59(5):524-531. doi:10.1111/sjop.12459
174. Leonhardt M, Overå S. Are There Differences in Video Gaming and Use of Social Media among Boys and Girls?—A Mixed Methods Approach. *Int J Environ Res Public Health*. 2021;18(11):6085. doi:10.3390/ijerph18116085
175. Gioia F, Rega V, Boursier V. Problematic Internet Use and Emotional Dysregulation Among Young People: A Literature Review. *Clin Neuropsychiatry*. 18(1):41-54. doi:10.36131/cnfioritieditore20210104
176. Panayiotou M, Black L, Carmichael-Murphy P, Qualter P, Humphrey N. Time spent on social media among the least influential factors in adolescent mental health: preliminary results from a panel network analysis. *Nat Ment Health*. 2023;1(5):316-326. doi:10.1038/s44220-023-00063-7
177. Beyens I, Valkenburg PM, Piotrowski JT. Screen media use and ADHD-related behaviors: Four decades of research. *Proc Natl Acad Sci*. 2018;115(40):9875-9881. doi:10.1073/pnas.1611611114
178. Ra CK, Cho J, Stone MD, et al. Association of Digital Media Use With Subsequent Symptoms of Attention-Deficit/Hyperactivity Disorder Among Adolescents. *JAMA*. 2018;320(3):255-263. doi:10.1001/jama.2018.8931
179. Barry CT, Sidoti CL, Briggs SM, Reiter SR, Lindsey RA. Adolescent social media use and mental health from adolescent and parent perspectives. *J Adolesc*. 2017;61(1):1-11. doi:10.1016/j.adolescence.2017.08.005
180. Liu Z. Reading in the age of digital distraction. *J Doc*. 2021;78(6):1201-1212. doi:10.1108/JD-07-2021-0130
181. Wiradhany W, Koerts J. Everyday functioning-related cognitive correlates of media multitasking: a mini meta-analysis. *Media Psychol*. 2021;24(2):276-303. doi:10.1080/15213269.2019.1685393
182. Parry DA, Roux DB le. “Cognitive control in media multitaskers” ten years on: A meta-analysis. *Cyberpsychology J Psychosoc Res Cyberspace*. 2021;15(2). doi:10.5817/CP2021-2-7
183. Calderwood C, Ackerman PL, Conklin EM. What else do college students “do” while studying? An investigation of multitasking. *Comput Educ*. 2014;75:19-29. doi:10.1016/j.compedu.2014.02.004

184. Saiphoo AN, Dahoah Halevi L, Vahedi Z. Social networking site use and self-esteem: A meta-analytic review. *Personal Individ Differ*. 2020;153:109639. doi:10.1016/j.paid.2019.109639
185. Holland G, Tiggemann M. A systematic review of the impact of the use of social networking sites on body image and disordered eating outcomes. *Body Image*. 2016;17:100-110. doi:10.1016/j.bodyim.2016.02.008
186. Salomon I, Brown CS. The Selfie Generation: Examining the Relationship Between Social Media Use and Early Adolescent Body Image. *J Early Adolesc*. 2019;39(4):539-560. doi:10.1177/0272431618770809
187. Choukas-Bradley S, Roberts SR, Maheux AJ, Nesi J. The Perfect Storm: A Developmental–Sociocultural Framework for the Role of Social Media in Adolescent Girls’ Body Image Concerns and Mental Health. *Clin Child Fam Psychol Rev*. 2022;25(4):681-701. doi:10.1007/s10567-022-00404-5
188. Pruccoli J, De Rosa M, Chiasso L, Perrone A, Parmeggiani A. The use of TikTok among children and adolescents with Eating Disorders: experience in a third-level public Italian center during the SARS-CoV-2 pandemic. *Ital J Pediatr*. 2022;48(1):138. doi:10.1186/s13052-022-01308-4
189. Chung A, Vieira D, Donley T, et al. Adolescent Peer Influence on Eating Behaviors via Social Media: Scoping Review. *J Med Internet Res*. 2021;23(6):e19697. doi:10.2196/19697
190. Kucharczuk AJ, Oliver TL, Dowdell EB. Social media’s influence on adolescents’ food choices: A mixed studies systematic literature review. *Appetite*. 2022;168:105765. doi:10.1016/j.appet.2021.105765
191. Saura JR, Palacios-Marqués D, Iturricha-Fernández A. Ethical design in social media: Assessing the main performance measurements of user online behavior modification. *J Bus Res*. 2021;129:271-281. doi:10.1016/j.jbusres.2021.03.001
192. Blank G, Bolsover G, Dubois E. A New Privacy Paradox: Young People and Privacy on Social Network Sites. Published online August 13, 2014. doi:10.2139/ssrn.2479938
193. Auxier B, Anderson M, Perrin A, Turner E. *Parenting Children in the Age of Screens*. Pew Research Center; 2020. Accessed February 13, 2024. <https://www.pewresearch.org/internet/2020/07/28/parenting-children-in-the-age-of-screens/>
194. McClain C, Faverio M, Anderson M, Park E. *How Americans View Data Privacy*. Pew Research Center
195. Gambo S, Özad BO. The demographics of computer-mediated communication: A review of social media demographic trends among social networking site giants. *Comput Hum Behav Rep*. 2020;2:100016. doi:10.1016/j.chbr.2020.100016
196. Sherman LE, Hernandez LM, Greenfield PM, Dapretto M. What the brain ‘Likes’: neural correlates of providing feedback on social media. *Soc Cogn Affect Neurosci*. 2018;13(7):699-707. doi:10.1093/scan/nsy051
197. Gorwa R. The platform governance triangle: conceptualising the informal regulation of online content. *Internet Policy Rev*. 2019;8(2). doi:10.14763/2019.2.1407
198. International Organization for Standardization - ISO | Genève internationale. Accessed February 15, 2024. <https://www.geneve-int.ch/whoswho/international-organization-standardization-iso>
199. Napoli PM. What Social Media Platforms Can Learn from Audience Measurement: Lessons in the Self-Regulation of “Black Boxes.” Published online January 31, 2018. doi:10.2139/ssrn.3115916
200. Klönick K. The Facebook Oversight Board: Creating an Independent Institution to Adjudicate Online Free Expression. *Yale Law J*. 2019;129:2418.
201. Maroni M. Some reflections on the announced Facebook Oversight Board. Centre for Media Pluralism and Freedom. Published October 17, 2019. Accessed February 13, 2024. <https://cmpf.eui.eu/some-reflections-on-the-announced-facebook-oversight-board/>

202. Today's Law As Amended - AB-2273 The California Age-Appropriate Design Code Act. Accessed February 13, 2024. https://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=202120220AB2273&showamends=false
203. NetChoice v. Bonta: The Case That Threatens the Future of Privacy. EPIC - Electronic Privacy Information Center. Accessed February 19, 2024. <https://epic.org/netchoice-v-bontathe-case-that-couldthreaten-the-future-of-privacy/>
204. Henderson R, Migdal A, He T. Note: Industry Self-Regulation: Sustaining the Commons in the 21st Century? Harvard Business School Background Note 315-074. Published March 2015. Accessed February 13, 2024. <https://www.hbs.edu/faculty/Pages/item.aspx?num=48959>
205. Cusumano MA, Gawer A, Yoffie DB. Social media companies should self-regulate. *Now. Harv Bus Rev.* 2021;15.
206. 15 U.S. Code § 57a - Unfair or deceptive acts or practices rulemaking proceedings. LII / Legal Information Institute. Accessed February 19, 2024. <https://www.law.cornell.edu/uscode/text/15/57a>
207. Privacy and Security Enforcement. Federal Trade Commission. Published October 31, 2018. Accessed February 19, 2024. <https://www.ftc.gov/news-events/topics/protecting-consumer-privacy-security/privacy-security-enforcement>
208. Federal Trade Commission 2020 Privacy and Data Security Update. Federal Trade Commission. Published May 25, 2021. Accessed February 19, 2024. <https://www.ftc.gov/reports/federal-trade-commission-2020-privacy-data-security-update>
209. Mills JL, Allende PM. FTC Consent Decrees Are Best Guide to Cybersecurity Policies. *Daily Business Review.* Published September 21, 2015. Accessed February 13, 2024. <https://www.law.com/dailybusinessreview/almID/1202737711574/>
210. Rosch JT. Consent Decrees: Is the Public Getting Its Money's Worth? Federal Trade Commission. Published July 31, 2013. Accessed February 13, 2024. <https://www.ftc.gov/news-events/news/speeches/consent-decrees-public-getting-its-moneys-worth>
211. Wong RY, Madaio MA, Merrill N. Seeing Like a Toolkit: How Toolkits Envision the Work of AI Ethics. *Proc ACM Hum-Comput Interact.* 2023;7(CSCW1):145:1-145:27. doi:10.1145/3579621
212. Gebru T, Morgenstern J, Vecchione B, et al. Datasheets for datasets. *Commun ACM.* 2021;64(12):86-92. doi:10.1145/3458723
213. Children's Online Privacy Protection Rule ("COPPA"). Federal Trade Commission. Published July 25, 2013. Accessed February 15, 2024. <https://www.ftc.gov/legal-library/browse/rules/childrens-online-privacy-protection-rule-coppa>
214. *Google LLC and YouTube, LLC.* (Federal Court District of Columbia 2019). Accessed February 13, 2024. <https://www.ftc.gov/legal-library/browse/cases-proceedings/172-3083-google-llc-youtube-llc>
215. Sen. Markey EJ [D M. Text - S.1628 - 117th Congress (2021-2022): Children and Teens' Online Privacy Protection Act. Published December 15, 2022. Accessed February 15, 2024. <https://www.congress.gov/bill/117th-congress/senate-bill/1628/text>
216. Advertising and Marketing on the Internet: Rules of the Road. Federal Trade Commission. Published December 12, 2000. Accessed February 13, 2024. <https://www.ftc.gov/business-guidance/resources/advertising-marketing-internet-rules-road>
217. CAN-SPAM Act: A Compliance Guide for Business. Federal Trade Commission. Published August 9, 2023. Accessed February 13, 2024. <https://www.ftc.gov/business-guidance/resources/can-spam-act-compliance-guide-business>
218. *How to Make Effective Disclosures in Digital Advertising.* Federal Trade Commission; 2013.
219. Trade Regulation Rule on Commercial Surveillance and Data Security. Federal Register. Published August 22, 2022. Accessed February 13, 2024.

<https://www.federalregister.gov/documents/2022/08/22/2022-17752/trade-regulation-rule-on-commercial-surveillance-and-data-security>

220. *IEEE Standard for an Age Appropriate Digital Services Framework Based on the 5Rights Principles for Children*. IEEE doi:10.1109/IEEESTD.2021.9627644

221. States Search for Ways to Keep Kids Safe on Social Media. National Conference of State Legislatures. Accessed February 13, 2024. <https://www.ncsl.org/state-legislatures-news/details/states-search-for-ways-to-keep-kids-safe-on-social-media>

222. 2023 State Children's Privacy Law Tracker. Accessed February 14, 2024. <https://www.huschblackwell.com/2023-state-childrens-privacy-law-tracker>

223. SB0152. Accessed February 13, 2024. <https://le.utah.gov/~2023/bills/static/SB0152.html>

224. SB396 Bill Information. Accessed February 13, 2024.

<https://www.arkleg.state.ar.us/Bills/Detail>

225. Attorney General Bonta Continues Defense of California's Age-Appropriate Design Code Act. State of California - Department of Justice - Office of the Attorney General. Published December 13, 2023. Accessed February 19, 2024. <https://oag.ca.gov/news/press-releases/attorney-general-bonta-continues-defense-california%E2%80%99s-age-appropriate-design>

226. AAP Council on Communication and Media, Hill D, Ameenuddin N, et al. Media and Young Minds. *Pediatrics*. 2016;138(5):e20162591. doi:10.1542/peds.2016-2591

227. Sadagheyani HE, Tatari F. Investigating the role of social media on mental health. *Ment Health Soc Incl*. 2020;25(1):41-51. doi:10.1108/MHSI-06-2020-0039

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 11-A-24

Subject: Stand Your Ground Laws

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee D

1 INTRODUCTION

2

3 American Medical Association Policy H-145.966, “Stand Your Ground Laws” as adopted by the
4 House of Delegates at the 2023 Annual Meeting (Resolution 435), asked that our AMA study the
5 public health implications of “Stand Your Ground” laws and castle doctrine.

6

7 BACKGROUND

8

9 “Castle doctrine” refers to the legal right of a person to defend himself against an intruder in his
10 home or other property, even if the use of deadly force is required. Stand Your Ground (SYG) laws
11 expanded castle doctrine beyond one’s home or property to public spaces where individuals have a
12 legal right to be. Prior to the enactment of SYG laws, most states followed the common law self-
13 defense rule, which imposed a duty to retreat before using force in self-defense, if safe retreat was
14 possible. SYG laws generally removed the duty to retreat from a threat before using force in self-
15 defense. Under SYG laws, individuals are allowed to use force, including lethal force, if they
16 reasonably believe it is necessary to protect themselves or others from imminent harm.

17

18 In 2005, Florida passed the first SYG law in the United States.¹ According to the National
19 Conference of State Legislatures, as of March 2023, laws in at least 28 states and Puerto Rico
20 provide that there is no duty to retreat from an attacker in any place in which one is lawfully
21 present.² At least ten states include language stating one may “stand his or her ground,” while eight
22 states permit the use of deadly force in self-defense through judicial decisions or jury instructions.²

23

24 Those who support the enactment of SYG laws generally believe that people have a fundamental
25 right to “defend themselves from attack with proportionate force in every place they have a lawful
26 right to be” which is thought to deter criminals by increasing their perceived risk of encountering
27 an armed victim.² Critics are concerned these laws “unnecessarily encourage the use of deadly
28 force as a low-cost license to kill instead of reserving it only as a protective measure.”³ SYG laws
29 are commonly referred to as “shoot first” laws and are thought to encourage people to take the law
30 into their own hands. There are also concerns that the laws exacerbate social inequities.

31

32 In this report, your Council on Science and Public Health reviews the available evidence regarding
33 the public health impact of castle doctrine and SYG laws.

34

35 METHODS

36

37 English language articles were selected from searches of PubMed and Google Scholar using the
38 search terms “stand your ground”, “castle doctrine”, “self-defense law”. Additional articles were

1 identified by manual review of the reference lists of pertinent publications. Web sites managed by
 2 government agencies and nonprofit organizations were also reviewed for relevant information.

3
 4 DISCUSSION

5
 6 There has been little research on the public health implications of castle doctrine. Researchers have
 7 sought to evaluate the effect of SYG and expanded self-defense laws on various factors including
 8 crime rates, homicide rates, and racial disparities in the application of the laws. It is worth noting at
 9 the outset that evaluating the effects of SYG laws is challenging, in part because the duty to retreat
 10 is a less distinct element of self-defense in practice.⁴ Also because there are variations in the laws
 11 across jurisdictions and implementation of the law may also deviate from the original intent.⁴

12
 13 *Impact of SYG laws on homicide, firearm homicide, and violent crime*

14
 15 A retrospective analysis of data from 2000 to 2017 examined justifiable homicide (citizen-related
 16 justifiable homicide with a firearm) and homicide (non-justifiable citizen-related homicide) rates
 17 before and after enactment of SYG laws and in states with and without SYG laws. In states with
 18 SYG laws, the overall justifiable homicide rate was 0.126 per 100,000 population compared with
 19 0.047 per 100,000 population in states without SYG laws. The homicide rate was 4.663 per
 20 100,000 population in states with SYG laws compared to 3.301 per 100,000 population states
 21 without SYG laws.⁵ In states with SYG laws, the rate of justifiable homicide increased with the
 22 enactment of SYG laws, from 0.091 pre-law to 0.141 per 100,000 population post-law, a 54.9
 23 percent increase.⁵ The homicide rate also increased with the enactment of SYG from 4.208 to 4.663
 24 per 100,000 population, a 10.8 percent increase.⁵ In states without SYG laws, the justifiable
 25 homicide rates increased 20 percent, from 0.044 to 0.053 per 100,000 population, but homicide
 26 rates decreased from 3.424 to 3.344 per 100,000 population, a 2.3 percent decrease.⁵ The findings
 27 suggest that justifiable homicide and homicide were disproportionately higher in states with SYG
 28 laws and both the justifiable homicide rate by firearm and homicide rate had significant increases
 29 in states with SYG laws compared to states without such laws. While the intent of SYG laws was
 30 to deter violent crime, this analysis indicates the laws have had the opposite effect.⁵

31
 32 Similarly, a cohort study evaluating the association of SYG laws with homicide and firearm
 33 homicide, nationally and by state, found that SYG laws were associated with an 8 – 11 percent
 34 national increase in monthly rates of homicide and firearm homicide.⁶ Forty-one states were
 35 analyzed, including 23 states with SYG laws and 18 states without SYG laws. SYG laws were
 36 associated with a mean national increase of 7.8 percent in monthly homicide rates and 8.0 percent
 37 in monthly firearm homicide rates.⁶ Increases in violent deaths varied across states, with the largest
 38 increases (16.2 to 33.5 percent) found in the South (e.g., Alabama, Florida, Georgia, Louisiana).
 39 The study found no differential associations by demographic group.⁶

40
 41 A systematic review examining the available evidence on the impacts associated with SYG laws
 42 (or other expansions of self-defense laws) on violence, injury, crime, and firearm-related outcomes
 43 found the laws were associated with no change to small increases in violent crime (total and
 44 firearm homicide, aggravated assault, robbery) on average across states.⁷ While Florida-based
 45 studies showed robust increases (24 percent to 45 percent) in firearm and total homicide.⁷

46
 47 RAND's Gun Policy in America initiative examines the effects of firearm laws to improve public
 48 discussions and support the development of fair and effective firearm policies. Their review of the
 49 evidence on SYG laws concluded that there is moderate evidence that they may increase homicide
 50 rates, supportive evidence that they may increase firearm homicides, and limited evidence that they
 51 may increase the overall violent crime rates.⁸

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Evaluating Florida's SYG law

Several studies have focused on evaluating Florida's SYG law specifically. In addition to this being the first jurisdiction with a SYG law, the high-profile and fatal shooting of Trayvon Martin, an unarmed Black teenager occurred in Sanford, Florida on February 26, 2012. Martin was killed by a White neighborhood watch volunteer who was later acquitted of second-degree murder and manslaughter on the basis of self-defense. The jury in the case was instructed about Florida's SYG law. The Governor of Florida created a Task Force on Citizen Safety and Protection to review the Florida statute to help "ensure the rights of all Floridians and visitors, including the right to feel safe and secure in our state."⁹ The task force recommended keeping the SYG law in place, noting that all persons who are conducting themselves in a lawful manner have a fundamental right to stand their ground and defend themselves from attack with proportionate force in every place they have a lawful right to be.⁹

In evaluating the Florida law, several studies have found that it led to an increase in homicides and firearm homicides. A study evaluating whether Florida's SYG law had an impact on homicide and homicide by firearm between 2005 and 2014 found that the law was associated with a 24.4 percent increase in homicide and a 31.6 percent increase in firearm-related homicide.¹⁰ Researchers found no change in rates of suicide or suicide by firearm.¹⁰ A separate analysis of Florida's law found it was associated with a 44.6 percent increase in adolescent firearm homicide and may also exacerbate racial disparities.¹¹ A third analysis found that the impact of the law differed significantly by county urbanization, unemployment, and pre-law homicide rates.¹² The largest increases in homicide and firearm homicide occurred in proportionally safer, richer, and less ethnically diverse suburban counties. These findings suggest that the law may have had the opposite effect than intended, and more strongly impacted counties considered safe, suburban and economically successful.¹²

Social inequities

It has been hypothesized that SYG laws will exacerbate social inequities in violent victimization as and that Black defendants accused of crimes will not have the same protections under these laws as similarly situated White defendants.¹³ However, a systematic review that examined comparisons by race showed mixed findings, indicating there are not dramatic differences in increases in homicide rates among Black versus White people following the enactment of SYG laws.⁷ Data suggests that at least in Florida, there appears to be racial bias in the criminal justice process in rulings on SYG cases.⁷ In examining SYG cases in Florida from 2005 to 2013, it was found that race of the victim was a significant predictor of case outcome.¹⁴ After controlling for other variables, the defendant is two times more likely to be convicted in a case that involves White victims compared to those involving non-White victims.¹⁴

A separate examination of FBI data from 2005-2010, examining more than 53,000 homicides, found large disparities in rulings justified based on the race of the defendant and the victim.¹⁵ Nationally, the likelihood of a homicide being ruled justified is 281 percent greater when the defendant is White and the victim is Black compared to cases where both the defendant and victim are White.¹⁵ White-on-Black homicides were the most likely to be ruled as justified (11.4 percent) while Black-on-White homicide was least likely to be ruled as justified (1.2 percent).¹⁵

There is very little evidence examining gender differences in the implementation of SYG laws and a lack of focus on the impacts of these laws on intimate partner violence or domestic violence, the most common forms of violence against women.⁷

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POSITION OF OTHER NATIONAL ORGANIZATIONS

In 2013, the American Bar Association convened a National Task Force on SYG Laws to review and analyze the recently enacted Stand Your Ground laws in multiple states and their impact on public safety and the criminal justice system.³ The Task Force has conducted a comprehensive legal and multidisciplinary analysis of the impact of the SYG laws. The national investigation revealed several important findings:

1. Based on recent empirical studies, SYG states experienced an increase in homicides.
2. Multiple states have attempted to repeal or amend SYG laws.
3. The application of SYG laws is unpredictable, uneven, and results in racial disparities.
4. An individual’s right to self-defense was sufficiently protected prior to SYG laws.
5. Victims’ rights are undermined in states with statutory immunity from criminal prosecution and civil suits related to SYG cases.

EXISTING AMA POLICY

Existing AMA policy does not address self-defense, castle doctrine, or SYG laws. Current policy does recognize that violence represents a public health crisis which requires a comprehensive public health response and solution (Policy D-145.995, “Gun Violence as a Public Health Crisis”). Policy also recognizes that uncontrolled ownership and use of firearms is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths (Policy H-145.997, “Firearms as a Public Health Problem in the United States - Injuries and Death”). AMA policy also 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 (Policy H-515.95, “Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes”).

CONCLUSION

“Castle doctrine” refers to the legal right of a person to defend himself against an intruder in his home or other property, even if the use of deadly force is required. There is a lack of studies examining the impact of these laws. SYG laws, or expanded castle doctrine, generally removed the duty to retreat from a threat before using force in self-defense. Under SYG laws, individuals are allowed to use force, including lethal force, if they reasonably believe it is necessary to protect themselves or others from imminent harm. While SYG laws can be challenging to evaluate, the best available evidence shows that these laws are associated with increased homicide and firearm homicide rates, resulting in preventable violent deaths. The application of SYG laws is unpredictable, uneven, and likely results in racial disparities.

RECOMMENDATIONS

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

1. That Policy H-145.966, “Stand Your Ground Laws” be adopted by addition and deletion to read as follows:

Our AMA opposes stand your ground laws, which remove the duty to retreat before using lethal force if a person feels there is imminent risk of bodily harm, as these laws have been

1 shown to increase homicide and homicide firearm rates and there is evidence of racial
2 inequity in the implementation of the laws.

3

4 Our AMA ~~will~~ supports continued study of the public health implications of
5 “Stand Your Ground” laws and castle doctrine. (Modify Current HOD Policy)

6

7 2. That Policies H-145.997, “Firearms as a Public Health Problem in the United States -
8 Injuries and Death,” D-145.995, “Gun Violence as a Public Health Crisis,” H-145.975,
9 “Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to
10 Mental Health Care,” and D-145.999 “Epidemiology of Firearm Injuries” be reaffirmed.
11 (Reaffirm HOD Policy)

Fiscal Note: Less than \$1,000

REFERENCES

1. Fla. Stat. § 776.013. Available at: http://www.leg.state.fl.us/statutes/index.cfm?App_mode=Display_Statute&URL=0700-0799/0776/Sections/0776.013.html
2. National Conference of State Legislatures. Self Defense and “Stand Your Ground.” Available at: <https://www.ncsl.org/civil-and-criminal-justice/self-defense-and-stand-your-ground>
3. American Bar Association. National Task Force on Stand Your Ground Laws, Report and Recommendations. September 2015. Available at: NTF_SYG_Rpt15_final.indd.
4. Burris S. Civilian Use of Deadly Force in Self-Defense: Public Health, Stand Your Ground. *Am J Public Health*. 2021;111(4):559-561. doi:10.2105/AJPH.2021.306173
5. Levy M, Alvarez W, Vagelakos L, Yore M, Khallouq BB. Stand Your Ground: Policy and Trends in Firearm-Related Justifiable Homicide and Homicide in the US. *J Am Coll Surg*. 2020;230(1):161-167.e4. doi:10.1016/j.jamcollsurg.2019.11.003
6. Degli Esposti M, Wiebe DJ, Gasparrini A, Humphreys DK. Analysis of “Stand Your Ground” Self-defense Laws and Statewide Rates of Homicides and Firearm Homicides. *JAMA Netw Open*. 2022;5(2):e220077. doi:10.1001/jamanetworkopen.2022.0077
7. Yakubovich AR, Esposti MD, Lange BCL, et al. Effects of Laws Expanding Civilian Rights to Use Deadly Force in Self-Defense on Violence and Crime: A Systematic Review. *Am J Public Health*. 2021;111(4):e1-e14. doi:10.2105/AJPH.2020.306101
8. The Effects of Stand-Your-Ground Laws. Accessed January 5, 2024. <https://www.rand.org/research/gun-policy/analysis/stand-your-ground.html>
9. Citizen-Safety-and-Protection-Task-Force-Report-FINAL.pdf. Accessed March 2, 2024. <https://www.flgov.com/wp-content/uploads/2013/02/Citizen-Safety-and-Protection-Task-Force-Report-FINAL.pdf>
10. Humphreys DK, Gasparrini A, Wiebe DJ. Evaluating the Impact of Florida’s “Stand Your Ground” Self-defense Law on Homicide and Suicide by Firearm: An Interrupted Time Series Study. *JAMA Intern Med*. 2017;177(1):44-50. doi:10.1001/jamainternmed.2016.6811
11. Degli Esposti M, Wiebe DJ, Gravel J, Humphreys DK. Increasing adolescent firearm homicides and racial disparities following Florida’s “Stand Your Ground” self-defence law. *Inj Prev J Int Soc Child Adolesc Inj Prev*. 2020;26(2):187-190. doi:10.1136/injuryprev-2019-043530
12. Ukert B, Wiebe DJ, Humphreys DK. Regional differences in the impact of the “Stand Your Ground” law in Florida. *Prev Med*. 2018;115:68-75. doi:10.1016/j.ypmed.2018.08.010
13. The Dangerous Expansion of Stand-Your-Ground Laws and its Racial Implications. Duke Center for Firearms Law. Accessed March 3, 2024. <https://firearmslaw.duke.edu/2022/01/the-dangerous-expansion-of-stand-your-ground-laws-and-its-racial-implications>
14. Ackermann N, Goodman MS, Gilbert K, Arroyo-Johnson C, Pagano M. Race, law, and health: Examination of “Stand Your Ground” and defendant convictions in Florida. *Soc Sci Med* 1982. 2015;142:194-201. doi:10.1016/j.socscimed.2015.08.012
15. Roman J. Race, Justifiable Homicide, and Stand Your Ground Laws.
16. Murphy J. Are “Stand Your Ground” Laws Racist and Sexist? A Statistical Analysis of Cases in Florida, 2005–2013*. *Soc Sci Q*. 2018;99(1):439-452. doi:10.1111/ssqu.12402

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-24)
Decreasing Youth Access to E-Cigarettes (Resolution 919-I-22)
(Reference Committee D)

EXECUTIVE SUMMARY

BACKGROUND: This report examines the available evidence regarding the health effects of electronic cigarettes and the evidence of effectiveness of federal, state, and local regulations to restrict youth access to e-cigarettes (i.e., face-to-face sales mandates, limits on marketing and promotion, retailer licensing, price policy implementation, flavor restrictions, inclusion of e-cigarettes in smoke-free indoor air policies, and the development of educational initiatives).

METHODS: English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases using the search terms: “e-cigarettes”, “ENDS”, “electronic cigarette”, AND “youth access.” Additional articles were identified by manual review of the reference lists of pertinent publications. Web sites managed by federal agencies and applicable professional and advocacy organizations were also reviewed for relevant information.

RESULTS: Despite the recent decline in e-cigarette use among high school students and ongoing efforts at the national, state, and local levels to implement tobacco control strategies, including Food and Drug Administration (FDA) regulatory actions, e-cigarette use among adolescents remains alarmingly high. According to the National Youth Tobacco Survey (NYTS), 2.13 million students use e-cigarettes, with 4.6 percent of middle school and 10.0 percent of high school students reporting current use. There is clear evidence of adverse health effects due to e-cigarette use, but the evidence on the long-term impacts is more attenuated, not as strong, and often based on small cross-sectional or relatively short longitudinal epidemiological studies. Additionally, there is limited evidence of the effectiveness of state-level efforts like face-to-face sales mandates, marketing and promotion limits, retailer licensing, price policies and taxes, and flavor restrictions on reducing e-cigarette initiation and use.

CONCLUSION: Despite the limited evidence, many policies enacted to address youth access to e-cigarettes are rooted in evidence-based nicotine control strategies that worked well with traditional cigarettes. Therefore, it seems likely that they have the potential to reduce e-cigarette initiation and use. Continued research is needed to better understand effective interventions and policies, including how they influence traditional cigarette smoking, e-cigarette vaping, and other tobacco use.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 13-A-24

Subject: Decreasing Youth Access to E-Cigarettes

Presented by: David J. Welsh MD, MBA, Chair

Referred to: Reference Committee D

INTRODUCTION

1
2 The American Medical Association (AMA) House of Delegates (HOD) referred Resolution 919,
3 “Decreasing Youth Access to E-cigarettes” for study. This resolution asked that our AMA support
4 the inclusion of disposable and tank-based e-cigarettes in the language and implementation of any
5 restrictions that are applied by the Food and Drug Administration (FDA) or other bodies to
6 cartridge-based e-cigarettes. It also proposed amendments to policy H-495.986, “Tobacco Product
7 Sales and Distribution,” to (1) support measures that prevent retailers from opening new tobacco
8 specialty stores in proximity to elementary schools, middle schools, and high schools and (2)
9 support measures that decrease the overall density of tobacco specialty stores, including but not
10 limited to, preventing retailers from opening new tobacco specialty stores in proximity to existing
11 tobacco specialty stores.

12
13 The Reference Committee recommended adoption of the policy as amended, with amendment by
14 deletion of number 2 above due to concerns that the density recommendations represented the
15 restriction of free commerce capabilities. The resolution was ultimately referred for study due to
16 the introduction of significant amendments on the HOD floor seeking to clarify multiple points in
17 existing policy unrelated to the amendments proposed by the resolution.

18
19 The Council has previously presented several reports to the HOD on e-cigarettes, these include
20 CSAPH Report 6-A-10, “Use of Electronic Cigarettes in Smoking Cessation Programs,”; CSAPH
21 2-I-14, “Electronic Cigarettes, Vaping, and Health: 2014 Update”; and CSAPH 5-A-18, “Tobacco
22 Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by
23 Smoking.” The AMA Board of Trustees also provides the HOD with an annual update on tobacco,
24 which includes updates on e-cigarettes. This report will not repeat information included in those
25 reports, but rather will provide an update on the narrow ask of the resolution, which focuses on
26 youth access.

27
28 METHODS

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30 English language reports were selected from searches of the PubMed, Google Scholar, and
31 Cochrane Library databases using the search terms: “e-cigarettes”, “ENDS”, “electronic cigarette”,
32 AND “youth access.” Additional articles were identified by manual review of the reference lists of
33 pertinent publications. Web sites managed by federal agencies and applicable professional and
34 advocacy organizations were also reviewed for relevant information.

35
36 BACKGROUND

1 Tobacco use is the leading cause of preventable disease, disability, and death in the United States
2 (U.S.). Moreover, tobacco product use, including the use of e-cigarettes, during adolescence
3 increases the risk for lifelong nicotine addiction and adverse health consequences. This is an
4 extremely important issue considering that in 2023, roughly 2.80 million U.S. middle and high
5 school students used at least one tobacco product, including e-cigarettes.¹

6 7 *Current Prevalence and Recent Trends Among Youth*

8
9 Youth e-cigarette use remains a critical public health concern in the U.S. For the 10th year, e-
10 cigarettes have been the most commonly used tobacco product among both middle and high school
11 students. According to the most recent data from the National Youth Tobacco Survey (NYTS),
12 2.13 million students use e-cigarettes with 4.6 percent of middle school and 10.0 percent of high
13 school students reporting current use.^{1,2} From 2022 to 2023, a significant decline in current e-
14 cigarette use occurred among high school students (from 14.1 percent to 10.0 percent); this decline
15 did not reflect a switch to cigarettes, whose use remained stable at 1.6 percent. While e-cigarette
16 use increased among middle school students from 3.3 percent in 2022 to 4.6 percent in 2023, this
17 increase was not statistically significant. Among students who had ever used an e-cigarette, 46.7
18 percent reported current use, 25.2 percent used e-cigarettes daily, and 89.4 percent used flavored e-
19 cigarettes with fruit (63.4 percent) and candy (35.0 percent) being the most common flavors.¹

20
21 Disposables were the most used device type among students who reported current e-cigarette use,
22 with over 60 percent of students using disposable e-cigarettes. Prefilled and refillable pods or
23 cartridges and open tank and mod systems were less frequently used at 16.1 percent and 5.9 percent
24 respectively.¹ Disposable e-cigarettes have changed dramatically in recent years. Between 2017
25 and 2022, e-cigarettes quintupled in volume capacity, nearly tripled in average nicotine strength,
26 and fell in average per ml price of e-liquid by nearly 70 percent.³ The increased popularity of
27 disposable e-cigarettes may be because they are relatively inexpensive, have a high nicotine
28 content, and they are exempt from the 2020 FDA enforcement prioritization of prefilled and
29 closed-cartridge e-cigarettes for flavors other than tobacco and menthol.⁴

30 31 *Perceptions of harm and motivations for use*

32
33 Several systematic reviews and studies have evaluated motivations for e-cigarette use and
34 perceptions of harm. Commonly reported motivations include curiosity, appealing flavors, family
35 and peer influence, and stress reduction.⁵⁻⁸ One systematic review found that social acceptability,
36 convenient and customizable features, a variety of flavors, and a lack of awareness about the
37 presence of nicotine as common reasons for e-cigarette use.⁹ Another found that youth report flavor
38 variety, device modifiability, the ability to perform tricks, and concealment from authority figures
39 among the primary appeals of e-cigarettes.¹⁰ Findings suggest that prevalence of both e-cigarette
40 and cigarette use among parents, siblings, and close friends was higher in adolescents who have
41 ever used an e-cigarette.⁷

42
43 Adolescent e-cigarette users also exhibit lower perceptions of harm and more positive attitudes
44 towards e-cigarettes when compared with non-users.^{7,8,11} Specifically, in comparison to non-users,
45 young people who were e-cigarette users were more likely to perceive e-cigarettes as healthier and
46 less addictive than tobacco cigarettes.^{8,12-14} One study found most e-cigarette users view flavored e-
47 cigarettes as less harmful with 55.5 percent believing they were not addictive.¹³ Other reviews echo
48 this concerning finding that many individuals were unaware that e-cigarettes contained nicotine.^{9,11}
49 Still others found youth perceived gradations in harm relating to the frequency and intensity of use
50 and by type of product.¹⁵ In contrast, nonusers were more prone to consider e-cigarettes harmful to
51 children.⁷

1 HEALTH EFFECTS OF E-CIGARETTE USE

2
3 The health effects of e-cigarette use have been reviewed in previous CSAPH reports. The evidence
4 on the health impacts of e-cigarettes is mixed. There are clear short term adverse effects that could
5 result from using e-cigarettes including sore throat, headache, cough, elevated heart rate, nausea,
6 and vomiting.^{11,16} Additionally, there are severe acute adverse effects including nicotine poisoning
7 from accidental ingestion, e-cigarette or vaping product associated lung injury, and trauma from
8 exploding devices that has been reported.¹⁷ However, the evidence on long term impacts of e-
9 cigarettes is more attenuated, not as strong, and often based on small cross-sectional or relatively
10 short longitudinal epidemiological studies.

11
12 Despite the limited evidence on the long-term effects of e-cigarettes on health, there are potentially
13 concerning trends regarding the association between both e-cigarette use and exposure to the
14 ingredients found in e-cigarette vapor and negative cardiovascular, pulmonary, immune, and
15 developmental health impacts that warrant continued study and evaluation.

16 *Safety of Aerosolized e-liquid*

17
18 Propylene glycol, glycerol, nicotine, flavoring agents, and their degradation byproducts (e.g.,
19 formaldehyde, acetaldehyde, acrolein, glycidol) have all been shown to have deleterious effects on
20 respiratory tissues and function.^{18,19} An analysis of 30 products on the U.S. market revealed that 13
21 were more than one percent by weight flavor chemicals identified as reactive aldehydes.¹⁹ Reactive
22 aldehydes are also thought to be the primary contributors to combustible cigarette-induced
23 cardiovascular disease and chronic obstructive pulmonary disease (COPD).^{20,21} Multiple analyses
24 of e-cigarette vapor's cytotoxicity have demonstrated that while it varies, some flavors are
25 cytotoxic or contain flavoring chemicals at concentrations high enough to be cytotoxic when
26 vaped.^{19,22}

27
28 E-cigarette vapor also contains heavy metals, likely from the heating element metals that are
29 released into the aerosols.^{20,23,24} A lifetime of chromium and nickel exposure from daily inhalation
30 of two mL e-liquid was used to estimate the risk of cancer and noncancer health effects, with
31 chromium and nickel estimated to be the primary contributors. Notably, nickel is one of the few
32 carcinogens found to be higher in e-cigarettes than in combustible cigarettes.^{20,25} E-cigarette vapor
33 contains copious fine and ultra fine particles.²² There is strong evidence that frequent low or short-
34 term levels of exposure to fine and ultrafine particles can contribute to pulmonary and systemic
35 inflammatory processes as well as potentially increasing the risk of cardiovascular and respiratory
36 disease.^{22,26-28} Moreover, higher e-liquid nicotine concentration is associated with higher particle
37 numbers.²²

38
39 Finally, most e-cigarettes contain nicotine, which activates the sympathetic nervous system,
40 thereby directly effecting the cardiovascular system.^{20,29} Nicotine-stimulated catecholamine release
41 by the sympathetic nervous system activates β -adrenergic receptors in the heart, resulting in
42 increased heart rate, cardiac contractility, and workload.^{20,30} Long-term overstimulation of the
43 sympathetic nervous system can result in cardiac remodeling, which promotes the development of
44 heart failure and increases arrhythmogenesis.^{20,29} Nicotine also affects the vasculature by inducing
45 vasoconstriction, resulting in elevated blood pressure.^{20,29,30} In a randomized study of healthy
46 younger smokers, acute use of nicotine-containing e-cigarettes had vascular hemodynamic effects
47 suggestive of vascular remodeling and increased sympathetic activation of the cardiovascular
48 system.^{20,31} The findings suggest cardiovascular changes consistent with the development of
49 cardiovascular disease with nicotine inhalation from e-cigarettes.²⁰
50

1 *Cardiovascular, Pulmonary, and Immunological Impacts of e-cigarette use*

2
3 There is some evidence that using e-cigarettes may negatively affect cardiovascular function. One
4 review found that cardio-respiratory function in e-cigarette users was more impaired than in never
5 smokers.^{16,32} Reviews have also found that chronic e-cigarette users had elevated heart rate and
6 blood pressure.^{16,20} Other studies found that e-cigarettes may be associated with inflammation,
7 oxidative stress, and hemodynamic imbalance, leading to increased risk of cardiovascular
8 disease.^{20,33–35} E-cigarette use might be linked to pre-symptomatic cardiovascular dysfunction,
9 which could have a significant health impact during adulthood.³³ Research has also found that e-
10 cigarette use was associated with sympathetic activation, vascular stiffening, and endothelial
11 dysfunction.^{20,36} There is also evidence of higher incidence tissue damage and compromised
12 vascular function among e-cigarette users compared to non-users.³⁶

13
14 The aerosol condensate generated from different e-cigarette devices, products, and e-liquids results
15 in different effects on endothelial and pulmonary epithelial cell toxicity, likely a result of the
16 extreme variability in product characteristics.²⁰ There is some evidence that e-cigarette users'
17 airways are more friable than non-users.^{16,37} The same review found changes in lung function over
18 3.5 years of use and speculated that long-term exposure could lead to emphysema, loss of
19 pulmonary capillaries, and reduced airway function.^{16,38} Another review found increased
20 biomarkers of pulmonary disease among observational epidemiological studies associated with
21 vaping as well as a higher incidence of pulmonary disease.³⁶ Several large population-based studies
22 in adolescents have noted increased asthma diagnoses, school absences due to asthma, and
23 respiratory symptoms for youth who currently use or have used e-cigarettes.^{20,33}

24
25 There is some evidence suggesting e-cigarette use is associated with increased oxidative stress
26 which can cause the release of pro-inflammatory cytokines.^{16,39,40} Therefore, it is possible that e-
27 cigarette use may impair ability to fight infection.¹⁶ Similarly, research has found that e-cigarette
28 use might be associated with reduced pulmonary immune function.¹¹

29
30 FEDERAL ACTIONS

31
32 *Legislative actions*

33
34 Since 2018, federal legislative activity has included the 2019 amendment of the Federal Food,
35 Drug, and Cosmetic Act to raise the federal minimum age for sale of tobacco products from 18 to
36 21 years. In 2020, the Preventing All Cigarette Trafficking (PACT) act was amended to prevent
37 online sales of e-cigarettes to children.⁴¹ Specifically, it requires remote sellers of tobacco products
38 to pay all applicable federal, state, and local taxes, and comply with all applicable state and local
39 laws including age verification. PACT also prohibits delivery vendors from using the U.S. postal
40 service to ship e-cigarettes. These federal legislative actions arose in conjunction with
41 administrative and judicial actions.

42
43 *Administrative actions*

44
45 In January of 2020, the FDA finalized enforcement policy on unauthorized flavored open-system
46 tank- and cartridge-based e-cigarettes that appeal to children, including fruit and mint ingredients,
47 but excluded menthol and tobacco-flavored products.⁴² Importantly, disposable e-cigarettes were
48 exempt from the policy and as a result there was a market shift to disposables. More recently,
49 federal legislation expanded the definition of tobacco products to include synthetic nicotine in
50 March 2022, in response to the emergence and market proliferation of disposable e-cigarettes with
51 e-liquids advertising synthetic nicotine -- thereby granting FDA regulatory authority over these

1 products. To date, the FDA has authorized marketing of 23 tobacco-flavored e-cigarette products
2 and devices from three companies with the FDA citing potential smoking cessation benefits to
3 adults and low risks posed to youth.^{43,44} Meanwhile, all other disposable e-cigarette brands are
4 being sold without marketing authorization.³

5 6 STATE AND LOCAL ACTIONS

7
8 Considering the success of tobacco control policies to reduce traditional cigarette smoking among
9 youth, there is reason to believe extending similar policies like online sales restrictions, limits on
10 marketing and promotion, package and labeling requirements, retailer licensing requirements,
11 retailer zoning and location restrictions, taxes, and flavor restrictions could reduce e-cigarette
12 initiation and use among youth.⁴⁵

13 14 *Online Sales Restrictions*

15
16 In 2020, PACT was amended to include e-cigarettes, thus prohibiting online sales of e-cigarettes to
17 children. Yet, there are serious enforcement challenges posed by online sales and delivery services.
18 A study that reviewed FDA e-cigarette warning letters issued by the Center for Tobacco Products
19 to online retailers in 2018 showed that 98.2 percent of violations pertained to the sales of an e-
20 cigarette product to a minor and/or use of marketing that appeals to children.⁴⁶

21
22 In response, state and local governments have begun enacting legislation to further prohibit and
23 regulate online sales. In June 2019, San Francisco, California, became the first city in the U.S. to
24 ban the retail and online sale of e-cigarettes.^{47,48} As of May 2022, the Public Health Law Center
25 also found that at least fourteen states have laws prohibiting direct-to-consumer shipments of some
26 tobacco products. Five of these states have enacted more comprehensive laws, including extending
27 these prohibitions to e-cigarettes.⁴⁹ Additionally, an evaluation of e-cigarette delivery laws found
28 extensive heterogeneity. There were 34 states with e-cigarette delivery sales laws in place, and of
29 those states, 27 required at least one form of age verification, 12 required mandatory packaging
30 labels, seven required permits for online vendors, seven required government ID for release, four
31 did not specify, and 11 had no specific requirements.⁵⁰

32 33 *Limits on marketing and promotion*

34
35 While the FDA has broad authority to restrict the advertising and marketing of all tobacco
36 products, the FDA and FTC only currently require e-cigarette ads to be factually accurate and
37 avoid targeting youth.^{10,45}

38
39 A recent study of online e-cigarette vendors in California found that 50 percent of the websites
40 included marketing themes related to physical health benefits of e-cigarette use, 57.7 percent had
41 sales, discounts, and other promotions, 65.4 percent had fruit-flavored disposable e-cigarettes, 69.2
42 percent had promotional email newsletters, and 88.9 percent did not require users to create an age-
43 verified account to receive email newsletters.⁵¹ This is concerning considering that the lessons
44 learned from traditional cigarette control demonstrate that the retail environment is a key driver of
45 cigarette use.^{52,53} Furthermore, a longitudinal cohort study using PATH data found that past 12-
46 month and past 30-day e-cigarette use was significantly associated with recalled exposure to e-
47 cigarette advertisement on social media, websites, and at gas stations and convenience stores.⁵⁴
48 Similarly, research demonstrates that e-cigarette use was associated with advertising and media
49 exposure.⁵³

50

1 Presently, there is little to no evidence that limits on marketing and promotion reduce e-cigarette
2 use among youth, but there is a growing body of evidence that suggests marketing and promotion
3 to youth are common and that exposure to e-cigarette advertising is associated with e-cigarette use.
4 Therefore, continued efforts to regulate youth exposure to e-cigarettes in media, advertising, and
5 other promotion is warranted.

6 7 *Retailer licensing*

8
9 Requiring retailers to obtain a license to sell e-cigarettes is another traditional cigarette control
10 measure that might be helpful at reducing e-cigarette initiation and use. One cross-sectional study
11 suggests that strong local tobacco retailer license ordinances, particularly those that also provide
12 adequate resources to fund regular compliance checks and enforcement, may lower rates of
13 cigarette and e-cigarette use among youth and young adults.⁵⁵ For instance, participants in
14 jurisdictions with more restrictive ordinances had lower odds of ever cigarette use and of past 30-
15 day use.⁵⁵ Additionally, compliance checks of vendors have been shown to reduce sales to minors;
16 however, the actual impact on smoking rates is less clear as youth obtain e-cigarettes from means
17 other than legal purchase.⁵⁵

18
19 Currently, 40 states and territories require retailers to obtain a license to sell e-cigarettes over the
20 counter.⁵⁶ Furthermore, when retailer licensing was implemented in Pennsylvania, it resulted in a
21 significant decline in past 30-day e-cigarette use by adolescents.⁴⁵ A review of e-cigarette tobacco
22 retail licensing law, identified 23 laws that clearly defined a license term, 23 laws required a
23 license fee, and 19 laws identified penalties for violations that included both license suspension and
24 revocation.⁵⁷ The evidence of effectiveness of retailer licensing regulations on e-cigarette initiation
25 and use is limited, but promising.

26 27 *E-cigarette tax and other price strategies*

28
29 There is strong evidence that increasing traditional cigarette taxes decreases cigarette consumption
30 and increases quit rates among both adults and adolescents.⁵⁸⁻⁶⁰ Additionally, increasing the price
31 of tobacco reduces tobacco initiation among youth.⁵⁹ Therefore, e-cigarette taxes and price
32 strategies have been proposed as a potential tool to reduce e-cigarette use. However, the
33 effectiveness of e-cigarette taxes and price strategies may depend on whether e-cigarettes and
34 traditional cigarettes are used concurrently or as substitutes. If either e-cigarettes or traditional
35 cigarettes are substitutes, then increased taxes on one would drive users to the other and vice
36 versa.⁵⁸

37
38 As of February 2024, 36 states and Washington DC have enacted an e-cigarette tax.⁵⁶ There is
39 some evidence that e-cigarette taxes increased e-cigarette prices and reduced sales of e-cigarettes,
40 but they also increase sales of traditional cigarettes, suggesting the two may be substitutes.^{3,61-63} In
41 contrast, one study found that higher cigarette excise taxes decrease both cigarette and e-cigarette
42 purchases, suggesting that cigarettes and e-cigarettes are used in tandem.⁶⁴ as Additionally, one
43 prospective cohort study of young adults in the U.S. found that increased prices of rechargeable e-
44 cigarette products did not significantly change past 30-day e-cigarette use or cigarette use.⁶⁵

45
46 While there is some evidence e-cigarette taxes curb e-cigarette use among youth, more evidence is
47 needed to assess their effectiveness and better understand their impact on traditional cigarette use.

1 *Flavor restrictions*

2
3 In 2009 the FDA banned flavored cigarettes, but it was not until 2020 that similar federal bans
4 were extended to e-cigarettes -- banning all non-tobacco and non-menthol flavored cartridge-based
5 e-cigarettes.¹⁰ Although the FDA flavor ban is a step in the right direction, disposable e-cigarettes
6 were exempt, and the market shifted accordingly. A longitudinal cohort survey of adults aged 18-
7 24 from Atlanta, Boston, Minneapolis, Oklahoma City, San Diego, Seattle found that only 8.4
8 percent of participants reduced their e-cigarette use after the FDA ban was implemented.⁶⁶ Instead,
9 while 35.8 percent used available flavors like tobacco and menthol, 30.4 percent continued to use
10 tank-based e-cigarettes, and 10.1 percent switched to tank-based e-cigarettes.⁶⁶

11
12 This highlights the need for additional action at the state and local level. In 2018, San Francisco
13 was the first city to ban all flavored tobacco products, including menthol, in conventional
14 cigarettes.⁴⁷ After more than 200 localities imposed a variety of restrictions, Michigan became the
15 first state to ban all flavored e-cigarettes under a temporary emergency order that is renewable.⁴⁷
16 Currently, over 360 localities have passed flavor restrictions.⁶⁷ Evidence is limited, but there are
17 some promising findings from New York City and Massachusetts suggesting that sales for flavored
18 tobacco products decreased overall following a ban.⁴⁵ Additionally, a cross-sectional study found
19 that statewide restrictions on the sale of flavored e-cigarettes in Massachusetts, New York, Rhode
20 Island, and Washington were associated with a reduction in total e-cigarette sales.⁶⁸

21
22 *E-cigarette retailer zoning and location restrictions*

23
24 Current evidence indicates that e-cigarette retailers are frequently located near schools. In a study
25 of two counties in Kentucky, an estimated 67.5 percent of sampled schools had at least one tobacco
26 retailer that also sold e-cigarettes within one mile (1.61 km) of the school.⁶⁹ Another study from
27 Orange County, California found that over half of public middle and high schools had at least one
28 e-cigarette specialty retailer within one mile of the school.⁷⁰

29
30 One study identified a significant positive association between e-cigarette retailer density within a
31 half-mile of a high school and the likelihood that a student ever and currently used e-cigarettes.⁷¹
32 Another study identified a significant positive association between the presence of e-cigarette
33 specialty retailers within one-quarter mile of a middle school and the likelihood of e-cigarette
34 lifetime use. However, a significant positive association was not present among high school
35 students.⁷² While site-based studies have found varying results, a study based on geospatial data
36 found an association between the presence of tobacco retailers near certain schools and e-cigarette
37 use among students, but this association was not consistent across all the studied counties.⁷³ Other
38 research suggests a positive association between higher retailer density in egocentric residential
39 neighborhoods around homes and current smoking in adults and adolescents; however, the density
40 of retailers and their proximity to schools showed either no association or an inverse association
41 with adolescent smoking.⁷⁴ Likewise, another study found that e-cigarette retailer proximity and
42 density surrounding a school were not significantly associated with the likelihood of ever or
43 currently using e-cigarettes.⁷⁵

44
45 Many states and localities have tried to reduce exposure, initiation, and use of e-cigarettes through
46 retailer zoning and location restrictions and these efforts are rationally grounded; however more
47 research is needed to conclusively determine the impact of retailer proximity and youth initiation.

1 *Product packaging*

2
3 Under the Deeming Rule, e-cigarettes are required to include warning labels about the
4 addictiveness of nicotine. Additionally, 33 states have implemented their own packaging laws.⁴⁵
5 There is some evidence that text-based warning messages influenced young non-smokers'
6 perceptions in a way that may dissuade e-cigarette use, but warnings appearing on advertisements
7 had little impact.⁷⁶ One study found that the perceived warning effectiveness for discouraging
8 youth initiation was higher for warnings that focused on negative impacts to the brain and harmful
9 chemicals compared to warnings focusing on nicotine dependency or use disorder.⁷⁷ In conclusion,
10 there is limited evidence of the effectiveness of warning labels on e-cigarettes; however, there is
11 evidence that many adolescents are unaware that e-cigarettes contain nicotine. Ultimately, more
12 research is needed on nicotine warnings for e-cigarettes, including on the message content,
13 placement, and the impact on consumers' product knowledge, risk perceptions, and use
14 intentions.⁷⁸

15
16 *State and local regulatory efforts and pre-emption issues*

17
18 State and local efforts to enact e-cigarette regulations often come across preemption barriers.
19 Although many states have made efforts to enhance e-cigarette regulations through limits on
20 promotions and advertising, requiring licensing for over-the-counter sales, including e-cigarettes in
21 smoke free air policies, and implementing face-to-face sales mandates, state level preemption is
22 prohibiting many cities and municipalities from implementing stricter local policies. In the U.S., 25
23 states preempt stricter local e-cigarette regulations in 55 laws. Specifically, 19 laws preempt
24 advertising regulations, 11 laws preempt licensure requirements, four laws preempt ordinances for
25 indoor clean air, and 21 laws preempt youth access. States without preemption laws should be
26 encouraged to adopt language that expressly preserves local authority.⁷⁹

27
28 EXISTING AMA POLICY

29
30 Existing AMA policy recognizes that the use of products containing nicotine in any form among
31 youth, including e-cigarettes, is unsafe and can cause addiction. Furthermore, the AMA supports
32 legislation and associated initiatives to prevent e-cigarettes from reaching youth and young adults
33 through various means, including, but not limited to, CDC research, education, and a campaign for
34 preventing and reducing use by youth, young adults and others of e-cigarettes, and combustible and
35 emerging tobacco products (Policy H-495.972, "Electronic Cigarettes, Vaping, and Health"). The
36 AMA also supports applying the same marketing and sales restrictions that are applied to tobacco
37 cigarettes, including prohibitions on television advertising, product placement in television and
38 films, and the use of celebrity spokespeople; requires the use of secure, child- and tamper-proof
39 packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-
40 cigarettes (Policy H-495.973, "FDA to Extend Regulatory Jurisdiction Over All Non-
41 Pharmaceutical Nicotine and Tobacco Products").

42
43 AMA policy supports the development of model legislation regarding enforcement of laws
44 restricting children's access to tobacco, including but not limited to attention to the following
45 issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate
46 civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws
47 restricting children's access to and possession of tobacco; (c) requirements for merchants to post
48 notices warning minors against attempting to purchase tobacco and to obtain proof of age for
49 would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette
50 sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age
51 (Policy H-495.986, "Tobacco Product Sales and Distribution").

1 CONCLUSION

2
3 Despite the recent decline in e-cigarette use among high school students and ongoing efforts at the
4 national, state, and local levels to implement tobacco control strategies, including FDA regulatory
5 actions, e-cigarette use among adolescents remains unacceptably high. According to the NYTS,
6 2.13 million students use e-cigarettes, with 4.6 percent of middle school and ten percent of high
7 school students reporting current use.¹ There is clear evidence of adverse health effects due to e-
8 cigarette use, but the evidence on the long-term impacts is more attenuated, not as strong, and often
9 based on small cross-sectional or relatively short longitudinal epidemiological studies.

10 Additionally, there is limited evidence of the effectiveness of state-level efforts like face-to-face
11 sales mandates, marketing and promotion limits, retailer licensing, price policies and taxes, and
12 flavor restrictions on reducing e-cigarette initiation and use. Despite the limited evidence, many
13 policies enacted to address youth access are rooted in evidence-based nicotine control strategies that
14 worked well with traditional cigarettes. Therefore, it seems likely that they have the potential to
15 reduce e-cigarette initiation and use. Continued research is needed to better understand effective
16 interventions and policies, including how they influence traditional cigarette smoking, e-cigarette
17 vaping, and other tobacco use.

18
19 RECOMMENDATIONS

20
21 The Council on Science and Public Health recommends that the following be adopted, and the
22 remainder of the report be filed:

- 23
24 1. That our AMA supports the inclusion of all forms of e-cigarettes (e.g., disposable, refillable
25 cartridge, and tank-based e-cigarettes) in the language and implementation of relevant nicotine-
26 based policies and regulations by the Food and Drug Administration or other regulatory
27 agencies. (New HOD Policy)
28
29 2. That current AMA Policy H-495.986, "Tobacco Product Sales and Distribution," be amended
30 by addition to read as follows:

31
32 Tobacco Product Sales and Distribution, H-495.986

33 (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will
34 actively work with the Food and Drug Administration and other relevant stakeholders to
35 counteract the marketing and use of addictive e-cigarette and vaping devices, including but not
36 limited to bans and strict restrictions on marketing to minors under the age of 21;

37 (2) encourages the passage of laws, ordinances and regulations that would set the minimum age
38 for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-
39 cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco
40 products to minors;

41 (3) supports the development of model legislation regarding enforcement of laws restricting
42 children's access to tobacco, including but not limited to attention to the following issues: (a)
43 provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or
44 criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws
45 restricting children's access to and possession of tobacco; (c) requirements for merchants to
46 post notices warning minors against attempting to purchase tobacco and to obtain proof of age
47 for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package
48 cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal
49 smoking age;

50 (4) requests that states adequately fund the enforcement of the laws related to tobacco sales to
51 minors;

- 1 (5) opposes the use of vending machines to distribute tobacco products and supports
2 ordinances and legislation to ban the use of vending machines for distribution of tobacco
3 products;
4 (6) seeks a ban on the production, distribution, and sale of candy products that depict or
5 resemble tobacco products;
6 (7) opposes the distribution of free tobacco products by any means and supports the enactment
7 of legislation prohibiting the disbursement of samples of tobacco and tobacco products by
8 mail;
9 (8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy
10 owners who have chosen not to sell tobacco products, and asks its members to encourage
11 patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages
12 other pharmacists and pharmacy owners individually and through their professional
13 associations to remove such products from their stores; (c) urges the American Pharmacists
14 Association, the National Association of Retail Druggists, and other pharmaceutical
15 associations to adopt a position calling for their members to remove tobacco products from
16 their stores; and (d) encourages state medical associations to develop lists of pharmacies that
17 have voluntarily banned the sale of tobacco for distribution to their members; and
18 (9) opposes the sale of tobacco at any facility where health services are provided; and
19 (10) supports measures that decrease the overall density of tobacco specialty stores, including
20 but not limited to, preventing retailers from opening new tobacco specialty stores in close
21 proximity to schools. (Modify Current AMA Policy)

22
23 That our AMA reaffirm Policies H-495.970, “Regulation of “Cool/Non-Menthol” Tobacco
24 Products, H-495.971 “Opposition to Addition of Flavors to Tobacco Products,” and H-495.976,
25 “Opposition to Exempting the Addition of Menthol to Cigarettes.” (Reaffirm HOD Policy)

Fiscal Note: less than \$1,000

REFERENCES

1. Birdsey J, Cornelius M, Jamal A, et al. Tobacco Product Use Among U.S. Middle and High School Students — National Youth Tobacco Survey, 2023. *MMWR Morb Mortal Wkly Rep.* 2023;72(44):1173-1182. doi:10.15585/mmwr.mm7244a1
2. E-cigarette Use Down Among U.S. High School Students in 2023. CDC. Published November 2, 2023. Accessed February 14, 2024. <https://www.cdc.gov/media/releases/2023/s1102-e-cigarettes-down.html>
3. Diaz MC, Silver NA, Bertrand A, Schillo BA. Bigger, stronger and cheaper: growth in e-cigarette market driven by disposable devices with more e-liquid, higher nicotine concentration and declining prices. *Tob Control.* Published online August 3, 2023:tc-2023-058033. doi:10.1136/tc-2023-058033
4. Ali FRM, Seidenberg AB, Crane E, Seaman E, Tynan MA, Marynak K. E-cigarette Unit Sales by Product and Flavor Type, and Top-Selling Brands, United States, 2020–2022. *MMWR Morb Mortal Wkly Rep.* 2023;72(25):672-677. doi:10.15585/mmwr.mm7225a1
5. Kong G, Morean ME, Cavallo DA, Camenga DR, Krishnan-Sarin S. Reasons for Electronic Cigarette Experimentation and Discontinuation Among Adolescents and Young Adults. *Nicotine Tob Res.* 2015;17(7):847-854. doi:10.1093/ntr/ntu257
6. Singh S, Windle SB, Fillion KB, et al. E-cigarettes and youth: Patterns of use, potential harms, and recommendations. *Prev Med.* 2020;133:106009. doi:10.1016/j.ypmed.2020.106009
7. Virgili F, Nenna R, Ben David S, et al. E-cigarettes and youth: an unresolved Public Health concern. *Ital J Pediatr.* 2022;48(1):97. doi:10.1186/s13052-022-01286-7
8. Sharma A, McCausland K, Jancey J. Adolescents' Health Perceptions of E-Cigarettes: A Systematic Review. *Am J Prev Med.* 2021;60(5):716-725. doi:10.1016/j.amepre.2020.12.013
9. Lee SJ, Rees VW, Yossefy N, Emmons KM, Tan ASL. Youth and Young Adult Use of Pod-Based Electronic Cigarettes From 2015 to 2019: A Systematic Review. *JAMA Pediatr.* 2020;174(7):714. doi:10.1001/jamapediatrics.2020.0259
10. Trucco EM, Fallah-Sohy N, Hartmann SA, Cristello JV. Electronic Cigarette Use Among Youth: Understanding Unique Risks in a Vulnerable Population. *Curr Addict Rep.* 2020;7(4):497-508. doi:10.1007/s40429-020-00340-w
11. Fadus MC, Smith TT, Squeglia LM. The rise of e-cigarettes, pod mod devices, and JUUL among youth: Factors influencing use, health implications, and downstream effects. *Drug Alcohol Depend.* 2019;201:85-93. doi:10.1016/j.drugalcdep.2019.04.011
12. Aly AS, Mamikutty R, Marhazlinda J. Association between Harmful and Addictive Perceptions of E-Cigarettes and E-Cigarette Use among Adolescents and Youth—A Systematic Review and Meta-Analysis. *Children.* 2022;9(11):1678. doi:10.3390/children9111678
13. Cooper M, Harrell MB, Pérez A, Delk J, Perry CL. Flavorings and Perceived Harm and Addictiveness of E-cigarettes among Youth. *Tob Regul Sci.* 2016;2(3):278-289. doi:10.18001/TRS.2.3.7
14. Pepper JK, Brewer NT. Electronic nicotine delivery system (electronic cigarette) awareness, use, reactions and beliefs: a systematic review. *Tob Control.* 2014;23(5):375-384. doi:10.1136/tobaccocontrol-2013-051122
15. Ambrose BK, Rostron BL, Johnson SE, et al. Perceptions of the Relative Harm of Cigarettes and E-cigarettes Among U.S. Youth. *Am J Prev Med.* 2014;47(2):S53-S60. doi:10.1016/j.amepre.2014.04.016
16. Bozier J, Chivers EK, Chapman DG, et al. The Evolving Landscape of e-Cigarettes. *Chest.* 2020;157(5):1362-1390. doi:10.1016/j.chest.2019.12.042
17. Tzortzi A, Kapetanstrataki M, Evangelopoulou V, Behrakis P. A Systematic Literature Review of E-Cigarette-Related Illness and Injury: Not Just for the Respiriologist. *Int J Environ Res Public Health.* 2020;17(7):2248. doi:10.3390/ijerph17072248

18. Pipe AL, Mir H. E-Cigarettes Reexamined: Product Toxicity. *Can J Cardiol.* 2022;38(9):1395-1405. doi:10.1016/j.cjca.2022.08.001
19. Tierney PA, Karpinski CD, Brown JE, Luo W, Pankow JF. Flavour chemicals in electronic cigarette fluids. *Tob Control.* 2016;25(e1):e10-e15. doi:10.1136/tobaccocontrol-2014-052175
20. Rose JJ, Krishnan-Sarin S, Exil VJ, et al. Cardiopulmonary Impact of Electronic Cigarettes and Vaping Products: A Scientific Statement From the American Heart Association. *Circulation.* 2023;148(8):703-728. doi:10.1161/CIR.0000000000001160
21. Haussmann HJ. Use of Hazard Indices for a Theoretical Evaluation of Cigarette Smoke Composition. *Chem Res Toxicol.* 2012;25(4):794-810. doi:10.1021/tx200536w
22. Grana R, Benowitz N, Glantz SA. E-Cigarettes: A Scientific Review. *Circulation.* 2014;129(19):1972-1986. doi:10.1161/CIRCULATIONAHA.114.007667
23. Olmedo P, Goessler W, Tanda S, et al. Metal Concentrations in e-Cigarette Liquid and Aerosol Samples: The Contribution of Metallic Coils. *Environ Health Perspect.* 2018;126(2):027010. doi:10.1289/EHP2175
24. Na CJ, Jo SH, Kim KH, Sohn JR, Son YS. The transfer characteristics of heavy metals in electronic cigarette liquid. *Environ Res.* 2019;174:152-159. doi:10.1016/j.envres.2019.04.025
25. Fowles J, Barreau T, Wu N. Cancer and Non-Cancer Risk Concerns from Metals in Electronic Cigarette Liquids and Aerosols. *Int J Environ Res Public Health.* 2020;17(6):2146. doi:10.3390/ijerph17062146
26. Brook RD, Rajagopalan S, Pope CA, et al. Particulate Matter Air Pollution and Cardiovascular Disease. *Circulation.* 2010;121(21):2331-2378. doi:10.1161/CIR.0b013e3181d8e1
27. Pope CA, Burnett RT, Krewski D, et al. Cardiovascular Mortality and Exposure to Airborne Fine Particulate Matter and Cigarette Smoke: Shape of the Exposure-Response Relationship. *Circulation.* 2009;120(11):941-948. doi:10.1161/CIRCULATIONAHA.109.857888
28. Fuoco FC, Buonanno G, Stabile L, Vigo P. Influential parameters on particle concentration and size distribution in the mainstream of e-cigarettes. *Environ Pollut.* 2014;184:523-529. doi:10.1016/j.envpol.2013.10.010
29. Benowitz NL, Gourlay SG. Cardiovascular Toxicity of Nicotine: Implications for Nicotine Replacement Therapy 1. *J Am Coll Cardiol.* 1997;29(7):1422-1431. doi:10.1016/S0735-1097(97)00079-X
30. Benowitz NL, Burbank AD. Cardiovascular toxicity of nicotine: Implications for electronic cigarette use. *Trends Cardiovasc Med.* 2016;26(6):515-523. doi:10.1016/j.tcm.2016.03.001
31. Franzen KF, Willig J, Cayo Talavera S, et al. E-cigarettes and cigarettes worsen peripheral and central hemodynamics as well as arterial stiffness: A randomized, double-blinded pilot study. *Vasc Med.* 2018;23(5):419-425. doi:10.1177/1358863X18779694
32. Li D, Sundar IK, McIntosh S, et al. Association of smoking and electronic cigarette use with wheezing and related respiratory symptoms in adults: cross-sectional results from the Population Assessment of Tobacco and Health (PATH) study, wave 2. *Tob Control.* Published online February 13, 2019;tobaccocontrol-2018-054694. doi:10.1136/tobaccocontrol-2018-054694
33. Groner J. Health effects of electronic cigarettes. *Curr Probl Pediatr Adolesc Health Care.* 2022;52(6):101202. doi:10.1016/j.cppeds.2022.101202
34. Buchanan ND, Grimmer JA, Tanwar V, Schwieterman N, Mohler PJ, Wold LE. Cardiovascular risk of electronic cigarettes: a review of preclinical and clinical studies. *Cardiovasc Res.* 2020;116(1):40-50. doi:10.1093/cvr/cvz256
35. Higham A, Bostock D, Booth G, Dungwa JV, Singh D. The effect of electronic cigarette and tobacco smoke exposure on COPD bronchial epithelial cell inflammatory responses. *Int J Chron Obstruct Pulmon Dis.* 2018;13:989-1000. doi:10.2147/COPD.S157728
36. Neczypor EW, Mears MJ, Ghosh A, et al. E-Cigarettes and Cardiopulmonary Health: Review for Clinicians. *Circulation.* 2022;145(3):219-232. doi:10.1161/CIRCULATIONAHA.121.056777

37. Ghosh A, Coakley RC, Mascenik T, et al. Chronic E-Cigarette Exposure Alters the Human Bronchial Epithelial Proteome. *Am J Respir Crit Care Med.* 2018;198(1):67-76. doi:10.1164/rccm.201710-2033OC
38. Polosa R, Cibella F, Caponnetto P, et al. Health impact of E-cigarettes: a prospective 3.5-year study of regular daily users who have never smoked. *Sci Rep.* 2017;7(1):13825. doi:10.1038/s41598-017-14043-2
39. Higham A, Rattray NJW, Dewhurst JA, et al. Electronic cigarette exposure triggers neutrophil inflammatory responses. *Respir Res.* 2016;17(1):56. doi:10.1186/s12931-016-0368-x
40. Scott A, Lugg ST, Aldridge K, et al. Pro-inflammatory effects of e-cigarette vapour condensate on human alveolar macrophages. *Thorax.* 2018;73(12):1161-1169. doi:10.1136/thoraxjnl-2018-211663
41. Prevent All Cigarette Trafficking (PACT) Act | Bureau of Alcohol, Tobacco, Firearms and Explosives. Accessed February 14, 2024. <https://www.atf.gov/alcohol-tobacco/prevent-all-cigarette-trafficking-pact-act>
42. Commissioner O of the. FDA finalizes enforcement policy on unauthorized flavored cartridge-based e-cigarettes that appeal to children, including fruit and mint. FDA. Published March 24, 2020. Accessed February 14, 2024. <https://www.fda.gov/news-events/press-announcements/fda-finalizes-enforcement-policy-unauthorized-flavored-cartridge-based-e-cigarettes-appeal-children>
43. Owotomo O, Walley S. The youth e-cigarette epidemic: updates and review of devices, epidemiology and regulation. *Curr Probl Pediatr Adolesc Health Care.* 2022;52(6):101200. doi:10.1016/j.cppeds.2022.101200
44. FDA Authorized E-Cigarette Products - Tobacco Education Resource Library Print Materials & Downloads. Accessed February 14, 2024. https://digitalmedia.hhs.gov/tobacco/print_materials/CTP-250?locale=en
45. O'Connell M, Kephart L. Local and State Policy Action Taken in the United States to Address the Emergence of E-Cigarettes and Vaping: A Scoping Review of Literature. *Health Promot Pract.* 2022;23(1):51-63. doi:10.1177/1524839920963691
46. Nguyen HV, Bornstein S. Changes in adults' vaping and smoking behaviours associated with aerosol-free laws. *Tob Control.* 2021;30(6):644-652. doi:10.1136/tobaccocontrol-2020-055705
47. Koh HK, Douglas CE. The San Francisco Ban and the Future of e-Cigarettes. *JAMA.* 2019;322(16):1540. doi:10.1001/jama.2019.16181
48. Bhalerao A, Sivandzade F, Archie SR, Cucullo L. Public Health Policies on E-Cigarettes. *Curr Cardiol Rep.* 2019;21(10):111. doi:10.1007/s11886-019-1204-y
49. Online-Sales-E-Cigarettes-Other-Tobacco-Products.pdf.
50. Azagba S, Ebling T, Adekeye OT, Hall M, Jensen JK. Loopholes for Underage Access in E-Cigarette Delivery Sales Laws, United States, 2022. *Am J Public Health.* 2023;113(5):568-576. doi:10.2105/AJPH.2023.307228
51. Donaldson SI, Beard T, Dormanesh A, et al. Monitoring website marketing among leading e-cigarette brands and vendors in California: content analysis. *Tob Control.* Published online August 29, 2023. doi:10.1136/tc-2023-058000
52. Berg CJ, Melena A, Wittman FD, Robles T, Henriksen L. The Reshaping of the E-Cigarette Retail Environment: Its Evolution and Public Health Concerns. *Int J Environ Res Public Health.* 2022;19(14):8518. doi:10.3390/ijerph19148518
53. Berg CJ, Duan X, Getachew B, et al. Young Adult E-cigarette Use and Retail Exposure in 6 US Metropolitan Areas. *Tob Regul Sci.* 2021;7(1):59-75. doi:10.18001/TRS.7.1.5
54. Sun T, Vu G, Lim CCW, et al. Longitudinal association between exposure to e-cigarette advertising and youth e-cigarette use in the United States. *Addict Behav.* 2023;146:107810. doi:10.1016/j.addbeh.2023.107810
55. Astor RL, Urman R, Barrington-Trimis JL, et al. Tobacco Retail Licensing and Youth Product Use. *Pediatrics.* 2019;143(2):e20173536. doi:10.1542/peds.2017-3536

56. U.S. E-Cigarette Regulations - 50 State Review | An overview of U.S. state and territorial laws related to e-cigarettes, updated quarterly by the Public Health Law Center. Accessed February 14, 2024. <https://www.publichealthlawcenter.org/resources/us-e-cigarette-regulations-50-state-review>
57. Patel M, Donovan EM, Perks SN, et al. E-cigarette Tobacco Retail Licensing Laws: Variance Across US States as of January 1, 2020. *Am J Public Health*. 2020;110(9):1380-1385. doi:10.2105/AJPH.2020.305771
58. DeCicca P, Kenkel D, Lovenheim MF. The Economics of Tobacco Regulation: A Comprehensive Review. *J Econ Lit*. 2022;60(3):883-970. doi:10.1257/jel.20201482
59. Hoffman SJ, Tan C. Overview of systematic reviews on the health-related effects of government tobacco control policies. *BMC Public Health*. 2015;15(1):744. doi:10.1186/s12889-015-2041-6
60. Wilson LM, Avila Tang E, Chander G, et al. Impact of Tobacco Control Interventions on Smoking Initiation, Cessation, and Prevalence: A Systematic Review. *J Environ Public Health*. 2012;2012:e961724. doi:10.1155/2012/961724
61. Cotti C, Courtemanche C, Maclean JC, Nesson E, Pesko MF, Tefft NW. The effects of e-cigarette taxes on e-cigarette prices and tobacco product sales: Evidence from retail panel data. *J Health Econ*. 2022;86:102676. doi:10.1016/j.jhealeco.2022.102676
62. Abouk R, Courtemanche C, Dave D, et al. Intended and unintended effects of e-cigarette taxes on youth tobacco use. *J Health Econ*. 2023;87:102720. doi:10.1016/j.jhealeco.2022.102720
63. Pesko M, Courtemanche C, Maclean JC. *The Effects of Traditional Cigarette and E-Cigarette Taxes on Adult Tobacco Product Use*. National Bureau of Economic Research; 2019:w26017. doi:10.3386/w26017
64. Cotti C, Nesson E, Tefft N. The relationship between cigarettes and electronic cigarettes: Evidence from household panel data. *J Health Econ*. 2018;61:205-219. doi:10.1016/j.jhealeco.2018.08.001
65. Cantrell J, Huang J, Greenberg M, Willett J, Hair E, Vallone D. History and Current Trends in the Electronic Cigarette Retail Marketplace in the United States: 2010–2016. *Nicotine Tob Res*. 2020;22(5):843-847. doi:10.1093/ntr/nty214
66. Romm KF, Henriksen L, Huang J, et al. Impact of existing and potential e-cigarette flavor restrictions on e-cigarette use among young adult e-cigarette users in 6 US metropolitan areas. *Prev Med Rep*. 2022;28:101901. doi:10.1016/j.pmedr.2022.101901
67. Flavored-Tobacco-Sales-Prohibitions-Enforcement-Options.pdf.
68. Ali FRM, Vallone D, Seaman EL, et al. Evaluation of Statewide Restrictions on Flavored e-Cigarette Sales in the US From 2014 to 2020. *JAMA Netw Open*. 2022;5(2):e2147813. doi:10.1001/jamanetworkopen.2021.47813
69. Hahn EJ, Begley K, Gokun Y, Johnson AO, Mundy ME, Rayens MK. Electronic Cigarette Retail Outlets and Proximity to Schools. *Am J Health Promot*. 2015;29(6):380-383. doi:10.4278/ajhp.130627-ARB-335
70. Bostean G, Crespi CM, Vorapharuek P, McCarthy WJ. E-cigarette specialty retailers: Data to assess the association between retail environment and student e-cigarette use. *Data Brief*. 2017;11:32-38. doi:10.1016/j.dib.2016.12.022
71. Giovenco DP, Casseus M, Duncan DT, Coups EJ, Lewis MJ, Delnevo CD. Association Between Electronic Cigarette Marketing Near Schools and E-cigarette Use Among Youth. *J Adolesc Health*. 2016;59(6):627-634. doi:10.1016/j.jadohealth.2016.08.007
72. Bostean G, Crespi CM, Vorapharuek P, McCarthy WJ. E-cigarette use among students and e-cigarette specialty retailer presence near schools. *Health Place*. 2016;42:129-136. doi:10.1016/j.healthplace.2016.09.012
73. Perez A, Chang Chien L, Harrell MB, Pasch KE, Obinwa UC, Perry CL. Geospatial Associations Between Tobacco Retail Outlets and Current Use of Cigarettes and e-Cigarettes among Youths in Texas. *J Biom Biostat*. 2017;08(05). doi:10.4172/2155-6180.1000375

74. Travis N, Levy DT, McDaniel PA, Henriksen L. Tobacco retail availability and cigarette and e-cigarette use among youth and adults: a scoping review. *Tob Control*. 2022;31(e2):e175-e188. doi:10.1136/tobaccocontrol-2020-056376
75. Cole AG, Aleyan S, Leatherdale ST. Exploring the association between E-cigarette retailer proximity and density to schools and youth E-cigarette use. *Prev Med Rep*. 2019;15:100912. doi:10.1016/j.pmedr.2019.100912
76. Mays D, Smith C, Johnson AC, Tercyak KP, Niaura RS. An experimental study of the effects of electronic cigarette warnings on young adult nonsmokers' perceptions and behavioral intentions. *Tob Induc Dis*. 2016;14(1):17. doi:10.1186/s12971-016-0083-x
77. Wackowski O, Sontag J, Hammond D, et al. The Impact of E-Cigarette Warnings, Warning Themes and Inclusion of Relative Harm Statements on Young Adults' E-Cigarette Perceptions and Use Intentions. *Int J Environ Res Public Health*. 2019;16(2):184. doi:10.3390/ijerph16020184
78. Wackowski O, Hammond D, O'Connor R, Strasser A, Delnevo C. Considerations and Future Research Directions for E-Cigarette Warnings—Findings from Expert Interviews. *Int J Environ Res Public Health*. 2017;14(7):781. doi:10.3390/ijerph14070781
79. Azagba S, Jensen JK, Ebling T, Hall M. E-cigarette preemption laws: Limiting local communities from protecting youth. *Prev Med*. 2023;170:107462. doi:10.1016/j.yjmed.2023.107462

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(A-24)

Introduced by: Integrated Physician Practice Section

Subject: Addressing Social Determinants of Health Through Closed Loop Referral Systems

Referred to: Reference Committee D

1 Whereas, existing policy addresses data collection on social determinants of health (H-165.822)
2 as well as data interoperability between physician practices, community-based organizations,
3 and other related social care organizations (H-160.896); and
4
5 Whereas, once patients are screened positive for social needs, these patients are then referred
6 to community-based organizations and other related social care organizations for intervention;
7 and
8
9 Whereas, the White House Office of Science and Technology Policy's *U. S. Playbook to*
10 *Address Social Determinants of Health* supports the development of "backbone organizations"
11 as infrastructure to link health care systems to community service organizations¹; and
12
13 Whereas, "backbone organizations" should be able to act as closed loop referral systems that
14 keep updated lists of community resources and track completion of referrals; and
15
16 Whereas, physician practices still report challenges with using closed loop referral systems to
17 address social determinants of health²; therefore be it
18
19 RESOLVED, that our American Medical Association study the effectiveness and best practices
20 of closed loop referral systems in addressing social determinants of health. (Directive to Take
21 Action)
22

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

Received: 4/17/2024

REFERENCES

1. Domestic Policy Council Office of Science and Technology Policy. "The U.S. Playbook to Address Social Determinants of Health. 2023. (<https://www.whitehouse.gov/wp-content/uploads/2023/11/SDOH-Playbook-3.pdf>)
2. Biedler LB et al. "More than just giving them a piece of paper": Interviews with Primary Care on Social Needs Referrals to Community-Based Organizations. *J Gen Intern Med.* 2022.

RELEVANT AMA POLICY

Health Plan Initiatives Addressing Social Determinants of Health H-165.822

Our AMA:

1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

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

Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896

1. Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.
2. Our AMA: (a) will advocate for data interoperability between physicians' practices, public health, vaccine registries, community-based organizations, and other related social care organizations to promote coordination across the spectrum of care, while maintaining appropriate patient privacy; (b) adopts the position that electronic health records should integrate and display information on social determinants of health and social risk so that such information is actionable by physicians to intervene and mitigate the impacts of social factors on health outcomes; (c) will advocate for adequate standards and capabilities for electronic health records to effectively tag and protect sensitive data before it can be shared or reshared; and (d) supports ongoing monitoring and data collection regarding unintended harm to patients from sharing information on social determinants of health and social risk.

Citation: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19; Appended: Res. 40, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-24)

Introduced by: Medical Student Section

Subject: Guardianship and Conservatorship Reform

Referred to: Reference Committee D

1 Whereas, 1.3 million people (including their \$50 billion in assets) are in court-appointed
2 guardianships or conservatorships, the vast majority of which are permanent guardianships, the
3 most restrictive form and the most difficult and expensive to amend¹; and
4

5 Whereas, due to wide state variation, data on guardian abuse is limited, but reports indicate
6 hundreds of cases of physical and financial abuse¹⁻⁴; and
7

8 Whereas, a Senate Committee on Aging report noted the harm of our guardianship system on
9 older and disabled patients, and emphasized the need for less restrictive alternatives¹; and
10

11 Whereas, the elderly American population is projected to nearly double by 2060 and comprise
12 over 20% of the total population^{1,5-6}; and
13

14 Whereas, physicians play a major role in determining guardianships by providing medical
15 evidence and expertise⁷; and
16

17 Whereas, individuals with intellectual and developmental disabilities (IDD) face barriers to
18 adequate capacity determinations that increase their risk of overly restrictive guardianships⁸;
19 and
20

21 Whereas, supported decision making (SDM) is a less restrictive alternative to guardianships
22 already adopted by 12 states and several other countries that demonstrates preservation of
23 decision-making capacity, cognitive function, and social support⁹⁻¹¹; therefore be it
24

25 RESOLVED, that our American Medical Association support federal and state efforts to collect
26 anonymized data on guardianships and conservatorships to assess the effects on medical
27 decision making and rates of abuse (New HOD Policy); and be it further
28

29 RESOLVED, that our AMA study the impact of less restrictive alternatives to guardianships and
30 conservatorships including supported decision making on medical decision making, health
31 outcomes, and quality of life. (Directive to Take Action)
32

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

Received: 03/28/2024

REFERENCES

1. Senate Aging Committee Examines Ways to Strengthen Guardianship Programs. US Senate Committee on Aging. <https://www.aging.senate.gov/press-releases/senate-aging-committee-examines-ways-to-strengthen-guardianship-programs>. Published November 28, 2018. Accessed August 24, 2021.
2. Elder Abuse: The Extent of Abuse by Guardians is Unknown, but Some Measures Exist to Help Protect Older Adults. United States Government Accountability Office. November 2016, <https://www.gao.gov/assets/690/681088.pdf>.
3. Margaret "Jenny" Hatch, Samantha Alexandra Crane, Jonathan G. Martinis; Unjustified Isolation Is Discrimination: The *Olmstead* Case Against Overbroad and Undue Organizational and Public Guardianship. *Inclusion* 1 June 2015; 3 (2): 65–74. doi: <https://doi.org/10.1352/2326-6988-3.2.65>
4. Andreasian, Karen et al. Revisiting S.C.P.A. 17-A: Guardianship for people with Intellectual and Developmental Disabilities, *CUNY Law review* 18, no. 287 (2015): 335.
5. Projected Future Growth of Older Population. Administration for Community Living. <https://acl.gov/aging-and-disability-in-america/data-and-research/projected-future-growth-older-population#:~:text=In%202019%2C%20there%20were%2054.1,and%2094.7%20million%20by%202060>. Published May 4, 2022. Accessed August 29, 2023.
6. Teasdale B, Daigle LE, Gann T. The contingent effect of guardianship on victimization: An examination of people with and without mental health problems. *J Interpers Violence*. 2021;36(11-12):5186-5208. <https://pubmed.ncbi.nlm.nih.gov/30303026>. Accessed August 24, 2021.
7. Representation and Investigation in Guardianship Proceedings. American Bar Association Commission on Law and Aging, 2021. https://www.americanbar.org/content/dam/aba/administrative/law_aging/chartrepresentationandinvestigation.authcheckdam.pdf
8. Turning Rights Into Reality: How Guardianship and Alternatives Impact the Autonomy of People With Intellectual and Developmental Disabilities. National Council on Disability, 10 June 2019. https://ncd.gov/sites/default/files/NCD_Turning-Rights-into-Reality_508_0.pdf
9. Kristin, Glen B. Supported Decision-Making and the Human Right of Legal Capacity. *Inclusion* 1 March 2015; 3 (1): 2–16. doi: <https://doi.org/10.1352/2326-6988-3.1.2>
10. Peterson, Andrew et al. "Supported Decision Making With People at the Margins of Autonomy." *The American journal of bioethics : AJOB* vol. 21,11 (2021): 4-18. doi:10.1080/15265161.2020.1863507
11. National Resource Center for Supported Decision-Making, In Your State, accessed March 10, 2022. <http://www.supporteddecisionmaking.org/states>

RELEVANT AMA POLICY

H-140.845 Encouraging the Use of Advance Directives and Health Care Powers of Attorney

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives. [CCB/CLRPD Rep. 3, A-14; Reaffirmed: BOT Rep. 9, I-15; Reaffirmed: Res. 517, A-16; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17]

Code of Medical Ethics Opinion 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.

AMA Principles of Medical Ethics: I,III,VIII; Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(A-24)

Introduced by: Medical Student Section

Subject: Occupational Screenings for Lung Disease

Referred to: Reference Committee D

1 Whereas, from 1999 to 2016, the average years of potential life lost due to pneumoconiosis has
2 increased from 8.1 to 12.6 years¹; and

3
4 Whereas, the recent resurgence of pneumoconiosis poses a threat to younger patients, with
5 increased disease burden at initial diagnosis, and affects a growing number of occupations such
6 as metal miners, denim workers, pottery and ceramics workers, and stone masons²⁻⁶; and

7
8 Whereas, laborers affected by pneumoconiosis are disproportionately of Latine or American
9 Indian descent, are more likely to live in isolated and rural communities without access to
10 adequate preventive care, and are less likely to have graduated high school⁷⁻⁸; and

11
12 Whereas, many laborers who depended heavily on mobile health clinics and screening centers
13 were left without options for care when many of these were halted due to COVID⁸; and

14
15 Whereas, occupational screening measures, including the federal National Institute for
16 Occupational Safety & Health's Coal Workers' Health Surveillance Program for radiographic and
17 spirometric screenings, have helped decrease pneumoconiosis mortality^{5,9-12}; therefore be it

18
19 RESOLVED, that our American Medical Association amend Policy H-365.988, "Integration of
20 Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public
21 Health Agencies" by addition and deletion as follows:

22
23 Integration of Occupational Medicine, Environmental Health, and
24 Injury Prevention Programs into Public Health Agencies, H-365.988
25 Our AMA ~~supports~~: (1) supports the integration of occupational
26 health and environmental health and injury prevention programs
27 within existing health departments at the state and local level; (2)
28 supports taking a leadership role in assisting state medical societies
29 in implementation of such programs; ~~and~~ (3) supports working with
30 federal agencies to ensure that "health" is the primary determinant
31 in establishing environmental and occupational health policy; (4)
32 recognizes barriers to accessibility and utilization of such programs;
33 (5) recognizes inequities in occupational health screenings for
34 pulmonary lung disease and supports efforts to increase
35 accessibility of these screenings in marginalized communities; and
36 (6) encourages utilization of accessible screenings, such as those
37 used in the NIOSH Coal Workers Health Surveillance Program, for
38 other at risk occupational groups and utilization of these free
39 screenings. (Modify Current HOD Policy)
40

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

Received: 3/28/2024

REFERENCES

1. Mazurek JM, Wood J, Blackley DJ, Weissman DN. Coal Workers' Pneumoconiosis-Attributable Years of Potential Life Lost to Life Expectancy and Potential Life Lost Before Age 65 Years - United States, 1999-2016. *MMWR Morb Mortal Wkly Rep.* 2018;67(30):819-824. Published 2018 Aug 3.
2. Qi, Xian-Mei1; Luo, Ya1; Song, Mei-Yue2; Liu, Ying1; Shu, Ting1; Liu, Ying3; Pang, Jun-Ling1; Wang, Jing1; Wang, Chen3. Pneumoconiosis: current status and future prospects. *Chinese Medical Journal: April 20, 2021 - Volume 134 - Issue 8 - p 898-907* doi: 10.1097/CM9.0000000000001461
3. Blackley DJ, Crum JB, Halldin CN, Storey E, Laney AS. Resurgence of Progressive Massive Fibrosis in Coal Miners - Eastern Kentucky, 2016. *MMWR Morb Mortal Wkly Rep.* 2016;65(49):1385-1389. Published 2016 Dec 16. doi:10.15585/mmwr.mm6549a1
4. Rose C, Heinzerling A, Patel K, et al. Severe Silicosis in Engineered Stone Fabrication Workers - California, Colorado, Texas, and Washington, 2017-2019. *MMWR Morb Mortal Wkly Rep.* 2019;68(38):813-818. Published 2019 Sep 27. doi:10.15585/mmwr.mm6838a1
5. Bell JL, Mazurek JM. Trends in Pneumoconiosis Deaths - United States, 1999-2018. *MMWR Morb Mortal Wkly Rep.* 2020;69(23):693-698. Published 2020 Jun 12. doi:10.15585/mmwr.mm6923a1
6. Akgün M. Denim production and silicosis. *Curr Opin Pulm Med.* 2016;22(2):165-169. doi:10.1097/MCP.0000000000000249
7. Evans K, Lerch S, Boyce TW, et al. An Innovative Approach to Enhancing Access to Medical Screening for Miners using a Mobile Clinic with Telemedicine Capability. *J Health Care Poor Underserved.* 2016;27(4A):62-72. doi:10.1353/hpu.2016.0182
8. Sood A, Pollard C, Suer KL, Vlahovich K, Walker J. Caring for Miners During the Coronavirus Disease-2019 (COVID-19) Pandemic. *J Rural Health.* 2021;37(1):165-168. doi:10.1111/jrh.12444
9. Reynolds LE, Wolfe AL, Clark KA, et al. Strengthening the Coal Workers' Health Surveillance Program. *J Occup Environ Med.* 2017;59(4):e71. doi:10.1097/JOM.0000000000000993
10. Voelker R. Black Lung Resurgence Raises New Challenges for Coal Country Physicians. *JAMA.* 2019;321(1):17-19. doi:10.1001/jama.2018.15966
11. Laney AS, Blackley DJ, Halldin CN. Radiographic disease progression in contemporary US coal miners with progressive massive fibrosis. *Occup Environ Med.* 2017;74(7):517-520. doi:10.1136/oemed-2016-104249
12. Li T, Yang X, Xu H, Liu H. Early Identification, Accurate Diagnosis, and Treatment of Silicosis. *Can Respir J.* 2022;2022:3769134. Published 2022 Apr 25. doi:10.1155/2022/3769134

RELEVANT AMA POLICY

H-185.936 Lung Cancer Screening to be Considered Standard Care

Our AMA: (1) recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit; (2) will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States; and (3) will work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and education to improve awareness and utilization of the screening among eligible enrollees. [Sub. Res. 114, A-14; Appended: Res. 418, A-22; Appended: Res. 112, A-23]

H-135.944 Further Limit of Asbestos in the United States

Our AMA supports legislation further restricting the use of asbestos in the United States. [Res. 215, A-07; Reaffirmed: BOT Rep. 22, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(A-24)

Introduced by: Medical Student Section

Subject: Protections Against Surgical Smoke Exposure

Referred to: Reference Committee D

1 Whereas, surgical smoke refers to smoke produced by electrical surgical devices in the
2 operating room, which can pose an occupational hazard to healthcare workers^{1, 2, 3}; and
3
4 Whereas, the carcinogenic effects of surgical smoke exposure from one operation have been
5 estimated to be equal to the effects of smoking one pack of cigarettes (or six unfiltered
6 cigarettes per gram of tissue ablated)^{2,4}; and
7
8 Whereas, surgical smoke can cause acute effects such as headache, cough, sore throat, eye
9 irritation, nausea, and dizziness^{5,6}; and
10
11 Whereas, surgical smoke is associated with an increased risk of cancer, inflammatory interstitial
12 pneumonia, and emphysema among surgeons compared to the general population^{7,8,9}; and
13
14 Whereas, the harms of surgical smoke cannot be sufficiently prevented by use of surgical
15 masks or by general operating room ventilation^{5,10}; and
16
17 Whereas, the CDC recommends the use of local exhaust ventilation (such as portable smoke
18 evacuators and room suction systems) alongside general ventilation to adequately reduce
19 exposure to harmful particulates, but local exhaust ventilation is often not used¹¹⁻¹⁴; and
20
21 Whereas, NIOSH's Health and Safety Practices Survey of Healthcare Workers indicates that
22 staff who receive increased training and who work at employers with standard procedures for
23 surgical smoke hazards are more likely to use local exhaust ventilation¹³; and
24
25 Whereas, the Occupational Safety and Health Association (OSHA) has no standardized
26 protocol for surgical smoke exposure, but the National Fire Protection Association (NFPA)
27 recently included a requirement to capture smoke in their 2024 edition of the Health Care
28 Facilities Code, which is used by the Centers for Medicare and Medicaid Services¹⁵⁻¹⁶; and
29
30 Whereas, fifteen states have laws to reduce surgical smoke exposure¹⁶; therefore be it
31
32 RESOLVED, that our American Medical Association support efforts to limit surgical smoke
33 exposure in operating rooms. (New HOD Policy)

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

Received: 4/5/2024

REFERENCES

1. Limchantra IV, Fong Y, Melstrom KA. Surgical Smoke Exposure in Operating Room Personnel: A Review. *JAMA Surg.* 2019;154(10):960-967. doi:10.1001/jamasurg.2019.2515
2. Tomita Y, Mihashi S, Nagata K, et al. Mutagenicity of smoke condensates induced by CO₂-laser irradiation and electrocauterization. *Mutat Res.* 1981;89(2):145-149.
3. Merajikhah A, Imani B, Khazaei S, Bouraghi H. Impact of Surgical Smoke on the Surgical Team and Operating Room Nurses and Its Reduction Strategies: A Systematic Review. *Iran J Public Health.* 2022;51(1):27-36. doi:10.18502/ijph.v51i1.8289
4. Hill DS, O'Neill JK, Powell RJ, Oliver DW. Surgical smoke - a health hazard in the operating theatre: a study to quantify exposure and a survey of the use of smoke extractor systems in UK plastic surgery units. *J Plast Reconstr Aesthet Surg.* 2012;65(7):911-916. doi:10.1016/j.bjps.2012.02.012
5. Ilce A, Yuzden GE, Yavuz van Giersbergen M. The examination of problems experienced by nurses and doctors associated with exposure to surgical smoke and the necessary precautions. *J Clin Nurs.* 2017;26(11-12):1555-1561. doi:10.1111/jocn.13455
6. Okoshi K, Kobayashi K, Kinoshita K, et al. Health risks associated with exposure to surgical smoke for surgeons and operation room personnel. *Surg Today.* 2015;45:957-965.
7. Tseng HS, Liu SP, Uang SN, et al. Cancer risk of incremental exposure to polycyclic aromatic hydrocarbons in electrocautery smoke for mastectomy personnel. *World J Surg Oncol.* 2014;12:31. Published 2014 Feb 4. doi:10.1186/1477-7819-12-31
8. Liu Y, Song Y, Hu X, Yan L, Zhu X. Awareness of surgical smoke hazards and enhancement of surgical smoke prevention among the gynecologists. *J Cancer.* 2019;10(12):2788-2799. Published 2019 Jun 2. doi:10.7150/jca.31464
9. Gates MA, Feskanich D, Speizer FE, Hankinson SE. Operating room nursing and lung cancer risk in a cohort of female registered nurses. *Scand J Work Environ Health.* 2007;33(2):140-147. doi:10.5271/sjweh.1117
10. Gao S, Koehler RH, Yermakov M, et al. Performance of facepiece respirators and surgical masks against surgical smoke: Simulated workplace protection factor study. *Ann Occup Hyg.* 2016;60:608-618.
11. Control of smoke from laser/electric surgical procedures. Centers for Disease Control and Prevention. June 6, 2014. Accessed August 25, 2023.
12. Tokuda, Y., Okamura, T., Maruta, M. et al. Prospective randomized study evaluating the usefulness of a surgical smoke evacuation system in operating rooms for breast surgery. *J Occup Med Toxicol* 15, 13 (2020). <https://doi.org/10.1186/s12995-020-00259-y>
13. Steege AL, Boiano JM, Sweeney MH. Secondhand smoke in the operating room? Precautionary practices lacking for surgical smoke. *Am J Ind Med.* 2016;59(11):1020-1031. doi:10.1002/ajim.22614.
14. Bracale U, Silvestri V, Pontecorvi E, et al. Smoke evacuation during laparoscopic surgery: a problem beyond the COVID-19 period. A quantitative analysis of CO₂ environmental dispersion using different devices. *Surg Innov.* 2022;29:154-159.
15. OSHA. Electrosurgery Plume. Accessed Sept 4, 2023. <https://www.osha.gov/etools/hospitals/surgical-suite/smoke-plume>
16. Association of Perioperative Registered Nurses (AORN). Surgical Smoke-Free OR. AORN[<https://www.aorn.org/get-involved/government-affairs/policy-agenda/surgical-smoke-free-or>]. Accessed Aug 22 2023.

RELEVANT AMA POLICY

H-365.996 Regulation of Occupational Carcinogens

The AMA supports using the best available scientific data, including data derived from animal models, as a basis for regulation of occupational carcinogens.

[Sub. Res. 81, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Modified: CSAPH Rep. 8, A-23]

H-365.980 OSHA Regulations Pertaining to Physicians' Offices and Hospitals

The AMA continues to review the data and rationale used to substantiate OSHA regulations pertaining to medical practice in physician offices and health care facilities. Where OSHA rules and regulations are found to be unnecessary or inappropriate, the AMA will work for their modification or repeal. [Sub. Res. 218, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: BOT Rep. 19, A-14]

H-295.939 Protecting Medical Trainees from Hazardous Exposure

1. Our AMA will encourage all health care-related educational institutions to apply the Occupational Safety and Health Administration (OSHA) Blood Borne Pathogen standard and OSHA hazardous exposure regulations, including communication requirements, equally to employees, students, and residents/fellows.
2. Our AMA recommends: (a) that the Accreditation Council for Graduate Medical Education revise the common program requirements to require education and subsequent demonstration of competence regarding potential exposure to hazardous agents relevant to specific specialties, including but not limited to: appropriate handling of hazardous agents, potential risks of exposure to hazardous agents, situational avoidance of hazardous agents, and appropriate responses when exposure to hazardous material may have occurred in the workplace/training site; (b) (i) that medical school policies on hazardous exposure include options to limit hazardous agent exposure in a manner that does not impact students' ability to successfully complete their training, and (ii) that medical school policies on continuity of educational requirements toward degree completion address leaves of absence or temporary reassignments when a

pregnant trainee wishes to minimize the risks of hazardous exposures that may affect the trainee's and/or fetus' personal health status; (c) that medical schools and health care settings with medical learners be vigilant in updating educational material and protective measures regarding hazardous agent exposure of its learners and make this information readily available to students, faculty, and staff; and (d) medical schools and other sponsors of health professions education programs ensure that their students and trainees meet the same requirements for education regarding hazardous materials and potential exposures as faculty and staff. [Sub. Res. 229, I-92; Reaffirmed: CME Rep. 2, A-03; Reaffirmed: CME Rep. 2, A-13; Modified: CME/CSAPH Joint Rep. 01, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(A-24)

Introduced by: Medical Student Section

Subject: Default Proceed Firearm Sales and Safe Storage Laws

Referred to: Reference Committee D

1 Whereas, default proceed sales, referred to as the “Charleston loophole,” allow vendors to
2 proceed with firearm sales if a background check is inconclusive after three business days, and
3 related deaths and injuries have resulted in \$88 million in settlements¹⁻³; and
4

5 Whereas, in 2021, the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) received
6 5,201 transaction denials due to delayed background checks, which are intended to result in
7 retrieval of firearms from individuals who were able to purchase a firearm but later failed their
8 background check⁴⁻⁹; and
9

10 Whereas, perpetrators in both the 2015 Charleston Church and 2017 Sutherland Springs
11 shootings obtained firearms through default proceed sales, despite criminal records that should
12 have restricted them from purchasing firearms⁹⁻¹¹; and
13

14 Whereas, 22% of default proceed sales in 2018 resulted in transfer of a gun to prohibited
15 purchasers with a history of domestic violence¹²; and
16

17 Whereas, 77% of delayed background checks remain unresolved after 88 days, resulting in
18 destruction of the record, the transaction request, and any data collected from the Federal
19 Bureau of Investigation’s National Instant Criminal Background Check System¹³⁻¹⁵; and
20

21 Whereas, while the AMA has supported the Bipartisan Background Checks Act, the AMA has
22 not publicly supported the Default Proceed Sale Transparency Act¹⁶⁻¹⁸; and
23

24 Whereas, the Giffords Law Center defines safe storage of firearms as locked storage of an
25 unloaded firearm with ammunition stored in a separate location¹⁹; and
26

27 Whereas, while the AMA supports child access prevention (CAP) laws, these laws vary widely
28 in their applicability, with some only applying if reasonable belief exists that a child could gain
29 access to the firearm, some only if a child does gain access to a firearm, and some only if a
30 child causes injury or death with a firearm¹⁹⁻²⁰; and
31

32 Whereas, unlike CAP laws, safe storage laws broadly require storage that also prevents access
33 by unauthorized adults and firearm theft²⁰; and
34

35 Whereas, 20 states have CAP laws, but only 5 states have safe storage laws²⁰⁻²¹; and
36

37 Whereas, 1 million firearms were stolen from private owners from 2017 to 2021, and studies
38 indicate that guns stored unlocked are more likely to be stolen and that 80% of perpetrators in
39 K-12 school shootings stole their firearms from a relative²²⁻²⁵; and
40

1 Whereas, most firearms used in crimes start as legal purchases that are later trafficked as
2 illegal firearms, often through theft, with nearly half of the 1.4 million documented firearms used
3 in crimes from 2017 to 2021 being purchased 3 years or less prior to the crime²⁶⁻²⁹; and
4

5 Whereas, the majority of stolen firearms are stolen from vehicles, with at least 40,000 firearms
6 stolen in 2020³⁰⁻³¹; and
7

8 Whereas, while household access to a firearm is associated with a 1700% increased suicide
9 risk, safe storage can account for 60% of the reduction in suicide mortality³²⁻³⁶; and
10

11 Whereas, the AMA has not publicly supported the Firearm Owners Responsibility and Safety
12 Act, which would have created a comprehensive federal safe storage requirement not limited to
13 child access³⁷; therefore be it
14

15 RESOLVED, that our American Medical Association amend Policy H-145.996, "Firearm
16 Availability," by addition as follows;
17

18 Firearm Availability H-145.996

19 1. Our AMA: (a) advocates a waiting period and background check
20 for all firearm purchasers; (b) encourages legislation that enforces
21 a waiting period and background check for all firearm purchasers;
22 (c) opposes firearm sales to individuals for whom a background
23 check has not been completed; (d) opposes destruction of any
24 incomplete background checks for firearm sales; (e) advocates for
25 public annual reporting by relevant agencies on inappropriate
26 firearm sales, including number of default proceed sales; number of
27 firearms retrieved from individuals after these sales through
28 criminal investigations, across state lines, or via other means; and
29 average time passed between background check completion and
30 retrieval; and (f) urges legislation to prohibit the manufacture, sale
31 or import of lethal and non-lethal guns made of plastic, ceramics, or
32 other non-metallic materials that cannot be detected by airport and
33 weapon detection devices.

34 2. Our AMA supports requiring the licensing/permitting of firearms-
35 owners and purchasers, including the completion of a required
36 safety course, and registration of all firearms.

37 3. Our AMA supports "gun violence restraining orders" for
38 individuals arrested or convicted of domestic violence or stalking,
39 and supports extreme risk protection orders, commonly known as
40 "red-flag" laws, for individuals who have demonstrated significant
41 signs of potential violence. In supporting restraining orders and
42 "red-flag" laws, we also support the importance of due process so
43 that individuals can petition for their rights to be restored.

44 4. Our AMA advocates for (a) federal and state policies that prevent
45 inheritance, gifting, or transfer of ownership of firearms without
46 adhering to all federal and state requirements for background
47 checks, waiting periods, and licensure; (b) federal and state policies
48 to prevent "multiple sales" of firearms, defined as the sale of
49 multiple firearms to the same purchaser within five business days;
50 and (c) federal and state policies implementing background checks
51 for ammunition purchases.

52 (Modify Current HOD Policy); and be it further

1 RESOLVED, that our American Medical Association amend Policy H-145.990, "Prevention of
2 Firearm Accidents in Children," by addition as follows:

3
4 Prevention of Firearm Accidents in Children H-145.990

5 1) Our AMA (a) supports increasing efforts to reduce pediatric
6 firearm morbidity and mortality by encouraging its members to (i)
7 inquire as to the presence of household firearms as a part of
8 childproofing the home; (ii) educate patients to the dangers of
9 firearms to children; (iii) encourage patients to educate their
10 children and neighbors as to the dangers of firearms; and (iv)
11 routinely remind patients to obtain firearm safety locks, to store
12 firearms under lock and key, and to store ammunition separately
13 from firearms;(b) encourages state medical societies to work with
14 other organizations to increase public education about firearm
15 safety; (c) encourages organized medical staffs and other physician
16 organizations, including state and local medical societies, to
17 recommend programs for teaching firearm safety to children; and
18 (d) supports enactment of Child Access Prevention laws and other
19 types of comprehensive safe
20 storage laws that are consistent with AMA policy.

21 2) Our AMA and all interested medical societies wil (a) educate the
22 public about: (b) best practices for firearm storage safety; (c)
23 misconceptions families have regarding child response to
24 encountering a firearm in the home; and (c) the need to ask other
25 families with whom the child interacts regarding the presence and
26 storage of firearms in other homes the child may enter.

27 (Modify Current HOD Policy)

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

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REFERENCES

1. U.S. Department of Justice Office of the Inspector General (DOJ OIG). (2016). Audit of the Handling of Firearms Purchase Denials Through the National Instant Criminal Background Check System: Audit Report 16-32. <https://oig.justice.gov/reports/2016/a1632.pdf>
2. National Public Radio (NPR). (2021, October 28). Charleston church shooting: DOJ settlement families. <https://www.npr.org/2021/10/28/1050035997/charleston-church-shooting-doj-settlement-families>
3. The New York Times. (2021, October 28). Dylann Roof settlement families. <https://www.nytimes.com/2021/10/28/us/dylann-roof-settlement-families.html>
4. Everytown for Gun Safety. (n.d.). Close the Charleston loophole. <https://www.everytown.org/solutions/close-the-charleston-loophole/>
5. Federal Bureau of Investigation (FBI). (2019). 2019 NICS Operations Report [PDF]. <https://www.fbi.gov/file-repository/2019-nics-operations-report.pdf>
6. Federal Bureau of Investigation (FBI). (2021). 2020-2021 NICS Operations Report [PDF]. <https://www.fbi.gov/file-repository/nics-2020-2021-operations-report.pdf>
7. Mascia, J. (2015, July 11). Everything you need to know about federal background checks. The Trace. <https://www.thetrace.org/2015/07/gun-background-check-nics-guide/>
8. Federal Bureau of Investigation (FBI). (2018). 2018 NICS Operations Report [PDF]. <https://www.fbi.gov/file-repository/2018-nics-operations-report.pdf/view>
9. Bureau of Alcohol, Tobacco, Firearms and Explosives. Current Processing Times | Bureau of Alcohol, Tobacco, Firearms and Explosives. (n.d.). <https://www.atf.gov/resource-center/current-processing-times>
10. Department of Justice Office of the Inspector General (DOJ OIG). (2004). ATF Investigations of Individuals Attempting to Illegally Obtain Firearms. <https://oig.justice.gov/reports/ATF/e0406/results.htm>
11. Frequently asked questions about the "Charleston Loophole." (2021, February 10). <https://www.americanprogress.org/wp-content/uploads/sites/2/2021/02/Charleston-Loophole-FAQ212.pdf>
12. Frosch, D., Elinson, Z. (2019, February 20). Armed and dangerous: How the ATF retrieves guns from banned buyers. The Wall Street Journal. https://www.wsj.com/articles/thousands-of-guns-are-mistakenly-sold-to-banned-buyers-its-the-atfs-job-to-get-them-back-11550591324?mod=hp_lead_pos5

13. Everytown for Gun Safety. (2021). Background check loopholes. https://everytownresearch.org/report/background-check-loopholes/?_gl=1*1coxdqr*_ga*MTIzNDMyMzA1LjE2ODQ4NTA2MjIj.*_ga_LTOFWV3EK3*MTY5MTkzNzU3NS40LjEuMTY5MTkzNzU5MS4wLjAuMA
14. Feinstein, D. (2023). Feinstein unveils updated assault weapons ban. <https://www.feinstein.senate.gov/public/index.cfm/press-releases?id=8201C1CD-2085-41B8-B54F-CD829ED463C0>
15. Federal Bureau of Investigation (FBI). (2022). NICS operations report 2020-2021. <https://www.fbi.gov/file-repository/nics-2020-2021-operations-report.pdf>
16. H.R.8929 - 116th Congress (2019-2020): Default Proceed Sale Transparency Act. (2020, December 9). <https://www.congress.gov/bill/116th-congress/house-bill/8929>
17. H.R.817 - 118th Congress (2023-2024): Default Proceed Sale Transparency Act. (2023, February 2). <https://www.congress.gov/bill/118th-congress/house-bill/817>
18. American Medical Association. (2021, March 9). *Executive Office of the president - american medical association*. American Medical Association. <https://searchf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2021-7-9-Letter-to-LaBelle-re-ONDCP-2022-Strategy-v2.pdf>
19. Everytown. Secure gun storage. Accessed August 20, 2023. <https://www.everytown.org/solutions/responsible-gun-storage>
20. Giffords. Child access prevention & safe storage. Updated 2023. Accessed August 20, 2023. <https://giffords.org/gun-laws/policy-areas/child-consumer-safety/child-access-prevention-and-safe-storage>
21. Everytown Research & Policy. Secure storage or child access prevention required. Updated 2023. Accessed August 20, 2023. <https://everytownresearch.org/rankings/law/secure-storage-or-child-access-prevention-required>
22. Dettelbach S. National firearms commerce and trafficking assessment (NFCTA): Crime guns - volume two: Part V: Firearm thefts. 2023
23. Hemenway D, Azrael D, Miller M. Whose guns are stolen? The epidemiology of gun theft victims. *Inj Epidemiol.* 2017;4(1):11. Published Aug 10, 2017. doi:10.1186/s40621-017-0109-8
24. Dunn L. Do safe storage gun laws prevent gun violence? *Guns & America*. Published Jul 13, 2020. Accessed September 17, 2023. <https://gunsandamerica.org/story/20/07/13/do-safe-storage-gun-laws-prevent-violence/>
25. National Institute of Justice. Public mass shootings: Database amasses details of a half century of U.S. mass shootings with firearms, generating psychosocial histories. Updated 2023. Accessed August 27, 2023. <https://nij.ojp.gov/topics/articles/public-mass-shootings-database-amasses-details-half-century-us-mass-shootings>
26. Center for American Progress. Frequently asked questions about firearm safe storage. Updated 2021. Accessed August 27, 2023. <https://www.americanprogress.org/article/frequently-asked-questions-firearm-safe-storage/>
27. Diaz J. 6 major takeaways from the ATF's first report in 20 years on U.S. gun crime. NPR. February 10, 2023. Accessed August 27, 2023. <https://www.npr.org/2023/02/10/1153977949/major-takeaways-from-the-atf-gun-violence-report>
28. Everytown Research & Policy. Who is manufacturing crime guns? City-level data on crime gun recoveries by manufacturer. Accessed August 27, 2023. <https://everytownresearch.org/report/city-level-data-crime-gun-recoveries/>. Updated 2023.
29. Dettelbach S. National firearms commerce and trafficking assessment (NFCTA): Crime guns - volume two: Part III: Crime guns recovered and traced within the United States and its territories. 2023.
30. O'Toole M, Szkola J, Burd-Sharps S. Gun thefts from cars: The largest source of stolen guns. Everytown Research. Updated 2022. Accessed August 27, 2023. <https://everytownresearch.org/gun-thefts-from-cars-the-largest-source-of-stolen-guns/>
31. Fausset R. The largest source of stolen guns? Parked cars. *The New York Times*. Published March 25, 2023. Accessed August 27, 2023. <https://www.nytimes.com/2023/03/25/us/illegal-guns-parked-cars.html>
32. Deisenhammer EA, Ing C, Strauss R, Kemmler G, Hinterhuber H, Weiss EM. The duration of the suicidal process: How much time is left for intervention between consideration and accomplishment of a suicide attempt? *J Clin Psychiatry*. 2009;70(1):19-24. Accessed August 27, 2023. <https://pubmed.ncbi.nlm.nih.gov/19026258/>
33. U.S. Department of Defense. DOD: Safe handling, storage of 'lethal means' key to suicide prevention. Accessed August 27, 2023. <https://www.defense.gov/News/News-Stories/Article/Article%2F2998717%2Fdod-safe-handling-storage-of-lethal-means-key-to-suicide-prevention%2F>. Updated 2022.
34. Shenassa ED, Rogers ML, Spalding KL, Roberts MB. Safer storage of firearms at home and risk of suicide: A study of protective factors in a nationally representative sample. *J Epidemiol Community Health*. 2004;58(10):841-848. doi:10.1136/jech.2003.017343.
35. The White House. Fact sheet: Biden administration takes steps to prevent suicide, including by promoting safe storage of firearms. Updated 2021. Accessed August 27, 2023. <https://www.whitehouse.gov/briefing-room/statements-releases/2021/11/02/fact-sheet-biden-administration-takes-steps-to-prevent-suicide-including-by-promoting-safe-storage-of-firearms/>
36. Anestis M, Anestis J. Suicide rates and state laws regulating access and exposure to handguns. *Am J Public Health*. 2015;105(10):2049-2058. doi:10.2105/AJPH.2015.302753
37. H.R.4836 Firearm Owners Responsibility and Safety Act. 2022 (117th Congress). Accessed Sep 17, 2023. <https://www.congress.gov/bill/117th-congress/house-bill/4836/text>

RELEVANT AMA POLICY

H-145.970 Violence Prevention

Our AMA: (1) encourages the enactment of state laws requiring the reporting of all classes of prohibited individuals, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of relevant information to NICS to improve the quality and timeliness of the data. [BOT Rep. 11, I-18; Reaffirmed: CSAPH Rep. 3, I-21]

H-145.972 Firearms and High-Risk Individuals

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

Our AMA will work with relevant parties to update medical curricula and physician training regarding how to approach conversations with patients and families and to utilize Extreme Risk Protection Orders. [CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18; Reaffirmed: CSAPH Rep. 3, I-21; Modified: Res. 405, A-23]

H-145.991 Waiting Periods for Firearm Purchases

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country. [Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: A-18; Reaffirmation: I-18]

H-145.992 Waiting Period Before Gun Purchase

The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S. [Res. 171, A-89; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Reaffirmation: A-18]

H-145.978 Gun Safety

Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed. [Res. 425, I-98; Reaffirmed: Res. 409, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13; Modified: CSAPH Rep. 8, A-23]

H-145.999 Gun Regulation

Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm. [Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(A-24)

Introduced by: Medical Student Section, American Association of Public Health Physicians

Subject: Opposition to Pay-to-Stay Incarceration Fees

Referred to: Reference Committee D

1 Whereas, "pay-to-stay" fees require individuals to pay for their own imprisonment to cover
2 housing and food costs and are used in 49 states, including \$249 daily in Connecticut, \$80 daily
3 in Maine and Kentucky, \$66 daily in Ohio, and \$20 daily in Alabama¹⁻⁵; and
4

5 Whereas, average hourly wages during incarceration are \$0.13 to \$1.30 per hour, and in the
6 first year after release, 49% earn \$500 or less and 80% earn less than \$15,000⁶⁻⁷; and
7

8 Whereas, because only 10-15% are ever collected, pay-to-stay fees do not significantly
9 contribute to prison budgets, but permanently damage the credit records of individuals leaving
10 incarceration if not paid within 180 days after release and harm future prospects for stable
11 employment and housing^{5,8,9}; and
12

13 Whereas, pay-to-stay fees keep formerly incarcerated individuals trapped in a cycle of poverty
14 and imprisonment, as debts hinder re-entry, contribute to recidivism, and force individuals to
15 forgo basic necessities in order to make payments¹⁰⁻¹²; therefore be it
16

17 RESOLVED, that our American Medical Association oppose fees charged to incarcerated
18 individuals for room and board and advocate for federal and state efforts to repeal statutes and
19 ordinances which permit inmates to be charged for room and board. (Directive to Take Action)

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

Received: 4/10/2024

REFERENCES

1. Friedman B. Unveiling the Necrocapitalist Dimensions of the Shadow Carceral State: On Pay-to-Stay to Recoup the Cost of Incarceration. *Journal of Contemporary Criminal Justice*. 2021 Feb.; 37(1):66-87.
2. Fernandes, A. et al. The "Damaged" State vs. the "Willful" Nonpayer: Pay-to-Stay and the Social Construction of Damage, Harm, and Moral Responsibility in a Rent-Seeking Society. *The Russell Sage Foundation Journal of the Social Sciences*. 2022 Jan.; 8(1) 82-105.
3. Teresa Beatty and Michael Llorens v Ned Lamont and William Tong. 3:22-cv-00380 (2022).
4. Is Charging Inmates to Stay in Prison Smart Policy? Brennan Center for Justice. September 9, 2019.
5. Link, C. et al. In Jail & In Debt: Ohio's Pay-to-Stay Fees. *American Civil Liberties Union of Ohio*. Fall 2015.
6. Captive Labor: Exploitation of Incarcerated Workers. *American Civil Liberties Union and Global Human Rights Clinic*. June 15, 2022.
7. Haight, K. Paying for the Privilege of Punishment: Reinterpreting Excessive Fines Clause Doctrine to Allow State Prisoners to Seek Relief from Pay-to-Stay Fees. *William & Mary Law Review*. 2020; 62(1):287.
8. Lehr, S. The Vast Majority of States Allow People to be Charged for Time Behind Bars. *National Public Radio*. March 4, 2022.
9. Fines, Fees, and Bail: Payments in the Criminal Justice System that Disproportionately Impact the Poor. *Council of Economic Advisers*. December 2015.
10. Ortiz, J. M., & Jackey, H. (2019). The System Is Not Broken, It Is Intentional: The Prisoner Reentry Industry as Deliberate Structural Violence. *The Prison Journal*. 2019; 99(4): 484-503.

11. Link, N. Is There a Link Between Criminal Debt and Recidivism in Reentry?. *Federal Sentencing Reporter* 2022; 34(2-3):188–192.
12. Harper A, Ginapp C, Bardelli T, Grimshaw A, Justen M, Mohamedali A, Thomas I, Puglisi L. Debt, Incarceration, and Re-entry: a Scoping Review. *American Journal of Criminal Justice*. 2021; 46(2):250-278.

RELEVANT AMA Policy

D-430.992 Reducing the Burden of Incarceration on Public Health

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. [Res. 902, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(A-24)

Introduced by: Medical Student Section, American Association of Public Health Physicians

Subject: Racial Misclassification

Referred to: Reference Committee D

- 1 Whereas, the National Center for Health Statistics maintains a National Death Index (NDI), a
2 centralized database of death record information on file in state vital statistics offices¹⁻²; and
3
- 4 Whereas, this data can be linked to databases maintained by agencies like the Centers for
5 Disease Control, Food and Drug Administration, and Centers for Medicare and Medicaid
6 Services to increase the availability of information on an individual's cause of death¹⁻⁵; and
7
- 8 Whereas, a key limitation of these vital statistic data is the misclassification of race and ethnicity
9 on death certificates and in other databases (e.g., inaccurate from minority identification to
10 white), limiting the quality and applicability of data available for racial and ethnic minority
11 populations experiencing health disparities⁶⁻⁷; and
12
- 13 Whereas, populations more likely to be misclassified on their death certificates include, but are
14 not limited to, American Indians and Alaska Natives (AI/AN), Asian Americans, and Native
15 Hawaiians and Other Pacific Islanders (NHPI)^{6,8-13}; and
16
- 17 Whereas, a retrospective linkage of regional records maintained by the Indian Health Service
18 and Oklahoma State Health Department Vital Records reported a 29% underestimation of all-
19 cause mortality in the AI/AN population⁶; and
20
- 21 Whereas, an updated version of the National Longitudinal Mortality Study (1999-2011
22 decedents versus 1990-1998 decedents) found that racial misclassification remained high at
23 40% for the AI/AN population and changed from 5% to 3%, for the Hispanic population and from
24 7% to 3% for the Asian or Pacific Islander (API) population¹⁴⁻¹⁵; and
25
- 26 Whereas, racial misclassification on death certificates is compounded by missing or incorrect
27 race and ethnicity data in other databases, such as those maintained by federal health
28 programs, hospital systems, and related entities¹⁵⁻¹⁹; and
29
- 30 Whereas, a 2021 study of 4,231,370 Medicare beneficiaries who utilized home health care
31 services in 2015 found substantial racial misclassification of self-identified Hispanic, Asian
32 American, Pacific Islander, and AI/AN beneficiaries (more than 80% for AI/AN in 24 states and
33 Puerto Rico) as non-Hispanic white²⁰; and
34
- 35 Whereas, a 2019 study that conducted ICD-9/ICD-10 record linkages between the Northwest
36 Tribal Registry and Oregon and Washington hospital discharge datasets increased the
37 ascertainment of neonatal abstinence syndrome cases among AI/AN newborns by 8.8% in
38 Oregon and by 18.1% in Washington²¹; and

1 Whereas, according to the United States Centers for Disease Control and Prevention, more
2 AI/AN patients are misclassified as another race in cancer registry records than patients in other
3 racial groups, likely from one group to identification as non-Hispanic white²²⁻²³; and
4

5 Whereas, a 2021 prospective observational study of patients admitted to an urban Level 1
6 trauma center found that 45 of 98 patients self-identifying as Hispanic (45.9%) had inaccurately
7 recorded ethnicity in the trauma registry²⁴; and
8

9 Whereas, decedent race and ethnicity may be subject to bias as a 2018 project by the National
10 Consortium for Urban Indian Health found that 48% of surveyed funeral directors were recording
11 an individual's race on death certificates by observation of the individual rather than asking their
12 next of kin^{9,25}; and
13

14 Whereas, mortality-related research data, combined with other clinically-based registries, is a
15 fundamental tool for establishing public health priorities (e.g., advocacy, resource allocation,
16 stakeholder engagement) at the local, state, tribal and federal level and is an important part of
17 Indigenous Data Sovereignty (H-460.884)²⁶; therefore be it
18

19 RESOLVED, that our American Medical Association amend H-85.953, "Improving Death
20 Certification Accuracy and Completion," by addition as follows:
21

22 Improving Death Certification Accuracy and Completion H-85.953

23 1. Our AMA: (a) acknowledges that the reporting of vital events is
24 an integral part of patient care; (b) urges physicians to ensure
25 completion of all state vital records carefully and thoroughly with
26 special attention to the use of standard nomenclature, using legible
27 writing and accurate diagnoses; and (c) supports notifying state
28 medical societies and state departments of vital statistics of this
29 policy and encouraging their assistance and cooperation in
30 implementing it.

31 2. Our AMA also: (a) supports the position that efforts to improve
32 cause of death statistics are indicated and necessary; (b) endorses
33 the concept that educational efforts to improve death certificates
34 should be focused on physicians, particularly those who take care
35 of patients in facilities where patients are likely to die, namely in
36 acute hospitals, nursing homes and hospices; and (c) supports the
37 concept that training sessions in completion of death certificates
38 should be (i) included in hospital house staff orientation sessions
39 and clinical pathologic conferences; (ii) integrated into continuing
40 medical education presentations; (iii) mandatory in mortality
41 conferences; and (iv) included as part of in-service training
42 programs for nursing homes, hospices and geriatric physicians.

43 3. Our AMA further: (a) promotes and encourages the use of ICD
44 codes among physicians as they complete medical claims, hospital
45 discharge summaries, death certificates, and other documents; (b)
46 supports cooperating with the National Center for Health Statistics
47 (NCHS) in monitoring the four existing models for collecting
48 tobacco-use data; (c) urges the NCHS to identify appropriate
49 definitions, categories, and methods of collecting risk-factor data,
50 including quantification of exposure, for inclusion on the U.S.
51 Standard Certificates, and that subsequent data be appropriately
52 disseminated; and (d) continues to encourage all physicians to
53 report tobacco use, exposure to environmental tobacco smoke, and
54 other risk factors using the current standard death certificate format.

1 4. Our AMA further supports HIPAA-compliant data linkages
2 between Native Hawaiian and Tribal Registries, population-based
3 and hospital-based clinical trial and disease registries, and local,
4 state, tribal, and federal vital statistics databases aimed at
5 minimizing racial misclassification. (Modify Current HOD Policy)
6

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

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REFERENCES

1. Enhancing Data Resources for Researching Patterns of Mortality in Patient-Centered Outcomes Research. ASPE Office of the Assistant Secretary for Planning and Evaluation. Published online 2017. <https://aspe.hhs.gov/enhancing-data-resources-researching-patterns-mortality-patient-centered-outcomes-research>
2. National Death Index. Centers for Disease Control and Prevention. Published online 2022. <https://www.cdc.gov/nchs/ndi/index.htm>
3. Chopra S. Access to the National Death Index Made Easy. Published online March 21, 2022. <https://irp.nih.gov/catalyst/28/6/news-you-can-use-national-death-index>
4. Kwong SL, Perkins CI, Snipes KP, Wright WE. Improving American Indian cancer data in the California Cancer Registry by linkage with the Indian Health Service. *J Registry Manage.* 1998;25(1):17–20.
5. Partin MR, Rith-Najarian SJ, Slater JS, Korn JE, Cobb N, Soler JT. Improving cancer incidence estimates for American Indians in Minnesota. *Am J Public Health.* 1999;89(11):1673–1677
6. Dougherty TM, Janitz AE, Williams MB, et al. Racial Misclassification in Mortality Records Among American Indians/Alaska Natives in Oklahoma From 1991 to 2015. *J Public Health Manag Pract.* 2019;25 Suppl 5, Tribal Epidemiology Centers: Advancing Public Health in Indian Country for Over 20 Years(Suppl 5 TRIBAL EPIDEMIOLOGY CENTERS ADVANCING PUBLIC HEALTH IN INDIAN COUNTRY FOR OVER 20 YEARS):S36-S43. doi:10.1097/PHH.0000000000001019
7. Puukka E, Stehr-Green P, Becker TM. Measuring the health status gap for American Indians/Alaska Natives: getting closer to the truth. *Am J Public Health.* 2005;95(5):838–843.
8. Rhoades DA. Racial misclassification and disparities in cardiovascular disease among American Indians and Alaska Natives. *Circulation.* 2005;111(10):1250-1256. doi:10.1161/01.CIR.0000157735.25005.3F
9. Jim MA, Arias E, Seneca DS, et al. Racial misclassification of American Indians and Alaska Natives by Indian Health Service Contract Health Service Delivery Area. *Am J Public Health.* 2014;104 Suppl 3(Suppl 3):S295-S302. doi:10.2105/AJPH.2014.301933
10. Thoroughman DA, Frederickson D, Cameron HD, Shelby LK, Cheek JE. Racial misclassification of American Indians in Oklahoma State surveillance data for sexually transmitted diseases. *Am J Epidemiol.* 2002;155(12):1137-1141. doi:10.1093/aje/155.12.1137
11. Stehr-Green P, Bettles J, Robertson LD. Effect of racial/ethnic misclassification of American Indians and Alaskan Natives on Washington State death certificates, 1989-1997. *Am J Public Health.* 2002;92(3):443-444. doi:10.2105/ajph.92.3.443
12. McClure, Gartner, Bell. Challenges with misclassification of American Indian/Alaska Native race and Hispanic ethnicity on death records in North Carolina occupational fatalities surveillance. *Frontiers in Epidemiology.* Published online October 21, 2022. <https://www.frontiersin.org/articles/10.3389/fepid.2022.878309/full>
13. Harwell TS, Hansen D, Moore KR, Jeanotte D, Gohdes D, Helgerson SD. Accuracy of race coding on American Indian death certificates, Montana 1996-1998. *Public Health Rep.* 2002;117(1):44–49.
14. Arias E, Heron M, Hakes JK. The validity of race and Hispanic-origin reporting on death certificates in the United States: An update. National Center for Health Statistics. *Vital Health Stat* 2(172). 2016.
15. Johnson CL, Paulose-Ram R, Ogden CL, et al. National Health and Nutrition Examination Survey: Analytic guidelines, 1999–2010. National Center for Health Statistics. *Vital Health Stat* 2(161). 2013.
16. Yi, Kwon, Doan, John, Islam, Trinh-Shevrin. The Mutually Reinforcing Cycle Of Poor Data Quality And Racialized Stereotypes That Shapes Asian American Health. *Health Affairs.* 2022;41. <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2021.01417>
17. Erikson, Flannery, Leipertz, et al. Data Genocide of American Indians and Alaska Natives in COVID-19 Data. Urban Indian Health Institute. Published online February 15, 2021. <https://www.uihi.org/projects/data-genocide-of-american-indians-and-alaska-natives-in-covid-19-data/>
18. Friedman J, Hansen H, Gone JP. Deaths of despair and Indigenous data genocide [published online ahead of print, 2023 Jan 25]. *Lancet.* 2023;S0140-6736(22)02404-7. doi:10.1016/S0140-6736(22)02404-7
19. Weikel BW, Klawetter S, Bourque SL, et al. Defining an Infant's Race and Ethnicity: A Systematic Review. *Pediatrics.* 2023;151(1):e2022058756. doi:10.1542/peds.2022-058756
20. Grafova IB, Jarrín OF. Beyond Black and White: Mapping Misclassification of Medicare Beneficiaries Race and Ethnicity. *Med Care Res Rev.* 2021;78(5):616-626. doi:10.1177/1077558720935733
21. Lan CW, Joshi S, Dankovchik J, et al. Racial Misclassification and Disparities in Neonatal Abstinence Syndrome Among American Indians and Alaska Natives. *J Racial Ethn Health Disparities.* 2022;9(5):1897-1904. doi:10.1007/s40615-021-01127-z

22. U.S. Cancer Statistics American Indian and Alaska Native Incidence Data. Centers for Disease Control and Prevention. Published online June 6, 2022. <https://www.cdc.gov/cancer/uscs/about/tools/AIAN-incidence-analytic-db.htm>
23. Frost F, Taylor V, Fries E. Racial misclassification of Native Americans in a Surveillance, Epidemiology, and End Results cancer registry. *J Natl Cancer Inst.* 1992;84(12):957–962.
24. Gore A, Truche P, Iskerskiy A, Ortega G, Peck G. Inaccurate Ethnicity and Race Classification of Hispanics Following Trauma Admission. *J Surg Res.* 2021;268:687-695. doi:10.1016/j.jss.2021.08.003
25. Kalweit, Clark, Ishcomer-Aazami. Determinants of Racial Misclassification in COVID-19 Mortality Data: The Role of Funeral Directors and Social Context. *American Indian Culture and Research Journal.* Published online July 6, 2021. <http://www.books.aisc.ucla.edu/abstracts/44.3.KALWEITCLARKISHCOMER-AAZAMI.pdf>
26. RACIAL MISCLASSIFICATION. National Council of Urban Indian Health. <https://ncuih.org/misclassification>

RELEVANT AMA Policy

H-315.963 Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to Characterize Health Disparities

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. [Res. 03, I-19]

H-350.950 Tribal Public Health Authority

Our AMA will support; (1) the Department of Health and Human Services issuing guidance, through the Centers for Disease Control and Prevention and the Indian Health Service, on Public Health and Tribal-affiliated data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers; and (2) 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. [Res. 206, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(A-24)

Introduced by: Medical Student Section, American College of Physicians

Subject: Indian Water Rights

Referred to: Reference Committee D

1 Whereas, the United States is a signatory of the 2007 United Nations Declaration on the Rights
2 of Indigenous People (UNDRIP), which states that Indigenous Peoples “have the right to own,
3 use, develop, and control the lands, territories and resources that they possess by reason of
4 traditional ownership or other traditional occupation or use, as well as those which they have
5 otherwise acquired”¹; and

6
7 Whereas, nearly half of American Indian/Alaska Native (AI/AN) households on reservations lack
8 access to clean water or adequate sanitation, including 6.5% of American Indian households on
9 and off reservations and 13.5% of Alaska Native villages and reservations (compared to under
10 1% of the general US population)²⁻⁶; and

11
12 Whereas, regardless of income, AI/AN households are 10 times as likely as white households to
13 lack indoor plumbing, an early correlate of high COVID rates on reservations^{2,7}; and

14
15 Whereas, only 42 AI/AN Tribes and Villages meet Environmental Protection Agency (EPA)
16 standards for water quality⁸; and

17
18 Whereas, a third of Navajo Nation residents lack access to clean water and are 67 times more
19 likely than other Americans to live without running water or toilets, due in part to drought and
20 heavy metals, such as uranium, leached from abandoned mining sites⁹⁻¹¹; and

21
22 Whereas, unsafe groundwater resources on the Navajo Nation and other Tribal lands, lead to
23 higher rates of cancer, kidney disease, autoimmune disorders, skin infection, diabetes, and
24 infant hospitalizations for pneumonia¹²⁻¹⁴; and

25
26 Whereas, water systems are part of Indigenous ways of knowing and ceremonies in many
27 Indigenous cultures, thus water insecurity impacts physical, cultural, and spiritual wellbeing in
28 AI/AN communities, with loss of culture itself a risk factor for many chronic conditions among
29 AI/AN individuals¹³⁻¹⁷; and

30
31 Whereas, individuals without adequate water sources require vehicles, sleds, or wheelbarrows
32 to travel miles to wells and water stations and haul water back to their homes¹⁸; and

33
34 Whereas, Navajo Nation families spend \$43,000 per acre-foot of water with hauled water,
35 compared to \$600 for the average American with running water¹⁶; and

36
37 Whereas, *Winters v US* (1908) ruled that Tribes and their members have a right to sufficient
38 water access for residential, economic, governmental, and other needs¹⁹⁻²⁰; and

1 Whereas, lengthy disputes over Indian water rights to settle claims of water rights holders and
2 improve water management in AI/AN communities are expensive to litigate²¹; and
3

4 Whereas, Congress must approve all Indian water right settlements between Tribes, states, and
5 the US, delaying implementation, funds, and land transfers for years²²⁻²⁴; and
6

7 Whereas, the Biden-Harris Administration is coordinating federal agencies to meet Tribal water
8 needs, support Indian water right settlements, and increase Tribal participation in stewardship of
9 federal lands and water systems of significance to Tribal Nations²⁵; and
10

11 Whereas, the Indian Health Service (IHS) investigates and manages environmental health
12 services on Tribal lands, including the provision of health services²⁶; and
13

14 Whereas, the IHS provides environmental engineering and sanitation facilities to AI/AN
15 communities, including the cooperative development and construction of safe water sources,
16 wastewater management, and solid waste systems²⁷⁻²⁸; and
17

18 Whereas, Indian water rights settlements harm access to health care, considering the year long
19 closure of a newly constructed hospital on the Navajo Nation due to inadequate access to on-
20 site water²⁹; and
21

22 Whereas, for every \$1 spent on water and sewage infrastructure, the IHS could save \$1.23 in
23 healthcare costs from diseases related to unsafe water³⁰; therefore be it
24

25 RESOLVED, that our American Medical Association raise awareness about ongoing water
26 rights issues for federally-recognized American Indian and Alaska Native Tribes and Villages in
27 appropriate forums (Directive to Take Action); and be it further
28

29 RESOLVED, that our AMA support improving access to water and adequate sanitation, water
30 treatment, and environmental support and health services on American Indian and Alaska
31 Native trust lands. (New HOD Policy)

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

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REFERENCES

1. United Nations Declaration on the Rights of Indigenous Peoples. United Nations. Published online September 13, 2007. <https://www.un.org/development/desa/indigenouspeoples/declaration-on-the-rights-of-indigenous-peoples.html#:~:text=The%20United%20Nations%20Declaration%20on,%2C%20Bangladesh%2C%20Bhutan%2C%20Burundi%2C>
2. Tanana H. Universal Access to Clean Water for Tribes in the Colorado River Basin. Water and Tribes Initiative. Published online April 2021. <https://www.naturalresourcespolicy.org/docs/water-tribes/wti-full-report-4.21.pdf>
3. Whitt R. Turning the tide: addressing water rights in Indigenous communities. University of New Mexico Newsroom. Published online November 24, 2020. <http://news.unm.edu/news/turning-the-tide-addressing-water-rights-in-indigenous-communities>
4. Alaska Native Tribal Health Consortium. In rural Alaska, access to water is preventive medicine. Anchorage Daily News. Published online September 15, 2020. <https://www.adn.com/sponsored-content/2020/09/15/in-rural-alaska-access-to-water-is-preventative-medicine/>
5. Mattos K. Water Infrastructure Brief. Alaska Native Tribal Consortium. Published online August 2020. <https://anthc.org/wp-content/uploads/2021/04/Washeteria-Technical-Brief.pdf>
6. Creating The Healthiest Nation: Water and Health Equity. American Public Health Association. Published online 2022. https://www.apha.org/-/media/Files/PDF/factsheets/WaterHealthEquity_Factsheet2022_FinalVersion.ashx
7. Rodriguez-Lonebear D, Barcelo N, Akee R, Carroll S. American Indian Reservations and COVID-19: Correlates of Early Infection Rates in the Pandemic. https://journals.lww.com/jphmp/fulltext/2020/07000/american_indian_reservations_and_covid_19_.14.aspx

8. FY 2017 Indian Country Budget Request. National Congress of American Indians. Published online 2017. https://www.ncai.org/resources/ncai-publications/13_FY2017_environmental_protection.pdf
9. Dig Deep. The Navajo Water Project. <https://www.navajowaterproject.org/project-specifics>
10. Barney Y. Providing Safe Drinking Water in Areas with Abandoned Uranium Mines. Environmental Protection Agency. Published June 21, 2022. <https://www.epa.gov/navajo-nation-uranium-cleanup/providing-safe-drinking-water-areas-abandoned-uranium-mines>
11. Ingram JC, Jones L, Credo J, Rock T. Uranium and arsenic unregulated water issues on Navajo lands. *J Vac Sci Technol A*. 2020 May;38(3):031003. doi: 10.1116/1.5142283. Epub 2020 Mar 20. PMID: 32226218; PMCID: PMC7083651.
12. Thomas T, Heavener M. Extreme water conservation in Alaska: limitations in access to water and consequences to health. *Public Health*. Published online February 16, 2016. <https://pubmed.ncbi.nlm.nih.gov/27395332/>
13. Our Relationship to Water and Experience of Water Insecurity among Apsáalooke (Crow Indian) People, Montana. *Int J Environ Res Public Health*. Published online January 12, 2021. <https://www.mdpi.com/1660-4601/18/2/582>
14. Erdei E, Shuey C, Pacheco B, Cajero M, Lewis J, Rubin RL. Elevated autoimmunity in residents living near abandoned uranium mine sites on the Navajo Nation. *J Autoimmun*. 2019 May;99:15-23. doi: 10.1016/j.jaut.2019.01.006. Epub 2019 Mar 14. PMID: 30878168; PMCID: PMC6489502.
15. Larned S. Water is Life: The Native American Tribal Role in Protecting Natural Resources. *Barry University Environmental and Earth Law Journal*. 2018;8(1). <https://lawpublications.barry.edu/cgi/viewcontent.cgi?article=1072&context=ejej>
16. Tanana H, Combs J, Hoss A. Water Is Life: Law, Systemic Racism, and Water Security in Indian Country. *Health Security*. 2021;19. <https://www.liebertpub.com/doi/10.1089/hs.2021.0034>
17. Ahmed N, Jouk N. Cultural Competence In Caring For American Indians and Alaska Natives. *Stat Pearls*. Published online May 8, 2022. <https://www.ncbi.nlm.nih.gov/books/NBK570619>
18. Solomon, Starks, Attacki, Molina, Cordova-Marks. The Generational Impact Of Racism On Health: Voices From American Indian Communities. *Health Affairs*. 2022;41. <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01419>
19. U.S. Reports: *Winters v. United States*, 207 U.S. 564 (1908). <https://www.loc.gov/item/usrep207564/>
20. Federal Reserved Water Rights and State Law Claims. The United States Department of Justice. Published online January 3, 2022. <https://www.justice.gov/enrd/federal-reserved-water-rights-and-state-law-claims#:~:text=Reserved%20Water%20Rights%20and%20the%20Supreme%20Court&text=There%2C%20the%20United%20States%20Supreme,the%20date%20of%20the%20reservation>
21. Groundwater and Streamflow Information Program. Indian Water Rights Settlements. US Geological Survey. Published online 2023. <https://www.usgs.gov/programs/groundwater-and-streamflow-information-program/indian-water-rights-settlements>
22. S. 306. Tule River Tribe Reserved Water Rights Settlement Act of 2023. US Senate. February 7, 2023. <https://www.congress.gov/bill/118th-congress/senate-bill/306/text?s=2&r=1&q=%7B%22search%22%3A%5B%22water+rights%22%5D%7D>
23. S. 4104. Hualapai Tribe Water Rights Settlement Act of 2022. US Senate. April, 28, 2022. <https://www.congress.gov/bill/117th-congress/senate-bill/4104?q=%7B%22search%22%3A%5B%22water+rights%22%5D%7D&s=3&r=5>
24. S. 4898. Pueblos of Acoma and Laguna Water Rights Settlement Act of 2022. US Senate. September 20, 2022. <https://www.congress.gov/bill/117th-congress/senate-bill/4898?q=%7B%22search%22%3A%5B%22water+rights%22%5D%7D&s=4&r=8>
25. Biden-Harris Administration Announces New Actions to Support Indian Country and Native Communities Ahead of the Administration's Second Tribal Nations Summit. The White House. Published online November 30, 2022. <https://www.whitehouse.gov/briefing-room/statements-releases/2022/11/30/fact-sheet-biden-harris-administration-announces-new-actions-to-support-indian-country-and-native-communities-ahead-of-the-administrations-second-tribal-nations-summit#:~:text=President%20Biden%20has%20recognized%20the,of%20significance%20to%20Tribal%20communities>
26. IHS Profile. Indian Health Service. Published online August 2020. <https://www.ihs.gov/newsroom/factsheets/ihsprofile>
27. Division of Sanitation Facilities Construction. Indian Health Service. <https://www.ihs.gov/dsfc>
28. FY 2022 Annual Report of Sanitation Deficiency Levels. Indian Health Service. Published online 2022. https://www.ihs.gov/sites/dsfc/themes/responsive2017/display_objects/documents/FY_2022_Appendix_Project_Listing.pdf
29. Smith AV, Olalde M, Farooq U. How Arizona squeezes tribes for water. *High Country News*. June 14, 2023. Accessed September 2, 2023. <https://www.hcn.org/issues/55.7/indigenous-affairs-colorado-river-how-arizona-stands-between-tribes-and-their-water-squeezed#:~:text=For%20the%20people%20of%20the,so%20the%20hospital%20sits%20empty>
30. IHS Allocates \$700 Million From President Biden's Bipartisan Infrastructure Law to Improve Tribal Water and Sanitation Systems. Health and Human Services. Published online May 31, 2022. <https://www.hhs.gov/about/news/2022/05/31/ihs-allocates-700-million-dollars-from-president-bidens-bipartisan-infrastructure-law-to-improve-tribal-water-sanitation-systems.html>

RELEVANT AMA Policy

H-135.928 Safe Drinking Water

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.
- [Res. 409, A-16; Modified: Res. 422, A-18; Reaffirmed: BOT Rep. 29, A-19]

D-440.924 Universal Access for Essential Public Health Services

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. [Res. 419, A-19; Modified: CSAPH Rep. 2, A-22]

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.

(6) Our AMA will advocate that the Indian Health Service (IHS) establish an Office of Academic Affiliations responsible for coordinating partnerships with LCME- and COCA-accredited medical schools and ACGME-accredited residency programs.

(7) Our AMA will encourage the development of funding streams to promote rotations and learning opportunities at Indian Health Service, Tribal, and Urban Indian Health Programs. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Appended: Res. 305, A-23; Reaffirmed: BOT Rep. 09, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(A-24)

Introduced by: Medical Student Section and American Association of Public Health
Physicians

Subject: Toxic Heavy Metals

Referred to: Reference Committee D

- 1 Whereas, toxic heavy metals (THMs) including mercury, lead, cadmium, chromium, and arsenic
2 enter the environment through natural processes as well as via anthropogenic activities such as
3 power plants, landfills, mining, fossil fuel use, urban runoff, and agriculture¹⁻³; and
4
5 Whereas, national regulations protecting the public from THM exposure are sporadic, eg no air
6 quality standards for cadmium levels, no regulations on heavy metals in soil⁴⁻⁶; and
7
8 Whereas, urban farms and gardens are at risk of higher levels of heavy metal contaminants in
9 soil, air, water, and food⁶⁻⁹; and
10
11 Whereas, individuals at military bases are chronically exposed to toxic heavy metals due to the
12 use of burn pits¹⁰; and
13
14 Whereas, the World Health Organization (WHO) ranks the US in the top 10 for highest levels of
15 arsenic contamination in groundwater, and dangerous levels of arsenic have been found in
16 drinking water wells in over 25 states, exposing over 2 million people¹¹⁻¹²; and
17
18 Whereas, infant and toddler foods have been found to contain THM levels above recommended
19 limits by the Food and Drug Administration (FDA), although the FDA advises that even low
20 levels of THMs can accumulate in children causing chronic illness¹³; and
21
22 Whereas, American Indian persons are exposed to THMs from historic mining sites and on
23 average have higher THM blood levels, associated with heart and lung disease risk¹⁴⁻¹⁵; and
24
25 Whereas, low-income and minoritized communities are disproportionately exposed to
26 chronically high THM levels from hazardous waste sites and air pollution^{9,16-23}; and
27
28 Whereas, THMs may cause acute adverse effects at high concentrations such as psychosis and
29 multi-organ toxicities, and chronic exposure, even below current regulatory limits, may increase
30 risk for heart disease, stroke, dementia, cancer, and infertility^{1,3-4,24-25}; and
31
32 Whereas, the American Heart Association states that THMs are a direct risk factor for
33 cardiovascular disease and recommends protections to prevent public exposure and
34 development of clinical monitoring standards³⁻⁴; and
35
36 Whereas, inconsistency across thresholds between the FDA, EPA, Agency for Toxic
37 Substances and Disease Registry, and WHO and lack of updates reflecting new research
38 contribute to difficulty in THM regulation and resulting unchecked bioaccumulation^{12,15,26};
39 therefore be it

1 RESOLVED, that our American Medical Association urge governmental agencies to establish
2 and enforce limits for identified hazardous pollutants and heavy metals in our food, water, soil,
3 and air (Directive to Take Action); and be it further
4

5 RESOLVED, that our AMA support efforts to monitor and educate individuals on (a) the chronic
6 effects of exposure to toxic heavy metals including at levels below regulation limits, and (b) the
7 burden of toxicity in communities, especially near urban, Superfund, and industrial sites.
8 (New HOD Policy)

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

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REFERENCES

1. Rahman Z, Singh VP. The relative impact of toxic heavy metals (THMs) (arsenic (As), cadmium (Cd), chromium (Cr)(VI), mercury (Hg), and lead (Pb)) on the total environment: an overview. *Environmental Monitoring and Assessment*. 2019;191(7). doi:<https://doi.org/10.1007/s10661-019-7528-7>
2. Metals Overview. United States Environmental Protection Agency. Published online March 20, 2023. <https://www.epa.gov/caddis-vol2/metals>
3. Factsheet on Water Quality Parameters. Environmental Protection Agency. Published Online December 2021.
4. Lamas GA, Bhatnagar A, Jones MR, et al. Contaminant Metals as Cardiovascular Risk Factors: A Scientific Statement From the American Heart Association. *Journal of the American Heart Association*. 2023;12(13). doi:<https://doi.org/10.1161/jaha.123.029852>
5. Wang X, Mukherjee B, Park SK. Does Information on Blood Heavy Metals Improve Cardiovascular Mortality Prediction? *Journal of the American Heart Association*. 2019;8(21). doi:<https://doi.org/10.1161/jaha.119.013571>
6. Kessler R. Urban Gardening: Managing the Risks of Contaminated Soil. *Environmental Health Perspectives*. 2013;121(11-12). doi:<https://doi.org/10.1289/ehp.121-a326>
7. Cooper AM, Felix D, Alcantara F, et al. Monitoring and mitigation of toxic heavy metals and arsenic accumulation in food crops: A case study of an urban community garden. *Plant Direct*. 2020;4(1). doi:<https://doi.org/10.1002/pld3.198>
8. Sekou KD, and Patel H. A Review on the interaction between Nanoparticles and Toxic metals in Soil: Meta-analysis of their effects on soil, plants and human health. *Soil and Sediment Contamination: An International Journal*. Published online July 17, 2022. <https://doi.org/10.1080/15320383.2022.2096564>
9. Masri S, LeBrón AMW, Logue MD, et al. Risk assessment of soil heavy metal contamination at the census tract level in the city of Santa Ana, CA: implications for health and environmental justice. *Environmental Science: Processes & Impacts*. 2021;23(6):812-830. doi:<https://doi.org/10.1039/d1em00007a>
10. Kim YH, Warren SH, Kooter I, et al. Chemistry, lung toxicity and mutagenicity of burn pit smoke-related particulate matter. *Particle and Fibre Toxicology*. 2021;18:45. doi:<https://doi.org/10.1186/s12989-021-00435-w>
11. Ayotte JD, Medalie L, Qi SL, Backer LC, Nolan BT. Estimating the High-Arsenic Domestic-Well Population in the Conterminous United States. *Environmental Science & Technology*. 2017;51(21):12443-12454. doi:<https://doi.org/10.1021/acs.est.7b02881>
12. World Health Organization. Arsenic. World Health Organization. Published February 15, 2018. <https://www.who.int/news-room/fact-sheets/detail/arsenic>
13. Bair EC. A Narrative Review of Toxic Heavy Metal Content of Infant and Toddler Foods and Evaluation of United States Policy. *Frontiers in Nutrition*. 2022;9:919913. doi:<https://doi.org/10.3389/fnut.2022.919913>
14. Zheng L, Lewin M, Ruiz P, et al. Blood cadmium, lead, manganese, mercury, and selenium levels in American Indian populations: The Strong Heart Study. *Environmental Research*. 2022;215:114101-114101. doi:<https://doi.org/10.1016/j.envres.2022.114101>
15. Sobel M, Navas-Acien A, Powers M, et al. Environmental-level exposure to metals and metal-mixtures associated with spirometry-defined lung disease in American Indian adults: Evidence from the Strong Heart Study. *Environmental Research*. 2022;207:112194. doi:<https://doi.org/10.1016/j.envres.2021.112194>
16. Howarth MV, Eiser AR. Environmentally Mediated Health Disparities. *The American Journal of Medicine*. Published online June 2023. doi:<https://doi.org/10.1016/j.amjmed.2023.02.008>
17. Kodros JK, Bell ML, Dominici F, et al. Unequal airborne exposure to toxic metals associated with race, ethnicity, and segregation in the USA. *Nature Communications*. 2022;13(1). doi:<https://doi.org/10.1038/s41467-022-33372-z>
18. Kiaghadi A, Rifai HS, Dawson CN. The presence of Superfund sites as a determinant of life expectancy in the United States. *Nature Communications*. 2021;12(1). doi:<https://doi.org/10.1038/s41467-021-22249-2>
19. Christensen K. The Price of Proximity: Black Women Disproportionately Exposed to Superfund Metals. *Environmental Health Perspectives*. 2023;131(8). doi:<https://doi.org/10.1289/ehp13124>
20. Jones DH, Yu X, Guo Q, Duan X, Jia C. Racial Disparities in the Heavy Metal Contamination of Urban Soil in the Southeastern United States. *International Journal of Environmental Research and Public Health*. 2022;19(3):1105. doi:<https://doi.org/10.3390/ijerph1903110>
21. Norwood C. How infrastructure has historically promoted inequity. PBS NewsHour. Published online April 23, 2021. <https://www.pbs.org/newshour/politics/how-infrastructure-has-historically-promoted-inequality>
22. Interaction Profile For: Arsenic, Cadmium, Chromium, and Lead.; 2004. Accessed September 17, 2023. <https://www.atsdr.cdc.gov/interactionprofiles/ip-metals1/ip04.pdf>
23. Li C, Zhou K, Qin W, et al. A Review on Heavy Metals Contamination in Soil: Effects, Sources, and Remediation Techniques. *Soil and Sediment Contamination: An International Journal*. 2019;28(4):380-394. doi:<https://doi.org/10.1080/15320383.2019.1592108>

24. Mitra S, Chakraborty AJ, Tareq AM, et al. Impact of Heavy Metals on the Environment and Human health: Novel Therapeutic Insights to Counter the Toxicity. *Journal of King Saud University - Science*. 2022;34(3):101865. doi:<https://doi.org/10.1016/j.jksus.2022.101865>
25. Guo AH, Kumar S, Lombard DB. Epigenetic mechanisms of cadmium-induced nephrotoxicity. *Current Opinion in Toxicology*. 2022;32:100372. doi:<https://doi.org/10.1016/j.cotox.2022.100372>
26. Sekou KD, and Patel H. A Review on the interaction between Nanoparticles and Toxic metals in Soil: Meta-analysis of their effects on soil, plants and human health. *Soil and Sediment Contamination: An International Journal*. Published online July 17, 2022. <https://doi.org/10.1080/15320383.2022.2096564>

RELEVANT AMA Policy

H-135.911 Environmental Health Equity in Federally Subsidized Housing

1. Our American Medical Association acknowledges the potential adverse health impacts of living in close proximity to Superfund sites or other contaminated lands.
2. Our AMA advocates for mandated disclosure of Superfund sites or other contaminated lands proximity to those purchasing, leasing, or currently residing in housing in close proximity to Superfund sites or other contaminated lands.
3. Our AMA supports 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. [Res. 415, A-23]

H-135.949 Support of Clean Air and Reduction in Power Plant Emissions:

(1)Our AMA supports (a) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (b) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels. (2) Our AMA will: (a) support the Environmental Protection Agency's proposal, under the Clean Air Act, to regulate air quality for heavy metals and other air toxins emitted from smokestacks. The risk of dispersion through air and soil should be considered, particularly for people living downwind of smokestacks; and (b) urge the EPA to finalize updated mercury, cadmium, and air toxic regulations for monitoring air quality emitted from power plants and other industrial sources, ensuring that recommendations to protect the public's health are enforceable. [Res. 429, A-03; Reaffirmation I-07; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Modified: Res. 506, A-15; Modified: Res. 908, I-17; Appended: Res. 401, A-22]

D-135.022 Addressing Inequity in Onsite Wastewater Treatment

(1)Our American Medical Association supports that federal, state, local, and tribal, governments suspend enforcement of sanitation laws that could result in criminal charges, fines, jail time, and potential property loss for residents who lack the means to purchase functioning septic systems, especially in underserved communities and American Indian reservations. (2) 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. (3) Our AMA will work with interested parties to reduce and eliminate inadequate wastewater treatment systems. [Res. 407, A-23]

D- 135.997 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. [Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of: Res. 505, A-19; Modified: Res. 415, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(A-24)

Introduced by: Medical Student Section

Subject: Access to Public Restrooms

Referred to: Reference Committee D

1 Whereas, when surveyed, 1 in 5 reported experiencing a public bowel/urinary accident, and
2 over half said they or a relative struggled to find public restrooms in the past week;¹ and
3
4 Whereas, the US has only 8 public toilets per 100,000 people, far fewer than Iceland (56),
5 Switzerland (46), and New Zealand (45);² and
6
7 Whereas, public restrooms are important to sanitation and infection control, with limited access
8 directly tied to recent hepatitis A outbreaks in San Diego and Philadelphia;³⁻⁹ and
9
10 Whereas, people who are unhoused, especially those who menstruate, are affected by
11 restricted restroom access due to inability to pay, and public urination or defecation can lead to
12 criminal and civil penalties, including lifelong sex offender registration homelessness;¹⁰⁻¹⁴ and
13
14 Whereas, several states and municipalities' Restroom Access Acts (RAAs) require business to
15 provide restrooms to customers with permanent bowel-related conditions, but these laws are
16 minimally enforced and exclude many other individuals with medical needs;¹⁴ and
17
18 Whereas, public restrooms are often inequitable in size in number for women and transgender,
19 nonbinary, and gender-diverse individuals, despite different usage than cis men;¹⁵⁻¹⁷ and
20
21 Whereas, women often need restrooms more than cis men due to menstruation and higher
22 rates of Crohn's disease, irritable bowel syndrome, cystitis, and incontinence;¹⁸⁻²² and
23
24 Whereas, while restroom parity laws in numerous states and municipalities have increased the
25 ratio of women's to men's stalls and improved access, they often do not apply retroactively and
26 do not address parity for transgender, nonbinary, and gender-diverse individuals;²³ and
27
28 Whereas, transgender people are up to 6 times more likely to avoid public restrooms due to
29 discrimination, harassment, and being questioned for their gender;²⁴ and
30
31 Whereas, gender-inclusive bathrooms have demonstrated reductions in wait times for women
32 by over 60 seconds while increasing wait times for men by only 20 seconds;²⁵ and
33
34 Whereas, several cities have passed ordinances requiring new buildings to have gender-neutral
35 bathrooms and incentivizing construction of new public restrooms;²⁶⁻³⁰ therefore be it
36
37 RESOLVED, that our American Medical Association support access to clean, accessible, and
38 permanent public restrooms that, at minimum, contain a toilet and sink, regardless of any
39 identifying characteristics such as gender identity, appearance, employment status, or
40 commercial status (New HOD Policy); and be it further

1 RESOLVED, that our AMA support parity in restroom access by gender identity, including
2 increasing the number of female and gender-neutral bathrooms available in both new and
3 existing buildings. (New HOD Policy)

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

Received: 4/19/2024

REFERENCES

1. New National Survey Shows that Lack of Public Restrooms is Widespread Public Health Issue. Crohn's Colitis Foundation. November 17, 2022. Accessed August 27, 2023. <https://www.crohnscolitisfoundation.org/new-national-survey-shows-lack-of-public-restrooms-widespread-public-health-issue>
2. The Public Toilet Index. QS Supplies. November 10, 2021. Accessed August 27, 2023. <https://www.qssupplies.co.uk/the-public-toilet-index.html>
3. What Your Bladder is Trying to Tell You About Your Health. Cleveland Clinic. July 17, 2019. Accessed August 27, 2023. <https://health.clevelandclinic.org/what-your-bladder-is-trying-to-tell-you-about-your-health-2/>
4. Freeman MC, et al. The Impact of Sanitation on Infectious Disease and Nutritional Status: A Systematic Review & Meta-Analysis. *International Journal of Hygiene and Environmental Health*. 2017;220(6):928-949. <https://doi.org/10.1016/j.ijheh.2017.05.007>
5. Re: Grand Jury Report: "The San Diego Hepatitis A Epidemic: (Mis)Handling A Public Health Crisis. 2017/2018 San Diego County Grand Jury. https://www.sandiego.gov/sites/default/files/hepa_grand_jury_report_submitted_to_the_city.pdf
6. Solomon A. The Struggle to Find a Public Toilet. Smart Cities Dive. July 17, 2022. Accessed August 27, 2023. <https://www.smartcitiesdive.com/news/the-struggle-to-find-a-public-toilet/628194/>
7. Amato HK, Martin D, Hoover CM, et al. Somewhere to go: assessing the impact of public restroom interventions on reports of open defecation in San Francisco, California from 2014 to 2020. *2022BMC Public Health* 2022;22(1673): 1-10. <https://doi.org/10.1186/s12889-022-13904-4>
8. Elsamadony M, Fujii M, Miura T, et al. Possible transmission of viruses from contaminated human feces and sewage: Implications for SARS-CoV-2. *Sci Total Environ*. 2021;755:1-10. <https://doi.org/10.1016/j.scitotenv.2020.142575>
9. Mass AY, Goldfarb DS, Shah O. Taxi cab syndrome: a review of the extensive genitourinary pathology experienced by taxi cab drivers and what we can do to help. *Rev Urol*. 2014;16(3):99-104.
10. Maroko AR, Hopper K, Gruer C, et al. Public restrooms, periods, and people experiencing homelessness: An assessment of public toilets in high needs areas of Manhattan, New York. *PLOS ONE* 2021;16(6): 1-20. <https://doi.org/10.1371/journal.pone.0252946>
11. No Easy Answers: Sex Offender Laws in the U.S. Human Rights Watch. 2007;19(4). <https://www.hrw.org/sites/default/files/reports/us0907webwcover.pdf>
12. RCW 70A.200.060.
13. United States v. Morgan, No. 09-CR-00573 BMC MDG, 2010 WL 4168624, at *6 (E.D.N.Y. Oct. 19, 2010) (allegation of public urination led to charges for a more serious felony).
14. Weinmeyer R. Lavatories of Democracy: Recognizing a Right to Public Toilets Through International Human Rights and State Constitutional Law. *University of Pennsylvania Journal of Constitutional Law*. 2023;26. <http://dx.doi.org/10.2139/ssrn.4434348>
15. Anthony, KH, Dufresne M. Potty Parity in Perspective: Gender and Family Issues in Planning and Designing Public Restrooms. *Journal of Planning Literature*. 2007;21(3): 267–294. <https://doi.org/10.1177/0885412206295846>
16. Potty Parity. American Restroom Association. Accessed August 27, 2023. <https://americanrestroom.org/potty-parity/#:~:text=%E2%80%9CPotty%20Parity%E2%80%9D%20refers%20to%20advocacy,%20of%20date%20building%20codes>
17. Pinsker J. The Long Lines for Women's Bathrooms Could Be Eliminated. Why Haven't They Been? The Atlantic. January 23, 2019. Accessed August 27, 2023. <https://www.theatlantic.com/family/archive/2019/01/women-men-bathroom-lines-wait/580993/>
18. Baillie MA, Fraser S, Brown MJ. Do women spend more time in the restroom than men? *Psychol Rep*. 2009 Dec;105(3 Pt 1):789-90. doi:10.2466/PRO.105.3.789-790
19. NO MORE QUEUEING AT THE LADIES' ROOM: HOW TRANSGENDER-FRIENDLINESS MAY HELP IN BATTLING FEMALE-UNFRIENDLY TOILET CULTURE. SCIENCEDAILY. JULY 14, 2017. ACCESSED AUGUST 27, 2023. <WWW.SCIENCEDAILY.COM/RELEASES/2017/07/170714142749.HTM>.
20. Acute cystitis: Overview. Institute for Quality and Efficiency in Health Care. 2011 [Updated 2019]. <https://www.ncbi.nlm.nih.gov/books/NBK279403/>
21. Kim YS, Kim N. Sex-Gender Differences in Irritable Bowel Syndrome. *J Neurogastroenterol Motil*. 2018;24(4):544-558. doi:10.5056/jnm18082
22. Urinary Incontinence. NIH Maternal Morbidity & Mortality Web Portal. January 31, 2019. Accessed August 27, 2023. <https://orwh.od.nih.gov/research/maternal-morbidity-and-mortality/information-for-women/urinary-incontinence/#:~:text=Urinary%20incontinence%20affects%20twice%20as,muscles%20that%20support%20these%20organs>.

23. Anthony, K. H., & Dufresne, M. Potty Parity in Perspective: Gender and Family Issues in Planning and Designing Public Restrooms. *Journal of Planning Literature*, 2007;21(3), 267–294. <https://doi.org/10.1177/0885412206295846>
24. Lerner JE. Having to "Hold It": Factors That Influence the Avoidance of Using Public Bathrooms among Transgender People. *Health & Social Work*. 2021;46(4): 260–267. <https://doi.org/10.1093/hsw/hlab027>
25. Bovens, L & Marocci, A. The gender-neutral bathroom: A new frame and some nudges. *Behavioural Public Policy*, 2023;7(1), 1-24. doi:10.1017/bpp.2020.23.
26. CITY COUNCIL EXPANDS REQUIREMENTS FOR GENDER NEUTRAL PUBLIC RESTROOMS. CITY OF SANTA MONICA. APRIL 26, 2023. ACCESSED AUGUST 27, 2023. <HTTPS://WWW.SANTAMONICA.GOV/PRESS/2023/04/26/CITY-COUNCIL-EXPANDS-REQUIREMENTS-FOR-GENDER-NEUTRAL-PUBLIC-RESTROOMS>
27. C.A. Legislative Assembly. S.B. 1194. 2021-2022 (2022). https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB1194
28. Schick, W. Thanks to DC's new toilet law, it's going to be easier to find a place to go. Greater Greater Washington. December 9, 2019. Accessed August 27, 2023. <https://ggwash.org/view/75001/behind-the-fight-to-provide-dc-residents-with-public-restrooms>
29. Chicago, Illinois. Resolution R2021-1489.
30. City of Denver Public Restrooms Pilot Project. Progressive Urban Management Associates. 2018. <https://www.denvergov.org/content/dam/denvergov/Portals/705/documents/projects/Denver-Public-Restrooms-Pilot-Final-Report-2018.pdf>

RELEVANT AMA Policy

H-65.964 Access to Basic Human Services for Transgender Individuals

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. [Res. 010, A-17]

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

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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(A-24)

Introduced by: Oklahoma

Subject: Missing and Murdered Indigenous Persons

Referred to: Reference Committee D

1 Whereas, there is an epidemic of violence and a rising number of cases of abduction and
2 murder of American Indian and Alaska Native persons (AI/AN) in the United States (U.S.), with
3 greater than 2 in 5 AI/AN women raped in their lifetime, and homicide reported in the top 10
4 leading causes of death according to The National Intimate Partner and Sexual Violence Survey
5 (NIPSVS) ^{1, 2, 3}; and
6

7 Whereas, the NIPSVS reported that non-Hispanic AI/AN individuals experienced the second
8 highest rate of homicide compared to their counterparts in all other racial and ethnic groups in
9 2020³; and
10

11 Whereas, due to factors such as racial misclassification, underreporting, and distrust between
12 law enforcement and Indigenous communities, published statistics likely underestimate the
13 number of sexual violence crimes and missing and murdered AI/AN persons⁴; and
14

15 Whereas, the U.S. Bureau of Indian Affairs has called for additional investigative resources to
16 address this epidemic of violence¹; and
17

18 Whereas, in 2019, President Trump signed Executive Order 13898, which established the two-
19 year, multi-agency Operation Lady Justice Task Force to address the concerns of AI/AN Tribes
20 and Villages regarding missing and murdered persons⁵; and
21

22 Whereas, in 2020, Operation Lady Justice released their first report in collaboration with tribal
23 leaders and community members which suggested establishing local, tribal, regional, and
24 national alert systems for AI/AN persons similar to Amber Alert⁵; and
25

26 Whereas, in 2020, Public Law No. 116-165, Savanna's Act, was signed into law to increase
27 coordination and data-sharing among Federal, State, Tribal, and local law enforcement
28 agencies in an attempt to improve federal prosecution rates and involvement in missing or
29 murdered AI/AN person-cases⁶; and
30

31 Whereas, in 2021, the US Department of Interior launched the formation of the Missing &
32 Murdered Unit (MMU) to provide additional resources and interagency cooperation with
33 necessary stakeholders such as the Federal Bureau of Investigation on this pressing issue⁷; and
34

35 Whereas, the Urban Indian Health Institute, one of the nation's 12 Tribal Epidemiology Centers,
36 found that the rate of missing AI/AN women in Washington State was 78.64 per 100,000, which
37 was more than four times the rate for non-Hispanic white women in 2018⁸; and

1 Whereas, in 2022, Washington State established a statewide and first-in-the-nation Missing and
2 Murdered Indigenous Women's and People's Alert System (MIPA)⁹; and

3
4 Whereas, MIPA makes AI/AN persons eligible for law enforcement assistance who do not
5 otherwise meet strict AMBER Alert criteria and can also be used for AI/AN persons believed to
6 be in danger and presumed to be unable to return to safety without assistance⁹; and

7
8 Whereas, in the 6 months since it was first implemented, the Washington State MIPA has been
9 activated 33 times and 27 individuals have been located, with 4 of those cases directly
10 attributed to MIPA¹⁰; and

11
12 Whereas, several states have now passed legislation to coordinate responses between tribal
13 and non-tribal law enforcement entities and implement AI/AN-specific emergency alert systems,
14 including Arizona, Colorado, Minnesota, Montana, North Dakota, Nebraska, New Mexico,
15 Oregon, South Dakota, and California^{8, 11, 12}; and

16
17 Whereas, the Urban Indian Health Institute has also challenged lawmakers and policymakers to
18 consider a number of factors in their responses to this crisis, including law enforcement stigma
19 towards substance use in AI/AN communities, non-reporting of LGBTQ2S+ identification for
20 missing and murdered AI/AN persons, lack of coordination between tribal, state, and federal law
21 enforcement, and inadequate protocols regarding AI/AN persons living away from their tribal
22 lands⁹; therefore be it

23
24 RESOLVED, that our American Medical Association supports emergency alert systems for
25 American Indian and Alaska Native tribal members reported missing on reservations and in
26 urban areas. (New HOD Policy)

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

Received: 4/22/2024

REFERENCES

1. Missing and Murdered Indigenous People Crisis. IndianAffairs.gov. Accessed August 19, 2023. <https://www.bia.gov/service/mmu/missing-and-murdered-indigenous-people-crisis>.
2. Wilson BDM, Bouton L, Mallory C. American Indian and Alaskan Native LGBT Adults in the US. UCLA School of Law Williams Institute. October 2021. Accessed August 19, 2023. <https://williamsinstitute.law.ucla.edu/wp-content/uploads/LGBT-AIAN-SES-Oct-2021.pdf>.
3. Basile KC, Smith SG, Kresnow M, Khatiwada S, Leemis RW. The National Intimate Partner and Sexual Violence Survey: 2016/2017 Report on Sexual Violence. National Center for Injury Prevention and Control, Centers for Disease Control and Prevention. June 2022. Accessed August 19, 2023.
4. Lucchesi A, Echo-Hawk A. Missing and Murdered Indigenous Women & Girls. Urban Indian Health Institute. November 14, 2018. Accessed August 20, 2023. <https://www.uhi.org/resources/missing-and-murdered-indigenous-women-girls/>.
5. Operation Lady Justice's First Report on Increasing the Safety of American Indians and Alaska Natives. The Community Policing Dispatch. January 2021. Accessed August 20, 2023. https://cops.usdoj.gov/html/dispatch/01-2021/cp_dispatch_jan_lady_justice.html.
6. U.S. Department of Justice. Savanna's Act. March 31, 2023. Accessed August 22, 2023.
7. About the MMU. IndianAffairs.gov. Accessed August 20, 2023. <https://www.bia.gov/mmu/about>.
8. We Demand More: Partner Toolkit. Urban Indian Health Institute. September 20, 2019. Accessed August 20, 2023. <https://www.uhi.org/resources/mmiwg-we-demand-more/>.
9. State Launches M.I.P.A. - Missing Indigenous Person Alert System. Washington State Patrol. June 30, 2022. Accessed August 20, 2023. <https://www.wsp.wa.gov/2022/06/30/state-launches-m-i-p-a-missing-indigenous-person-alert-system/>.
10. Oron G. Washington state taking action to address MMIWP crisis. www.realchangenews.org. Published January 18, 2023. Accessed September 17, 2023. <https://www.realchangenews.org/news/2023/01/18/washington-state-taking-action-address-mmiwp-crisis>
11. Missing or Murdered Indigenous Persons (MMIP): State Resources. Office for Victims of Crime. May 23, 2023. Accessed August 20, 2023. <https://ovc.ojp.gov/topics/missing-murdered-indigenous-persons/state-resources>.
12. Missing or Murdered Indigenous People Information and Resources. Human Trafficking Capacity Building Center. Accessed August 20, 2023. <https://htcbc.ovc.ojp.gov/mmp#faq-coordination-tribal-local-and-state-governments>.

RELEVANT AMA POLICY

Addressing Sexual Violence and Improving American Indian and Alaska Native Women's Health Outcomes D-350.985

1. Our AMA advocates for mitigation of the critical issues of American Indian/Alaska Native women's health that place Native women at increased risk for sexual violence, and encourages allocation of sufficient resources to the clinics serving this population to facilitate health care delivery commensurate with the current epidemic of violence against Native women.
2. Our AMA will collaborate with the Indian Health Service, Centers for Disease Control and Prevention (CDC), Tribal authorities, community organizations, and other interested stakeholders to develop programs to educate physicians and other health care professionals about the legal and cultural contexts of their American Indian and Alaska Native female patients as well as the current epidemic of violence against Native women and the pursuant medical needs of this population.
3. Our AMA will collaborate with the Indian Health Service, CDC, Tribal authorities, and community organizations to obtain or develop appropriate American Indian and Alaska Native women's health materials for distribution to patients in the spirit of self-determination to improve responses to sexual violence and overall health outcomes. [Res. 208, I-15]

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

Missing Children Identification H-60.996

The AMA supports (1) development of a means of identifying children; and (2) education of the public and parents on the fingerprinting and documentation of characteristic identifying marks as a matter of record, should it be necessary to assist officials in locating a missing child. [Res. 98, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14]

Fund for Public Health Emergency Response H-440.825

Our AMA supports the reauthorization and appropriation of sufficient funds to a public health emergency fund within the Department of Health and Human Services to facilitate adequate responses to public health emergencies without redistributing funds from established public health accounts. [Res. 420, A-16]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(A-24)

Introduced by: Indiana

Subject: Lithium Battery Safety

Referred to: Reference Committee D

1 Whereas, more pieces of equipment utilize lithium batteries; and
2
3 Whereas, lithium batteries have limited useful lifetime use; and
4
5 Whereas, disposal and recycling of lithium batteries is not a well-established system; and
6
7 Whereas, improper storage of lithium batteries can lead to fires; and
8
9 Whereas, putting out lithium battery fires can be difficult and requires robust resources; and
10
11 Whereas, rural communities' fire department coverage resources can be less robust and less
12 able to handle lithium battery fires; and
13
14 Whereas, local agencies often are not aware of lithium battery storage in their area; therefore be
15 it
16
17 RESOLVED, that our American Medical Association seek legislation to increase environmental
18 and public safety oversight of lithium batteries and businesses that store and dispose of lithium
19 batteries. (Directive to Take Action)
20

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

Received: 4/23/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(A-24)

Introduced by: Michigan

Subject: Sexuality and Reproductive Health Education

Referred To: Reference Committee D

1 Whereas, the American Academy of Pediatrics (AAP) has identified the timely need for equitable
2 access to comprehensive sex education as a critical component of adolescent health; and
3

4 Whereas, the Centers for Disease Control and Prevention (CDC) states: “A quality sexual health
5 education curriculum includes medically accurate, developmentally appropriate, and culturally
6 relevant content and skills that target key behavioral outcomes and promote healthy sexual
7 development. The curriculum is age-appropriate and planned across grade levels to provide
8 information about health risk behaviors and experiences.”; and
9

10 Whereas, the CDC identifies the following benefits of students receiving sexual health education:
11 Delay initiation of sexual intercourse; Have fewer sex partners; Have fewer experiences of
12 unprotected sex; Increase their use of protection, specifically condoms; and, Improve their
13 academic performance; and
14

15 Whereas, meta-analysis of comprehensive sex education programs showed marked effectiveness
16 reducing sexual partners, unprotected sex, sexually transmitted infections (STIs), and pregnancy,
17 while abstinence-only sex education programs did not indicate a statistically significant reduction in
18 these measures; and
19

20 Whereas, states that have laws that require or stress abstinence-only programs have higher rates
21 of teenage pregnancy; and
22

23 Whereas, in states that do not require medically accurate sexual education, rates of teen
24 pregnancy, birth, and sexually transmitted infection are the highest; and
25

26 Whereas, 95 percent of unintended pregnancies were due to lack of contraception use and
27 incorrect or inconsistent contraception usage; and
28

29 Whereas, the APP states that “comprehensive sex education should occur across the
30 developmental spectrum, beginning at early ages and continuing throughout childhood and
31 adolescence”; and
32

33 Whereas, our American Medical Association Policy H-170.968 also recognizes the importance of
34 “developmentally appropriate sexuality education programming in the schools at all levels, at local
35 option and direction”; therefore be it
36

37 RESOLVED, that our American Medical Association reaffirm AMA Policy H-170.968, “Sexuality
38 Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools,” and
39 continue to advocate for the adoption of developmentally appropriate, culturally sensitive,
40 comprehensive sexuality and reproductive health education and reproductive rights curriculum.
41 (Reaffirm HOD Policy)

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

Received: 4/23/2024

REFERENCES

1. American College of Obstetricians and Gynecologists. Women's global health and rights. Statement of Policy. Reaffirmed July 2021.
2. <https://www.aap.org/en/patient-care/adolescent-sexual-health/equitable-access-to-sexual-and-reproductive-health-care-for-all-youth/>.
3. <https://www.cdc.gov/healthyyouth/whatworks/what-works-sexual-health-education.htm>.
4. Chin H, Sipe T, Elder R, et al. (2012, March). The Effectiveness of Group-Based Comprehensive Risk-Reduction and Abstinence Education Interventions to Prevent or Reduce the Risk of Adolescent Pregnancy, Human Immunodeficiency Virus, and Sexually Transmitted Infections: Two Systematic Reviews for the Guide to Community Preventive Services. *American Journal of Preventive Medicine*. 2012;42(3):272-294. Doi: 10.1016/j.amepre.2011.11.006
5. Stanger-Hall, K. F., & Hall, D. W. (2011, October 14). Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S. Retrieved from http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0024658&utm_source=AOL&utm_medium=readMore&utm_campaign=partner
6. Jozkowski, K. N., & Crawford, B. L. (2015). The Status of Reproductive and Sexual Health in Southern USA: Policy Recommendations for Improving Health Outcomes. *Sexuality Research and Social Policy*, 13(3), 252-262. doi:10.1007/s13178-015-0208-7
7. Gold, RB, Sonfield A, Richards CL, Frost JJ. (2009). Next Steps for America's Family Planning Program. New York: Guttmacher Institute

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

- (1) Supports the concept of sexuality education in the home, when possible, as well as developmentally appropriate sexuality education programming in the schools at all levels, at local option and direction;
- (2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms and other effective barrier protection methods available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of LGBTQ+ youth; (f) appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; (g) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; (h) are part of an overall health education program; and (i) include culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils;
- (3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;
- (4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;
- (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems;
- (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes;
- (7) Supports federal funding of comprehensive sex education programs that stress the importance of preventing unwanted teenage pregnancy and sexually transmitted infections via comprehensive education, including contraceptive choices, abstinence, and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and
- (8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy;
- (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and
- (10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and

technically accurate. [CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09; Modified: Res. 405, A-16; Appended: Res. 401, A-16; Appended: Res. 414, A-18; Appended: Res. 428, A-18; Modified: Res. 413, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(A-24)

Introduced by: California

Subject: Addressing the Health Sector’s Contributions to the Climate Crisis

Referred to: Reference Committee D

1 Whereas, the sharp rises of greenhouse gas (GHG) emissions has already warmed the planet
2 by more than 1.2°C over pre-industrial levels, which has negatively affected public health;¹ and
3

4 Whereas, globally, the U.S. health care sector is responsible for 25% of all health care GHG
5 emissions, more than any other country;² and
6

7 Whereas, health care organizations spend over \$6.5 billion on energy each year, with that
8 amount rising to meet patients’ needs;³ and
9

10 Whereas, effective use of virtual health services can also reduce emissions in the health care
11 sector by reducing patient travel to physician offices and facilities;⁴ and
12

13 Whereas, “greenwashing” occurs when an entity makes a misleading claim or implies to
14 consumers that a product or service is environmentally friendly or has a greater positive
15 environmental impact than it actually does;⁵ and
16

17 Whereas, many physicians and health care facilities are looking for more sustainable and
18 environmentally friendly health care equipment and medications and can thus be vulnerable to
19 claims of “greenwashing” because the environmental reporting standards for health care
20 products can contain gaps that can make interpretation difficult and inconsistent;⁶ and
21

22 Whereas, the Securities and Exchange Commission (SEC) has proposed rule changes that
23 would require, among other things, GHG emissions reporting by all registrants, which would
24 also require reporting of a company’s climate targets, how they will meet those goals, and data
25 on their progress and how that progress was achieved;⁷ and
26

27 Whereas, the Inflation Reduction Act (IRA) has allocated almost \$400 billion toward efforts to
28 increase green energy and reduce carbon emissions;^{8,9} and
29

30 Whereas, the IRA also allocated \$3 billion to fund an environmental justice grant program to
31 provide grants to community-based organizations in disadvantaged communities;^{8,9} and
32

33 Whereas, in March 2023, the Centers for Medicare and Medicaid Services (CMS) issued a
34 categorical waiver that would allow most health care facilities to use a health care microgrid
35 system (HCMS) as a source of emergency power;¹⁰ and
36

37 Whereas, HCMS power sources can rely entirely on, or be supplemented by, a combination of
38 clean energy technologies, which include fuel cells, solar panels, wind turbines, and energy
39 storage systems;¹⁰ and

1 Whereas, our AMA has extensive policy establishing climate changes as a public health crisis,
2 supporting measurable targets for limiting global warming, reducing greenhouse gas emissions,
3 and encouraging the health sector to lead by example but does not have specific policy related
4 to efforts specific to the health care sector; therefore be it

5
6 RESOLVED, that our American Medical Association recognizes that clinical quality and safety
7 should not be sacrificed as strategies for reducing greenhouse gasses and waste (New HOD
8 Policy); and be it further

9
10 RESOLVED, that our AMA recognizes that animal-based agriculture is a significant contributor
11 to greenhouse gas emissions and supports efforts to increase and promote plant-based menu
12 options in hospital food services, for both health and environmental reasons (New HOD Policy);
13 and be it further

14
15 RESOLVED, that our AMA expects that health systems will provide transparency and avoid
16 misleading the public regarding their greenhouse gas emissions, including but not limited to
17 providing definitions used in the calculations of their net-zero emissions (New HOD Policy); and
18 be it further

19
20 RESOLVED, that our AMA opposes corporate “greenwashing,” or the act of making misleading
21 statements about the environmental benefits of products and/or services (New HOD Policy);
22 and be it further

23
24 RESOLVED, that our AMA supports the development of locally managed and reliable electrical
25 microgrids that operate independently from the larger electrical grid for hospitals and other
26 health care facilities to use as a way to reduce reliance on diesel generation for back-up
27 services while maintaining critical care functions during emergencies and supports grants being
28 provided to independent practices to facilitate this development (New HOD Policy); and be it
29 further

30
31 RESOLVED, that our AMA supports the use of virtual health care, where appropriate, with
32 reasonable reimbursement, as a strategy to reduce the carbon footprint of health care (New
33 HOD Policy); and be it further

34
35 RESOLVED, that our AMA support financial assistance for health care entities, including
36 community health centers, clinics, rural health centers, small- and medium-sized physician
37 practices, transitioning to environmentally sustainable operations (New HOD Policy); and be it
38 further

39
40 RESOLVED, that our AMA support the development of concise clinical guidelines and patient
41 education materials to assist physician practices and patients to reduce adverse organizational
42 and personal impacts on climate change. (New HOD Policy)

43
Fiscal Note: Minimal - less than \$1,000

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REFERENCES

1. Watts N., Amann M., et. al. The 2020 Report of The Lancet Countdown on Health and Climate Change: Responding to Converging Crises. LANCET (January 2021), available at [https://doi.org/10.1016/S0140-6736\(20\)32290-X](https://doi.org/10.1016/S0140-6736(20)32290-X). PMID: 33278353.
2. Eckelman M. J., Huang K., Lagasse R., et. al. (2020). Health Care Pollution and public health damage in the United States: An update. Health Affairs, 39(12), 2071–2079. <https://doi.org/10.1377/hlthaff.2020.01247>.
3. *Healthcare: An overview of energy use and energy efficiency opportunities*, ENERGY STAR website at <https://www.energystar.gov/ia/partners/publications/pubdocs/Healthcare.pdf>.
4. Schneider, Mary E. (2023) *Do no harm: Is health care polluting the earth?* American Society of Hematology Clinical News. <https://ashpublications.org/ashclinicalnews/news/7228/Do-No-Harm-Is-Health-Care-Polluting-the-Earth>.
5. Gordon, D. & Zuegge, K.L. (2020). Greenwashing in health care marketing. American Society of Anesthesiologists Monitor, 84, 18–21. <https://pubs.asahq.org/monitor/article/84/4/18/108451/Greenwashing-in-Health-Care-Marketing>.
6. Leah Kirts, *How to Avoid Greenwashing, According to the Experts*, CNN UNDERSCORED (April 28, 2023), available at <https://www.cnn.com/cnn-underscored/home/what-is-greenwashing>.
7. *Press release: SEC Proposes Rules to Enhance and Standardize Climate-Related Disclosures for Investors*. Securities and Exchange Commission, Securities and Exchange Commission website at <https://www.sec.gov/news/press-release/2022-4>.
8. *What Climate Change Means for California*, United States Environmental Protection Agency website at <https://19january2017snapshot.epa.gov/sites/production/files/2016-09/documents/climate-change-ca.pdf>.
9. *Building a Clean Energy Economy: A Guidebook to the Inflation Reduction Act's Investments in Clean Energy and Climate Action*, THE WHITE HOUSE (January 2023), available at <https://www.whitehouse.gov/wp-content/uploads/2022/12/Inflation-Reduction-Act-Guidebook.pdf>.
10. *Categorical Waiver – Health Care Microgrids Systems (HCMSs)*, Centers for Medicare & Medicaid Services website at <https://www.cms.gov/files/document/qso-23-11-lsc.pdf>.

RELEVANT AMA POLICY

H-135.938 Global Climate Change and Human Health

Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change. 2. Supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies. 3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes. 4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability. 5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk. 6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment. 7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training. [Modified: CSAPH Rep. 2, I-22; Modified: Res. 424, A-22; Reaffirmation: I-19; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation A-14; CSAPH Rep. 3, I-08]

D-135.966 Declaring Climate Change a Public Health Crisis

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.
[Appended: CSAPH Rep. 02, I-22; Res. 420, A-22]

H-150.949 Healthful Food Options in Health Care Facilities

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.

[Appended: Res. 304, A-21; Modified: Res. 904, I-19; Modified: Res. 425, A-18; Appended: Res. 406, A-17; Reaffirmed: CSAPH Rep. 1, A-14; Res. 410, A-04]

G-630.135 Eliminating Food Waste Through Recovery

Our AMA will: (1) consider 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 donations.

[Res. 603, A-18]

H-135.939 Green Initiatives and the Health Care Community

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.

[Modified: Res. 923, I-19; Modified: Res. 516, A-18; Reaffirmed in lieu of: Res. 504, A-16; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation A-09; CSAPH Rep. 1, I-08]

D-120.929 Permitting the Dispensing of Stock Medications for Post Discharge Patient Use and the Safe Use of Multi-dose Medications for Multiple Patients

Our AMA will: (1) work with national specialty societies, state medical societies and/or other interested parties to advocate for legislative and regulatory language that permits the practice of dispensing stock-item medications to individual patients upon discharge in accordance with labeling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste; and (2) work with the Food and Drug Administration, national specialty societies, state medical societies and/or other interested parties to advocate for legislative and regulatory language that permits the practice of using multi dose medications, such as eye drops, injectables and topical medications in accordance with safe handling and dispensing protocols that help ensure patient safety, minimize duplicated patient costs, and reduce medication waste.

[Res. 234, I-21]

H-135.949 Support of Clean Air and Reduction in Power Plant Emissions

(1) Our AMA supports (a) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (b) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels. 2. Our AMA will: (a) support the Environmental Protection Agency's proposal, under the Clean Air Act, to regulate air quality for heavy metals and other air toxins emitted from smokestacks. The risk of dispersion through air and soil should be considered, particularly for people living downwind of smokestacks; and (b) urge the EPA to finalize updated mercury, cadmium, and air toxic regulations for

monitoring air quality emitted from power plants and other industrial sources, ensuring that recommendations to protect the public's health are enforceable.

[Appended: Res. 401, A-22; Modified: Res. 908, I-17; Modified: Res. 506, A-15; Reaffirmed: Res. 421, A-14; Reaffirmed in lieu of Res. 526, A-12; Reaffirmation I-07; Res. 429, A-03]

D-135.996 Reducing Sources of Diesel Exhaust

Our AMA will: (1) encourage the US Environmental Protection Agency (EPA) to set and enforce the most stringent feasible standards to control pollutant emissions from both large and small non-road engines including construction equipment, farm equipment, boats and trains; (2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from glider trucks and existing diesel engines; (3) call for all trucks traveling within the United States, regardless of country of origin, to be in compliance with the most stringent and current diesel emissions standards promulgated by US EPA; and (4) send a letter to US EPA Administrator opposing the EPA's proposal to roll back the "glider Kit Rule" which would effectively allow the unlimited sale of re-conditioned diesel truck engines that do not meet current EPA new diesel engine emission standards.

[Modified: Res. 521, A-18; Reaffirmation A-14; Reaffirmation A-11; Reaffirmed in lieu of Res. 507, A-09; Res. 428, A-04]

H-135.931 Health Risks of Hydraulic Fracturing

1. Our AMA encourages appropriate agencies and organizations to study the potential human and environmental health risks and impacts of hydraulic fracturing. 2. Our AMA: (A) supports the full disclosure of chemicals placed into the natural environment during the petroleum, oil and natural gas exploration and extraction process; and (B) supports the requirement that government agencies record and monitor the chemicals placed into the natural environment for petroleum oil and natural gas extraction and the chemicals found in flowback fluids, to monitor for human exposures in well water and surface water, and to share this information with physicians and the public. 3. Our AMA supports research on the implementation of buffer zones or well set-backs between oil and gas development sites and residences, schools, hospitals, and religious institutions, to determine the distance necessary to ensure public health and safety.

[Appended: Res. 908, I-17; Appended: Sub. Res. 508, A-15; Res. 405, A-13]

D-480.963 COVID-19 Emergency and Expanded Telemedicine Regulations

Our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-COV-2; (2) will advocate that the Federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care.

[Reaffirmation: A-22; Reaffirmed: Res. 239, A-22; Reaffirmed: CMS Rep. 7, A-21; Alt. Res. 203, I-20]

H-480.936 Telemedicine Services and Health Equity

Our AMA will encourage policymakers to recognize the scope and circumstances for underserved populations including seniors and patients with complex health conditions with the aim to ensure that these patients have the technology-use training needed to maximize the benefits of telehealth and its potential to improve health outcomes.

[Res. 213, A-23]

H-135.923 AMA Advocacy for Environmental Sustainability and Climate

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.

[Reaffirmation: I-19; Res. 924, I-16]

D-135.997 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.

[Modified: Res. 415, A-23; Reaffirmed in lieu of: Res. 505, A-19; Appended: Res. 927, I-11; Res. 402, A-03]

D-440.912 AMA Public Health Strategy

1. Our AMA will distribute evidence-based information on the relationship between climate change and human health through existing platforms and communications channels, identify advocacy and leadership opportunities to elevate the voices of physicians on the public health crisis of climate change, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050. 2. Our AMA Board of Trustees will provide an update on loss of coverage and uninsurance rates following the return to regular Medicaid redeterminations and the end of the COVID-19 Public Health Emergency, the ensuing financial and administrative challenges experienced by physicians, physician practices, hospitals, and the healthcare system; and a report of actions taken by the AMA and recommendation for further action to address these issues at I-2023. 3. Our AMA Board of Trustees will provide a strategic plan or outline for the AMA's plan to address and combat the health effects of climate change at I-2023. 4. Our AMA Board of Trustees will provide an update on the efforts and initiatives of the AMA's gun violence task force at I-2023. 5. Our AMA will continue to support increased funding for public health infrastructure and workforce, which should include funding for preventative medicine-related residency programs, to increase public health leadership in this country.

[Modified: BOT Rep. 05, I-23; BOT Rep. 17, A-23]

H-470.953 Evaluating Green Space Initiatives

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.

[Res. 905, I-15]

H-135.923 AMA Advocacy for Environmental Sustainability and Climate

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.

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[Modified: Res. 415, A-23; Reaffirmed in lieu of: Res. 505, A-19; Appended: Res. 927, I-11; Res. 402, A-03]

H-135.973 Stewardship of the Environment

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.

[Reaffirmation I-16; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of Res. 417, A-04; Amended: CSA Rep. 8, A-03; Amended: CLRPD Rep. D, I-92; CSA Rep. G, I-89]

H-135.919 Climate Change Education Across the Medical Education Continuum

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.

[Res. 302, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(A-24)

Introduced by: California

Subject: Building Environmental Resiliency in Health Systems and Physician Practices

Referred to: Reference Committee D

1 Whereas, climate change disproportionately impacts the most vulnerable;¹⁻³ and

2
3 Whereas, “resilience” is an effort to preemptively prepare for a crisis, absorb the impact of a
4 crisis, adjust to new conditions, and build on lessons learned to create a more robust future;⁴and

5
6 Whereas, significant investments in renewable energy sources, such as solar and hydro power,
7 can reduce facility emissions due to energy use;⁵and

8
9 Whereas, the World Health Organization (WHO) highlights the health care workforce as key
10 actors in developing a facility’s climate resilience because they are the main implementors of
11 climate change mitigation measures and serve as a direct link to communities and populations
12 most adversely affected by climate change;⁴ and

13
14 Whereas, the WHO notes that health care facilities can greatly reduce the potential risk to staff,
15 patients, and the surrounding communities by appropriately responding to, and reducing
16 exposure to, hazardous water and waste;⁴ and

17
18 Whereas, investments in flood- and storm-resistant construction and low-carbon construction
19 practices can increase a facility’s safety and durability in a changing climate;⁶ and

20
21 Whereas, the Inflation Reduction Act (IRA) has allocated almost \$400 billion toward efforts to
22 increase green energy and reduce carbon emissions;⁷ therefore be it

23
24 RESOLVED, that our American Medical Association support a resilient, accountable health care
25 system capable of delivering effective and equitable care in the face of changing health care
26 demands due to climate change (New HOD Policy); and be it further

27
28 RESOLVED, that our AMA encourage health care organizations to develop climate resilience
29 plans, for the continuity of operations in an emergency, that take into account the needs of
30 groups in their community that experience disproportionate risk of climate-related harm and
31 ensure the necessary collaboration between different types of healthcare facilities (New HOD
32 Policy); and be it further

33
34 RESOLVED, that our AMA recognizes that climate resilience and mitigation efforts will be
35 community-specific and supports physician engagement at the local level to promote community
36 alliances for environmental justice and equity. (New HOD Policy)

37
Fiscal Note: Minimal - less than \$1,000

Received: 4/23/2024

REFERENCES

1. Gutierrez K. S., & LePrevost C. E. (2016). Climate justice in rural southeastern United States: A review of climate change impacts and effects on human health. *International Journal of Environmental Research and Public Health*, 13(2), 189. <https://doi.org/10.3390/ijerph13020189>.
2. Portier C.J., Tart K.T., Carter S.R., et al. A Human Health Perspective on Climate Change: A Report Outlining the Research Needs on the Human Health Effects of Climate Change. ENVIRONMENTAL HEALTH PERSPECTIVES and the NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES (April 2010), available at https://www.niehs.nih.gov/health/materials/a_human_health_perspective_on_climate_change_full_report_508.pdf.
3. Vickery J., & Hunter L. M. (2016). Native Americans: Where in environmental justice research? *Society & Natural Resources*, 29(1), 36–52. <https://doi.org/10.1080/08941920.2015.1045644>.
4. Augustynowicz, A.; Opolski, J.; Waszkiewicz, M. (2022) Resilient health and the healthcare system. A few introductory remarks in times of the COVID-19 pandemic. *International Journal of Environmental Research and Public Health*, 19, 3603. <https://doi.org/10.3390/ijerph19063603>.
5. Delivering a "Net Zero" National Health Service, NATIONAL HEALTH SERVICE ENGLAND (July 2022), available at <https://www.england.nhs.uk/greenemhs/wp-content/uploads/sites/51/2022/07/B1728-delivering-a-net-zero-nhs-july-2022.pdf>.
6. *Categorical Waiver – Health Care Microgrids Systems (HCMSS)*, Centers for Medicare & Medicaid Services website at <https://www.cms.gov/files/document/gso-23-11-lsc.pdf>.
7. *Building a Clean Energy Economy: A Guidebook to the Inflation Reduction Act's Investments in Clean Energy and Climate Action*, THE WHITE HOUSE (January 2023), available at <https://www.whitehouse.gov/wp-content/uploads/2022/12/Inflation-Reduction-Act-Guidebook.pdf>.

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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; Appended: CSAP Rep. 02, I-22]

H-135.939 Green Initiatives and the Health Care Community

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. [Modified: Res. 923, I-19; Modified: Res. 516, A-18; Reaffirmed in lieu of: Res. 504, A-16; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation A-09; CSAPH Rep. 1, I-08]

H-135.923 AMA Advocacy for Environmental Sustainability and Climate

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. [Reaffirmation: I-19; Res. 924, I-16]

D-440-912 AMA Public Health Strategy

1. Our AMA will distribute evidence-based information on the relationship between climate change and human health through existing platforms and communications channels, identify advocacy and leadership opportunities to elevate the voices of physicians on the public health crisis of climate change, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050. 2. Our AMA Board of Trustees will provide an update on loss of coverage and uninsurance rates following the return to regular Medicaid redeterminations and the end of the COVID-19 Public Health Emergency, the ensuing financial and administrative challenges experienced by physicians, physician practices, hospitals, and the healthcare system; and a report of actions taken by the AMA and recommendation for further action to address these issues at I-2023. 3. Our AMA Board of Trustees will provide a strategic plan or outline for the AMA's plan to address and combat the health effects of climate change at I-2023. 4. Our AMA Board of Trustees will provide an update on the efforts and initiatives of the AMA's gun violence task force at I-2023. 5. Our AMA will continue to support increased funding for public health infrastructure and workforce, which should include funding for preventative medicine-related residency programs, to increase public health leadership in this country. [Modified: BOT Rep. 05, I-23; BOT Rep. 17, A-23]

H-135.923 AMA Advocacy for Environmental Sustainability and Climate

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. [Reaffirmation: I-19; Res. 924, I-16]

H-135.973 Stewardship of the Environment

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. [Reaffirmation I-16; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of Res. 417, A-04; Amended: CSA Rep. 8, A-03; Amended: CLRPD Rep. D, I-92; CSA Rep. G, I-89]

H-135.919 Climate Change Education Across the Medical Education Continuum

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. [Res. 302, A-19]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(A-24)

Introduced by: California

Subject: Furthering Environmental Justice and Equity

Referred to: Reference Committee D

1 Whereas, climate change disproportionately impacts the most vulnerable;¹⁻³ and

2
3 Whereas, communities of color, communities with predominantly low socioeconomic status,
4 immigrant and refugee communities and Indigenous communities are some of the communities
5 disproportionately burdened by “environmental hazards, unhealthy land uses, psychosocial
6 stressors, historical traumas, and systemic racism,” which can drive environmental health
7 disparities;⁵ and

8
9 Whereas, environmental impact statements and health impact assessments can help
10 communities understand the distribution of environmental burdens and benefits they face and
11 begin re-evaluating how the benefits and costs of environmental resources are distributed;⁵ and

12
13 Whereas, “redlined” areas were neighborhoods that local lenders flagged as high-risk
14 investments by virtue of the neighborhood’s racial and ethnic composition;⁶ and

15
16 Whereas, because of the redlining practices of the 1930s, large sources of pollution, such as
17 industrial plants, major roadways and shipping ports, were sited in and around these targeted
18 neighborhoods and these neighborhoods remain attractive to new polluting projects that require
19 access to cheap land, such as transportation projects;⁷ and

20
21 Whereas, redlining practices allowed for zoning decisions that exposed, and continue to
22 disproportionately expose, communities of color to the damaging effects of pollution and poor air
23 quality;⁸ and

24
25 Whereas, heat islands are urbanized areas that experience higher temperatures than outlying
26 areas and areas formerly graded D under Home Owners’ Loan Corporation policy have on
27 average approximately 23% tree canopy cover today;⁹ and

28
29 Whereas, the Inflation Reduction Act allocated \$3 billion to fund an environmental justice grant
30 program to provide grants to community-based organizations in disadvantaged communities;⁴
31 therefore be it

32
33 RESOLVED, that our American Medical Association support state and local climate-health risk
34 assessments, disease surveillance and early warning systems, and research on climate and
35 health, with actions to improve and/or correct the findings (New HOD Policy); and be it further

36
37 RESOLVED, that our AMA support measures to protect frontline communities from the health
38 harms of proximity to fossil fuel extraction, refining and combustion, such as the best available
39 technology to reduce local pollution exposure from oil refineries, or health safety buffers from oil
40 extraction operations (New HOD Policy); and be it further

1 RESOLVED, that our AMA support prioritizing greenspace access and tree canopy coverage for
2 communities that received a “D” rating from the Home Owners’ Loan Corporation, otherwise
3 known as being “redlined,” or that have been impacted by other discriminatory development and
4 building practice, thereby protecting residents of these communities from displacement. (New
5 HOD Policy)
6

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

Received: 4/23/2024

REFERENCES

1. Gutierrez K. S., & LePrevost C. E. (2016). Climate justice in rural southeastern United States: A review of climate change impacts and effects on human health. *International Journal of Environmental Research and Public Health*, 13(2), 189. <https://doi.org/10.3390/ijerph13020189>.
2. Portier C.J., Tart K.T., Carter S.R., et al. A Human Health Perspective on Climate Change: A Report Outlining the Research Needs on the Human Health Effects of Climate Change. ENVIRONMENTAL HEALTH PERSPECTIVES and the NATIONAL INSTITUTE OF ENVIRONMENTAL HEALTH SCIENCES (April 2010), available at https://www.niehs.nih.gov/health/materials/a_human_health_perspective_on_climate_change_full_report_508.pdf.
3. Vickery J., & Hunter L. M. (2016). Native Americans: Where in environmental justice research? *Society & Natural Resources*, 29(1), 36–52. <https://doi.org/10.1080/08941920.2015.1045644>.
4. *Building a Clean Energy Economy: A Guidebook to the Inflation Reduction Act’s Investments in Clean Energy and Climate Action*, THE WHITE HOUSE (January 2023), available at <https://www.whitehouse.gov/wp-content/uploads/2022/12/Inflation-Reduction-Act-Guidebook.pdf>.
5. “Environmental Justice.” *American Public Health Association*. <https://www.apha.org/Topics-and-Issues/Environmental-Health/Environmental-Justice>.
6. Tracy Jan, Redlining was Banned 50 Years Ago. It’s Still Hurting Minorities Today, THE WASHINGTON POST (March 28, 2018), available at <https://www.washingtonpost.com/news/wonk/wp/2018/03/28/redlining-was-banned-50-years-ago-its-still-hurting-minorities-today/>.
7. Darryl Fears, Redlining Means 45 Million Americans are Breathing Dirtier Air, 50 Years After It Ended, THE WASHINGTON POST (March 9, 2022), available at <https://www.washingtonpost.com/climate-environment/2022/03/09/redlining-pollution-environmental-justice/>.
8. Lane, H.M.; Morello-Frosch, R.; Marshall, J.D.; & Apte, J.S. (2022). Historical redlining is associated with present-day air pollution disparities in U.S. cities. *Environmental Science & Technology Letters*, 9, 345-350. <https://doi.org/10.1021/acs.estlett.1c01012>.
9. Locke, D.H.; Hall, B.; Grove, J.M.; Pickett, S.T.A.; Ogden, L.A.; Aoki, C.; Boone, C.G.; & O’Neil-Dunne, J.P.M. (2020). Residential housing segregation and urban tree canopy in 37 US cities. SocArXiv. <https://doi.org/10.1038/s42949-021-00022-0>.

RELEVANT AMA POLICY

H-135.938 Global Climate Change and Human Health

Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change. 2. Supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies. 3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes. 4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability. 5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk. 6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change

policy decisions related to health care and treatment. 7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training. [Modified: CSAPH Rep. 2, I-22; Modified: Res. 424, A-22; Reaffirmation: I-19; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation A-14; CSAPH Rep. 3, I-08]

D-135.966 Declaring Climate Change a Public Health Crisis

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. [Appended: CSAPH Rep. 02, I-22; Res. 420, A-22]

H-135.939 Green Initiatives and the Health Care Community

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. [Modified: Res. 923, I-19; Modified: Res. 516, A-18; Reaffirmed in lieu of: Res. 504, A-16; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation A-09; CSAPH Rep. 1, I-08]

H-135.923 AMA Advocacy for Environmental Sustainability and Climate

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. [Reaffirmation: I-19; Res. 924, I-16]

D-135.997 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 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. [Modified: Res. 415, A-23; Reaffirmed in lieu of: Res. 505, A-19; Appended: Res. 927, I-11; Res. 402, A-03]

D-440.912 AMA Public Health Strategy

1. Our AMA will distribute evidence-based information on the relationship between climate change and human health through existing platforms and communications channels, identify advocacy and leadership opportunities to elevate the voices of physicians on the public health crisis of climate change, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050. 2. Our AMA Board of Trustees will provide an update on loss of coverage and uninsurance rates following the return to regular Medicaid redeterminations and the end of the COVID-19

Public Health Emergency, the ensuing financial and administrative challenges experienced by physicians, physician practices, hospitals, and the healthcare system; and a report of actions taken by the AMA and recommendation for further action to address these issues at I-2023. 3. Our AMA Board of Trustees will provide a strategic plan or outline for the AMA's plan to address and combat the health effects of climate change at I-2023. 4. Our AMA Board of Trustees will provide an update on the efforts and initiatives of the AMA's gun violence task force at I-2023. 5. Our AMA will continue to support increased funding for public health infrastructure and workforce, which should include funding for preventative medicine-related residency programs, to increase public health leadership in this country. [Modified: BOT Rep. 05, I-23; BOT Rep. 17, A-23]

H-470.953 Evaluating Green Space Initiatives

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. [Res. 905, I-15]

H-135.923 AMA Advocacy for Environmental Sustainability and Climate

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. [Reaffirmation: I-19; Res. 924, I-16]

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H-135.949 Support of Clean Air and Reduction in Power Plant Emissions

(1) Our AMA supports (a) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (b) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels. 2. Our AMA will: (a) support the Environmental Protection Agency's proposal, under the Clean Air Act, to regulate air quality for heavy metals and other air toxins emitted from smokestacks. The risk of dispersion through air and soil should be considered, particularly for people living downwind of smokestacks; and (b) urge the EPA to finalize updated mercury, cadmium, and air toxic regulations for monitoring air quality emitted from power plants and other industrial sources, ensuring that recommendations to protect the public's health are enforceable. [Appended: Res. 401, A-22; Modified: Res. 908, I-17; Modified: Res. 506, A-15; Reaffirmed: Res. 421, A-14; Reaffirmed in lieu of Res. 526, A-12; Reaffirmation I-07; Res. 429, A-03]

H-135.973 Stewardship of the Environment

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. [Reaffirmation I-16; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of Res. 417, A-04; Amended: CSA Rep. 8, A-03; Amended: CLRPD Rep. D, I-92; CSA Rep. G, I-89]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(A-24)

Introduced by: California

Subject: Reducing Job-Related Climate Risk Factors

Referred to: Reference Committee D

1 Whereas, heat causes more deaths per year in the U.S. than any other weather hazard; and

2
3 Whereas, individuals who work outdoors, especially those working in construction and
4 agriculture, may be frequently exposed to extreme heat conditions and be at-risk for
5 occupational heat-related illnesses, such as dehydration, heat exhaustion, and heat stroke;¹³
6 and

7
8 Whereas, the Occupational Safety and Health Administration Heat Illness Prevention tool
9 includes “indoor work in warm/hot environments with heat sources such as ovens, fires, hot tar,
10 and/or other radiant heat sources,” as a job-related risk factor for heat exposure at a
11 workplace;¹⁴ and

12
13 Whereas, indoor and outdoor cold work conditions need to be addressed as well; therefore be it

14
15 RESOLVED, that our American Medical Association support enforcement of existing outdoor
16 health standards and the establishment of enforceable indoor heat and outdoor cold illness
17 prevention standards, for occupational settings, schools, licensed health care and other
18 congregate facilities. (New HOD Policy)

19
Fiscal Note: Minimal - less than \$1,000

Received: 4/23/2024

REFERENCES

1. Brenda Jacklitsch, Jon Williams, Kristin Musolin, Aitor Coca, Jung-Hyun Kim, & Nina Turner, *Criteria for a Recommended Standard: Occupational Exposure to Heat and Hot Environments, Revised Criteria 2016*, NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH (February 2016), available at <https://www.cdc.gov/niosh/docs/2016-106/pdfs/2016-106.pdf?id=10.26616/NIOSH PUB2016106>.
2. *Employer Checklist for Outdoor and Indoor Heat-Related Injury and Illness Prevention*, Occupational Safety and Health Administration website at https://www.osha.gov/sites/default/files/Activity_FF_EmployerHeatChecklist.pdf.

RELEVANT AMA POLICY

D-135.967 Advocating for Heat Exposure Protections for All Workers

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]

H-130.951 Heat-Related Illness

The AMA recognizes the significant public health threat imposed by heat-related emergencies, and provides the following policy: (1) Physicians should identify patients at risk for extreme heat-related illness such as the elderly, children, individuals with physical or mental disabilities, alcoholics, the chronically ill, and the socially isolated. Patients, family members, friends, and caretakers should be counseled about prevention strategies to avoid such illness. Physicians should provide patients at risk with information about cooling centers and encourage their use during heat emergencies. (2) The AMA encourages patients at risk for heat-related illness to consider wearing appropriate medical identification. [Reaffirmed: CSAPH Rep. 01, A-17; Reaffirmed: CSAPH Rep. 3, A-07; CSA Rep. 10, A-97]

H-135.938 Global Climate Change and Human Health

Our AMA: 1. Supports scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes have adversely affected the physical and mental health of people. We recognize that minoritized and marginalized populations, children, pregnant people, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate harm from climate change. 2. Supports educating the medical community on the adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies. 3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes. 4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability. 5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk. 6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment. 7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training. [Modified: CSAPH Rep. 2, I-22; Modified: Res. 424, A-22; Reaffirmation: I-19; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation A-14; CSAPH Rep. 3, I-08]

D-135.966 Declaring Climate Change a Public Health Crisis

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H-135.923 AMA Advocacy for Environmental Sustainability and Climate

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D-135.997 Environmental Contributors to Disease and Advocating for Environmental Justice

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D-440.912 AMA Public Health Strategy

1. Our AMA will distribute evidence-based information on the relationship between climate change and human health through existing platforms and communications channels, identify advocacy and leadership opportunities to elevate the voices of physicians on the public health crisis of climate change, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050. 2. Our AMA Board of Trustees will provide an update on loss of coverage and uninsurance rates following the return to regular Medicaid redeterminations and the end of the COVID-19 Public Health Emergency, the ensuing financial and administrative challenges experienced by physicians, physician practices, hospitals, and the healthcare system; and a report of actions taken by the AMA and recommendation for further action to address these issues at I-2023. 3. Our AMA Board of Trustees will provide a strategic plan or outline for the AMA's plan to address and combat the health effects of climate change at I-2023. 4. Our AMA Board of Trustees will provide an update on the efforts and initiatives of the AMA's gun violence task force at I-2023. 5. Our AMA will continue to support increased funding for public health infrastructure and workforce, which should include funding for preventative medicine-related residency programs, to increase public health leadership in this country. [Modified: BOT Rep. 05, I-23; BOT Rep. 17, A-23]

H-135.973 Stewardship of the Environment

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. [Reaffirmation I-16; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of Res. 417, A-04; Amended: CSA Rep. 8, A-03; Amended: CLRPD Rep. D, I-92; CSA Rep. G, I-89]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(A-24)

Introduced by: Resident and Fellow Section
Subject: Early and Periodic Eye Exams for Adults
Referred to: Reference Committee D

1 Whereas, eye exams are a screening tool that uses evidence-based medicine to assess for the
2 presence or absence of diseases to provide treatment and work to preserve vision¹⁻²; and
3
4 Whereas, the American Academy of Ophthalmology (AAO) recommends that all adults get a
5 complete eye examination by an ophthalmologist at age 40 in order to detect common diseases,
6 provide early treatment, and preserve vision³⁻⁴; and
7
8 Whereas, those under the age of 40 who are healthy and have good vision should receive a eye
9 exam every 5–10 years³⁻⁵; and
10
11 Whereas, adults who suffer from chronic systemic conditions are more likely to develop eye
12 disorders and subsequent vision loss from eye disorders than their healthy peers and would
13 benefit from earlier screening to better manage their disorders⁶⁻⁷; and
14
15 Whereas, diseases such as diabetes and high blood pressure, as well as family history of eye
16 disease, significantly raise an individual's chances of developing eye related disease, and
17 people with this history are not recommended to wait to get an eye exam until they are 40 years
18 old^{3,6-7}; and
19
20 Whereas, diabetic patients can develop diabetic retinopathy, earlier cataracts, and glaucoma;
21 this increased risk does not start when the patient can be classified as elderly, but has rather
22 been shown to start from the age of 45 years according to the Centers for Disease Control and
23 Prevention (CDC)⁸⁻¹¹; and
24
25 Whereas, according to the CDC, approximately 4.5% of adults aged 45–64 have undiagnosed
26 diabetes, something which a baseline or routine eye exam could aid in diagnosing as according
27 to the National Eye Institute⁸⁻¹²; and
28
29 Whereas, 40–45% of Americans with diabetes have visibly evident diabetic retinopathy, which
30 can show up early in the disease process of diabetes¹¹; and
31
32 Whereas, according to the CDC, early detection and treatment can prevent or delay blindness
33 due to diabetic retinopathy in 90% of people with diabetes, but 50% or more of them don't get
34 their eyes examined or are diagnosed too late for effective treatment and could therefore benefit
35 from early eye examinations¹; and

1 Whereas, hypertensive patients likewise have similar ocular manifestations such as:
2 hypertensive retinopathy, choroidopathy, and ocular neuropathy¹³⁻¹⁴; and
3

4 Whereas, earlier screening and treatment for these patients has been shown to reduce the
5 burden of blindness due to diabetic retinopathy and hypertensive eye disease¹⁵; and
6

7 Whereas, diabetes and hypertension continue to increase in prevalence in the U.S. making this
8 a growing issue that should be addressed sooner rather than later to decrease sequelae and
9 financial burden^{9,16}; and
10

11 Whereas, Medicare and other insurance companies do not cover routine eye examinations
12 without a pre-existing diagnosis¹⁷; and
13

14 Whereas, the AMA supports evidence-based screening in policy G-600.064, "AMA
15 Endorsement of Screening Tests or Standards," stating "Our AMA continues to advocate its
16 policies on medical necessity determinations to government agencies, managed care
17 organizations, third party payers, and private sector health care accreditation organizations."¹⁸;
18 and
19

20 Whereas, the AMA has policy supporting eye screenings for children (Encouraging Vision
21 Screenings for Schoolchildren H-425.977) and for the elderly (Eye Exams for the Elderly H-
22 25.990); however, for all adults, but especially for those adults at high risk, screenings need to
23 occur between childhood and old age¹⁹⁻²⁰; and
24

25 Whereas, the AAO has policy that supports the screening of children and the elderly, as well as
26 healthy adults at age 40, and particularly supports that all individuals who are "at high risk of
27 developing ocular abnormalities related to systemic diseases such as diabetes mellitus and
28 hypertension or who have a family history of eye disease, require periodic comprehensive eye
29 examinations to prevent or minimize vision loss²¹"; and
30

31 Whereas, the AMA does not have a policy encouraging eye screenings for either adults
32 between childhood and elderliness nor those especially vulnerable adults who are at high risk of
33 developing ocular abnormalities related to systemic diseases or who have a family history of
34 eye disease and addressing this gap will actively decrease vision loss; and
35

36 Whereas, current United States Preventive Services Task Force (USPSTF) guidelines do not
37 have any recommendations regarding adult eye examinations and have only weighed in on the
38 evidence regarding vision screening, stating "evidence is insufficient to assess the balance of
39 benefits and harms of screening for impaired visual acuity in older adults"²²; and
40

41 Whereas, vision screening as discussed in the USPSTF is a completely distinct diagnostic tool
42 to an eye examination which is discussed in this resolution; and
43

44 Whereas, the AAO describes vision screening as a distinct entity from eye examinations; and
45 furthermore that vision screenings are unable "to provide the same results as a comprehensive
46 eye and vision examination" from an ophthalmologist or optometrist and that "Comprehensive
47 eye examinations are the only effective way to confirm or rule out any eye disease²³"; and
48

49 Whereas, this is especially true in the setting of undiagnosed hypertensive and diabetic
50 retinopathies, where vision loss happens late in the course of the disease and where, according

1 to the CDC, patients “may not notice symptoms in the early stage. That’s why it’s very important
2 to get a dilated eye exam at least once a year to catch any problems early when treatment is
3 most effective²⁴”; and

4
5 Whereas, various recent proposals from the executive and legislative branches (including
6 President Biden’s 2022 budget request, House bill H.R. 33 introduced to the House of
7 Representatives in 2023, and the Senate bill S.842 introduced to the Senate also in 2023) have
8 proposed the creation of additional benefits for routine eye exams under Medicare Part B,
9 showing significant political interest in increasing insurance benefits for eye exams²⁵⁻²⁷; and

10
11 Whereas, by updating AMA policy H-25.990 to include eye examinations for those older than 40
12 years and who have chronic systemic conditions affecting development of eye disease our AMA
13 will be in line with current AAO guidelines^{3,4}; therefore be it

14
15 RESOLVED, that our American Medical Association amend policy H-25.990 “Eye Exams for the
16 Elderly” by addition to read as follows:

17
18 **Eye Exams for the Elderly and Adults H-25.990**

19 Our AMA (1) encourages the development of programs and/or outreach efforts to
20 support periodic eye examinations and access to affordable prescription eyeglasses for
21 elderly patients and adults who suffer from chronic systemic conditions that increase
22 their likelihood of developing eye disease as well as a baseline eye examination for all
23 adults aged 40 and above. (2) Our AMA encourages physicians to work with their state
24 medical associations and appropriate specialty societies to create statutes that uphold
25 the interests of patients and communities and that safeguard physicians from liability
26 when reporting in good faith the results of vision screenings.

27 (Modify Current HOD Policy)

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

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REFERENCES:

1. Centers for Disease Control and Prevention. Keep an eye on your vision health. Vision Health Initiative. <https://www.cdc.gov/visionhealth/resources/features/keep-eye-on-vision-health.html> Updated October 2020. Accessed March 8, 2023.
2. Vision screenings and eye exams. Prevent Blindness. <https://preventblindness.org/vision-screenings-and-eye-exams/>. Published May 9, 2020. Accessed March 7, 2023.
3. American Academy of Ophthalmology. Eye screening recommendations for adults by age and risk. Eye Health Tips. <https://www.aao.org/eye-health/tips-prevention/screening>. Updated January 2022. Accessed March 8, 2023.
4. American Academy of Ophthalmology. Get an eye disease screening at 40. <https://www.aao.org/eye-health/tips-prevention/screening>. Published April 19, 2022. Accessed March 8, 2023.
5. Boyd K. Eye health information for adults under 40. American Academy of Ophthalmology. <https://www.aao.org/eye-health/tips-prevention/young-adults#:~:text=When%20to%20Have%20Regular%20Eye,some%20exceptions%20to%20this%20recommendation>. Published February 15, 2021. Accessed March 8, 2023.
6. Crews, J. E., Chou, C. F., Sekar, S., & Saaddine, J. B. The Prevalence of Chronic Conditions and Poor Health Among People With and Without Vision Impairment, Aged ≥ 65 Years, 2010–2014. American journal of ophthalmology, 182, 18-30. 2017. Accessed March 8, 2023.
7. Centers for Disease Control and Prevention . Vision Impairment and chronic health conditions. Centers for Disease Control and Prevention. <https://www.cdc.gov/visionhealth/living/index.html>. Published December 19, 2022. Accessed March 8, 2023.
8. American Academy of Ophthalmology. Eye care for young adults. Eye Health Tips. <https://www.aao.org/eye-health/tips-prevention/young-adults>. Updated January 2022.
9. Centers for Disease Control and Prevention. (2021). National Health and Nutrition Examination Survey: Eye Disorders and Vision Loss Among U.S. Adults Aged 45 and Over With Diagnosed Diabetes, 2016–2017, United States. Data brief no. 344. <https://www.cdc.gov/nchs/products/databriefs/db344.htm> Updated July 2019. Accessed March 8, 2023.

10. Centers for Disease Control and Prevention. National diabetes statistics report: Prevalence of Both Diagnosed and Undiagnosed Diabetes. <https://www.cdc.gov/diabetes/data/statistics-report/diagnosed-undiagnosed-diabetes.html>. September 2022. Accessed March 8, 2023.
11. Blitstein, M. K. Ocular manifestations of diabetes. Consultant360. <https://www.consultant360.com/articles/ocular-manifestations-diabetes>. Published September 11, 2019. Accessed March 8, 2023.
12. Products - data briefs - number 344 - July 2019. Centers for Disease Control and Prevention. <https://www.cdc.gov/nchs/products/databriefs/db344.htm>. Published July 18, 2019. Accessed March 8, 2023.
13. Modi P, Arsiwalla T. Hypertensive Retinopathy. [Updated 2022 Jul 4]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; Available from: <https://www.ncbi.nlm.nih.gov/books/NBK525980/> January 2022
14. Cheung CY, Biousse V, Keane PA, Schiffrin EL, Wong TY. Hypertensive eye disease. Nat Rev Dis Primers. 2022;8(1):14. Published 2022 Mar 10. doi:10.1038/s41572-022-00342-0
15. Vashist P, Singh S, Gupta N, Saxena R. Role of early screening for diabetic retinopathy in patients with diabetes mellitus: an overview. Indian J Community Med. 2011;36(4):247-252. doi:10.4103/0970-0218.91324
16. Centers for Disease Control and Prevention. High blood pressure facts. <https://www.cdc.gov/bloodpressure/facts.htm>. Updated January 5, 2023.
17. AARP. Does Medicare cover vision care? Updated July 14, 2023. Accessed August 27, 2023. <https://www.aarp.org/health/medicare-ga-tool/does-medicare-cover-vision-care/>.
18. American Medical Association. AMA Policy finder. AMA Endorsement of Screening Tests or Standards G-600.064. <https://policysearch.ama-assn.org/policyfinder/detail/%22AMA%20Endorsement%20of%20Screening%20Tests%20or%20Standards%20G-600.064%22?uri=%2FAMADoc%2FHODGOV.xml-0-28.xml>. Accessed August 27, 2023.
19. American Medical Association. AMA Policy finder. Encouraging Vision Screenings for Schoolchildren H-425.977. <https://policysearch.ama-assn.org/policyfinder/detail/%22Encouraging%20Vision%20Screenings%20for%20Schoolchildren%20H-425.977%22?uri=%2FAMADoc%2FHOD.xml-0-3751.xml>. Accessed August 27, 2023.
20. American Medical Association. AMA Policy finder. Eye Exams for the Elderly H-25.990. <https://policysearch.ama-assn.org/policyfinder/detail/H-25.990?uri=%2FAMADoc%2FHOD.xml-0-1744.xml>. Accessed August 27, 2023.
21. American Academy of Ophthalmology. Frequency of ocular examinations. Clinical statement. <https://www.aaopt.org/education/clinical-statement/frequency-of-ocular-examinations>. Updated February 2015.
22. U.S. Preventive Services Task Force. Impaired Visual Acuity Screening in Older Adults. Accessed September 17, 2023. Available at: <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/impaired-visual-acuity-screening-older-adults>. Updated May 24, 2022
23. American Optometric Association. Eye Exams. Accessed September 17, 2023. Available at: <https://www.aoa.org/healthy-eyes/caring-for-your-eyes/eye-exams?sso=y>.
24. Centers for Disease Control and Prevention. Managing Diabetes and Vision Loss. Accessed September 17, 2023. Available at: <https://www.cdc.gov/diabetes/managing/diabetes-vision-loss.html>.
25. Ali R, Hellow L. Small share of Medicare Supplement plans offer access to dental, vision, and other benefits not covered by traditional Medicare. Commonwealth Fund. <https://www.commonwealthfund.org/blog/2021/small-share-medicare-supplement-plans-offer-access-dental-vision-and-other-benefits-not>. Published August 13, 2021. Accessed August 27, 2023.
26. Medicare Dental, Vision, and Hearing Benefit Act of 2023, H.R.33, 118th Congress. January 9, 2023. Accessed August 27, 2023. <https://www.congress.gov/bill/118th-congress/house-bill/33>.
27. Medicare and Medicaid Dental, Vision, and Hearing Benefit Act of 2023, S.842, 118th Congress. March 16, 2023. Accessed August 27, 2023. <https://www.congress.gov/bill/118th-congress/senate-bill/842>.

RELEVANT AMA POLICY:

AMA Endorsement of Screening Tests or Standards G-600.064

(1) Delegates, state, or specialty societies submitting a resolution seeking endorsement or AMA adoption of specific screening tests must also submit an evidence-based review that determines the strength or quality of the evidence supporting their request, and that evaluates the degree to which the test satisfies the minimal criteria for validating the appropriateness of the screening test, which are: (a) the test must be able to detect the target condition earlier than without screening and with sufficient accuracy to avoid producing large numbers of false-positive and false-negative results; and (b) screening for and treating persons with early disease should improve the likelihood of favorable health outcomes compared with treating patients when they present with signs or symptoms of disease. (2) This review will be made available to the reference committee, which will either recommend to the House of Delegates that the resolution be referred or not be adopted. [CSA Rep. 7, A-02CC&B Rep. 3, I-08 Reaffirmed: CCB/CLRPD Rep. 3, A-12 Reaffirmed: CCB/CLRPD Rep. 1, A-22]

Early and Periodic Screening, Diagnosis, and Treatment D-290.987

Our AMA recognizes the importance of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and will advocate for EPSDT to remain intact as critical to the health and well-being of children. [Res. 708, I-05 Modified: CMS Rep. 1, A-15]

Insurance Coverage of Periodic Health Care Services H-185.965

Our AMA adopts the policy that patients should be able to receive insurance coverage for periodic services performed within an appropriately flexible interval (i.e., once annually, rather than having to wait precisely 365 days). [Res. 128, A-99 Reaffirmed: CMS Rep. 5, A-09 Modified: Sub. Res. 811, I-10 Reaffirmed: CMS Rep. 01, A-20]

Eye Exams for the Elderly H-25.990

1. Our American Medical Association encourages the development of programs and/or outreach efforts to support periodic eye examinations and access to affordable prescription eyeglasses for elderly patients.
2. Our AMA encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings.

[Res. 813, I-05 Reaffirmed: CSAPH Rep. 1, A-15, Modified: CMS Rep. 02, A-23]

Encouraging Vision Screenings for Schoolchildren H-425.977

Our AMA: (1) encourages and supports outreach efforts to provide vision screenings for school-age children prior to primary school enrollment; (2) encourages the development of programs to improve school readiness by detecting undiagnosed vision problems; and (3) supports periodic pediatric eye screenings based on evidence-based guidelines with referral to an ophthalmologist for a comprehensive professional evaluation as appropriate. [Res. 430, A-05 Modified: CSAPH Rep. 1, A-15]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(A-24)

Introduced by: Medical Student Section

Subject: Addressing the Health Risks of Extreme Heat

Referred to: Reference Committee D

1 Whereas, since the 1960s, the annual number of heat waves in the US has tripled from 2 to 6,
2 with concurrent increases in heat intensity resulting in the hottest summer ever in 2023^{1,2}; and
3
4 Whereas, heat is the most deadly weather phenomenon and caused 1,714 deaths in 2022,
5 nearly 6 times as much as the 297 deaths in 2004^{3,4}; and
6
7 Whereas, prolonged heat exposure is associated with emergency visits, hospitalizations, and
8 deaths due to cardiovascular, kidney, respiratory, and psychiatric illnesses, adverse pregnancy
9 and birth outcomes, and increased healthcare costs⁵⁻⁷; and
10
11 Whereas, a 2023 study in *Circulation*, the journal of the American Heart Association, estimates
12 4,300 to 5,500 excess deaths due to heat by mid-century, based on socioeconomic status⁸; and
13
14 Whereas, 25% of the US experiences reduced resilience to extreme heat exposure, especially
15 due to housing quality, vehicle access, and poverty⁹; and
16
17 Whereas, because infrastructure in urban areas absorbs and re-emits heat more than natural
18 landscapes, daytime temperatures in these cities can increase by 1.7 degrees compared to
19 other areas, which further intensifies heat waves in metropolitan regions^{10,11}; and
20
21 Whereas, greenspaces in cities, such as large parks, can reduce temperatures by up to 2
22 degrees, mitigating the heat island effect and heat-related morbidity and mortality^{12,13}; and
23
24 Whereas, historically redlined neighborhoods have decreased tree canopy coverage and lower
25 normalized difference vegetation indexes (NDVIs) compared to other areas¹⁴; and
26
27 Whereas, the Stafford Act, passed in 1988, does not consider extreme heat a major disaster
28 eligible for Federal Emergency Management Agency (FEMA) assistance^{15,16}; and
29
30 Whereas, the Centers for Disease Control and Prevention (CDC) Climate and Health Technical
31 Report on “heat response plans” defines them as “a coordinated plan that describes and
32 organizes activities to prevent heat-related morbidity and mortality in a community,” including
33 surveillance, public health messaging, front-line health and social services, cooling centers,
34 water and fan distribution, energy assistance, and greenspaces¹⁷; and
35
36 Whereas, heat response plans, household air conditioning, and availability of cool areas have
37 been associated with decreased heat-related mortality, with a greater effect for elderly
38 populations and people in neighborhoods with low education levels^{18,19}; and

1 Whereas, many homes experience dangerously high indoor heat indexes during extreme heat,
2 but 7.5% lack air conditioning, including 12% of low-income households^{20,21}; and

3
4 Whereas, a 2021 study of 25 US cities found that nearly 90% of people were not within walking
5 distance of a cooling center and that people aged 65 and over were particularly affected²²;

6
7 Whereas, a US Census survey found that 26% of Americans were forced to forgo food,
8 medicine, or another necessary expense to pay an energy bill, and 17% had kept their home at
9 an unsafe or unhealthy temperature in the past year²³; and

10
11 Whereas, funding for the Low Income Home Energy Assistance Program (LIHEAP), which helps
12 families pay for energy bills and basic weatherization, has fallen from \$5.1 billion in 2009 to \$3.8
13 billion in 2022, and now less than 20% of eligible households receive aid^{24,25}; and

14
15 Whereas, an analysis of US public and private prisons revealed that a 10-degree temperature
16 increase is correlated with a 5.2% increase in mortality, 6.7% increase in cardiovascular
17 mortality, and 22% increase in suicide (mostly affecting men over 65)²⁶; and

18
19 Whereas, the Federal Bureau of Prisons suggests temperatures at “76°F in the cooling season
20 and 68°F in the heating season,” but its Facilities Operations Manual acknowledges that the
21 “age of heating and cooling systems” affects the ability to maintain these ranges²⁷; and

22
23 Whereas, many state attempts to implement temperature standards in prisons have stalled, and
24 44 states lack universal air conditioning in their prison systems, many of which are located in
25 deteriorating facilities that will be further affected by climate change^{28,29}; therefore be it

26
27 RESOLVED, that our American Medical Association support funding for subsidizing energy
28 costs and air conditioning units for low-income households to maintain safe temperatures during
29 periods of extreme temperature (New HOD Policy); and be it further

30
31 RESOLVED, that our AMA support the implementation and enforcement of state and federal
32 temperature standards in prisons, jails, and detention centers, including the implementation of
33 air conditioning in areas that experience dangerously high temperatures. (New HOD Policy)

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

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REFERENCES

1. Climate Change Indicators: Heat Waves. www.epa.gov. Published February 4, 2021. [https://www.epa.gov/climate-indicators/climate-change-indicators-heat-waves#:~:text=Data%20%7C%20Technical%20Documentation-](https://www.epa.gov/climate-indicators/climate-change-indicators-heat-waves#:~:text=Data%20%7C%20Technical%20Documentation-.). Accessed August 21, 2023.
2. Center for Climate And Energy Solutions. Heat Waves and Climate Change | Center for Climate and Energy Solutions. Center for Climate and Energy Solutions. Published November 13, 2018. <https://www.c2es.org/content/heat-waves-and-climate-change/>. Accessed August 21, 2023.
3. US Department of Commerce N. Weather Related Fatality and Injury Statistics. www.weather.gov. <https://www.weather.gov/hazstat/>. Accessed August 21, 2023.
4. How many people die from extreme heat in the US? USAFacts. Published July 13, 2023. Accessed August 26, 2023. <https://usafacts.org/articles/how-many-people-die-from-extreme-heat-in-the-us/>.
5. USGCRP. The Impacts of Climate Change on Human Health in the United States: A Scientific Assessment. [Globalchange.gov](http://globalchange.gov). Published online 2016:1-312. <https://health2016.globalchange.gov/>. Accessed August 23, 2023.
6. Temperature Extremes. Centers for Disease Control and Prevention. Published 2019. https://www.cdc.gov/climateandhealth/effects/temperature_extremes.htm. Accessed August 23, 2023.
7. Ebi KL, Capon A, Berry P, et al. Hot weather and heat extremes: health risks. *The Lancet*. 2021;398(10301):698-708. doi:[https://doi.org/10.1016/s0140-6736\(21\)01208-3](https://doi.org/10.1016/s0140-6736(21)01208-3)
8. Khatana SAM, Eberly LA, Nathan AS, Groeneveld PW. Projected Change in the Burden of Excess Cardiovascular Deaths Associated With Extreme Heat by Midcentury (2036-2065) in the Contiguous United States. *Circulation*. 2023 Nov

- 14;148(20):1559-1569. doi: 10.1161/CIRCULATIONAHA.123.066017. Epub 2023 Oct 30. PMID: 37901952; PMCID: PMC10840949.
9. Hoffman JS, Shandas V, Pendleton N. The Effects of Historical Housing Policies on Resident Exposure to Intra-Urban Heat: A Study of 108 US Urban Areas. *Climate*. 2020;8(1):12. doi:https://doi.org/10.3390/cli8010012
 10. Mitchell BC, Chakraborty J, Basu P. Social Inequities in Urban Heat and Greenspace: Analyzing Climate Justice in Delhi, India. *International Journal of Environmental Research and Public Health*. 2021;18(9):4800. doi:https://doi.org/10.3390/ijerph18094800
 11. US EPA. Learn About Heat Islands. US EPA. Published August 28, 2023. Accessed September 17, 2023. <https://www.epa.gov/heatislands/learn-about-heat-islands>
 12. Aram F, Higuera García E, Solgi E, Mansournia S. Urban green space cooling effect in cities. *Heliyon*. 2019 Apr 8;5(4):e01339. doi: 10.1016/j.heliyon.2019.e01339. PMID: 31008380; PMCID: PMC6458494.
 13. Choi HM, Lee W, Roye D, et al. Effect modification of greenness on the association between heat and mortality: A multi-city multi-country study. *eBioMedicine*. 2022;84:104251. doi:https://doi.org/10.1016/j.ebiom.2022.104251
 14. Nardone A, Rudolph KE, Morello-Frosch R, Casey JA. Redlines and Greenspace: The Relationship between Historical Redlining and 2010 Greenspace across the United States. *Environmental Health Perspectives*. 2021;129(1):017006. doi:https://doi.org/10.1289/ehp7495
 15. FEMA. How a Disaster Gets Declared. FEMA.gov. Published 2022. Accessed August 26, 2023. <https://www.fema.gov/disaster/how-declared23.FEMA>.
 16. FEMA. Stafford Act. FEMA.gov. Published November 18, 2021. Accessed August 26, 2023. <https://www.fema.gov/disaster/stafford-act>.
 17. Abbinett J, Schramm P, Widerynski S, et al. Heat Response Plans: Summary of Evidence and Strategies for Collaboration and Implementation Climate and Health Technical Report Series Climate and Health Program, Centers for Disease Control and Prevention. https://www.cdc.gov/climateandhealth/docs/HeatResponsePlans_508.pdf. Accessed August 24, 2023.
 18. Benmarhnia T, Bailey Z, Kaiser D, Auger N, King N, Kaufman JS. A Difference-in-Differences Approach to Assess the Effect of a Heat Action Plan on Heat-Related Mortality, and Differences in Effectiveness According to Sex, Age, and Socioeconomic Status (Montreal, Quebec). *Environmental Health Perspectives*. 2016;124(11):1694-1699. doi:https://doi.org/10.1289/ehp203
 19. Bouchama A, Dehbi M, Mohamed G, Matthies F, Shoukri M, Menne B. Prognostic Factors in Heat Wave-Related Deaths. *JAMA Internal Medicine*. 2007;167(20).
 20. Quinn A, Tamerius JD, Perzanowski M, et al. Predicting indoor heat exposure risk during extreme heat events. *Science of The Total Environment*. 2014;490:686-693. doi:https://doi.org/10.1016/j.scitotenv.2014.05.039
 21. 2021 National — Heating, Air Conditioning, and Appliances — All Occupied Units. American Housing Survey; 2021.
 22. Kim K, Jung J, Schollaert C, Spector JT. A Comparative Assessment of Cooling Center Preparedness across Twenty-Five U.S. Cities. *International Journal of Environmental Research and Public Health*. 2021;18(9). doi:https://doi.org/10.3390/ijerph18094801
 23. US Census Bureau. Household Pulse Survey Data Tables. Census.gov. Published 2020. <https://www.census.gov/programs-surveys/household-pulse-survey/data.html>.
 24. LIHEAP Math is Simple: More Funding, More Families Get Help. NEADA.ORG. Published October 2, 2021. Accessed August 27, 2023. <https://neada.org/served-eligible2022/>
 25. LIHEAP Fact Sheet. Administration for Children and Families. Accessed August 27, 2023. <https://www.acf.hhs.gov/ocs/fact-sheet/liheap-fact-sheet>
 26. Skarha J, Spangler K, Dosa D, Rich J, Savitz D, Zanobetti A. Heat-related mortality in U.S. state and private prisons: A case-crossover analysis. *PLOS ONE*. 2023;18(3). doi:https://doi.org/10.1371/journal.pone.0281389
 27. Kane TR. Facilities Operations Manual. U.S. Department of Justice Federal Bureau of Prisons. Published April 12, 2016. Accessed August 27, 2023. <https://www.bop.gov/policy/progstat/4200.11.pdf>
 28. Asgarian R. Why people are freezing in America's prisons. Vox. Published December 13, 2019. <https://www.vox.com/identities/2019/12/13/21012730/cold-prison-incarcerated-winter>
 29. Wu P, Felder D, Korbin D. *Fordham Urban Law Journal*. 2022;49(2). Accessed August 27, 2023. <https://ir.lawnet.fordham.edu/cgi/viewcontent.cgi?article=2866&context=ulj>

RELEVANT AMA Policy

Heat-Related Illness H-130.951

The AMA recognizes the significant public health threat imposed by heat-related emergencies, and provides the following policy: (1) Physicians should identify patients at risk for extreme heat-related illness such as the elderly, children, individuals with physical or mental disabilities, alcoholics, the chronically ill, and the socially isolated. Patients, family members, friends, and caretakers should be counseled about prevention strategies to avoid such illness. Physicians should provide patients at risk with information about cooling centers and encourage their use during heat emergencies. (2) The AMA encourages patients at risk for heat-related illness to consider wearing appropriate medical identification. [CSA Rep. 10, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17]

H-470.953 Evaluating Green Space Initiatives

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. [Res. 905, I-15]

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]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 420
(A-24)

Introduced by: Pennsylvania, Mississippi

Subject: Equity in Dialysis Care

Referred to: Reference Committee D

1 Whereas, kidney disease disproportionately affects communities of color; and
2
3 Whereas, Black or African Americans are almost four times more likely and Hispanic or Latino
4 Americans are 1.3 times more likely to have kidney failure compared to White or Caucasian
5 Americans; and
6
7 Whereas, although they make up only 13.5% of the population, Black Americans make up more
8 than 35% of dialysis patients; and
9
10 Whereas, the major causes of kidney disease, including diabetes, hypertension, and
11 cardiovascular disease, are all more prevalent among Black patients; and
12
13 Whereas, although a kidney transplant is the optimal treatment for kidney failure, Black patients
14 face barriers to access at every step of the process and on average wait a year longer than
15 White patients to receive a kidney transplant; and
16
17 Whereas, Black patients are less likely to receive a transplant evaluation, have less access to
18 the waitlist, spend longer on the transplant waitlist, are less likely to survive on the waitlist, and
19 have lower rates of graft survival post-transplant; and
20
21 Whereas, despite being preferred by many patients, home dialysis is underutilized compared to
22 dialysis delivered in a facility, particularly among communities of color; and
23
24 Whereas, Black and Hispanic patients are less likely to initiate home dialysis and are more likely
25 to fail on the modality within the first 90 days, after which point disparities in home dialysis
26 utilization widen; and
27
28 Whereas, this may be because common barriers to home dialysis such as unstable living
29 situations, poor health literacy and lower socioeconomic status may be overrepresented among
30 Black and Hispanic dialysis patients; and
31
32 Whereas, the National Kidney Foundation calls kidney disease ‘the under recognized public
33 health crisis’; therefore be it
34
35 RESOLVED, that our American Medical Association declare kidney failure as a significant public
36 health problem with disproportionate affects and harm to under-represented communities (New
37 HOD Policy); and be it further

1 RESOLVED, that our AMA vigorously pursue potential solutions and partnerships to identify
2 economic, cultural, clinical and technological solutions that increase equitable access to all
3 modalities of care including home dialysis. (Directive to Take Action)
4

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

Received: 4/24/2024

RELEVANT AMA POLICY

Assuring Patient Access to Kidney Transplantation D-370.983

1. Our AMA will: (a) work with professional and patient-centered organizations to advance patient and physician-directed coordinated care for End Stage Renal Disease (ESRD) patients; (b) actively oppose any legislative or regulatory efforts to remove patient choice and physician involvement in ESRD care decisions; and (c) actively oppose any legislative or regulatory effort that would create financial incentives that would curtail the access to kidney transplantation.

2. Our AMA House of Delegates will be advised in a timely fashion regarding any legislative or regulatory efforts to abrogate patient and physician-advised decision-making regarding modality of care for ESRD.

3. Our AMA supports federal legislative and regulatory policies that improve kidney transplantation access by using evidence-based outcome measures which do not impede sound clinical judgment of physicians and surgeons.

Citation: Res. 201, A-19; Appended: Res. 210, I-19;

Medicaid Dialysis Policy for Undocumented Patients H-290.957

Our AMA will work with the Centers for Medicare and Medicaid Services and state Medicaid programs to cover scheduled outpatient maintenance dialysis for undocumented patients with end stage kidney disease under Emergency Medicaid.

Citation: Res. 121, A-21;

Advancing Quality Coordinated Care for Patients with End Stage Renal Disease H-370.957

Our AMA will work with Members of Congress and their staffs to ensure that any legislation which promotes integrated and patient-centered care for End Stage Renal Disease (ESRD) patients does not inappropriately impinge on the patient-physician relationship and is in the best interest of ESRD patients.

Citation: BOT Action in response to referred for decision: Res. 219, A-18;

UNOS Kidney Paired Donation Program H-370.960

Our AMA: (1) encourages the continued expansion of the United Network for Organ Sharing's (UNOS) Kidney Paired Donation program which provides a national registry of living donors, carries out ongoing data collection on key issues of concern in transplantation from living donors, and through its operational guidelines provides consistent, national standards for the transplant community; and (2) encourages voluntary coordination among private donor registries and UNOS to enhance the availability of organs for transplantation.

Citation: BOT Action in response to referred for decision Res. 2, A-13; Reaffirmation: I-19;

Cost-Saving Public Coverage for Renal Transplant Patients H-370.963

1. Our AMA supports private and public mechanisms that would extend insurance coverage for evidence-based treatment of renal transplant care for the life of the transplanted organ.

2. Our AMA will continue to offer technical assistance to individual state and specialty societies when those societies lobby state or federal legislative or executive bodies to implement evidence-based cost-saving policies within public health insurance programs.

Citation: Res. 104, A-13; Reaffirmation: I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 421
(A-24)

Introduced by: American Society for Metabolic and Bariatric Surgery, Obesity Medicine Association, Society of American Gastrointestinal and Endoscopic Surgeons

Subject: Annual Conference on the State of Obesity and its Impact on Disease in America (SODA)

Referred to: Reference Committee D

1 Whereas, the American Medical Association (AMA) recognizes the critical importance of
2 addressing the impact of obesity on various chronic diseases, including hypertension,
3 cardiovascular disease, type 2 diabetes, and metabolic dysfunction-associated hepatitis; and
4
5 Whereas, obesity significantly increases the risk of developing these chronic conditions, leading
6 to substantial morbidity, mortality, and healthcare costs across the United States; and
7
8 Whereas, the AMA is committed to advancing evidence-based approaches to prevent and
9 manage obesity-related chronic diseases, improve patient outcomes, and enhance healthcare
10 delivery systems; and
11
12 Whereas, regular monitoring of epidemiological trends, development of effective disease
13 progression algorithms, and coordination of efforts to improve access to care are essential
14 components of addressing the multifaceted challenges posed by obesity-related chronic
15 diseases; therefore be it
16
17 RESOLVED, that our American Medical Association convene an annual meeting of its
18 Federation partners to comprehensively review the impact of obesity on hypertension,
19 cardiovascular disease, type 2 diabetes, metabolic dysfunction-associated hepatitis (MASH)
20 and other related comorbidities with a focus on monitoring epidemiology, developing algorithms
21 to combat disease progression, and coordinating efforts to improve access to care (Directive to
22 Take Action); and be it further
23
24 RESOLVED, that our AMA shall feature presentations, workshops, and panel discussions
25 covering the latest research findings, clinical guidelines, and best practices related to the
26 prevention, diagnosis, and management of obesity-related chronic diseases (Directive to Take
27 Action); and be it further
28
29 RESOLVED, that our AMA shall invite renowned experts, researchers, clinicians, policymakers,
30 and patient advocates to contribute their insights, experiences, and recommendations during
31 the annual meeting (Directive to Take Action); and be it further
32
33 RESOLVED, that our AMA shall collaborate with relevant stakeholders, including government
34 agencies, healthcare systems, insurers, community organizations, and industry partners, to
35 develop and implement strategies for combating obesity-related chronic diseases (Directive to
36 Take Action); and be it further

- 1 RESOLVED, that our AMA assist in the discussion of epidemiological trends, development of
2 evidence-based algorithms for disease management, and coordination of efforts to improve
3 access to care for patients affected by obesity-related chronic diseases (Directive to Take
4 Action); and be it further
5
6 RESOLVED, that our AMA shall publish a comprehensive report summarizing the discussions,
7 findings, and recommendations from each annual meeting and disseminate it to member
8 organizations, policymakers, healthcare providers, and the public (Directive to Take Action); and
9 be it further
10
11 RESOLVED, that the AMA shall convene the first annual meeting in 2025 and subsequent
12 meetings annually thereafter. (Directive to Take Action)

Fiscal Note: \$252,347 Annually: Convene an annual meeting of Federation partners on obesity

Received: 4/30/2024

REFERENCES

1. Younossi ZM, Golabi P, Price JK, Owrangi S, Gundu-Rao N, Satchi R, Paik J. The Global Epidemiology of Nonalcoholic Fatty Liver Disease and Nonalcoholic Steatohepatitis Among Patients With Type 2 Diabetes. *Clin Gastroenterol Hepatol*. 2024 Mar 21:S1542-3565(24)00287-8. doi: 10.1016/j.cgh.2024.03.006. Epub ahead of print. PMID: 38521116.
2. Powell-Wiley TM, Poirier P, Burke LE, Després JP, Gordon-Larsen P, Lavie CJ, Lear SA, Ndumele CE, Neeland IJ, Sanders P, St-Onge MP; American Heart Association Council on Lifestyle and Cardiometabolic Health; Council on Cardiovascular and Stroke Nursing; Council on Clinical Cardiology; Council on Epidemiology and Prevention; and Stroke Council. Obesity and Cardiovascular Disease: A Scientific Statement From the American Heart Association. *Circulation*. 2021 May 25;143(21):e984-e1010. doi: 10.1161/CIR.0000000000000973. Epub 2021 Apr 22. PMID: 33882682; PMCID: PMC8493650.
3. Yanovski SZ, Yanovski JA. Approach to Obesity Treatment in Primary Care: A Review. *JAMA Intern Med*. Published online March 11, 2024. doi:10.1001/jamainternmed.2023.8526
4. Almuwaqqat Z, Hui Q, Liu C, et al. Long-Term Body Mass Index Variability and Adverse Cardiovascular Outcomes. *JAMA Netw Open*. 2024;7(3):e243062. doi:10.1001/jamanetworkopen.2024.3062

RELEVANT AMA POLICY

Recognition of Obesity as a Disease H-440.842

Our American Medical Association recognizes obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention.

Res. 420, A-13 Reaffirmed: CSAPH Rep. 08, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 422
(A-24)

Introduced by: Ohio
Subject: Immunization Registry
Referred to: Reference Committee D

1 Whereas, the critical role of vaccines in our public health infrastructure is well-established; and
2
3 Whereas, every state maintains an immunization registry; and
4
5 Whereas, pediatric vaccines are routinely reported electronically to the appropriate state
6 registry; and
7
8 Whereas, immunization registry data is crucial for determining the effectiveness of a given
9 vaccine; and
10
11 Whereas, an increasing number of adult vaccines are administered by pharmacies; and
12
13 Whereas, a significant number of adult vaccines provided by pharmacies are not recorded in the
14 patient's primary medical records; and
15
16 Whereas, reporting vaccinations to government entities may require additional resources or
17 time; therefore be it
18
19 RESOLVED, that our American Medical Association develop model legislation requiring all
20 vaccine providers to participate in their statewide immunization information system (Directive to
21 Take Action); and be it further
22
23 RESOLVED, that our AMA support mandating all vaccine providers to report all immunizations
24 to their respective state immunization registry, for both adults and children (New HOD Policy);
25 and be it further
26
27 RESOLVED, that our AMA support reimbursement for reporting immunizations to state
28 registries by both public and private payers. (New HOD Policy)
29

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

Received: 4/26/2024

REFERENCES

1. Stolpe, S., & Choudhry, N. K. (2019). Effect of automated immunization registry-based telephonic interventions on adult vaccination rates in community pharmacies: a randomized controlled trial. *Journal of Managed Care & Specialty Pharmacy*, 25(9), 989-994.
2. Woods, L. O., Bridges, C. B., Graitcer, S. B., & Lamont, B. (2016). US Immunization program adult immunization activities and resources. *Human Vaccines & Immunotherapeutics*, 12(4), 1045-1050.
3. Placzek, H., & Madoff, L. C. (2011). The use of immunization registry-based data in vaccine effectiveness studies. *Vaccine*, 29(3), 399-411.

RELEVANT AMA POLICY

H-440.899 Immunization Registries

Our AMA encourages: (1) Physicians to participate in the development of immunization registries in their communities and use them in their practices for patients of all ages; (2) electronic health record (EHR) vendors to add features to automate the exchange of vaccination information in the patient EHR to state immunization registries to improve and help ensure completeness and accuracy of vaccination records. EHR vendors and registry administrators need to work with physicians and other health professionals to facilitate the exchange of needed vaccination information by establishing seamless, bidirectional communication capabilities for physicians, other vaccine providers, and immunization registries; and (3) all states to move rapidly to provide comprehensive lifespan immunization registries that are interfaced with other state registries. [Res. 415, A-99; Reaffirmed: 415, A-01; Reaffirmation A-09; Modified: CSAPH Rep. 4, I-14]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 423
(A-24)

Introduced by: Senior Physicians Section

Subject: HPV Vaccination to Protect Healthcare Workers over Age 45

Referred to: Reference Committee D

1 Whereas, there has been an increase with human papilloma virus (HPV) associated with head
2 and neck cancers¹; and

3
4 Whereas, health care workers (HCW) may be exposed to these oncogenic HPV in the course of
5 performance of their clinical tasks such as cauterization of cervical, vaginal, vulvar, penile
6 and/or anal cancers²; and

7
8 Whereas, many HCWs are over age 45 and thus not deemed eligible for HPV vaccine
9 insurance coverage or reimbursement according to Merck and Co., the current manufacturer, or
10 Center for Disease Control and Prevention (CDC) guidelines^{3,4}; and

11
12 Whereas, the cost of GARDASIL 9 without insurance coverage will cost a patient approximately
13 \$335 per dose with three doses required for maximum immunity attainment; and

14
15 Whereas, N-95 or equivalent masks are essential for significant protection during procedures;
16 therefore be it

17
18 RESOLVED, that our American Medical Association support all health care workers (HCWs)
19 who might be exposed to HPV in the course of their clinical duties and strongly encourage them
20 to wear masks, preferably N-95 (New HOD Policy); and be it further

21
22 RESOLVED, that our AMA will work with appropriate stakeholders to ensure that the HPV
23 vaccine should be offered to all HCWs with potential exposure to HPV oncogenic material at no
24 or minimal cost to the HCW individual (Directive to Take Action); and be it further

25
26 RESOLVED, that our AMA work with relevant stakeholders, including the CDC, to recommend
27 HPV vaccine to HCWs to prevent health care related transmission. (Directive to Take Action)

28
Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/2/2024

REFERENCES

1. Forte, T., Niu, J., Lockwood, G. A., & Bryant, H. E. (2012). Incidence trends in head and neck cancers and human papillomavirus (HPV)-associated oropharyngeal cancer in Canada, 1992–2009. *Cancer Causes & Control*, 23, 1343-1348.
2. Harrison R., Huh W. Occupational Exposure to Human Papillomavirus and Vaccination for Health Care Workers. *Obstet Gynecol* 2020; 136:663.
3. American Society for Colposcopy and Cervical Pathology. ASCCP Recommends HPV Vaccination for Providers. <https://www.asccp.org/hpv-vaccination> (Accessed on January 10, 2024).
4. Gupta, A. K., MacLeod, M. A., & Abramovits, W. (2016). GARDASIL 9 (Human Papillomavirus 9-Valent Vaccine, Recombinant). *Skinmed*, 14(1), 33-37.

RELEVANT AMA POLICY

H-440.810 Availability of Personal Protective Equipment (PPE)

1. Our AMA affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.
 2. Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions.
 3. Our AMA will advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff, as well as trainees and contractors working in such facilities, in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need.
 4. Our AMA supports physicians and health care professionals and other workers in health care facilities in being permitted to use their professional judgement and augment institution-provided PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty.
 5. Our AMA supports the rights of physicians and trainees to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster.
 6. Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies.
 7. Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel.
- [Res. 412, I-20; Appended: Res. 414, A-21; Modified; Res. 410, I-21]

D-440.955 Insurance Coverage for HPV Vaccine

Our AMA:

- (1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices;
 - (2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and
 - (3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.
- [Res. 818 I-06; Reaffirmed: CMS Report 01, A-16]

H-440.872 HPV Associated Cancer Prevention

1. Our American Medical Association:
 - a. urges physicians and other health care professionals 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 supports legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers.
4. 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.
5. Our AMA encourages appropriate parties to investigate means to increase HPV vaccination rates by facilitating administration of HPV vaccinations in community-based settings including school settings.
6. Our AMA will study requiring HPV vaccination for school attendance.
7. Our AMA encourages collaboration with interested parties to make available human papillomavirus

vaccination to people who are incarcerated for the prevention of HPV-associated cancers.
[Res. 503, A-07; Appended: Res. 6, A-12; Reaffirmed: CSAPH Rep. 1, A-22; Reaffirmation:
A-22; Modified: Res. 916, I-22; BOT Action Sept 2023]

H-460.913 - Screening for HPV-Related Anal Cancer

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 424
(A-24)

Introduced by: Senior Physicians Section

Subject: LGBTQ+ Senior Health

Referred to: Reference Committee D

1 Whereas, an estimated 2.7 million older Americans who identify as part of the LGBTQ+
2 community face unique and challenging health issues due to a combination of factors including
3 discrimination, social stigma, and lack of culturally competent healthcare¹; and
4

5 Whereas, LGBTQ+ seniors are more likely than other seniors to report poor general health,
6 mental health issues, social isolation and higher rates of multiple chronic co-morbidities²; and
7

8 Whereas, subsets of this community, in particular transgender seniors, face even higher rates
9 when compared to their LGBTQ+ cohorts³; and
10

11 Whereas, addressing the unique health needs of LGBTQ+ seniors require a comprehensive
12 approach that recognizes and respects their diverse identities and experiences; therefore be it
13

14 RESOLVED, that our American Medical Association create and disseminate educational
15 initiatives to increase awareness and understanding of senior LGBTQ+ health aging issues
16 among the general public, healthcare professionals, and policy makers (Directive to Take
17 Action); and be it further
18

19 RESOLVED, that our AMA develop and promote cultural competency training for clinicians in
20 caring for senior LGBTQ+ individuals (Directive to Take Action); and be it further
21

22 RESOLVED, that our AMA develop and promote policies and practices for implementation
23 within all healthcare settings that are inclusive and affirming for LGBTQ+ seniors (Directive to
24 Take Action); and be it further
25

26 RESOLVED, that our AMA advocate for increased funding and resources for research into
27 health issues of LGBTQ+ seniors. (Directive to Take Action)
28

Fiscal Note: \$122,712: Contract with third parties to develop educational content and training
for physicians

Received: 5/2/2024

1. Movement Advancement Project and SAGE. May 2017. "Understanding Issues Facing LGBT Older Adults." <https://www.lgbtmap.org/policy-and-issue-analysis/understanding-issues-facing-lgbt-older-adults>. Accessed 19 February 2024.
2. Fredriksen Goldsen, K., Kim, H.-J., Jung, H. H., Davis, A. & Emler, C.A. (2021). Oregon LGBTQ+ Older Adult Survey Report. Seattle, WA: Goldsen Institute.
3. Adan, M., Scribani, M., Tallman, N., Wolf-Gould, C., Campo-Engelstein, L., Gadomski, A. Worry and Wisdom: A Qualitative Study of Transgender Elders' Perspectives on Aging. *Transgend Health*. 2021 Dec 2;6(6):332-342. doi: 10.1089/trgh.2020.0098. PMID: 34993305; PMCID: PMC8664103.

REFERENCES

RELEVANT AMA POLICY

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

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]

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

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

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

D-315.974 Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms

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.

[Res. 014, A-18]

G-635.125 AMA Membership Demographics

1. Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.

2. Our AMA will immediately release to each state medical and specialty society, on request, the names, category and demographics of all AMA members of that state and specialty.

3. Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues to expand demographics collected about our members to include both sexual orientation and gender identity information, which may be given voluntarily by members and will be handled in a confidential manner.

[BOT Rep. 26, A-10; Reaffirmed: CCB/CLRPD Rep. 3, A-12; Appended: Res. 603, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 425
(A-24)

Introduced by: Women Physicians Section

Subject: Perinatal Mental Health Disorders among Medical Students and Physicians

Referred to: Reference Committee D

- 1 Whereas, perinatal mental health disorders contribute to 23 percent of maternal deaths; and
- 2
- 3 Whereas, one in eight women experience postpartum depression, which is a common perinatal
- 4 mental health disorder; and
- 5
- 6 Whereas, the DSM-V notes postpartum depression to be as a major depressive episode with
- 7 onset of symptoms within 4 weeks of delivery; and
- 8
- 9 Whereas, clinical research shows postpartum depression may occur up to 12 months after
- 10 delivery; and
- 11
- 12 Whereas, an estimated 80% of female physicians become mothers; and
- 13
- 14 Whereas, 6.5% to 20% of women in the general population develop postpartum depression; and
- 15
- 16 Whereas, resident physicians have reported a nearly four times greater rate of postpartum
- 17 depression than the general population; and
- 18
- 19 Whereas, the rate of matriculation of female students into medical school in 2022 was 55.6%
- 20 and has been increasing every year; and
- 21
- 22 Whereas, many physicians report lack of support during both pregnancy and the postpartum
- 23 period by both colleagues and their workplace; and
- 24
- 25 Whereas, symptoms of postpartum depression are noted to be worse in jobs where women
- 26 perceive a decreased sense of control over both work-life and family-life or jobs with less
- 27 flexibility; and
- 28
- 29 Whereas, female physicians have reported feeling discriminated at the workplace based on their
- 30 status as mothers; and
- 31
- 32 Whereas, untreated postpartum depression severely affects a woman's ability to return to
- 33 normal function and results in poorer outcomes for both the mother and infant; and
- 34
- 35 Whereas, 63% of physicians report symptoms or signs of burnout at least once per week in
- 36 2021; and
- 37
- 38 Whereas, suicide is a major cause of mortality for physicians relative to the general public; and
- 39
- 40 Whereas, untreated postpartum depression is a risk factor for suicide; and

1 Whereas, physicians are less likely to seek treatment for mental health conditions for fear of
2 repercussions; and

3
4 Whereas, postpartum depression often goes untreated due to concern from the mother for
5 stigma; and

6
7 Whereas, factors that help patients with postpartum depression include maternal-infant bonding,
8 familial and societal support, and maternal rest; therefore be it

9
10 RESOLVED, that our American Medical Association work with relevant stakeholders to identify
11 ways to increase screening for perinatal mental health conditions and reduce stigma
12 surrounding the diagnosis and treatment of perinatal mental health conditions (Directive to Take
13 Action); and be it further

14
15 RESOLVED, that our AMA advocate for reducing structural and systemic barriers to the
16 diagnosis and treatment of perinatal mental health conditions in physicians and medical
17 students. (Directive to Take Action)

18
Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 5/3/2024

REFERENCES

1. Four in 5 pregnancy-related deaths in the U.S. are preventable. Available at <https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html>.
2. Depression Among Women. Available at <https://www.cdc.gov/reproductivehealth/depression/index.htm>.
3. Bye E, Leval R, Sayles H, Doyle M, Mathes M, Cudzilo-Kelsey L. Parental postpartum depression among medical residents. *Archives of Women's Mental Health*. 2022 Dec;25(6):1129-35.
4. Chesak SS, Yngve KC, Taylor JM, Voth ER, Bhagra A. Challenges and solutions for physician mothers: a critical review of the literature. In *Mayo Clinic Proceedings* 2021 Jun 1 (Vol. 96, No. 6, pp. 1578-1591). Elsevier.
5. Dyrbye LN, West CP, Sinsky CA, Goeders LE, Satele DV, Shanafelt TD. Medical Licensure Questions and Physician Reluctance to Seek Care for Mental Health Conditions. *Mayo Clin Proc*. 2017;92(10):1486-1493. doi:10.1016/j.mayocp.2017.06.020
6. Freeman G, Bharwani A, Brown A, Ruzycki SM. Challenges to navigating pregnancy and parenthood for physician parents: a framework analysis of qualitative data. *Journal of General Internal Medicine*. 2021 Dec;36(12):3697-703.
7. Gila-Díaz A, Carrillo GH, López de Pablo ÁL, Arribas SM, Ramiro-Cortijo D. Association between maternal postpartum depression, stress, optimism, and breastfeeding pattern in the first six months. *International journal of environmental research and public health*. 2020 Oct;17(19):7153.
8. Goldman ML, Shah RN, Bernstein CA. Depression and suicide among physician trainees: recommendations for a national response. *JAMA psychiatry*. 2015 May 1;72(5):411-2.
9. Halley MC, Rustagi AS, Torres JS, Linos E, Plaut V, Mangurian C, Choo E, Linos E. Physician mothers' experience of workplace discrimination: a qualitative analysis. *bmj*. 2018 Dec 12;363.
10. Karl M, Schaber R, Kress V, Kopp M, Martini J, Weidner K, Garthus-Niegel S. Precarious working conditions and psychosocial work stress act as a risk factor for symptoms of postpartum depression during maternity leave: results from a longitudinal cohort study. *BMC public health*. 2020 Dec;20(1):1-1.
11. Mughal S, Azhar Y, Siddiqui W. Postpartum Depression. [Updated 2022 Oct 7]. In: *StatPearls* [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK519070/>.
12. Paris R, Bolton RE, Weinberg MK. Postpartum depression, suicidality, and mother-infant interactions. *Archives of Women's Mental Health*. 2009 Oct;12:309-21.
13. Shanafelt TD, Balch CM, Dyrbye L, Bechamps G, Russell T, Satele D, Rummans T, Swartz K, Novotny PJ, Sloan J, Oreskovich MR. Special report: suicidal ideation among American surgeons. *Archives of surgery*. 2011 Jan 1;146(1):54-62.
14. Shanafelt TD, West CP, Dyrbye LN, Trockel M, Tutty M, Wang H, Carlasare LE, Sinsky C. Changes in burnout and satisfaction with work-life integration in physicians during the first 2 years of the COVID-19 pandemic. In *Mayo Clinic Proceedings* 2022 Dec 1 (Vol. 97, No. 12, pp. 2248-2258). Elsevier.
15. Stewart DE, Vigod SN. Postpartum depression: pathophysiology, treatment, and emerging therapeutics. *Annual review of medicine*. 2019 Jan 27;70:183-96
16. Slomian J, Honvo G, Emonts P, Reginster JY, Bruyère O. Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. *Women's Health*. 2019 Apr;15:1745506519844044
17. Table A-7.2: Applicants, first-time applicants, acceptees, and ... - AAMC. AAMC. October 18, 2018. Accessed August 20, 2023. <https://www.aamc.org/media/9576/download>.
18. West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences and solutions. *Journal of internal medicine*. 2018 Jun;283(6):516-29.

RELEVANT AMA POLICY

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953

Our AMA will: (1) support improvements in current mental health services during pregnancy and postpartum periods; (2) support advocacy for inclusive insurance coverage of and sufficient payment for mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) support appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; (4) continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs; and (5) advocate for evidence-based postpartum depression screening and prevention services to be recognized as the standard of care for all federally-funded health care programs for persons who are pregnant or in a postpartum state. [Res. 102, A-12; Modified: Res. 503, A-17; Modified: Res. 227, A-23]

Study of Medical Student, Resident, and Physician Suicide D-345.983

Our AMA will: (1) explore the viability and cost-effectiveness of regularly collecting National Death Index (NDI) data and confidentially maintaining manner of death information for physicians, residents, and medical students listed as deceased in the AMA Physician Masterfile for long-term studies; (2) monitor progress by the Association of American Medical Colleges, the American Association of Colleges of Osteopathic Medicine, and the Accreditation Council for Graduate Medical Education (ACGME) to collect data on medical student and resident/fellow suicides to identify patterns that could predict such events; (3) support the education of faculty members, residents and medical students in the recognition of the signs and symptoms of burnout and depression and supports access to free, confidential, and immediately available stigma-free mental health and substance use disorder services; (4) collaborate with other stakeholders to study the incidence of and risk factors for depression, substance misuse and substance use disorders, and attempted and completed suicide among physicians, residents, and medical students; and (5) work with appropriate stakeholders to explore the viability of developing a standardized reporting mechanism for the collection of current wellness initiatives that institutions have in place to inform and promote meaningful mental health and wellness interventions in these populations. [CME Rep. 06, A-19; Modified: Res. 326, A-22]

Factors Causing Burnout H-405.948

Our AMA recognizes 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. [Res. 208, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 426
(A-24)

Introduced by: New Jersey

Subject: Maternal Morbidity and Mortality: The Urgent Need to Help Raise Professional and Public Awareness and Optimize Maternal Health – A Call to Action

Referred to: Reference Committee D

- 1 Whereas, maternal mortality rate is considered an indirect indicator of the strength of an entire
2 healthcare system; and
3
4 Whereas, despite the numerous efforts by various maternal health organizations, Maternal
5 Morbidity and Mortality rates are continuing to increase; and
6
7 Whereas, over the course of the past 30 years, there has been a 261 % increase in rates of
8 diabetes, 149 % increase in rates of hypertensive disorders of pregnancy (gestational
9 hypertension, preeclampsia, eclampsia, HELLP syndrome), 182 % increase in rates of chronic
10 hypertension; and
11
12 Whereas, obesity is a well-recognized key contributor to these increases; and
13
14 Whereas, there is also increasing and compelling evidence that maternal obesity may affect
15 long-term outcomes of offspring and further highlights the major public health concern maternal
16 obesity poses and the need for increased efforts to optimize maternal weight and health before
17 achieving pregnancy; and
18
19 Whereas, despite published recommendations by the National Academies of Sciences,
20 Engineering, and Medicine for gestational weight gain, conversation about weight during
21 pregnancy has remained limited during prenatal care and 50 – 60% of women gain more than
22 recommended; and
23
24 Whereas, interpregnancy periods are interrelated as the postpartum period may constitute the
25 pregnancy period of a women’s next pregnancy; and
26
27 Whereas, excess gestational weight gain, especially over multiple pregnancies, is also likely to
28 be retained 20 years later resulting in higher risk of chronic disease and negatively impact a
29 women’s health in the long term; and
30
31 Whereas, social drivers of health, structural racism and various stressors have placed Black
32 women at higher risks for obesity and its impact; and
33
34 Whereas, obesity is preventable if the resources to treat or prevent obesity are made available
35 to those who need them the most; and
36
37 Whereas, personal responsibility is a part of dialogue, recognizing our societal responsibility to
38 help prevent and treat obesity by reducing the various barriers to health such as access and

1 affordability to healthy food, safe spaces that favor an active lifestyle, and access to trained
2 clinicians who can provide a full range of equitable obesity care especially to those who need it
3 the most can no longer wait; therefore be it
4

5 RESOLVED, that our American Medical Association policy no. D-245.994 be amended to
6 include the importance of all women achieving their healthiest weight before pregnancy,
7 maintaining healthy gestational weight gain, and optimizing weight loss postpartum (Modify
8 Current HOD Policy); and be it further
9

10 RESOLVED, that our AMA:

- 11 a) Advocate for access to effective obesity treatment (either medical or surgical) for patients.
- 12 b) Advocate for supporting physicians' ability to provide obstetrical and obesity care.
- 13 c) Advocate for additional funding for research on medical technology that influences human
14 behavior to promote healthy living.
- 15 d) Reaffirm policy no. H-440.902 and report back at A-25 on research on the
16 medical, psychological, and socioeconomic issues associated with
17 obesity, including reimbursement for evaluation and management of patients with obesity,
18 emphasizing pre-conception, gestational and postpartum obesity.
- 19 e) Provide medical recommendations on ways to eliminate barriers identified in prior obesity
20 research by our AMA.
- 21 f) Recommend that approaches to obesity prevention and treatment be included as an
22 element of medical education.

23 (Directive to Take Action)

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

Received: 5/3/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 427
(A-24)

Introduced by: New England

Subject: Condemning the Universal Shackling of Every Incarcerated Patient in Hospitals

Referred to: Reference Committee D

1 Whereas, as of February 1, 2022, there are 6,033 total male individuals, of whom 5,440 are
2 criminally sentenced, 24 are pre-trial detainees, and 569 face civil commitments, and 199 total
3 female individuals, of whom 155 are criminally sentenced, 40 are pre-trial detainees, and 4 face
4 civil commitments, who are in the jurisdiction of the Massachusetts Department of Corrections;¹
5 and

6
7 Whereas, in 2021, the average male justice-involved individual was 44 years old, and the
8 average female justice-involved individual was 42 years old in Massachusetts, with 951
9 individuals 60 years of age and over as of January 1, 2021,² and average age of individuals who
10 are incarcerated rising concurrently with their health needs;³ and

11
12 Whereas, in 2016, about 43% of federal justice-involved individuals reported ever having a
13 chronic condition, 33% reported currently having a chronic condition, and 31% had medical
14 visits outside of carceral facilities;⁴ and

15
16 Whereas, people of color are overrepresented in prisons and jails in Massachusetts, with
17 Whites accounting for 76% of the state population but 49% of prison or jail population, Blacks
18 accounting for 7% of the state population but 26% of prison or jail population, and Latinos
19 accounting for 10% of the state population but 24% of prison or jail population;⁵ and

20
21 Whereas, US carceral facilities provide health care for justice-involved individuals in both on-site
22 and off-site facilities depending on the type of service, with emergency, obstetrics, gynecology,
23 and cardiology procedural services more commonly provided at non-carceral hospital facilities;⁶
24 and

25
26 Whereas, universal shackling in a hospital refers to the placement of metal restraints around the
27 legs, wrists, or waist of justice-involved patients, regardless of age, illness, mobility, or criminal
28 record disposition,⁷ with the recent exception of perinatal patients in Massachusetts; and

29
30 Whereas, Massachusetts enacted legislation in 2014 to prevent perinatal shackling, or the use
31 of shackles for patients who are incarcerated and pregnant, in labor, or in postpartum recovery,
32 by correction officers while the attending physician or nurse treating the perinatal patient may
33 request immediate removal of restraints;⁸ and

34
35 Whereas, our American Medical Association has model state legislation to prohibit the practice
36 of shackling pregnant prisoners;⁹ and

37
38 Whereas, US Senators Elizabeth Warren and Corey Booker introduced the Dignity for
39 Incarcerated Women Act in 2017,¹⁰ and the First Step Act of 2018 placed a federal prohibition

1 on the use of restraints on individuals who are pregnant and in the custody of the federal
2 Bureau of Prisons or the US Marshals Service;^{11,12} and Whereas, Thirty-two states have
3 implemented some form of restriction on perinatal shackling, with 13 states banning shackling
4 throughout pregnancy, labor, postpartum, and during transport between carceral and health
5 care facilities;¹³ and

6
7 Whereas, physicians and nurses in hospitals routinely assess the necessity of physical or
8 pharmacological restraints on non-justice-involved patients who may harm themselves or
9 others, as well as document their use in the electronic medical record with descriptions of the
10 reason for restraint, form of restraint, and periodic re-evaluations of continued need for restraint
11 and any consequence on patient health;^{14,15} and

12
13 Whereas, the use of restraints on non-justice-involved patients in the hospital setting is
14 regulated by the Centers for Medicare and Medicaid Services, which mandate that the least
15 restrictive form of restraint that protects the safety of the patient, health care staff, and others is
16 used;^{16,17} and

17
18 Whereas, shackling patients under special circumstances including, but not limited to, old age,
19 loss of consciousness, terminal illness, or limited mobility, is unnecessary and excessive
20 restraint, thus cruel, inhuman, and degrading as defined by the Universal Declaration of Human
21 Rights, the International Convention on the Elimination of All Forms of Racial Discrimination,
22 and the International Covenant on Civil and Political Rights^{18,19,20} and in violation of the medical
23 ethics principle of nonmaleficence; and

24
25 Whereas, physical restraint use on patients is associated with delays in necessary emergency
26 operations, increased falls and deliriums, as well as elevated risks of in-hospital deaths and
27 venous thrombosis;^{21,22} and

28
29 Whereas, in psychiatric settings, restraints have led to inappropriate actions by staff, invoking a
30 fear response in patients and a loss of trust in the psychiatric staff,²³ ultimately causing patients
31 to be less likely to follow their treatment plan, use medical care, or consent to a surgical
32 procedure;²⁴ and

33
34 Whereas, formerly justice-involved individuals of color who experienced discrimination in
35 healthcare settings due to their criminal records are less likely to use primary care resources
36 upon release,²⁵ report worse mental and physical health following their release,²⁶ and are more
37 likely to report increased psychological distress;²⁷ and

38
39 Whereas, physicians have written about the moral injury and contribution to physician burnout
40 due to practicing in hospitals that routinely shackle every justice-involved patient;^{28,29} and

41
42 Whereas, violence against health care workers is of critical importance that should be
43 addressed through effective hospital security protocols and staff training;³⁰ and

44
45 Whereas, current hospital policies for shackling in Massachusetts align with policies governing
46 the shackling of non-justice-involved patients only in regard to justice-involved pregnant
47 individuals, yet permit the universal shackling of all non-pregnant justice-involved patients,
48 regardless of other special circumstances including, but not limited to, old age, loss of
49 consciousness, terminal illness, or limited mobility; therefore be it

50
51 RESOLVED, that our American Medical Association condemns the practice of universally
52 shackling every patient who is involved with the justice system while they receive care in

1 hospitals and outpatient health care settings (New HOD Policy); and be it further

2
3 RESOLVED, that our AMA advocate for the universal assessment of every individual who is
4 involved with the justice system who presents for care, by medical and security staff in
5 collaboration with correctional officers, to determine whether shackles are necessary or may be
6 harmful, and, if restraint is deemed necessary, that the least restrictive alternative to shackling
7 with metal cuffs is used when appropriate (Directive to Take Action); and be it further

8
9 RESOLVED, that our AMA advocate nationally for the end of universal shackling, to protect
10 human and patient rights, improve patient health outcomes, and reduce moral injury among
11 physicians. (Directive to Take Action)

12
Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 5/7/2024

REFERENCES

- ¹ Massachusetts Department of Corrections, Research Division. Quick Statistics. Mass.gov. <https://www.mass.gov/service-details/quick-statistics>. Accessed March 8, 2022.
- ² Cannata N, McDonald S, Desrochers B, et al.; 2021. <https://www.mass.gov/doc/prison-population-trends-2020/download>. Accessed March 8, 2022.
- ³ Maruschak LM, Berzofsky M, Unangst J. (Young M, Cooperman I, Thomas J, eds.). Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice; 2015. <https://bjs.ojp.gov/content/pub/pdf/mpsfj1112.pdf>. Accessed March 8, 2022.
- ⁴ Maruschak LM, Bronson J, Alper M. Bureau of Justice Statistics, Office of Justice Programs, U.S. Department of Justice; 2021. <https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/mprpspi16st.pdf>. Accessed March 8, 2022.
- ⁵ Prison Policy Initiative. Massachusetts profile. <https://www.prisonpolicy.org/profiles/MA.html>. Published 2022. Accessed March 8, 2022.
- ⁶ Chari KA, Simon AE, DeFrances CJ, Maruschak L. National Center for Health Statistics, Centers for Disease Control and Prevention; 2016. <https://www.cdc.gov/nchs/data/nhsr/nhsr096.pdf>. Accessed March 8, 2022.
- ⁷ Feinauer E, Lee A, Park J, Walker T, Smith G. (Citro B, Dakwar J, Fettig A, Kalantry S, eds.). International Human Rights Clinic University of Chicago Law School, CLAIM, ACLU National Prison Project; 2013. https://tbinternet.ohchr.org/Treaties/CCPR/Shared%20Documents/USA/INT_CCPR_NGO_USA_15235_E.pdf. Accessed March 8, 2022.
- ⁸ An Act to Prevent Shackling and Promote Safe Pregnancies for Female Inmates. Session Laws Chapter 103 (2014). <https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter103>. Accessed March 8, 2022.
- ⁹ An "Act to prohibit the shackling of pregnant prisoners" model state legislation. 2015. <https://www.ama-assn.org/media/9791/download#:~:text=The%20AMA%20model%20state%20legislation%20is%20a%20straightforward%20prohibiti on%20on,personnel%20or%20substantial%20flight%20risk>. Accessed March 8, 2022.
- ¹⁰ S.1524 - 115th Congress (2017-2018): Dignity Act. (2017, July 11). <https://www.congress.gov/bill/115th-congress/senate-bill/1524>. Accessed March 8, 2022.
- ¹¹ S.756 - 115th Congress (2017-2018): First Step Act of 2018. (2018, December 21). <https://www.congress.gov/bill/115th-congress/senate-bill/756>. Accessed March 8, 2022
- ¹² James N. Congressional Research Service; 2019. <https://crsreports.congress.gov/product/pdf/R/R45558>. Accessed March 8, 2022.
- ¹³ Richardson A. Shackling of Pregnant Prisoners Is Ongoing. Bill of Health. March 2020. <https://blog.petrieflom.law.harvard.edu/2020/03/04/shackling-of-pregnant-prisoners-is-ongoing/>. Accessed March 8, 2022.
- ¹⁴ Thomann S, Zwakhalen S, Richter D, Bauer S, Hahn S. Restraint use in the acute-care hospital setting: A cross-sectional multi-centre study. *International Journal of Nursing Studies*. 2021;114:103807. doi:10.1016/j.ijnurstu.2020.103807
- ¹⁵ de Bruijn W, Daams JG, van Hunnik FJG, et al. Physical and Pharmacological Restraints in Hospital Care: Protocol for a Systematic Review. *Front Psychiatry*. 2020;10:921. Published 2020 Feb 28. doi:10.3389/fpsy.2019.00921
- ¹⁶ Centers for M&MS. Vol 71. Woodlawn, MD: Department of Health and Human Services; 2006:71380. <https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/downloads/finalpatientrightsrule.pdf>
- ¹⁷ Mental Health Legal Advisors C. Rights of Adults in Massachusetts Hospitals and Emergency Rooms Regarding Restraint and Seclusion. 2021. http://mhlac.org/wp-content/uploads/2018/10/Rights_in_hospitals_including_hospital_emergency_rooms_regarding_restraint_and_seclusion.pdf
- ¹⁸ Universal Declaration of Human Rights. United Nations. <https://www.un.org/en/about-us/universal-declaration-of-human-rights>. Accessed March 8, 2022. Article 5
- ¹⁹ International Convention on the Elimination of All Forms of Racial Discrimination. United Nations Human Rights. <https://www.ohchr.org/en/professionalinterest/pages/cerd.aspx>. Published 1969. Accessed March 8, 2022.
- ²⁰ International Covenant on Civil and Political Rights. United Nations Human Rights. <https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx>. Published 1976. Accessed March 8, 2022. Article 10

- ²¹ Bureau of Justice Assistance U.S. Department of Justice; 2014. <https://cjinvolvementwomen.org/wp-content/uploads/2015/09/Best-Practices-Use-of-Restraints-Pregnant.pdf>. Accessed March 8, 2022.
- ²² Robinson M, Lavere K, Porsa E. End the routine shackling of incarcerated inpatients. *Journal of Hospital Medicine*. 2021;16(6):376-377. doi:10.12788/jhm.3581
- ²³ Klein J. A Theory of Punishment: The Use of Mechanical Restraints in Psychiatric Care. *University of Southern California Review of Law and Social Justice*. 2011;21(1):47-72. <https://gould.usc.edu/students/journals/rlsj/issues/assets/docs/volume21/Fall2011/3.Klein.pdf>. Accessed March 8, 2022.
- ²⁴ Thom DH, Hall MA, Pawlson LG. Measuring patients' trust in physicians when assessing quality of care. *Health Affairs*. 2004;23(4):124-132. doi:10.1377/hlthaff.23.4.124
- ²⁵ Frank JW, Wang EA, Nunez-Smith M, Lee H, Comfort M. Discrimination based on criminal record and healthcare utilization among men recently released from prison: a descriptive study. *Health Justice*. 2014;2:6. doi:10.1186/2194-7899-2-6
- ²⁶ Redmond N, Aminawung JA, Morse DS, Zaller N, Shavit S, Wang EA. Perceived Discrimination Based on Criminal Record in Healthcare Settings and Self-Reported Health Status among Formerly Incarcerated Individuals. *J Urban Health*. 2020;97(1):105-111. doi:10.1007/s11524-019-00382-0
- ²⁷ Turney K, Lee H, Comfort M. Discrimination and Psychological Distress Among Recently Released Male Prisoners. *American Journal of Men's Health*. November 2013:482-493. doi:10.1177/1557988313484056
- ²⁸ Lescure T. Opinion: No patient should have to die in shackles. *The Washington Post*. October 5, 2021. <https://www.washingtonpost.com/opinions/2021/10/05/no-patient-should-have-die-shackles/>
- ²⁹ Replace the 'cold steel' of hospital-bed shackles with the warmth of compassion. *STAT*. December 4, 2020. <https://www.statnews.com/2020/12/04/replace-cold-steel-of-hospital-bed-shackles-with-warmth-of-compassion/>
- ³⁰ Preventing violence against health workers. World Health Organization. <https://www.who.int/activities/preventing-violence-against-health-workers>. Accessed March 8, 2022.

RELEVANT AMA POLICY

Shackling of Pregnant Women in Labor H-420.957

1. Our AMA supports language recently adopted by the New Mexico legislature that "an adult or juvenile correctional facility, detention center or local jail shall use the least restrictive restraints necessary when the facility has actual or constructive knowledge that an inmate is in the 2nd or 3rd trimester of pregnancy. No restraints of any kind shall be used on an inmate who is in labor, delivering her baby or recuperating from the delivery unless there are compelling grounds to believe that the inmate presents:

- An immediate and serious threat of harm to herself, staff or others; or
- A substantial flight risk and cannot be reasonably contained by other means.

If an inmate who is in labor or who is delivering her baby is restrained, only the least restrictive restraints necessary to ensure safety and security shall be used."

2. Our AMA will develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 428
(A-24)

Introduced by: New England

Subject: Advocating for Education and Action Regarding the Health Hazards of PFAS
Chemicals

Referred to: Reference Committee D

1 Whereas, in 2019 the American Medical Association resolved to support research and policy to
2 address the effects of PFAS exposure¹ and supported legislation and regulation seeking to
3 address contamination, exposure, classification, and clean-up of per- and polyfluoroalkyl
4 substances as follows:² “our AMA: (1) supports continued research on the impact of
5 perfluoroalkyl and polyfluoroalkyl chemicals on human health; (2) supports legislation and
6 regulation seeking to address contamination, exposure, classification, and clean-up of PFAS
7 substances; and (3) will advocate for states, at minimum, to follow guidelines presented in the
8 Environmental Protection Agency’s Drinking Water Health Advisories for perfluorooctanoic acid
9 (PFOA) and perfluorooctane sulfonic acid (PFOS), with consideration of the appropriate use of
10 Minimal Risk Levels (MRLs) presented in the CDC/ATSDR Toxicological Profile for PFAS”; and
11

12 Whereas, per- and polyfluoroalkyl substances (PFAS), are a large class of chemicals with at
13 least one aliphatic perfluorocarbon moiety; this carbon - fluorine bond is exceptionally strong
14 and therefore highly resistant to degradation; thus the moniker “forever chemicals” because
15 these chemicals persist, have the potential to bioaccumulate and become more concentrated in
16 the environment with the passage of time;³ and
17

18 Whereas, PFAS are ubiquitous: they are found in “non-stick” products that resist stains, oil,
19 grease, and water including cookware,⁴ artificial turf, clothing, leather, carpets, food packaging,
20 firefighting foam, cosmetics, shampoos, sunscreens, pesticides; medical equipment such as
21 PPE, masks, gowns, IV tubing, and medications;⁵ and petroleum extraction (“fracking”) fluids;⁶
22 the latter are sometimes repurposed as road salt or as “biosolids” that are then spread on
23 crops⁷; and
24

25 Whereas, the PFAS chemicals PFOA and PFOS have recently been designated by the US EPA
26 as hazardous substances that can be responded to via Superfund;⁸ and while the EPA has set
27 health advisory levels at between 0.002 and 0.004 ng/L, health effects, according to the EPA,
28 can occur at any level;⁹ and
29

30 Whereas, PFAS exposure has been associated with endocrine disruption, immune suppression,
31 impaired organogenesis, damage to reproductive organs, and hepatotoxicity; low infant birth
32 weight, preeclampsia,¹⁰ impaired fertility, obesity, Type 2 diabetes, harms to neurocognitive and
33 behavioral development in children, and malignancies, including prostate, kidney, and testicular
34 cancer;¹¹ and
35

36 Whereas, PFAS exposure occurs via food, air, and water, including drinking water and rain;¹²
37 water can become contaminated when PFAS leaches into water supplies from plastic
38 containers, landfills, industrial and agricultural runoff, or following pesticide spraying (PFOS has
39 been detected in 6/10 tested pesticides at levels between 3.92 to 19.2 mg/kg);¹³ other common

1 sources of exposure include: ingestion of contaminated dust (from carpets, upholstery, etc.) as
2 well as migration into food or beverages from boxes/packaging/plastic bottles); in infants,
3 toddlers, and children, hand-to-mouth behavior is a significant source of exposure; and
4

5 Whereas, PFAS has direct impacts on the practice of medicine since they are used extensively
6 in medical products, including medications, IV tubing, and PPE;¹⁴ pharmaceuticals often
7 include a fluorine molecule to increase cell permeability to increase uptake;¹⁵ and persons with
8 high PFAS levels may be less responsive to certain medications, like vaccines;¹⁶ and
9

10 Whereas, like lead, exposure to PFAS is widespread, but like lead, mitigating exposure and
11 focusing on children and adults who are highly exposed is helpful since these persons can then
12 be identified and helped (ie, parents can be cautioned to use a different, PFAS-free water
13 source to use to make up baby formula, etc); like lead, limiting length and extent of high
14 exposure could potentially improve health outcomes; and
15

16 Whereas, PFAS chemicals disproportionately pose challenges to low income and minority
17 communities: some of the highest levels found across the country exist in lower income
18 communities, even when the exposure hazard is not disproportionate between low and high
19 income communities, the ability to respond with adequate filtration and monitoring efforts is
20 unequal; and
21

22 Whereas, the National Academy of Science, Engineering and Medicine has recommended¹⁷
23 that individuals with significant exposure to PFAS (including those who live near commercial
24 airports, military bases and farms where sewage sludge may have been used) be tested and
25 receive ongoing medical monitoring; PFAS blood testing in the population based C8 Dupont
26 study in 69,030 participants was essential in determining associated health conditions with
27 PFAS chemicals;^{18,19} and PFAS blood tests are currently available through Quest and other
28 providers;²⁰ and
29

30 Whereas, 99% of United States residents have various PFAS detectable in their blood²¹; and
31

32 Whereas, newly developed educational resources on PFAS are available and include a free
33 CME course on PFAS and comprehensive medical information and guidance on PFAS-REACH
34 project's website (funded by the NIH's National Institute of Environmental Health Sciences
35 (NIEHS))²² and the July 2022 National Academy of Science, Engineering and Medicine report
36 on PFAS;²³ therefore be it
37

38 RESOLVED, that our American Medical Association improve physician and public education
39 around the adverse health effects of PFAS and potential mitigation and prevention efforts.
40 (Directive to Take Action)

Fiscal Note: \$51,420 Development of continuing medical education module to be hosted
on AMA EdHub

Received: 5/7/2024

REFERENCES

- ¹ https://pfas-exchange.org/wp-content/uploads/PFAS-REACH-Medical-screening-guidance_clinicians.pdf
- ² <https://www.ama-assn.org/system/files/2019-09/i19-901.pdf>
- ³ Carol F. Kwiatkowski et al., “Scientific Basis for Managing PFAS as a Chemical Class”, *Environ. Sci. Technol. Lett.* 2020, 7, 8, 532–543, June 30, 2020
<https://doi.org/10.1021/acs.estlett.0c00255>
- ⁴ Ramirez Carnero A, Lestido-Cardama A, Vazquez Loureiro P, Barbosa-Pereira L, Rodríguez Bernaldo de Quirós A, Sendón R. Presence of Perfluoroalkyl and Polyfluoroalkyl Substances (PFAS) in Food Contact Materials (FCM) and Its Migration to Food. *Foods*. 2021 Jun 22;10(7):1443. doi: 10.3390/foods10071443. PMID: 34206351; PMCID: PMC8306913.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8306913/>
- ⁵ Gluge J et al. An overview of the uses of per and polyfluoroalkyl substances (PFAS). *Environ. Sci.: Processes Impacts*, 2020, **22**, 2345-2373 DOI: [10.1039/D0EM00291G](https://doi.org/10.1039/D0EM00291G). <https://pubs.rsc.org/en/content/articlehtml/2020/em/d0em00291g>
- ⁶ Hiroko T. EPA approved toxic chemicals for fracking a decade ago, new files show. *NYT*. 07.12.2021.
<https://www.nytimes.com/2021/07/12/climate/epa-pfas-fracking-forever-chemicals.html#:~:text=For%20much%20of%20the%20past,to%20internal%20documents%20from%20the>
- ⁷ <https://extension.umaine.edu/agriculture/guide-to-investigating-pfas-risk-on-your-farm/>
- ⁸ <https://www.epa.gov/pfas>
- ⁹ <https://www.epa.gov/sdwa/drinking-water-health-advisories-pfoa-and-pfos>
- ¹⁰ Blake BE, Fenton SE. Early life exposure to per- and polyfluoroalkyl substances (PFAS) and latent health outcomes: A review including the placenta as a target tissue and possible driver of peri- and postnatal effects. *Toxicology*. 2020 Oct;443:152565. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7530144/>
- ¹¹ <https://www.atsdr.cdc.gov/pfas/health-effects/index.html>
- ¹² Cousins I, Johansson J et al. Outside the safe operating space of a new boundary for per and polyfluoroalkyl substances (PFAS), *Environ. Sci. Technol.* 2022, 56, 11172–11179
Publication Date: August 2, 2022
<https://doi.org/10.1021/acs.est.2c02765>
<https://pubs.acs.org/doi/10.1021/acs.est.2c02765>
- ¹³ <https://www.sciencedirect.com/science/article/pii/S266691102200020X>
- ¹⁴ Gluge J et al. An overview of the uses of per and polyfluoroalkyl substances (PFAS). *Environ. Sci.: Processes Impacts*, 2020, **22**, 2345-2373 DOI: [10.1039/D0EM00291G](https://doi.org/10.1039/D0EM00291G). <https://pubs.rsc.org/en/content/articlehtml/2020/em/d0em00291g>
- ¹⁵ Velcicky J, Schlapbach A, Heng R, Revesz L, Pflieger D, Blum E, Hawtin S, Huppertz C, Feifel R, Hersperger R. Modulating ADME Properties by Fluorination: MK2 Inhibitors with Improved Oral Exposure. *ACS Med Chem Lett.* 2018 Mar 20;9(4):392-396. doi: 10.1021/acsmedchemlett.8b00098. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5900337/>
- ¹⁶ Grandjean P et al., Serum vaccine antibody concentrations in children exposed to perfluorinated compounds. *JAMA* 307, 391–397 (2012)
- ¹⁷ National Academies of Sciences, Engineering, and Medicine. 2022. *Guidance on PFAS Exposure, Testing, and Clinical Follow-Up*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/26156>.
- ¹⁸ <http://www.c8sciencepanel.org/>
- ¹⁹ Frisbee SJ, Brooks AP Jr, Maher A, Flensburg P, Arnold S, Fletcher T, Steenland K, Shankar A, Knox SS, Pollard C, Halverson JA, Vieira VM, Jin C, Leyden KM, Ducatman AM. The C8 health project: design, methods, and participants. *Environ Health Perspect.* 2009 Dec;117(12):1873-82. doi: 10.1289/ehp.0800379.
<https://pfas-exchange.org/wp-content/uploads/PFAS-Blood-Testing-Document-May-2022.pdf>
- ²⁰ <https://pfas-exchange.org/wp-content/uploads/PFAS-Blood-Testing-Document-May-2022.pdf>
- ²¹ Kato K, Wong LY, Jia LT, Kuklennyk Z, Calafat AM. Trends in exposure to polyfluoroalkyl chemicals in the U.S. Population: 1999–2008. *Environ Sci Technol* 2011;45(19):8037–45.
- ²² <https://pfas-exchange.org/>
- ²³ <https://nap.nationalacademies.org/catalog/26156/guidance-on-pfas-exposure-testing-and-clinical-follow-up>

RELEVANT AMA POLICY

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).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 429
(A-24)

Introduced by: New England

Subject: Assessing and Protecting Local Communities from the Health Risks of
Decommissioning Nuclear Power Plants

Referred to: Reference Committee D

1 Whereas, decommissioning nuclear power plants has long been known to pose many risks to
2 health to workers and to residents of nearby communities;¹ and
3

4 Whereas, over the coming years, the United States will be decommissioning many of its more
5 than 90 aging nuclear power plants;¹¹ there is a need, therefore, to develop processes for
6 decommissioning these facilities that are protective of health in Massachusetts and in other
7 states; and
8

9 Whereas, while the company responsible for the decommissioning of the nuclear reactor in
10 Plymouth had initially planned to release more than a million gallons of radioactive water into
11 Cape Cod Bay, the permit to allow said discharges has been tentatively denied by the
12 Massachusetts Department of Environmental Protection;¹² and
13

14 Whereas, according to Woods Hole Oceanographic Institute expert Dr. Ken Buesseler, tritium
15 levels inside this reactor water exceed seawater levels for tritium by a factor of a million;
16 Cesium-137 in the reactor water is 200 million times higher than seawater levels; and even if 99
17 percent of the cesium from the Pilgrim water is removed, the radioactive water will still contain
18 Cesium-137 at levels 2 million times higher than the levels in Cape Cod Bay;² and
19

20 Whereas, according to Dr. Buesseler, since Cesium-137 levels are elevated, it can be assumed
21 that strontium-90 is present in the water, along with other elements that are part of a group
22 called transuranics, which include known carcinogens such as plutonium, uranium, americium;²
23 and
24

25 Whereas, all of the radioactive elements known and suspected to be released from the Pilgrim
26 Nuclear Power Station located in Plymouth can cause cancers in humans, including lung
27 cancer, bone cancer, thyroid cancer, adult leukemia, and childhood leukemia;⁴ and
28

29 Whereas, the scientific consensus is that every additional exposure to radiation adds to the total
30 risk for genetic damage and thus for cancers like leukemia and increased radiation implies
31 increased incidence of these diseases in exposed populations; for solid cancers, the risk for
32 cancer from radiation is linearly proportional to cumulative exposure;⁵ and
33

34 Whereas, Pilgrim Nuclear Power Station has specifically been associated with increased
35 leukemia incidence in the local community; Dr. Richard Clapp, former Massachusetts state
36 cancer epidemiologist and professor emeritus of the Boston University School of Public Health,
37 found a fourfold excess of leukemia cases among those who lived or worked near the Plymouth
38 nuclear power plant, in a dose-response relationship;⁶ and

1 Whereas, Dr. Clapp's peer-reviewed case control study also showed increased infant mortality
2 and thyroid cancer;⁶ and
3

4 Whereas, while more exposure is always worse, even low-dose exposures to radiation increase
5 cancer risk, according to the National Academy of Sciences BEIR VII report³, especially among
6 vulnerable populations such as pregnant women, infants in the womb, and young children;
7 moreover, exposures to ionizing radiation in early life can cause lifelong damage and increase
8 risk of cancer across the lifespan;⁷ infants, children, and pregnant women are therefore
9 particularly vulnerable to any radiation emitted from the Pilgrim Nuclear Power Station; and
10 Whereas, recent studies suggest that proximity to ionizing radiation sources is also associated
11 with an increased risk of dementia;⁸ and
12

13 Whereas, radiation from nuclear power plants and the radioactive waste it generates pose
14 disproportionate challenges to low income and minority communities; some of the highest levels
15 of radiation found across the country from these energy sources exist in these communities;⁹ in
16 Massachusetts, Superfund sites and hazardous waste are more likely to be located in close
17 proximity to these populations;¹⁰ and
18

19 Whereas, there is cause for concern regarding potential future serious health sequelae among
20 local communities due to radionuclide exposure from the decommissioning of the nuclear power
21 plant in Plymouth; therefore be it
22

23 RESOLVED, that our American Medical Association advocate for strict limitations of aerosol,
24 soil, and/or water radionuclide releases in the decommissioning of US nuclear power plants in
25 order to protect health, particularly that of local vulnerable populations. (Directive to Take
26 Action)

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

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REFERENCES

1. Dodic-Fikfak M, Clapp R, Kriebel D. The health risks of decommissioning nuclear facilities. *New Solut.* 1999;9(2):153-61. <https://pubmed.ncbi.nlm.nih.gov/17208791/>
2. <https://cafethorium.who.edu/wp-content/uploads/sites/9/2023/06/Notes-on-Radiation-Control-Report-RE-PNPS-from-Ken-Buesseler.pdf>
3. Health Risks from Exposure to Low Levels of Ionizing Radiation, BEIR VII, Phase 2
4. Gilbert ES. Ionising radiation and cancer risks: what have we learned from epidemiology? *Int J Radiat Biol.* 2009 Jun;85(6):467-82. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2859619/>
5. Harris E. Risk of Death From Low-Dose Radiation Might Be Higher Than Thought. *JAMA.* 2023;330(12):1128. <https://jamanetwork.com/journals/jama/fullarticle/2809400>
6. Clapp RW, Cobb S. Leukemia and other health outcomes in the vicinity of the Pilgrim Nuclear Power Station, Plymouth, MA. *United States. Archives of Environmental Health. Journal Volume: 45:5; Conference: 1. Annual meeting of the International Society for Environmental Epidemiology, Upton, NY (USA), 13–15 Sep 1989.* <https://www.osti.gov/biblio/5735008>
7. <https://www.epa.gov/radiation/radiation-health-effects>
8. Srivastava T, Chirikova E, Birk S, Xiong F, Benzouak T, Liu JY, Villeneuve PJ, Zablotzka LB. Exposure to Ionizing Radiation and Risk of Dementia: A Systematic Review and Meta-Analysis. *Radiat Res.* 2023 May;199(5):490–505. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10249679/>
9. Kyne D, Bolin B. Emerging Environmental Justice Issues in Nuclear Power and Radioactive Contamination. *Int J Environ Res Public Health.* 2016 Jul 12;13(7):700. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4962241/>
10. Faber DR, Krieg EJ. Unequal Exposure to Ecological Hazards: Environmental Injustices in the Commonwealth of Massachusetts. *Environ Health Perspect.* 2002 Apr;110(Suppl 2): 277–288
11. <https://www.eia.gov/todayinenergy/detail.php?id=33792#:~:text=As%20of%202017%2C%20a%20total,stages%20of%20the%20decommissioning%20process>
12. <https://www.mass.gov/doc/tentative-determination-to-deny-holtecs-surface-water-discharge-permit-modification-request/download>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 430
(A-24)

Introduced by: New England

Subject: Supporting the Inclusion of Information about Lung Cancer Screening within
Cigarette Packages

Referred to: Reference Committee D

- 1 Whereas, lung cancer is the leading cause of cancer-related death in Massachusetts, causing
2 more deaths than prostate cancer, breast cancer, and colorectal cancer combined;¹ and
3
4 Whereas, nearly three-fourths of people who smoke in the United States come from lower
5 socioeconomic statuses, with those below the poverty line twice as likely to smoke as those
6 above it;² and
7
8 Whereas, lung cancer incidence and lung cancer mortality are elevated among veterans and
9 Black Americans;³⁻⁶ and
10
11 Whereas, individuals who are lesbian, gay, or bisexual use tobacco at higher rates than those
12 who are straight, and those who are transgender use tobacco at higher rates than cisgender
13 individuals;⁷ and
14
15 Whereas, the tobacco industry spends nearly \$1,000,000 per hour on retail advertising and
16 price discounts, and the number of tobacco retailers per square mile is about five times higher in
17 the lowest-income neighborhoods than in the highest-income neighborhoods;⁸ and
18
19 Whereas, discriminatory marketing directed towards LBGTQ+ individuals has benefited the
20 tobacco industry while leading to higher smoking rates among LBGTQ+ individuals;⁹ and
21
22 Whereas, lung cancer screening has been shown to save lives in both large-scale randomized
23 trials and real-world settings,¹⁰⁻¹² but only 16.3 percent of individuals in Massachusetts who are
24 eligible undergo lung cancer screening with low-dose computed tomography (CT) annually;¹³
25 and
26
27 Whereas, 84 percent of individuals who meet the lung cancer screening eligibility criteria are not
28 aware of lung cancer screening through the low-dose CT scan;¹⁴ and
29
30 Whereas, 56 percent of individuals meeting lung cancer screening eligibility criteria in 2017
31 currently smoke and, therefore, frequently encounter health messaging
32 displayed within cigarette packages;¹⁵ and

1 Whereas, placing information about lung cancer screening effectiveness and eligibility along
2 with instructions on how to access screening could improve early detection through lung cancer
3 screening in populations at highest risk for lung cancer; and

4 Whereas, the combustible tobacco industry is expanding to include “non-combustible tobacco”
5 nicotine delivery devices such as (but not limited to) vaping and cheek pouches (e.g., Zyn); and
6

7 Whereas, use of some of these devices produces known carcinogens such as aerosolized
8 heavy metals and hydrocarbons;^{16,17} and
9

10 Whereas these devices have not been in use long enough to provide sufficient data on the
11 incidence of cancer associated with their use; therefore be it
12

13 RESOLVED, that our American Medical Association advocate for information about lung cancer
14 screening to be included within all combustible tobacco product packaging (Directive to Take
15 Action); and be it further
16

17 RESOLVED, that our AMA will work with appropriate public health organizations and
18 governmental agencies to monitor the impact of “non-combustible tobacco” nicotine delivery
19 devices on cancer epidemiology and promote appropriate cancer screening should the
20 suspected link be proven. (Directive to Take Action)

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

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REFERENCES

1. Siegel, R. L., et al. Cancer statistics, 2023. *Ca Cancer J Clin.* 2023;73(1), 17-48. <https://doi.org/10.3322/caac.21763>
2. Levinson, A. H. Where the US tobacco epidemic still rages: Most remaining smokers have lower socioeconomic status. *Journal of Health Care for the Poor and Underserved.* 2017;28(1), 100-107.
3. Odani, S., et al. Tobacco product use among military veterans—United States, 2010–2015. *Morbidity and Mortality Weekly Report.* 2018;67(1), 7.
4. Racial and Ethnic Disparities. American Lung Association. Published October 28, 2022. Accessed September 1, 2023. <https://www.lung.org/research/state-of-lung-cancer/racial-and-ethnic-disparities>
5. Bonner, S. N., et al. Understanding Racial Differences in Lung Cancer Surgery Through a Statewide Quality Collaborative. *Ann Surg Oncol.* 2023;30(1), 517-526. <https://doi.org/10.1245/s10434-022-12435-x>
6. Zhong, P., et al. Temporal trends in Black-White disparities in cancer surgery and cancer-specific survival in the United States between 2007 and 2015. *Cancer Med.* 2023;12(3), 3509-3519. <https://doi.org/10.1002/cam4.5141>
7. Big Tobacco Targets the LGBTQ+ Community. American Cancer Society. Published December 15, 2022. Accessed September 25, 2023. <https://www.fightcancer.org/policy-resources/big-tobacco-targets-lgbtq-community>
8. Advancing Science & Practice in the Retail Environment & Campaign for Tobacco-Free Kids. Tobacco Retailers. Published 2020. Accessed September 23, 2023. <https://aspirecenter.org/tobaccoretailers/>
9. Lung Disease and LGBTQ+ Communities. American Lung Association. Published June 14, 2021. Accessed September 25, 2023. <https://www.lung.org/blog/lung-disease-lgbtq>
10. Aberle, D. R., et al. Reduced lung-cancer mortality with low-dose computed tomographic screening. *N Engl J Med.* 2011;365(5), 395-409. <https://doi.org/10.1056/NEJMoa1102873>
11. de Koning, H. J., et al. Reduced Lung-Cancer Mortality with Volume CT Screening in a Randomized Trial. *New England Journal of Medicine.* 2020;382(6), 503-513. <https://doi.org/10.1056/NEJMoa1911793>
12. Potter, A. L., et al. Association of computed tomography screening with lung cancer stage shift and survival in the United States: quasi-experimental study. *Bmj.* 2022;376, e069008. <https://doi.org/10.1136/bmj-2021-069008>
13. Lung Cancer Screening. National Cancer Institute. Published April 2022. Accessed August 26, 2023. https://progressreport.cancer.gov/detection/lung_cancer
14. Why We Need More Awareness around Lung Cancer Screening. Published November 13, 2017. Accessed August 26, 2024. <https://www.lung.org/blog/lung-cancer-screening-awareness>
15. Richards, T. B., et al. Screening for lung cancer—10 states, 2017. *Morbidity and Mortality Weekly Report.* 2020;69(8), 201.
16. Esteban-Lopez et al. Health effects and known pathology associated with the use of E-cigarettes. *Toxicology Reports* (9), 2022, 1357-68
17. Bracken-Clarke et al. Vaping and lung cancer – A review of current data and recommendations. *Lung Cancer* (153) 2021, 11-20

RELEVANT AMA POLICY

H-495.989 Tobacco Product Labeling

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. CSA Rep. 3, A-04 Modified: Res. 402, A-13 Modified: Res. 925, I-16 Modified: Res. 428, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 431
(A-24)

Introduced by: Massachusetts

Subject: Combatting the Public Health Crisis of Gun Violence

Referred to: Reference Committee D

1 Whereas, gun violence remains a national crisis; and
2
3 Whereas, gun violence is now the leading cause of death in US children and teens; and
4
5 Whereas, effective means of addressing this scourge have been woefully lacking and data
6 demonstrate that gun deaths among US children and teens increased 50% between 2019 and
7 2021; and
8
9 Whereas, gun violence is not a crisis of our second amendment but rather a crisis of public
10 health; therefore be it
11
12 RESOLVED, that our American Medical Association advocate for and strongly support
13 legislation, regulation, and reform that seeks to address the public health crisis posed by gun
14 violence. (Directive to Take Action)

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

Received: 5/7/2024

REFERENCES

Retrieved from Pew Research Center: <https://www.pewresearch.org/short-reads/2023/04/26/what-the-data-says-about-gun-deaths-in-the-u-s/>

Retrieved from National Institute for Health Care Management: <https://nihcm.org/newsletter/gun-violence-is-a-public-health-problem>

Retrieved from New England Journal of Medicine: <https://www.nejm.org/doi/full/10.1056/nejmc2201761>

Retrieved from CDC: <https://wonder.cdc.gov/>

Retrieved from American Academy of Pediatrics: <https://publications.aap.org/pediatrics/article/152/3/e2023061296/193711/Trends-and-Disparities-in-Firearm-Deaths-Among?autologincheck=redirected>

RELEVANT AMA POLICY

D-145.992 Further Action to Respond to the Gun Violence Public Health Crisis

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. BOT Rep. 2, I-22

D-145.995 Gun Violence as a Public Health Crisis

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

to lift the gun violence research ban. Res. 1011, A-16 Reaffirmation: A-18 Reaffirmation: I-18 Reaffirmed: Res. 921, I-22

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

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

Therefore, the AMA:

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

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

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

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

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

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

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

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

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

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

5. Our AMA will collaborate with key stakeholders and advocate for national public forums including, but not limited to, online venues, national radio, and televised/streamed in-person town halls, that bring together key stakeholders and members of the general public to focus on finding common ground, non-partisan measures to mitigate the effects of firearms in our firearm injury public health crisis. CSA Rep. A, I-87 Reaffirmed: BOT Rep. I-93-50 Appended: Res. 403, I-99 Reaffirmation A-07 Reaffirmation A-13 Appended: Res. 921, I-13 Reaffirmed: CSAPH Rep. 04, A-18 Reaffirmation: A-18 Reaffirmation: I-18 Appended: Res. 405, A-19 Appended: Res. 907, I-22 Reaffirmed: Res. 921, I-22 Reaffirmation: A-23

D-440.912 AMA Public Health Strategy

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

2. Our AMA Board of Trustees will provide an update on loss of coverage and uninsurance rates following the return to regular Medicaid redeterminations and the end of the COVID-19 Public Health Emergency, the ensuing financial and administrative challenges experienced by physicians, physician practices, hospitals, and the healthcare system; and a report of actions taken by the AMA and recommendation for further action to address these issues at I-2023.

3. Our AMA Board of Trustees will provide a strategic plan or outline for the AMA's plan to address and combat the health effects of climate change at I-2023.

4. Our AMA Board of Trustees will provide an update on the efforts and initiatives of the AMA's gun violence task force at I-2023.
5. Our AMA will continue to support increased funding for public health infrastructure and workforce, which should include funding for preventative medicine related residency programs, to increase public health leadership in this country. BOT Rep. 17, A-23 Modified: BOT Rep. 05, I-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:432
(A-24)

Introduced by: American College of Preventive Medicine

Subject: Resolution to Decrease Lead Exposure in Urban Areas

Referred to: Reference Committee D

- 1 Whereas, lead is a toxic metal that can cause serious health problems, especially in children
2 and pregnant women^{1,2,3}; and
3
4 Whereas, the American Medical Association (AMA) supports efforts and advocacy to reduce
5 lead exposures⁴; and
6
7 Whereas, the Safe Drinking Water Act (amended 2020) prohibits the use of pipes, solder or flux
8 that were not “lead free” in the installation or repair of any public water system or any plumbing
9 in a residential or nonresidential facility providing water for human consumption⁵; and
10
11 Whereas, the AMA recognizes the importance of preventive health measures and the role of
12 environmental factors in public health⁶; therefore be it
13
14 RESOLVED, that our American Medical Association reaffirm the following policy H-135.928,
15 “Safe Drinking Water” in support of EPA’s Lead and Copper Rule and evidence-based research
16 demonstrating there is no safe level of lead for humans and therefore warrants immediate
17 Federal, State, and municipal action (Reaffirm HOD Policy); and be it further
18
19 RESOLVED, that our AMA advocates for accessible testing of domestic water supplies,
20 prioritizing testing for lead in potable water used by pregnant women, newborns and young
21 children, with the provision of accessible water filters in homes found to have elevated lead
22 levels in potable water (Directive to Take Action); and be it further
23
24 RESOLVED, that our AMA supports increased funding for lead pipe replacement and other
25 steps to eliminate lead from public and private drinking water supplies (New HOD Policy); and
26 be it further
27
28 RESOLVED, that our AMA promotes community awareness and education campaigns on the
29 causes and risks of lead and drinking water and steps that can be taken to eliminate these risks
30 (Directive to Take Action); and be it further
31
32 RESOLVED, that our AMA supports the development and use of searchable registries of
33 housing units known to have unresolved lead in the drinking water due to lead connectors to
34 water mains or other sources of lead in the drinking water in cities with significant public lead
35 exposure (Directive to Take Action); and be it further

- 1 RESOLVED, that our AMA urges healthcare providers to increase screening for lead exposure,
2 particularly in areas known to have lead pipes, and particularly in underserved areas (Directive
3 to Take Action); and be it further
4
5 RESOLVED, that our AMA calls for research into innovative and cost-effective methods for
6 elimination of lead in public and private water supplies and lead from lead pipe connectors to
7 such water supplies (Directive to Take Action).

Fiscal Note: Moderate - between \$5,000 - \$10,000

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REFERENCES

1. Curry SJ, Krist AH, et al. (2019). "Screening for Elevated Blood Lead Levels in Children and Pregnant Women: US Preventive Services Task Force Recommendation Statement". US Preventive Services Task Force, JAMA. Accessed May 3, 2024. 2019;321(15):1502-1509. doi:10.1001/jama.2019.3326
2. 40 CFR Parts 141 and 142 (2021). "National Primary Drinking Water Regulations: Lead and Copper Rule Revisions". Accessed May 7, 2024. <https://www.govinfo.gov/content/pkg/FR-2021-01-15/pdf/2020-28691.pdf>
3. Jia Z, Zhang H, Yu L, et al. (2023) "Prenatal Lead Exposure, Genetic Factors, and Cognitive Developmental Delay". JAMA network open. Accessed May 3, 2024. 2023;6(10):e2339108-e2339108. doi:<https://doi.org/10.1001/jamanetworkopen.2023.39108>
4. American Medical Association (2017). "Reducing Lead Poisoning H-60.924". PolicySearch.ama-assn.org, Accessed May 7, 2024. <https://policysearch.ama-assn.org/policyfinder/detail/lead?uri=%2FAMADoc%2FHOD.xml-0-5018.xml>
5. Environmental Protection Agency (2020). "Use of Lead Free Pipes, Fittings, Fixtures, Solder, and Flux for Drinking Water". EPA.gov, Accessed May 7, 2024. <https://www.federalregister.gov/documents/2020/09/01/2020-16869/use-of-lead-free-pipes-fittings-fixtures-solder-and-flux-for-drinking-water>
6. American Medical Association (2024). "Environmental Issues". American Medical Association Website, AMA-assn.org. Accessed May 3, 2024. <https://www.ama-assn.org/topics/environmental-issues>

RELEVANT AMA POLICY

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]

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. [Res. 409, A-16; Modified: Res. 422, A-18; Reaffirmed: BOT Rep. 29, A-19]

Reducing Lead Poisoning H-60.924

1. Our AMA: (a) supports regulations and policies designed to protect young children from exposure to lead; (b) urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure; (c) encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories; (d) promotes community awareness of the hazard of lead-based paints; and (e) urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.
2. Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level $>5 \mu\text{g/dL}$ ($>50 \text{ ppb}$) by 2021, and (b) eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level $>1 \mu\text{g/dL}$ (10 ppb).
3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: (a) adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment; (b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed; (c) continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services; (d) eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions; (e) provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and (f) establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above $1 \mu\text{g/dL}$ (10 ppb).
4. Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply. [CCB/CLRPD Rep. 3, A-14; Appended: Res. 926, I-16; Appended: Res. 412, A-17]

Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan H-60.918

1. Our AMA will advocate for biologic (including hematological) and neurodevelopmental monitoring at established intervals for children exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure.
2. Our AMA will urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL.
3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed children. Support should include Vitamin C, green leafy vegetables and other

calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow.

4. Our AMA promotes screening, diagnosis and acceptable treatment of lead exposure and iron deficiency in all people exposed to lead contaminated water. [Res. 428, A-16]

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. [Res. 419, A-19; Modified: CSAPH Rep. 2, A-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:433
(A-24)

Introduced by: Minority Affairs Section

Subject: Improving Healthcare of Rural Minority Populations

Referred to: Reference Committee D

1 Whereas, our American Medical Association recognizes that the health of rural communities
2 and their access to care are pressing concerns to our membership; and
3
4 Whereas, our AMA also recognizes that the health of minority communities and their access to
5 care are pressing concerns to our membership; and
6
7 Whereas, rural minorities are a unique population that are challenged by both minority and rural
8 concerns; and
9
10 Whereas, the U.S. Census Bureau reported that 97% of our country's total landmass is
11 considered rural with a total population of nearly 60 million people;¹ and
12
13 Whereas, the most recent census reported a significant increase in rural minorities, which now
14 account for 24% of all rural Americans;² and
15
16 Whereas, Black, Hispanic/Latino and American Indian & Alaska Native each comprise a
17 significant number of rural Americans;² and
18
19 Whereas, rural minorities have some of the lowest levels of income, educational attainment, and
20 life expectancy of all Americans;³ and
21
22 Whereas, the unique challenges of treating rural patients has led to a higher disease burden
23 and worse overall patient outcomes;³ and
24
25 Whereas, rural health providers currently experience profound physician vacancy rates and
26 staffing issues, particularly for agencies like the Indian Health Service;⁴ and
27
28 Whereas, Native Americans who live on tribal reservations carry the lowest life expectancy of
29 any racial group in the country and face unique challenges as a predominantly rural population;⁵
30 and
31
32 Whereas, our AMA membership has few rural minorities, which has potentially played a role in
33 this population not being adequately represented in our organization; and
34
35 Whereas, our AMA could benefit greatly from learning more about rural minorities, their health
36 care challenges, their perspectives, and their resourcefulness; therefore be it
37
38 RESOLVED, that our American Medical Association encourage health promotion, access to
39 care, and disease prevention through educational efforts and publications specifically tailored to
40 rural minorities (Directive to Take Action); and be it further

1 RESOLVED, that our AMA encourage federal, state and local governments of the unique health
2 and health-related needs of rural minorities in an effort to improve their quality of life (New HOD
3 Policy); and be it further

4
5 RESOLVED, that our AMA encourage the collection of vital statistics and other relevant
6 demographic data of rural minorities (New HOD Policy); and be it further

7
8 RESOLVED, that our AMA encourage organizations of the importance of rural minority health
9 (New HOD Policy); and be it further

10
11 RESOLVED, that our AMA research and study health issues unique to rural minorities, such as
12 access to care difficulties (Directive to Take Action); and be it further

13
14 RESOLVED, that our AMA channel existing policy for telehealth to support rural minority
15 communities (Directive to Take Action); and be it further

16
17 RESOLVED, that our AMA will encourage our Center for Health Equity to support rural minority
18 health through programming, equity initiatives, and other representation efforts. (New HOD
19 Policy)

20
Fiscal Note: To Be Determined

Received: 5/8/2024

REFERENCES

1. What is Rural America? United States Census Bureau. Accessed May 1, 2024. <https://www.census.gov/library/stories/2017/08/rural-america.html>
2. Mapping rural America's diversity and demographic change. Accessed March 31, 2024. <https://www.brookings.edu/articles/mapping-rural-americas-diversity-and-demographic-change/>
3. Thomas, K.L., Dobis, E.A., & McGranahan, D.A. (2024). The nature of the rural-urban mortality gap (Report No. EIB-265). U.S. Department of Agriculture, Economic Research Service. <https://www.ers.usda.gov/webdocs/publications/108702/eib-265.pdf?v=4077.9>
4. Agency Faces Ongoing Challenges Filling Provider Vacancies. U.S. Government Accountability Office. Published August 2018. Accessed March 31, 2022. <https://www.gao.gov/assets/gao-18-580.pdf>
5. United States Life Tables 2021, National Vital Statistics Reports. National Center for Health Statistics. November 2023. <https://www.cdc.gov/nchs/data/nvsr/nvsr72/nvsr72-12.pdf>

RELEVANT AMA POLICY

Improving Rural Health H-465.994

1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.
2. Our AMA will work with other entities and organizations interested in public health to:
 - Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
 - Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
 - Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
 - Advocate for adequate and sustained funding for public health staffing and programs.

[Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19; Modified: CSAPH Rep. 2, A-22; Reaffirmed: CMS Rep. 09, A-23; Reaffirmed: Res. 724, A-23]

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. [CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: Res. 233, A-13; Reaffirmed: BOT Rep. 09, A-23]

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]

Improving Healthcare of Black and Minority Populations H-350.972

Our AMA supports:

(1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.

(2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to

the Secretary's Task Force on Black and Minority Health.

(3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.

(4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis. [CLRPD Rep. 3, I-98; Reaffirmation A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 1, A-21]

Educational Strategies for Meeting Rural Health Physician Shortage H-465.988

1. In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that:

A. Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents.

B. Our AMA encourage medical schools to develop educationally sound primary care residencies in smaller communities with the goal of educating and recruiting more rural physicians.

C. Our AMA encourage state and county medical societies to support state legislative efforts toward developing scholarship and loan programs for future rural physicians.

D. Our AMA encourage state and county medical societies and local medical schools to develop outreach and recruitment programs in rural counties to attract promising high school and college students to medicine and the other health professions.

E. Our AMA urge continued federal and state legislative support for funding of Area Health Education Centers (AHECs) for rural and other underserved areas.

F. Our AMA continue to support full appropriation for the National Health Service Corps Scholarship Program, with the proviso that medical schools serving states with large rural underserved populations have a priority and significant voice in the selection of recipients for those scholarships.

G. Our AMA support full funding of the new federal National Health Service Corps loan repayment program.

H. Our AMA encourage continued legislative support of the research studies being conducted by the Rural Health Research Centers funded by the National Office of Rural Health in the Department of Health and Human Services.

I. Our AMA continue its research investigation into the impact of educational programs on the supply of rural physicians.

J. Our AMA continue to conduct research and monitor other progress in development of educational strategies for alleviating rural physician shortages.

K. Our AMA reaffirm its support for legislation making interest payments on student debt tax deductible.

L. Our AMA encourage state and county medical societies to develop programs to enhance work opportunities and social support systems for spouses of rural practitioners.

2. Our AMA will work with state and specialty societies, medical schools, teaching hospitals, the Accreditation Council for Graduate Medical Education (ACGME), the Centers for Medicare and Medicaid Services (CMS) and other interested stakeholders to identify, encourage and incentivize qualified rural physicians to serve as preceptors and volunteer faculty for rural rotations in residency.

3. Our AMA will: (a) work with interested stakeholders to identify strategies to increase residency training opportunities in rural areas with a report back to the House of Delegates; and (b) work with interested stakeholders to formulate an actionable plan of advocacy with the goal of increasing residency training in rural areas.

4. Our AMA will encourage ACGME review committees to consider adding exposure to rural medicine as appropriate, to encourage the development of rural program tracks in training programs and increase physician awareness of the conditions that pose challenges and lack of resources in rural areas.

5. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs.

[CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 956, I-18; Appended: Res. 318, A-19; Modified: CME Rep. 3, I-21; Reaffirmation: I-22; Reaffirmed: BOT Rep. 11, A-23]

Access to Physician Services in Rural Health Clinics H-465.984

Our AMA strongly encourages CMS and appropriate state departments of health to review the Rural Health Clinic Program eligibility and certification requirements to ensure that independent (e.g., physician) and provider-based (e.g., hospital) facilities are certified as Rural Health Clinics only in those areas that

truly do not have appropriate access to physician services. [Sub. Res. 717, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: CMS Rep. 1, A-21]

Rural Health Physician Workforce Disparities D-465.997

Our AMA will monitor the status and outcomes of the 2020 Census to assess the impact of physician supply and patient demand in rural communities. [CME Rep. 3, I-21]

Reference Committee E

Report(s) of the Council on Science and Public Health

- 01 Council on Science and Public Health Sunset Review of 2014 House Policies
- 02 Comparative Effectiveness Research
- 04 Sex and Gender Differences in Medical Research
- 05 Biosimilar/Interchangeable Terminology
- 07 Androgen Deprivation in Incarceration
- 08 Decreasing Regulatory Barriers to Appropriate Testosterone Prescribing
- 12 Universal Screening for Substance Use and Substance Use Disorders during Pregnancy

Resolutions

- 501 Fragrance Regulation
- 502 Tribally-Directed Precision Medicine Research
- 503 Unregulated Hemp-Derived Intoxicating Cannabinoids, and Derived Psychoactive Cannabis Products (DPCPs)
- 504 FDA Regulation of Biosimilars
- 505 Mitigating the Harms of Colorism and Skin Bleaching Agents
- 506 Screening for Image Manipulation in Research Publications
- 507 Ban on Dual Ownership, Investment, Marketing or Distribution of Recreational Cannabis by Medical Cannabis Companies
- 508 AMA to support regulations to decrease overdoses in children due to ingestion of edible cannabis
- 509 Addressing Sarcopenia and its Impact on Quality of Life
- 510 Study to investigate the validity of claims made by the manufacturers of OTC Vitamins, Supplements and “Natural Cures”
- 511 National Penicillin Allergy Day and Penicillin Allergy Evaluation & Appropriate Delabeling
- 512 Opioid Overdose Reversal Agents Where AED’s Are Located
- 513 Biotin Supplement Packaging Disclaimer

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-A-24

Subject: Council on Science and Public Health Sunset Review of 2014 House Policies

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee E

- 1 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of
2 American Medical Association (AMA) policies to ensure that our AMA’s policy database is
3 current, coherent, and relevant. This policy reads as follows, laying out the parameters for review
4 and specifying the needed procedures:
5
- 6 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A
7 policy will typically sunset after ten years unless action is taken by the House of Delegates to retain
8 it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset
9 the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.
10
 - 11 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
12 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies
13 that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to
14 the appropriate AMA councils for review; (c) Each AMA council that has been asked to review
15 policies shall develop and submit a report to the House of Delegates identifying policies that are
16 scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one
17 of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or
18 (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it
19 makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent
20 justification (f) The Speakers shall determine the best way for the House of Delegates to handle the
21 sunset reports.
22
 - 23 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier
24 than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or
25 has been accomplished.
26
 - 27 4. The AMA councils and the House of Delegates should conform to the following guidelines for
28 sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been
29 accomplished; or (c) when the policy or directive is part of an established AMA practice that is
30 transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of
31 Delegates Reference Manual: Procedures, Policies and Practices.
32
 - 33 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
34
 - 35 6. Sunset policies will be retained in the AMA historical archives.

1 RECOMMENDATION

2

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

Fiscal Note: \$1,000.

APPENDIX: RECOMMENDED ACTIONS

Policy Number	Title	Text	Recommendation
D-120.946	Modification to the USP Chapter 797 Guidelines as Currently Written	<ol style="list-style-type: none"> 1. Our AMA will inform physicians on the far-reaching effects of the immediate-use exception to practice and patient safety. 2. Our AMA will encourage and facilitate as a convener for all state, medical school, and specialty organization delegates to the United States Pharmacopeial Convention to protest the "immediate-use" exception to the USP Chapter 797 guidelines as currently written, including the "one-hour-rule," and seek reasonable accommodation and modification of Chapter 797 guidelines with interested stakeholders. 3. Our AMA will encourage and facilitate as a convener for all state, medical school, and specialty organization delegates to the United States Pharmacopeial Convention to protest the USP Chapter 797 guidelines as currently written, including the prohibition to enter a container no more than twice, and seek reasonable accommodation and modification of Chapter 797 guidelines with interested stakeholders. 4. Our AMA will urge The Joint Commission and other deeming organizations to suspend the enforcement of the "immediate-use" exception to USP Chapter 797 as currently written, including the "one-hour-rule" until the reconvening of the USP in June 2015. 5. Our AMA will urge the USP to employ evidence-based methods to survey current medical practice as it relates to USP Chapter 797 guidelines. (Res. 520, A-14) 	Rescind, completed. AMA's stance on USP Chapter 797 policy can be found in Policy H-120.930, "USP Compounding Rules."
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	Retain, still relevant. Note: May be modified by CSAPH5-A-24, "Biosimilar/Interchangeable Terminology"

		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 <u>a biologic or biosimilar an interchangeable product</u> ; (3) limit the authority of pharmacists to automatically substitute only those biosimilar products that are deemed interchangeable by the FDA in the absence of express physician authorization to the contrary, allow substitution of the biologic or biosimilar product when (a) the biologic product is highly similar to the reference product, notwithstanding minor differences in clinically inactive components; and (b) there are no data indicating clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product. (Res. 918, I-08; Modified: CSAPH Rep. 1, I-11; Modified: CSAPH Rep. 4, A-14)	Retain as amended. Amendments noted here are consistent with those currently proposed in CSAPH 5-A-24, "Biosimilar/Interchangeable Terminology"
D-135.973	Safer Chemical Policies	Our AMA will review the recommendations of the National Academies of Sciences, <u>Engineering, and Medicine</u> with respect to chemical policy reform. (Res. 415, A-14)	Retain as amended to update terminology.
D-135.985	Air Pollution and Public Health	Our AMA: (1) promotes education among its members and the general public and will support efforts that lead to significant reduction in fuel emissions in all states; and (2) will declare the need for authorities in all states to expeditiously adopt, and implement effective air pollution control strategies to reduce emissions, and this position will be disseminated to state and specialty societies. (Res. 408, A-08; Reaffirmation A-14)	Retain; still relevant.
D-135.992	Mercury Pollution	Our AMA: (1) recognizes that the trading of air pollutants is potentially harmful for vulnerable populations, and that the Clean Air Mercury Rule is inconsistent with our AMA's health protective approach to air pollution ; (2) encourages state governments to be proactive in protecting citizens from harmful mercury emissions; (3) encourages reduction in mercury use in manufacturing wherever possible, and recognize that more must be done using available and emerging technology to reduce mercury emissions; (4) recommends increased vigilance, monitoring and tracking of mercury use and emissions in	Retain as amended. Mercury air pollution is regulated under the Mercury & Air Toxics Standards, which was passed in 2012. The Clean Air Mercury Rule is no longer relevant.

		<p>chlor-alkali facilities that use mercury in manufacturing processes;</p> <p>(5) encourages the US government to assume a leadership role in reducing the global mercury burden and work toward promoting binding, health-protective international standards;</p> <p>(6) supports the Environmental Protection Agency's national mercury emissions standards for cement kilns at limits based on the latest pollution control technology; and</p> <p>(7) supports modern and strict source monitoring of mercury emissions from cement plants.</p> <p>(CSAPH Rep. 1, I-06; Appended: Res. 501, A-11; Reaffirmation A-14)</p>	
D-150.973	Powdered Caffeine and Easy Unintentional Overdose	<p>Our AMA will: (1) seek <u>supports</u> regulation or legislation to banning the sale of powdered caffeine to minors; and (2) issue a statement condemning the sale of powdered caffeine in packaging so concentrated, so difficult to measure, and in sufficient quantity that misuse and overdose is too common.</p> <p>(Res. 217, I-14)</p>	Retain as amended to remove the portion of the directive that has been accomplished; convert to H-policy.
D-150.983	Food Stamp Incentive Program	<p>Our AMA supports legislation to provide a meaningful increase in the value of <u>SNAP food stamps</u> when used to purchase fruits and vegetables.</p> <p>(Res. 405, A-07; Reaffirmation A-13; Reaffirmation A-14)</p>	Retain as amended to update terminology.
D-190.972	Physician Credit Card Payments by Health Insurance Companies	<p>Our AMA will consider legislation on behalf of physicians that any credit card transaction/bank fees are paid by the insurer and not the health care provider.</p> <p>(Res. 225, I-14)</p>	Retain; still relevant.
D-20.993	Promotion of Rapid HIV Test	<p>Our AMA will work with any and all local and state medical societies, and other interested US and international organizations, to increase access to and utilization of Food and Drug Administration-approved rapid HIV testing in accordance with the quality assurance guidelines for rapid HIV testing developed by the Centers for Disease Control and Prevention. Additionally, pre- and post-test counseling should be performed in accordance with guidelines established by the CDC.</p> <p>(Res. 511, A-05; Modified: CCB/CLRPD Rep. 2, A-14)</p>	Retain; still relevant.
D-440.943	Obstructive Sleep Apnea	<p>Our AMA: (1) recognizes Obstructive Sleep Apnea (OSA) as a major public health issue; (2) encourages a national public education campaign by appropriate federal agencies and relevant advocacy groups; (3) encourage research into the association of OSA with metabolic, cardiovascular, respiratory, and other diseases; and (4) encourages that all physicians become knowledgeable about the diagnosis and management of OSA.</p> <p>(Res. 521, A-09; Reaffirmed: Res. 107, A-14)</p>	Retain; convert to H-policy.

D-450.988	Performance Measures for Evidence-Based Medicine	Our AMA will continue to ensure the quality of medical care through the appropriate use of evidence-based clinical performance measures. (Res. 506, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	Retain; convert to H-policy.
D-460.969	Navajo Birth Cohort Study	1. Our AMA recognizes the public health importance of the Navajo Birth Cohort Study for our Native American population and other populations exposed to uranium. 2. Our AMA will urgently endeavor to convene key stakeholders involved with the Navajo Birth Cohort Study and appropriate high-level officials of the Centers for Disease Control and Prevention, with the goal of achieving a resolution of any issues that have prevented the release of full funding to the university contracted to perform this study, as mandated by Congress. (Res. 932, I-14)	Retain as amended; convert to H-Policy. The study is ongoing, so funding issues appear to have been addressed.
D-460.979	Physicians and Clinical Trials	Our AMA supports elimination of the use of restrictive covenants or clauses that interfere with scientific communication in agreements between pharmaceutical companies or manufacturers of medical instruments, equipment and devices, and physician researchers. (Res. 610, I-04; Modified: CSAPH Rep. 1, A-14)	Retain; convert to H-policy.
D-485.999	Unrealistic Expectations from Surgery on Television	Our AMA opposes television programs that minimize the seriousness and risks of surgery and distort patient expectations. (Res. 609, I-04; Modified: CSAPH Rep. 1, A-14)	Retain; convert to H-policy.
D-60.969	Legal Protection and Social Services for Commercially Sexually Exploited Youth	Our AMA will work with state medical societies and specialty societies to: (1) where appropriate, advocate for legal protection and alternatives to incarceration for commercially sexually exploited youth as an alternative to prosecution for crimes related to their sexual or criminal exploitation; and (2) encourage the development of appropriate and comprehensive services as an alternative to criminal detention in order to overcome barriers to necessary services and care for commercially sexually exploited youth. (Res. 4, I-14)	Rescind. Addressed in current policies H-60.912 and H-65.948.
D-60.976	Childhood Anaphylactic Reactions	Our AMA will: (1) urge all schools, from preschool through 12th grade, to: (a) develop Medical Emergency Response Plans (MERP); (b) practice these plans in order to identify potential barriers and strategies for improvement; (c) ensure that school campuses have a direct communication link with an emergency medical system (EMS); (d) identify students at risk for life-threatening emergencies and ensure these children have an individual emergency care plan that is formulated with input by a physician; (e) designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting	Retain; still relevant.

		<p>families; (f) train school personnel in cardiopulmonary resuscitation; (g) adopt the School Guidelines for Managing Students with Food Allergies distributed by FARE (Food Allergy Research & Education); and (h) ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff are familiar with using this equipment; (2) work to expand to all states laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis; (3) support increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis; (4) urge the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies; (5) urge physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan; and (6) work to allow all first responders to carry and administer epinephrine in suspected cases of anaphylaxis. (CSAPH Rep. 1, A-07; Modified: CCB/CLRPD Rep. 2, A-14)</p>	
<p>H-10.963</p>	<p>Safe In-Line Skating</p>	<p>1. Our AMA encourages physicians to counsel patients, and their parents when appropriate, that full protective equipment should be worn and appropriate safety measures be taken to prevent in-line skating injuries. Consistent with recommendations of the American Academy of Pediatrics, prevention efforts should include the following: (a) Full protective gear should be worn at all times. This would include wrist guards, elbow pads, kneepads, and a helmet. The helmet should be certified by the ASTM, the ANSI, or the Snell Foundation. (b) Unsafe activities such as hitching or truck surfing, which is latching onto a moving vehicle, should be avoided. (c) Training for beginners should be encouraged, and novice skaters should start in an indoor or outdoor rink rather than on the street. (d) Skaters should not skate in the dark and should learn to look for road debris or defects that could cause them to lose their balance. (e) Skaters, especially children with balance problems, physical disabilities, or uncorrected vision or hearing problems should do so in a rink or another protected place.</p> <p>2. Our AMA encourages federal agencies and industries to support research on patterns of equipment use and frequency of protective equipment use for in-line skating.</p> <p>3. Our AMA will continue to work with the Consumer Product Safety Commission, Centers for Disease Control and Prevention, national in-line skating organizations, and medical specialty</p>	<p>Retain; still relevant.</p>

		<p>societies, the AMA Alliance and the Federation to encourage in-line skaters to wear protective equipment.</p> <p>4. Our AMA encourages medical specialty societies and state and local medical societies to advocate for state and local legislation to improve the safety of in-line skating through: (a) the use of appropriate protective equipment (especially helmets); (b) the designation of protected areas for in-line skating; (c) prohibitions against hitching a ride behind a moving vehicle; (d) the assurance that protective equipment is available at skating rental shops; and (e) the provision of training and educational materials. Such legislation should include a surveillance component to monitor compliance.</p> <p>(CCB/CLRPD Rep. 3, A-14)</p>	
<p>H-10.964</p>	<p>Helmets for Riders of Motorized and Non-motorized Cycles</p>	<p>General Helmet Use: Our AMA: (1) encourages physicians to counsel their patients who ride motorized and non-motorized cycles to use approved helmets and appropriate protective clothing while cycling; (2) encourages patients and families to inform and train children about safe cycle-riding procedures, especially on roads and at intersections, the need to obey traffic laws, and the need for responsible behavior; (3) encourages community agencies, such as those involving law enforcement, schools, and parent-teacher organizations, to promote training programs for the responsible use of cycles; (4) urges manufacturers to improve the safety and reliability of the vehicles they produce and to support measures to improve cycling safety; (5) advocates further research on the effectiveness of helmets and on the health outcomes of community programs that mandate their use; (6) encourages efforts to investigate the impact of helmet use by riders of motorcycles and all bicycles, in order to establish the risk of major medical trauma from not wearing helmets, the costs added to the health care system by such behavior, and the payers of these added costs (i.e., private insurance, uncompensated care, Medicare, Medicaid, etc.); (7) supports the exploration of ways to ensure the wearing of helmets through the use of disincentives or incentives such as licensing fees, insurance premium adjustments and other payment possibilities.</p> <p>Bicycles: Our AMA: (1) actively supports bicycle helmet use and encourages physicians to educate their patients about the importance of bicycle helmet use; (2) encourages the manufacture, distribution, and utilization of safe, effective, and reasonably priced bicycle helmets; and (3) encourages the availability of helmets at the point of bicycle purchase.</p>	<p>Retain; still relevant.</p>

		<p>Scooters: Our AMA: (1) recommends the use of protective gear (certified helmets, elbow and knee pads, closed-toe shoes) for riders of scooters, especially children and adolescents; (2) encourages physicians to counsel patients, and their parents when appropriate, that full protective equipment should be worn and appropriate safety measures should be taken to prevent scooter injuries (e.g., riding away from traffic, and close supervision of riders under the age of eight); and (3) urges companies that manufacture or sell scooters to include appropriate information about the safe use of scooters on the scooters themselves, on or inside scooter packaging, on their web sites, and at the point of sale.</p> <p>Motorcycles: Our AMA: (1) encourages physicians to be aware of motorcycle risks and safety measures and to counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs; (2) endorses the concept of legislative measures to require the use of helmets when riding or driving a motorcycle; (3) supports federal regulatory rules to make the receipt of federal highway funds by a state dependent on passage of mandatory motorcycle helmet laws by that state; (4) urges constituent societies to support the enactment or preservation of state motorcycle helmet laws; and (5) supports rider education legislation, which is more easily implemented and more effective than legislation requiring manufacturers to emphasize the dangers of operating motorcycles. (CCB/CLRPD Rep. 3, A-14)</p>	
<p>H-120.936</p>	<p>Improve Safety of Mail-Ordered Medication</p>	<p>Our AMA supports the establishment of national guidelines for mail-order pharmacies to ensure that medications reach patients in a safe and timely manner with full potency, and that when medication is damaged or loses potency during shipment, it should be replaced by the pharmacy at no cost to the patient. (Res. 917, A-14)</p>	<p>Retain; still relevant.</p>
<p>H-120.962</p>	<p>National Mail Order Pharmacy Practices</p>	<p>1. The AMA insists that mail-order pharmacy companies respect the prescribing authority of physicians and dispense prescription medications only in the amounts prescribed; and recommends that mail order pharmacy companies charge only a reasonable and small shipping and handling fee per shipment in order not to encourage patients to request amounts of medications greater than those warranted by their physician's best judgment. 2. Our AMA opposes charging patients more than one co-pay for multiple prescriptions of the same</p>	<p>Retain as amended to remove clause that has been accomplished.</p>

		<p>or varying doses of a long-term medication within a 90-day period when evidence-based medicine dictates that less than 90-day prescriptions should be written during the initialization and dose stabilization of a newly prescribed long-term medication or during change in dosing of a long-term medication currently being taken.</p> <p>3. Our AMA will make traditional pharmacies, including national chains, mail order pharmacies, appropriate insurance carriers, and pharmaceutical benefit management companies aware of its policy opposing the charging of patients more than one co-pay for multiple prescriptions of the same or varying doses of a long term medication within a 90 day period when evidence based medicine dictates that less than 90 day prescriptions should be written during the initialization and dose stabilization of a newly prescribed long term medication or during change in dosing of a long term medication currently being taken.</p> <p>(Sub. Res. 506, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Appended: Res. 121, A-07; Reaffirmed: BOT Rep. 8, A-11; Reaffirmation A-14)</p>	
<p>H-120.968</p>	<p>Medication (Drug) Errors in Hospitals</p>	<p>(1) Our AMA encourages individual physicians to minimize medication errors by adhering to the following guidelines when prescribing medications:</p> <p>(a) Physicians should stay abreast of the current state of knowledge regarding optimal prescribing through literature review, use of consultations with other physicians and pharmacists, participation in continuing medical education programs, and other means.</p> <p>(b) Physicians should evaluate the patient's total status and review all existing drug therapy before prescribing new or additional medications (e.g., to ascertain possible antagonistic drug interactions).</p> <p>(c) Physicians should evaluate and optimize patient response to drug therapy by appropriately monitoring clinical signs and symptoms and relevant laboratory data; follow-up and periodically reevaluate the need for continued drug therapy.</p> <p>(d) Physicians should be familiar with the hospital's medication-ordering system, including the formulary system; the drug use review (DUR) program; allowable delegation of authority; procedures to alert nurses and others to new drug orders that need to be processed; standard medication administration times; and approved abbreviations.</p> <p>(e) Written drug or prescription orders (including signatures) should be legible. Physicians with poor handwriting should print or type medication orders if direct order entry capabilities for computerized systems are unavailable.</p>	<p>Retain; still relevant.</p>

		<p>(f) Medication orders should be complete and should include patient name; drug name (generic drug name or trademarked name if a specific product is required); route and site of administration; dosage form (if applicable); dose; strength; quantity; frequency of administration; and prescriber's name. In some cases, a dilution, rate, and time of administration should be specified. Physicians should review all drug orders for accuracy and legibility immediately after they have prescribed them.</p> <p>(g) Medication orders should be clear and unambiguous. Physicians should: (i) write out instructions rather than use nonstandard or ambiguous abbreviations (e.g., write "daily" rather than "qd" which could be misinterpreted as "qid" or "od"); (ii) not use vague instructions, such as "take as directed"; (iii) specify exact dosage strengths (such as milligrams) rather than dosage form units (such as one vial) (an exception would be combination products, for which the number of dosage form units should be specified); (iv) prescribe by standard nomenclature, using the United States Adopted Names (USAN)-approved generic drug name, official name, or trademarked name (if a specific product is required) and avoid locally coined names, chemical names, unestablished abbreviated drug names (e.g., AZT), acronyms, and apothecary or chemical symbols; (v) always use a leading "0" to precede a decimal expression of less than one (e.g., 0.5 ml), but never use a terminal "0" (e.g., 5.0 ml); (vi) avoid the use of decimals when possible (e.g., prescribe 500 mg instead of 0.5 g); (vii) spell out the word "units" rather than writing "u"; (viii) and use the metric system. Instructions with respect to "hold" orders for medications should be clear.</p> <p>(h) Verbal medication orders should be reserved only for those situations in which it is impossible or impractical for the prescriber to write the order or enter it in a computer. Verbal orders should be dictated slowly, clearly, and articulately to avoid confusion. The order should be read back to the prescriber by the recipient (e.g., nurse, pharmacist); when read back, the recipient should spell the drug name and avoid abbreviations when repeating the directions. A written copy of the verbal order should be placed in the patient's medical record and later confirmed by the prescriber in accordance with applicable state regulations and hospital policies.</p> <p>(2) Our AMA encourages the hospital medical staff to take a leadership role in their hospital, and in collaboration with pharmacy, nursing, administration, and others, to develop and improve organizational systems for monitoring, reviewing,</p>	
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		and reporting medication errors and, after identification, to eliminate their cause and prevent their recurrence. (BOT Rep. 11, A-94; Reaffirmed by Sub. Res. 508, I-94; Reaffirmed and Modified: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	
H-120.975	Certifying Indigent Patients Unable to Pay 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 for <u>patients unable to pay</u> ; 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; Reaffirmed and Modified: BOT Rep. 13, A-04; Reaffirmation I-04; Modified: CSAPH Rep. 1, A-14)	Retain as amended to include person-first language.
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)	Retain; still relevant. Note: May be modified by CSAPH5-A-24, "Biosimilar/Interchangeable Terminology."
H-130.936	Tornado Safety and Manufactured Homes	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	Retain; still relevant.

		<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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. (CSAPH Rep. 3, I-14)</p>	
<p>H-135.991</p>	<p>Clean Air</p>	<p>(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.</p>	<p>Retain as amended. The deleted sentence in first clause is not a complete sentence and does not add value to the policy as written. The third resolve recommended for deletion is redundant with existing and newer AMA policy H-135.949, with the newer resolve having more specific language on encouraging regulations that reduce hazardous emissions.</p>

		<p>(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.</p> <p>(3) The AMA endorses a more effective hazardous pollutant program to allow for efficient control of serious health hazards posed by airborne toxic pollutants.</p> <p>(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.</p> <p>(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.</p> <p>(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)</p>	
H-145.977	Use of Conducted Electrical Devices by Law Enforcement Agencies	<p>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.</p> <p>(CSAPH Rep. 6, A-09; Modified: Res. 501, A-14)</p>	Retain; still relevant.
H-15.950	Child Safety Seats - Public Education and Awareness	<p>Our AMA supports efforts to require child safety seat manufacturers to include information about the importance of rear-facing safety seats until children are two <u>at least four</u> years of age or until they reach the maximum height or weight specifications of their car seat, at which time they should be placed in a forward-facing child safety system with a harness as recommended by the American Academy of Pediatrics.</p> <p>(Res 922, I-14)</p>	Retain as amended to bring the age recommendation in line with current AAP recommendations.
H-15.951	All-Terrain Vehicles	<p>Our AMA: supports publicizing the dangers of all-terrain vehicles, especially to persons unlicensed to drive other vehicles; encourages manufacturers and</p>	Retain; still relevant.

		dealers of ATVs to provide information regarding the safe operation of such vehicles; and seeks federal legislation to require sellers of all-terrain vehicles in the United States to promote the sale and use of suitable helmets to be used when operating or riding as a passenger on ATVs; and federal and state legislation and/or regulation to maximize safety of ATV operation including but not limited to (a) wearing suitable helmets and protective gear when operating or riding as a passenger on an ATV, (b) providing some safety instruction and training to all operators of ATVs, and (c) ensuring appropriate licensure for all operators of ATVs. (CCB/CLRPD Rep. 3, A-14)	
H-15.986	Automatic (i.e., Passive) Restraints to Prevent Injuries and Deaths from Motor Vehicle Accidents	The AMA (1) supports legislation to promote availability of effective seat belts in school buses in the U.S.; and (2) supports legislative action to promote availability of effective seat belts in all motor vehicles in public use (e.g., public and private buses, taxicabs, and any other vehicles carrying passengers). (Sub. Res. 2, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmation A-04; Reaffirmed: BOT Rep. 29, A-04; Modified: CSAPH Rep. 1, A-14)	Retain; still relevant.
H-150.931	Payment for Nutrition Support Services	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. (Res. 705, A-14)	Retain; still relevant.
H-150.948	Increasing Awareness of Nutrition Information and Ingredient Lists	Our AMA supports federal 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. (Sub. Res. 411, A-04; Reaffirmation A-07; Reaffirmed in lieu of Res. 413, A-09, Res. 416, A-09 and Res. 418, A-09; Modified: BOT Rep. 1, A-14)	Retain as amended so as not limit legislation to the federal level.
H-155.988	Public Health and Safety Awareness	The AMA believes that attention to personal health and safety can dramatically improve well-being and reduce health care costs. (Res. 42, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	Retain; still relevant.
H-170.972	Role of Physicians in Improving Adolescent Health	The AMA supports programs that encourage teen health and supports the involvement of medical students, residents, and other physicians in educational efforts to enhance teen health. (Res. 431, A-94; Reaffirmed and Modified: CSA Rep. 6, A-04; Modified: CSAPH Rep. 1, A-14)	Retain; still relevant.

H-170.985	Science, Technology, Engineering and Mathematics Education	Our AMA is committed to working with other concerned organizations and agencies to improve science, technology, engineering and mathematics (STEM) education and literacy in the nation, and to increase interest in STEM on the part of the nation's youth, particularly underrepresented minorities. (Res. 2, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed in lieu of Res. 514, A-09; Reaffirmed in lieu of Res. 524, A-09; Modified: Res. 516, A-14)	Retain; still relevant.
H-175.995	Hair Analysis - A Potential for Medical Abuse	The AMA opposes chemical analysis of the hair as a determinant of the need for medical therapy and supports informing the American public and appropriate governmental agencies of this unproven practice and its potential for health care fraud. (Sub. Res. 67, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	Retain; still relevant.
H-245.981	Vitamin K Prophylaxis in Newborn Infants	The AMA supports the intramuscular administration of a single dose of 0.5-1 mg of vitamin K1 in neonates at birth to prevent vitamin K deficiency bleeding. (Res. 514, A-94; Reaffirmed: CSA Rep. 6, A-04; Modified: CSAPH Rep. 1, A-14)	Retain; still relevant.
H-25.994	Increased Liaison, Communication and Educational Efforts with the Elderly	The AMA supports (1) increasing communications and understanding between organized medicine and the elderly; (2) continuing contact with organizations such as the AARP, offering speakers for their meetings, and pursuing other steps to improve their understanding of physicians' problems and concerns; and (3) encouraging state and county medical societies to undertake similar efforts to increase liaison with the elderly. (Res. 133, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	Retain; still relevant.
H-280.962	Dehydration	Evaluation and Management in Older Adults: The policy of the AMA is that undergraduate, graduate and continuing education programs for physicians and allied health professionals be encouraged to teach the science of dehydration in older adults; and that assessment of hydration status and potential for dehydration be incorporated when appropriate in hospital discharge planning, home health agency and nursing home assessments. The AMA: (1) encourages development of programs to increase physician awareness and skills in the evaluation of dehydration in long-term care residents and older adults living in the community setting; (2) encourages a leadership role for physicians as active team participants in long-term care facilities	Retain; still relevant.

		<p>regarding quality assurance programs assessing the hydration status of residents and recommend appropriate reimbursement for those services; (3) encourages development of programs to increase awareness of the potential problem of dehydration in community residents; (4) encourages community nursing facilities that do not provide daily clinical laboratory services to make them available for residents so that necessary data on patient status can be provided promptly, even on a STAT basis. The ready availability of laboratory services could present unnecessary hospitalizations; and (5) encourages the expansion of research efforts in this area. (CSA Rep. 1, A-94; Reaffirmation A-04; Reaffirmed: CSAPH Rep. 1, A-14)</p>	
<p>H-30.936</p>	<p>Prevention of Impaired Driving</p>	<p>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</p>	<p>Retain as amended as on-board devices or ignition interlock devices are now well supported by evidence and recommended the Community Preventive Services Task Force (CPSTF) for people who have been convicted of drunk driving.</p>

		<p>such as Mothers Against Drunk Driving (MADD) to achieve those goals.</p> <p>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.</p> <p>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;</p> <p>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,</p>	
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		<p>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.</p> <p>On-board devices: Our AMA: (1) supports further testing of on-board devices <u>or ignition interlock devices</u> 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. (CCB/CLRPD Rep. 3, A-14)</p>	
H-365.978	Adult Film Industry Worker Safety and Health	<p>Our AMA: (1) supports legislation that would require the mandatory use of condoms in the production of adult films; (2) supports legislation that would improve the ability of local health departments and Occupational Safety and Health Administration (OSHA) to investigate and control occupational exposures to infectious diseases and enforce workplace regulations in a timely manner; and (3) urges that existing OSHA and other occupational standards be vigorously enforced to reduce exposure to infectious diseases within the adult film industry. (Res. 407, A-10; Reaffirmation A-14)</p>	Retain; still relevant.
H-370.966	Amend Federal Law to Allow Clinical Research on the Safety and Effectiveness of HIV-Infected-to-HIV-Infected Organ Transplantation	<p>Our AMA adopts a policy position in support of amending the Federal National Organ Transplant Act of 1984 (42 U.S.C. ? 274) to allow for clinical research to fully evaluate the clinical risks and benefits of HIV-infected organ donation to HIV-infected patients who elect to accept such organs and will work to support introduction and enactment of legislation to amend the Federal National Organ Transplant Act of 1984 (42 U.S.C. ? 274) to allow for clinical research to fully evaluate the clinical risks and benefits of HIV-infected organ donation to HIV-infected patients who elect to accept such organs. (Res. 2, I-11; Reaffirmed in lieu of Res. 5, I-14)</p>	Rescind, accomplished. This was accomplished by the HOPE Act, which AMA supported.
H-370.974	Working Toward an Increased	<p>The AMA supports efforts to increase the number of all potential bone marrow donors registered in</p>	Retain; still relevant.

	Number of Minorities Registered as Potential Bone Marrow Donors	national bone marrow registries, especially minority donors, to improve the odds of successful HLA matching and bone marrow transplantation. (Res. 501, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	
H-440.836	Role of Pharmacists in Improving Immunization Rates	Our AMA believes that: 1. Physicians and medical professional organizations should support state and federal efforts to engage pharmacists in vaccinating target populations that have difficulty accessing immunizations in a medical home. Before administration of a vaccine, pharmacists should assess the immunization status of the patient, which includes checking an immunization registry when one exists. Pharmacists should ensure that a record of vaccine administration is transmitted to the patient's primary care physician and documented in the immunization registry, and that written or electronic documentation is provided to the patient. 2. Vaccination programs in pharmacies should promote the importance of having a medical home to ensure appropriate and comprehensive preventive care, early diagnosis, and optimal therapy. Physicians and pharmacists should work together in the community to: (a) establish referral systems to facilitate appropriate medical care if the patient's conditions or symptoms are beyond the scope of services provided by the pharmacies; and (b) encourage patients to contact a primary care physician to ensure continuity of care. 3. State educational requirements for pharmacists who administer vaccines should be based on ACIP recommendations and recognized standards and guidelines derived with input from physicians and pharmacists with demonstrated expertise in immunization practices. (CSAPH Rep. 4, I-14)	Retain; still relevant.
H-440.837	Reducing Salmonella Outbreaks	Our AMA supports USDA and FDA efforts to improve standards for Salmonella testing and sampling in chicken slaughter facilities and other food processing plants to reduce human Salmonella infection. (Res. 506, A-14)	Retain; still relevant.
H-440.838	Genomic-Based Approaches to the Risk Assessment, Management and Prevention of Type 2 Diabetes	Our AMA encourages continued research into the potential of genomic information to improve risk assessment, management and prevention of type 2 diabetes, and will report back on important advances as appropriate. (CSAPH Rep. 2, A-14)	Retain; still relevant.
H-440.884	Food Allergic Reactions in Schools and Airplanes	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	Retain; still relevant.

		<p>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.</p> <p>(Res. 415, A-04; Reaffirmed: CSAPH Rep. 1, A-14)</p>	
<p>H-440.899</p>	<p>Immunization Registries</p>	<p>Our AMA encourages: (1) physicians to participate in the development of immunization registries in their communities and use them in their practices for patients of all ages; (2) electronic health record (EHR) vendors to add features to automate the exchange of vaccination information in the patient EHR to state immunization registries to improve and help ensure completeness and accuracy of vaccination records. EHR vendors and registry administrators need to work with physicians and other health professionals to facilitate the exchange of needed vaccination information by establishing seamless, bidirectional communication capabilities for physicians, other vaccine providers, and immunization registries; and (3) all states to move rapidly to provide comprehensive lifespan immunization registries that are interfaced with other state registries.</p> <p>(Res. 415, A-99; Reaffirmed: 415, A-01; Reaffirmation A-09; Modified: CSAPH Rep. 4, I-14)</p>	<p>Retain; still relevant.</p>
<p>H-440.919</p>	<p>Toward the Control of E. Coli Infection</p>	<p>The AMA: (1) urges physicians to: (a) familiarize themselves with infection due to E. coli 0157:H7; (b) regularly request culture for this organism in any study of infection associated with bloody diarrheal stools; and (c) expand efforts to educate consumers, food processors, and food handlers about the general importance of proper food handling and preparation; and (2) encourages and supports the continuing efforts of the FDA, and of the U.S. Department of Agriculture and its Food Safety and Inspection Service, to develop new and improved methods and technologies for reducing or eliminating bacterial contamination of meat and meat products for human consumption.</p> <p>(Sub. Res. 509, I-94; Reaffirmed and Modified: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14)</p>	<p>Retain; still relevant.</p>
<p>H-440.922</p>	<p>Gambling Can Become Compulsive Behavior</p>	<p>The AMA: (1) encourages physicians to advise their patients of the addictive potential of gambling; (2) encourages states which operate gambling programs to provide a fixed percentage of their revenue for education, prevention and treatment of gambling compulsive behavior disorder; and (3) requests that states which operate</p>	<p>Retain as amended to reflect updated language of the DSM-5-TR, which refers to “gambling disorder.”</p>

		<p>gambling programs affix to all lottery tickets and display at all lottery counters a sign which states that gambling <u>disorder</u> may become a compulsive behavior and help is available through your local gambling hotline.</p> <p>(Res. 430, A-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14)</p>	
H-440.938	Multiple-Drug Resistant Tuberculosis - A Multifaceted Problem	<p>(1) Testing <u>Screening</u> for tuberculous infection should be performed routinely on all HIV-infected patients, according to current recommendations from the <u>CDC U.S. Public Health Service</u>.</p> <p>(2) Testing for HIV infection should be routinely performed on all <u>Routine HIV testing is recommended for persons with active tuberculosis.</u></p> <p>(3) Reporting of HIV infection and tuberculosis should be linked to enhance appropriate medical management and epidemiologic surveillance.</p> <p>(43) Aggressive contact tracing should be pursued for cases of active tuberculosis, especially if HIV-infected contacts or multiple-drug resistant tuberculosis strains have been involved.</p> <p>(54) HIV-infected health care workers and their physicians must be aware of the high risk of clinical TB for persons whose immune systems are compromised, due to HIV or other causes. They should be carefully apprised of their risk, and the risks and benefits of their caring for persons with active TB or suspected TB should be carefully considered.</p> <p>(65) HIV-infected and other immunocompromised patients should be sufficiently separated from tuberculosis patients and the air they breathe so that transmission of infection is unlikely.</p> <p>(76) All health care workers should have a tuberculin skin test upon employment, with the frequency of retesting determined by the prevalence of the disease in the community in <u>accordance with CDC recommendations.</u> Individuals with a positive skin test should be evaluated and managed according to current public health service recommendations.</p> <p>(87) Health care facilities that treat patients with tuberculosis should rigorously adhere to published public health service <u>CDC guidelines</u> for preventing the nosocomial transmission of tuberculosis.</p> <p>(98) Adequate and safe facilities must be available for the care of patients with tuberculosis; in some areas this may necessitate the establishment of sanitariums or other regional centers of excellence in tuberculosis treatment.</p> <p>(109) Clinical tuberculosis laboratories should develop the capability of reliably performing or having reliably performed for them rapid identification and drug susceptibility tests for tuberculosis.</p>	Retain as amended. Updated terminology for accuracy, including reference of appropriate federal agency.

		<p>(41<u>10</u>) Routinely, drug susceptibility tests should be performed on isolates from patients with active tuberculosis as soon as possible.</p> <p>(42<u>11</u>) A program of directly observed therapy for tuberculosis <u>is a standard of care</u> should be implemented when patient compliance is a problem.</p> <p>(43<u>12</u>) The AMA should enlist the aid of the Pharmaceutical Research and Manufacturers of America (PhRMA) in encouraging manufacturers to develop new drugs and vaccines for tuberculosis.</p> <p>(44<u>13</u>) The federal government should increase funding significantly for tuberculosis control and research to curtail the further spread of tuberculosis and encourage development of new and effective diagnostics, drug therapies, and vaccines.</p> <p>(45<u>14</u>) The special attention of physicians, public health authorities, and funding sources should be directed toward high risk and high incidence populations such as the homeless, immigrants, minorities, health care workers in high risk environments, prisoners, children, adolescents, and pregnant people <u>women</u>.</p> <p>(46<u>15</u>) The AMA will develop educational materials for physicians that will include but not be limited to the subtleties of testing for TB in HIV-infected individuals; potential risk to HIV-infected individuals exposed to infectious diseases, including TB; and other issues identified in this report.</p> <p>(47<u>16</u>) The AMA encourages physicians to remain informed about advances in the treatment of tuberculosis, including the availability of combination forms of drugs, that may reduce the emergence of drug-resistant strains. (BOT Rep. OO, A-92; Sub. Res. 505, I-94; Reaffirmed and Modified: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14)</p>	
<p>H-440.942</p>	<p>State Health Officer Report at Annual Meeting of State Medical Society Meetings</p>	<p>The AMA urges each state medical society to extend to their respective state health officer a standing invitation to participate in and report to the annual meeting of their house of delegates upon issues, accomplishments, problems, and needs of public health significance within the state. (Res. 429, I-91; Reaffirmed by Res. 417, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14)</p>	<p>Retain; still relevant.</p>
<p>H-45.976</p>	<p>Drug and Alcohol Use in Aviation</p>	<ol style="list-style-type: none"> 1. Our AMA urges the FAA to establish programs for personnel involved in all facets of aviation that reduce the impact of drug and alcohol use in order to further aviation safety. 2. Our AMA encourages continued studies by the Federal Aviation Administration of problems in the use of alcohol by pilots in general aviation and flight crews of commercial airlines. 	<p>Retain; still relevant.</p>

		(CCB/CLRPD Rep. 3, A-14)	
H-460.901	Genomics in Hypertension: Risk Prediction and Treatment	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. (CSAPH Rep. 1, I-14)	Retain; still relevant.
H-460.938	Effects of Electric and Magnetic Fields	The AMA: (1) will continue to monitor developments and issues related to the effects of electric and magnetic fields, even though no scientifically documented health risk has been associated with the usually occurring levels of electromagnetic fields; (2) encourages research efforts sponsored by agencies such as the National Institutes of Health, U.S. Department of Energy, and the National Science Foundation to continue on exposures to electromagnetic fields and their effects, average public exposures, occupational exposures, and the effects of field surges and harmonics; and (3) supports broad dissemination of findings and recommendations of authoritative, multidisciplinary committees, such as those convened under the auspices of the National Academy of Sciences, National Council on Radiation Protection, International Agency for Research on Cancer, and the National Institute for Environmental Health Sciences. (CSA Rep. 7 - I-94; Reaffirmed and Modified: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	Retain; still relevant.
H-460.940	Support for Federal Funding of Early-Stage Embryo Research	The AMA supports federal funding of biomedical research which promises significant human and scientific benefits. (Res. 242, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	Retain; still relevant.
H-460.988	Need for Continued Use of Animals in Research and Education	The AMA supports (1) the humane use of animals essential to research, education and the development of drugs and medical devices; and (2) efforts to assure the availability of animals for these purposes. (Res. 140, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	Retain; still relevant.
H-480.949	Nanotechnology, Safety and Regulation	Our AMA: (1) recognizes the benefits and potential risks of nanotechnology; (2) supports responsible regulation of nanomaterial products and applications to protect the public's health and the environment; and (3) encourages continued study on the health and environmental effects of exposure to nanomaterials.	Retain; still relevant.

		(CSAPH Rep. 2, A-13; Reaffirmed in lieu of Res. 510, A-14)	
H-480.975	Patents on Medical and Surgical Procedures	The AMA condemns the patenting of medical and surgical procedures and will work with Congress to outlaw this practice. (Sub. Res. 2, A-94; Reaffirmed: BOT Rep. 29, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	Retain; still relevant.
H-490.910	Secondhand Smoke	1. Our AMA urges the President of the United States to issue an Executive Order making all federal workplaces, including buildings and campuses, entirely smoke free and urges its federation members to do the same. 2. Our AMA supports legislation that prohibits smoking while operating or riding in a vehicle that contains children. (Res. 417, A-09; Appended: Res. 202, A-14)	Retain; still relevant.
H-490.912	Tobacco as an Incentive in Behavior Modification Programs	The AMA condemns the use of tobacco as an incentive in behavior modification programs. (CSA Rep. 3, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	Retain; still relevant.
H-490.915	Tobacco Use in Prison Populations	It is the policy of our AMA to (1) recognize and promote the policy that all anti-smoking policies that apply to the general population should apply equally to persons who are incarcerated in local jails, state prisons, and federal prisons; (2) work actively to stop the manufacture of cigarettes by any prison or jail system in the United States; (3) work actively to stop the subsidy of cigarette sales in all jail and prison systems; (4) ensure that the prohibition of smoking by minors be enforced in the correctional system; (5) be committed to smoking cessation programs in correctional facilities and encourage physicians working in correctional systems to include smoking cessation counseling and programs for their patients who smoke; (6) work through its representative to the National Commission on Correctional Health Care to ensure that smoking cessation counseling be made a national standard for correctional medicine; (7) develop model legislation providing for smoke-free prison areas for all inmates, and particularly that common areas including cell blocks and recreation areas not be smoking areas; and (8) support legislation banning smoking in prisons and jails. (CSA Rep. 3, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	Retain; still relevant.
H-495.979	Evaluation of the Health Hazards of Clove Cigarettes	AMA's existing policy vigorously opposing the use of any tobacco product is extended to include explicit opposition to the use of clove cigarettes. Further, AMA recognizes that clove cigarette smoking may present an additional hazard to susceptible individuals. (CSA Rep. 3, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	Retain; still relevant.

H-495.980	Cigar Smoking	Our AMA will work to have federal and state governments take legal, regulatory, and educational action to protect the public from the ill effects of cigar smoking in a manner similar to those actions taken regarding cigarettes. (CSA Rep. 3, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	Retain; still relevant.
H-495.982	Tax-Free Tobacco Products	Our AMA encourages Native American nations to stop selling tax-free tobacco products because of the profound public health implications of the sale of tax-free tobacco products. (CSA Rep. 3, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	Retain; still relevant.
H-495.984	Tobacco Advertising and Media	Our AMA: (1) in keeping with its long-standing objective of protecting the health of the public, strongly supports a statutory ban on all advertising and promotion of tobacco products; (2) as an interim step toward a complete ban on tobacco advertising, supports the restriction of tobacco advertising to a "generic" style, which allows only black-and-white advertisements in a standard typeface without cartoons, logos, illustrations, photographs, graphics or other colors; (3) (a) recognizes and condemns the targeting of advertisements for cigarettes and other tobacco products toward children, minorities, and women as representing a serious health hazard; (b) calls for the curtailment of such marketing tactics; and (c) advocates comprehensive legislation to prevent tobacco companies or other companies promoting look-alike products designed to appeal to children from targeting the youth of America with their strategic marketing programs; (4) supports the concept of free advertising space for anti-tobacco public service advertisements and the use of counter-advertising approved by the health community on government-owned property where tobacco ads are posted; (5) (a) supports petitioning appropriate government agencies to exercise their regulatory authority to prohibit advertising that falsely promotes the alleged benefits and pleasures of smoking as well worth the risks to health and life; and (b) supports restrictions on the format and content of tobacco advertising substantially comparable to those that apply by law to prescription drug advertising; (6) publicly commends those publications that have refused to accept cigarette advertisements and supports publishing annually, via JAMA and other appropriate publications, a list of those magazines that have voluntarily chosen to decline tobacco ads, and circulation of a list of those publications to every AMA member; (7) urges physicians to mark the covers of magazines in the waiting area that contain tobacco	Retain; still relevant.

		<p>advertising with a disclaimer saying that the physician does not support the use of any tobacco products and encourages physicians to substitute magazines without tobacco ads for those with tobacco ads in their office reception areas;</p> <p>(8) urges state, county, and specialty societies to discontinue selling or providing mailing lists of their members to magazine subscription companies that offer magazines containing tobacco advertising;</p> <p>(9) encourages state and county medical societies to recognize and express appreciation to any broadcasting company in their area that voluntarily declines to accept tobacco advertising of any kind;</p> <p>(10) urges the 100 most widely circulating newspapers and the 100 most widely circulating magazines in the country that have not already done so to refuse to accept tobacco product advertisements, and continues to support efforts by physicians and the public, including the use of written correspondence, to persuade those media that accept tobacco product advertising to refuse such advertising;</p> <p>(11) (a) supports efforts to ensure that sports promoters stop accepting tobacco companies as sponsors; (b) opposes the practice of using athletes to endorse tobacco products and encourages voluntary cessation of this practice; and (c) 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;</p> <p>(12) will communicate to the organizations that represent professional and amateur sports figures that the use of all tobacco products while performing or coaching in a public athletic event is unacceptable. Tobacco use by role models sabotages the work of physicians, educators, and public health experts who have striven to control the epidemic of tobacco-related disease;</p> <p>(13) (a) encourages the entertainment industry, including movies, videos, and professional sporting events, to stop portraying the use of tobacco products as glamorous and sophisticated and to continue to de-emphasize the role of smoking on television and in the movies; (b) will aggressively lobby appropriate entertainment, sports, and fashion industry executives, the media and related trade associations to cease the use of tobacco products, trademarks and logos in their activities, productions, advertisements, and media accessible to minors; and (c) advocates comprehensive legislation to prevent tobacco companies from targeting the youth of America with their strategic marketing programs; and</p>	
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		<p>(14) encourages the motion picture industry to apply an "R" rating to all new films depicting cigarette smoking and other tobacco use. (CSA Rep. 3, A-04; Appended: Res. 427, A-04; Reaffirmation A-05; Reaffirmation A-14)</p>	
<p>H-500.975</p>	<p>AMA Corporate Policies on Tobacco</p>	<p>(1) Our AMA: (a) continues to urge the federal government to reduce and control the use of tobacco and tobacco products; (b) supports developing an appropriate body for coordinating and centralizing the Association's efforts toward a tobacco-free society; and (c) will defend vigorously all attacks by the tobacco industry on the scientific integrity of AMA publications. (2) It is the policy of our AMA to continue to use appropriate lobbying resources to support programs of anti-tobacco health promotion and advertising. (3) Our AMA's House of Delegates endorses the April 24, 1996, statement by the AMA Secretary-Treasurer that all physicians, health professionals, medical schools, hospitals, public health advocates, and citizens interested in the health and welfare of our children should review their personal and institutional investments and divest of any tobacco holdings (including mutual funds that include tobacco holdings); and specifically calls on all life and health insurance companies and HMOs to divest of any tobacco holdings. (4) Our AMA defines the Tobacco Industry as companies or corporate divisions that directly produce or purchase tobacco for production or market tobacco products, along with their research and lobbying groups, including the Council for Tobacco Research and the Smokeless Tobacco Research Council. A company or corporate division that does not produce or market tobacco products but that has a tobacco producing company as or among its owners will not be considered a prohibited part of the tobacco industry as long as it does not promote or contribute to the promotion, sale and/or use of tobacco products. If such promotional practices begin, the company will be placed on an "unacceptable for support" list. (5) Accordingly, it is the policy of our AMA (a) not to invest in tobacco stocks or accept financial support from the tobacco industry; (b) to urge medical schools and their parent universities to eliminate their investments in corporations that produce or promote the use of tobacco and discourage them from accepting research funding from the tobacco industry; (c) to likewise urge all scientific publications to decline such funded research for publication; and (d) to encourage state and county medical societies and members to divest of any and all tobacco stocks. (6) Our AMA (a) encourages state and local medical societies to determine whether candidates</p>	<p>Retain; still relevant.</p>

		for federal, state and local offices accept gifts or contributions of any kind from the tobacco industry, and publicize their findings to both their members and the public; and (b) urges state and county medical societies and local health professionals along with their allies to support efforts to strengthen state and local laws that require public disclosure of direct and indirect expenditures to influence legislation or ordinances, given recent allegations about tobacco industry strategies. (CSA Rep. 3, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	
H-505.962	Smoking on International Flights	The AMA (1) will join other concerned organizations to seek an FAA ban on smoking on all flights originating from or destined to the U.S.; and (2) in conjunction with the World Health Organization and the World Medical Association, will work with the medical department of the International Civil Aviation Organization to ban smoking on all international flights. (CSA Rep. 3, A-04; Reaffirmed: CSAPH Rep. 1, A-14)	Rescind, accomplished. Smoking is banned on international flights.
H-505.963	Federal Efforts Related to Smoking Cessation	Our AMA endorses supports the use of the federally-funded National Tobacco Quitline network and ongoing media campaigns to help Americans quit using tobacco. (CSA Rep. 3, A-04; Modified: CSAPH Rep. 1, A-14)	Retain as amended.
H-55.970	Uniform Cancer Staging	Our AMA (1) supports the tumor, node involvement, metastasis (TNM) system accepted by the American Joint Committee on Cancer and the Union for International Cancer Control for staging of cancer; (2) urges that this system be used in any published articles or information and be included as a requirement in Instructions to Authors; (3) encourages each state association to use this system in any educational forum or scientific meeting which it sponsors; and (4) supports general utilization of the Cancer Staging Manual developed by the American Joint Committee on Cancer. (CCB/CLRPD Rep. 3, A-14)	Retain; still relevant.
H-55.972	Early Detection and Prevention of Skin Cancer	Our AMA: (1) encourages all physicians to (a) perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday; (b) examine their patients' skins for the early detection of melanoma and nonmelanoma skin cancer; (c) urge their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; and (d) educate their patients concerning the correct way to perform skin self-examination; (2) supports mechanisms for the	Retain; still relevant.

		<p>education of lay professionals, such as hairdressers and barbers, on skin self-examination to encourage early skin cancer referrals to qualified health care professionals; and (3) supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color. Our AMA will continue to work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color. (CCB/CLRPD Rep. 3, A-14)</p>	
H-60.923	Meningococcal Vaccination for School Children	<p>Our AMA supports efforts to require that school children receive meningococcal vaccine per <u>as recommended by</u> the Advisory Committee on Immunization Practices guidelines. (Res. 414, A-14)</p>	<p>Retain as amended. The Advisory Committee on Immunization Practices recommends vaccines for use in the population but does not make decisions on school requirements.</p>
H-60.938	Adolescent Sexual Activity	<p>Our AMA (a) endorses the joint position "Protecting Adolescents: Ensuring Access to Care and Reporting Sexual Activity and Abuse"; and (b) supports the following principles for consideration in development of public policy: (i) Sexual activity and sexual abuse are not synonymous and that many adolescents have consensual sexual relationships; (ii) It is critical that adolescents who are sexually active receive appropriate confidential health care and screening; (iii) Open and confidential communication between the health professional and adolescent patient, together with careful clinical assessment, can identify the majority of sexual abuse cases; (iv) Physicians and other health care professionals must know their state laws and report cases of sexual abuse to the proper authority in accordance with those laws, after discussion with the adolescent and/or parent as appropriate; (v) Federal and state laws should support physicians and other health care professionals in their role in providing confidential health care to their adolescent patients; and (vi) Federal and state laws should affirm the authority of physicians and other health care professionals to exercise appropriate clinical judgment in reporting cases of sexual activity. (Res. 825, I-04; Modified: CSAPH Rep. 1, A-14)</p>	<p>Retain as amended to remove language endorsing a specific joint position statement, while retaining the principles.</p>
H-60.979	Physical Activity Guidelines	<p>Our AMA supports the continued expert review and development of national guidelines regarding physical activity for all ages and the dissemination of such guidelines to physicians. (Res. 186, I-90; Reaffirmed: Sunset Report, I-00; Modified: BOT Rep. 10, A-14)</p>	<p>Retain; still relevant.</p>
H-60.996	Missing Children Identification	<p>The AMA supports (1) development of a means of identifying children; and (2) education of the public and parents on the fingerprinting and</p>	<p>Retain; still relevant.</p>

		<p>documentation of characteristic identifying marks as a matter of record, should it be necessary to assist officials in locating a missing child. (Res. 98, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14)</p>	
<p>H-75.985</p>	<p>Access to Emergency Contraception</p>	<p>It is the policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through pharmacies, hospitals, clinics, emergency rooms, acute care centers, and physicians' offices; (3) to recognize that information about emergency contraception is part of the comprehensive information to be provided as part of the emergency treatment of sexual assault victims <u>and/or survivors</u>; (4) to support educational programs for physicians and patients regarding treatment options for the emergency treatment of sexual assault victims <u>and/or survivors</u>, including information about emergency contraception; and (5) to encourage writing advance prescriptions for these pills as requested by their patients until the pills are available over-the-counter. (CMS Rep. 1, I-00; Appended: Res. 408, A-02; Modified: Res. 443, A-04; Reaffirmed: CSAPH Rep. 1, A-14)</p>	<p>Retain as amended to reference updated terminology.</p>
<p>H-75.991</p>	<p>Requirements or Incentives by Government for the Use of Long-Acting Contraceptives</p>	<p>(1) Involuntary use of long-acting contraceptives because of child abuse raises serious questions about a person's fundamental right to refuse medical treatment, to be free of cruel and unusual punishment, and to procreate. The state's compelling interest in protecting children from abuse may be served by less intrusive means than imposing contraception on parents who have committed child abuse. The needs of children may be better met by providing close supervision of the parents, appropriate treatment and social services, and foster placement care when necessary. There is not sufficient evidence to demonstrate that long-acting contraceptives are an effective social response to the problem of child abuse. Before long-acting contraceptives could be considered as a response to individual cases of child abuse, the issue would need to be addressed by society broadly. Society must be careful about taking shortcuts to save resources when constitutional rights are involved. (2) Serious questions are raised by plea bargains, or negotiations with child welfare authorities, that</p>	<p>Retain as amended to update terminology.</p>

		<p>result in the use of long-acting contraceptives. Such agreements are made in inherently coercive environments that lack procedural safeguards. In addition, cultural and other biases may influence decisions by the state to seek the use of a long-acting contraceptive.</p> <p>(3) If welfare or other government benefits were based on the use of long-acting contraceptive agents, individuals would be required to assume a potentially serious health risk before receiving their benefits. Government benefits should not be made contingent on the acceptance of a health risk.</p> <p>(4) Individuals should not be denied access to effective contraception because of their <u>inability to pay indigence</u>. Use of long-acting contraceptives should be covered by Medicaid and other health insurance programs, both public and private.</p> <p>(5) Long-acting contraceptives may be medically contraindicated. Assessing the health risks of long-acting contraceptives is substantially outside the purview of courts and legislatures.</p> <p>(BOT Rep. EE, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmation A-04; Reaffirmed: CSAPH Rep. 1, A-14)</p>	
<p>H-80.996</p>	<p>Scientific Status of Refreshing Recollection by the Use of Hypnosis</p>	<p>The AMA believes that (1) With witnesses and victims concerning refreshing recollection, the use of hypnosis should be limited to the investigative process. Specific safeguards should be employed to protect the welfare of the subject and the public, and to provide the kind of record that is essential to evaluate the additional material obtained during and after hypnosis; (2) A psychological assessment of the subject's state of mind should be carried out prior to the induction of hypnosis in an investigative context, and informed consent should be obtained; (3) Hypnosis should be conducted by a skilled psychiatrist or psychologist, who is aware of the legal implications of the use of hypnosis for investigative purposes; a complete taped and/or precise written record of the clinician's prior knowledge of the case must be made; complete videotape recordings of the pre-hypnotic evaluation and history, the hypnotic session, and the post-hypnotic interview, showing both the subject and the hypnotist, should be obtained; (4) Ideally, only the subject and the psychiatrist or psychologist should be present; (5) Some test suggestions of known difficulty should be given to provide information about the subject's ability to respond to hypnosis; (6) The subject's response to the termination of hypnosis and the post-hypnotic discussion of the experience of hypnosis are of major importance in discussing the subject's response; (7) Medical responsibility for the health and welfare of the subject cannot be abrogated by</p>	<p>Retain; still relevant.</p>

		<p>the investigative intent of hypnosis; and (8) Continued research should be encouraged. (CSA Rep. K, I-84; Reaffirmed: CSA Rep. 5, A-94; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed and Modified: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 1, A-14)</p>	
<p>H-85.953</p>	<p>Improving Death Certification Accuracy and Completion</p>	<p>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.</p> <p>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.</p> <p>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. (CCB/CLRPD Rep. 3, A-14; Modified: Speakers Rep., A-15)</p>	<p>Retain; still relevant.</p>
<p>H-90.970</p>	<p>Disabled Parking</p>	<p>Our AMA: (1) encourages physicians to become familiar with laws in their states for certifying a patient's need for disabled parking privileges; and (2) supports efforts to educate the public on the appropriate use of parking spaces for the disabled.</p>	<p>Retain; still relevant.</p>

	(CCB/CLRPD Rep. 3, A-14)	
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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-A-24

Subject: Comparative Effectiveness Research

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee E

1 INTRODUCTION

2

3 American Medical Association (AMA) Policy H-450.922, “Comparative Effectiveness Research,”
4 as adopted at A-23 asked that “our American Medical Association study the feasibility of including
5 comparative effectiveness studies in various FDA drug regulatory processes, including
6 comparisons with existing standard of care, available generics and biosimilars, and drugs
7 commonly used off-label and over-the-counter.” This report serves as the Council on Science and
8 Public Health’s response to this charge.

9

10 METHODS

11

12 English language articles were selected from searches of PubMed and Google Scholar using the
13 search terms “comparative effectiveness research” and “comparative effectiveness research AND
14 regulation.” Additional articles were identified by manual review of the reference lists of pertinent
15 publications. Web sites managed by government agencies and applicable organizations were also
16 reviewed for relevant information.

17

18 BACKGROUND

19

20 Comparative effectiveness research (CER) is defined by the National Academy of Medicine as “the
21 generation and synthesis of evidence that compares the benefits and harms of alternative methods
22 to prevent, diagnose, treat, and monitor a clinical condition or to improve the delivery of care.”¹ At
23 the simplest level, CER shifts the clinical research question from “is this safe?” and “does this
24 work?” to “is this better?”. The question posed by the original resolution thus becomes whether the
25 U.S. Food and Drug Administration (FDA) should ask sponsors to prove their new drug (or device)
26 is superior to existing options on the market as a part of the regulatory process – either pre- or post-
27 market approval.

28

29 The AMA has published several previous reports detailing the benefits of CER (including Council
30 on Medical Service (CMS) Report 5-I-16 and CMS Report 4-I-19) and include a thorough list of
31 principles the AMA holds for a federally funded CER entity. Briefly, these reports were focused on
32 the incorporation of value into the pricing of pharmaceuticals, which include utilizing CER to
33 better understand the long-term cost of a treatment compared to its alternatives. As such, this report
34 will focus solely on the use of CER in the regulatory context.

1 DISCUSSION

2
3 *The Authority of the FDA*

4
5 Under the Food, Drug and Cosmetics Act, the FDA assesses new drug applications for two criteria:
6 safety and efficacy.² Within those criteria, however, the FDA commonly assesses new drug
7 applications in the context of the disease state and the drug landscape.³ Per the FDA's Guidance for
8 Industry, the risk-benefit analysis for new drug applications includes the following criteria: (1)
9 analysis of the condition, (2) current treatment options, (3) benefit, and (4) risk and risk
10 management.⁴ A new drug may be known to have serious side effects and toxicity, but if it is used
11 to treat a terminal disease with no currently available treatment, the risk-benefit analysis by the
12 FDA and its advisory committees may support approval. For example, the FDA advisory
13 committee evaluating Trogarzo (ibalizumab-uiyk) for the treatment of multi-drug resistant HIV
14 found that the underlying clinical trial design resulted in difficulty assessing the durability of the
15 drug's effectiveness.⁵ However, given the limited options for this high-need population, the
16 advisory committee found this uncertainty to be tolerable, and ultimately recommended approval.

17
18 Under the current regulatory framework, the most common method to demonstrate efficacy and
19 safety is through placebo-controlled studies. Using this model, researchers seek to prove that their
20 new drug is efficacious by having beneficial outcomes compared to a placebo (passive control). By
21 contrast, a CER approach for medications (or devices) may measure superiority, non-inferiority, or
22 equivalence. CER requires an active control, in which outcomes of the agent are compared to a
23 proven, efficacious treatment rather than being compared to placebo.^{6,7} It should be noted that CER
24 of active control superiority, non-inferiority, and equivalence studies are all routinely utilized by
25 the FDA in approval decisions in the current regulatory framework, most commonly in instances
26 where a placebo-controlled study may be unethical to perform.

27
28 *Re-labeling Generic Drugs*

29
30 CER is commonly used for evaluating the efficacy of off-label applications for drugs, as they may
31 not have placebo-controlled clinical trials supporting off-label use.⁸⁻¹⁰ One of the potential results
32 of CER in this context is that non-inferiority trials may result in the re-labeling of drugs to expand
33 approved indications. For example, lenvatinib (trade name Lenvima) was first granted orphan drug
34 status in 2012 for treating thyroid cancer, but later had its approved indications revised by the FDA
35 to include first-line treatment of unresectable hepatocellular carcinoma after a non-inferiority trial
36 was performed comparing lenvatinib and sorafenib.¹¹

37
38 The issue, however, comes down to which drugs are selected for evaluation and ultimately
39 submitted for re-labeling. In the instance of lenvatinib, which is still under patent, the non-
40 inferiority trial was sponsored by the patent holder and pharmaceutical company, Eisai.¹² Seeking
41 labeling changes for off patent products, like generic medicines or medical devices, with no
42 industry sponsor is much rarer due to the lack of financial incentive. One example of the
43 difficulties in updating the labeling for a generic medicine is metformin, a first-line treatment for
44 type 2 diabetes. In this instance, concerns over elevated rates of lactic acidosis resulted in the initial
45 1994 labeling having a contraindication of metformin in patients with elevated creatine levels.¹³ By
46 the mid-2000s, however, evidence suggested that this adverse event was rare, and lactic acidosis
47 incidence rates in patients with diabetes receiving metformin were similar to those not receiving
48 metformin.¹⁴ Despite this evidence, it took four years and two citizen petitions by a group of
49 physician experts and academic partners to get partial updates to the labeling of metformin.¹³ Given
50 the additional level of effort and advocacy required, using research (CER or otherwise) to inform
51 updates in labeling of generic drugs is exceedingly rare and burdensome.

1 The AMA vigorously supports the physician's ability to exercise clinical judgement and prescribe
2 medications off-label, yet the inclusion (or exclusion) of indications and contraindications in the
3 FDA labeling can have significant ramifications on clinical uptake of medications and coverage by
4 insurers.¹⁵⁻¹⁸

6 *Novel Drug Submissions*

8 Perhaps more nuanced is the potential role of CER in new drug applications and approvals, and
9 whether the FDA should consider if a new drug is superior to what already exists on the market
10 before granting approval. Proponents argue that this approach has multiple benefits to the system,
11 gives patients and physicians a better understanding of which medications to prioritize in treatment
12 plans, incentivizes research into understudied diseases, disincentivizes advertising which conflates
13 newness with effectiveness, and reduces the financial burden on government entities to fund post-
14 market CER trials.¹⁹

16 A common example of how CER could have been used in the approvals process is the case of
17 esketamine. Ketamine, which was originally approved by the FDA for as an anesthetic in 1970, has
18 received attention for use in treatment-resistant depression (TRD).²⁰ Under normal chemical
19 synthesis conditions, ketamine is made up of a 50:50 mixture of the enantiomers (R)-ketamine and
20 (S)-ketamine (also known as esketamine). In 2019, Janssen received FDA approval for a nasal
21 spray for TRD treatment that comprised of pure esketamine (i.e., no (R)-ketamine), under the trade
22 name Spravato.²¹ Esketamine was approved for TRD utilizing a placebo-controlled study, in which
23 esketamine performance was found to be effective compared to placebo.^{22,23}

25 Since its approval, however, esketamine has not been found to be superior to ketamine.²⁴ What is
26 different, though, is their price. Esketamine is an on-patent medication, and as such was estimated
27 by the Institute for Clinical and Economic Review to cost approximately \$39,000/year compared to
28 \$5,300/year for generic ketamine.²⁵ However, due to other factors such as insurance reimbursement
29 and manufacturer rebates, some studies found that patients may pay less out-of-pocket for
30 esketamine, thus driving them towards the product which generates the most profit for the
31 pharmaceutical company.²⁶

33 However, this is ultimately not an issue for the FDA to adjudicate. Deviation from the FDA's role
34 of evaluating "is it safe?" and "is it effective?" would be a radical expansion of scope and would
35 likely endanger the ability for new medications to enter the market. As described above, the FDA
36 already evaluates new drugs or devices within the context of available treatments and the severity
37 of the disease.

39 Instead, the case of esketamine/ketamine further highlights the importance of AMA's advocacy
40 efforts to make sure patients have access and insurance coverage to all medications that are deemed
41 appropriate by their physician, whether they are prescribed for off-label indications or not.
42 Esketamine and ketamine, while similar, have different administration routes and side effect
43 profiles. As such, having both available in the physician's toolbox allows for the patient-physician
44 relationship to be the guide to the treatment plan.

46 Additionally, "is it better?" may be a difficult bar to quantify, particularly for use cases with high
47 levels of heterogeneity. For example, the addition of a zipper to a new medical device may not
48 directly result in improved outcomes for patients, but a physician may appreciate the option. There
49 are also questions as to for *whom* these new medications or devices need to be better. As noted
50 above, esketamine may be more accessible for individuals who are averse to needles or otherwise

1 unable to receive an infusion. Similarly, a new device may make modifications to allow for easier
2 implantation by a physician with a dexterity impairment, but not impact patient care. It is unclear
3 how CER could effectively capture these important use-cases in which innovation and choice is
4 beneficial, but not measurable by clinical outcomes.

5
6 Finally, a requirement to prove that new medicines are better than current options may
7 inadvertently isolate patient populations and make health inequities harder to overcome. For
8 example, clopidogrel is an anti-platelet medicine commonly used for reducing the risk of stroke
9 and heart attack. It is available as a generic medicine, taken orally, and is cheap, highly effective,
10 and well-studied.²⁷ As such, it may be difficult for any new competing medication to become
11 approved if it were required to prove superiority to clopidogrel, placing some patients at a
12 disadvantage. Alternatives to clopidogrel are incredibly important to individuals with CYP2C19
13 genetic mutations, which can make them either hyper- or hypo-metabolizers of clopidogrel,
14 leading to reduced efficacy or increased side effects, respectively.²⁸ CYP2C19 mutations are more
15 prevalent in individuals of Asian and African ancestry.²⁹

16
17 The pharmacogenomic response to clopidogrel is well-known and has resulted in an FDA black
18 box warning on its label.³⁰ As such, one could imagine that CER for the purposes of a clopidogrel
19 alternative could instead focus on its performance in relevant CYP2C19 genotypes. But this
20 difference in response was not always known (the black box warning was added 13 years after
21 approval), and there are likely an incalculable number of genetic mutations that influence drug
22 interactions that are yet to be known and considered in prospective CER.

23 24 CURRENT AMA POLICY

25
26 As described above, the AMA has a long history of supporting off-label prescribing and
27 reimbursement. Per Policy H-120.988, “Patient Access to Treatments Prescribed by Their
28 Physicians,” “[o]ur AMA confirms its strong support for the autonomous clinical decision-making
29 authority of a physician and that a physician may lawfully use an FDA approved drug product or
30 medical device for an off-label indication when such use is based upon sound scientific evidence or
31 sound medical opinion; and affirms the position that, when the prescription of a drug or use of a
32 device represents safe and effective therapy, third party payers, including Medicare, should
33 consider the intervention as clinically appropriate medical care, irrespective of labeling, should
34 fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover
35 appropriate 'off-label' uses of drugs on their formulary.”

36
37 Additionally, per Policy H-460.909, “Comparative Effectiveness Research,” the AMA broadly
38 supports well-funded, scientifically rigorous CER entities, with two highlighted principles: “[t]he
39 CER entity must not have a role in making or recommending coverage or payment decisions for
40 payers,” and “[p]hysician discretion in the treatment of individual patients remains central to the
41 practice of medicine. CER evidence cannot adequately address the wide array of patients with their
42 unique clinical characteristics, co-morbidities and certain genetic characteristics. In addition,
43 patient autonomy and choice may play a significant role in both CER findings and
44 diagnostic/treatment planning in the clinical setting.”

45 46 CONCLUSION

47
48 Comparative effectiveness research is a critical tool for helping physicians give patients the highest
49 quality, most affordable care possible. However, it may not be the most effective tool for
50 determining what drugs should be available on the market. Instead of using CER as a regulatory

1 requirement, it is likely better suited to be used as a tool for bringing affordable, effective
2 medications to patients.

3

4 RECOMMENDATIONS

5

6 The Council on Science and Public Health recommends that the following be adopted and the
7 remainder of the report be filed:

8

9 (1) That policy H-450.922, "Comparative Effectiveness Research" be amended by deletion to
10 read as follows:

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12

Our AMA will:

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~~(1) 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)~~ (1) 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. (Amend HOD Policy)

(2) That policies H-120.988, "Patient Access to Treatments Prescribed by Their Physicians", and H-460.909, "Comparative Effectiveness Research" be reaffirmed. (Reaffirm HOD Policy)

Fiscal note: less than \$1,000

REFERENCES

1. Comparative Effectiveness Research: A Report From the Institute of Medicine. *Annals of Internal Medicine*. 2009;151(3):203-205.
2. Lam C, Patel P. Food, Drug, and Cosmetic Act. In: *StatPearls [Internet]*. StatPearls Publishing; 2022.
3. U.S. Food and Drug Administration. Development & Approval Process. <https://www.fda.gov/drugs/development-approval-process-drugs>. Published 2022. Accessed January 24, 2024.
4. U.S. Food and Drug Administration. Benefit-Risk Assessment for New Drug and Biological Products. <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/benefit-risk-assessment-new-drug-and-biological-products>. Published 2023. Accessed 2024.
5. Lackey L, Thompson G, Eggers S. FDA's Benefit-Risk Framework for Human Drugs and Biologics: Role in Benefit-Risk Assessment and Analysis of Use for Drug Approvals. *Ther Innov Regul Sci*. 2021;55(1):170-179.
6. Temple R, Ellenberg SS. Placebo-controlled trials and active-control trials in the evaluation of new treatments. Part 1: ethical and scientific issues. *Annals of internal medicine*. 2000;133(6):455-463.
7. Ellenberg SS, Temple R. Placebo-controlled trials and active-control trials in the evaluation of new treatments. Part 2: practical issues and specific cases. *Annals of Internal Medicine*. 2000;133(6):464-470.
8. Kaguelidou F, Le Roux E, Mangiarini L, et al. Non-inferiority double-blind randomised controlled trial comparing gabapentin versus tramadol for the treatment of chronic neuropathic or mixed pain in children and adolescents: the GABA-1 trial-a study protocol. *BMJ Open*. 2019;9(2):e023296.
9. Maher AR, Theodore G. Summary of the comparative effectiveness review on off-label use of atypical antipsychotics. *J Manag Care Pharm*. 2012;18(5 Suppl B):S1-20.
10. Ladanie A, Ioannidis JPA, Stafford RS, Ewald H, Bucher HC, Hemkens LG. Off-label treatments were not consistently better or worse than approved drug treatments in randomized trials. *Journal of Clinical Epidemiology*. 2018;94:35-45.
11. Nair A, Reece K, Donoghue MB, et al. FDA Supplemental Approval Summary: Lenvatinib for the Treatment of Unresectable Hepatocellular Carcinoma. *The Oncologist*. 2020;26(3):e484-e491.
12. Kudo M, Finn RS, Qin S, et al. Lenvatinib versus sorafenib in first-line treatment of patients with unresectable hepatocellular carcinoma: a randomised phase 3 non-inferiority trial. *Lancet*. 2018;391(10126):1163-1173.
13. Lipska KJ, Flory JH, Hennessy S, Inzucchi SE. Citizen Petition to the US Food and Drug Administration to Change Prescribing Guidelines: The Metformin Experience. *Circulation*. 2016;134(18):1405-1408.
14. Inzucchi SE, Lipska KJ, Mayo H, Bailey CJ, McGuire DK. Metformin in Patients With Type 2 Diabetes and Kidney Disease: A Systematic Review. *JAMA*. 2014;312(24):2668-2675.
15. Dorsey ER, Rabbani A, Gallagher SA, Conti RM, Alexander GC. Impact of FDA Black Box Advisory on Antipsychotic Medication Use. *Archives of Internal Medicine*. 2010;170(1):96-103.
16. Dusetzina SB, Higashi AS, Dorsey ER, et al. Impact of FDA Drug Risk Communications on Health Care Utilization and Health Behaviors: A Systematic Review. *Medical Care*. 2012;50(6):466-478.

17. Rosenberg M, Sheehan S, Zhou E, et al. FDA postmarketing safety labeling changes: What have we learned since 2010 about impacts on prescribing rates, drug utilization, and treatment outcomes. *Pharmacoepidemiology and Drug Safety*. 2020;29(9):1022-1029.
18. Wallace ZS, Harkness T, Fu X, Stone JH, Choi HK, Walensky RP. Treatment Delays Associated With Prior Authorization for Infusible Medications: A Cohort Study. *Arthritis Care & Research*. 2020;72(11):1543-1549.
19. O'Connor AB. Building Comparative Efficacy and Tolerability Into the FDA Approval Process. *JAMA*. 2010;303(10):979-980.
20. James W. Murrugh, M.D. ,, Dan V. Iosifescu, M.D. ,, Lee C. Chang, M.D. ,, et al. Antidepressant Efficacy of Ketamine in Treatment-Resistant Major Depression: A Two-Site Randomized Controlled Trial. *American Journal of Psychiatry*. 2013;170(10):1134-1142.
21. U.S. Food and Drug Administration. FDA approves new nasal spray medication for treatment-resistant depression; available only at a certified doctor's office or clinic. <https://www.fda.gov/news-events/press-announcements/fda-approves-new-nasal-spray-medication-treatment-resistant-depression-available-only-certified>. Published 2019. Accessed January 24, 2024.
22. Fu DJ, Ionescu DF, Li X, et al. Esketamine Nasal Spray for Rapid Reduction of Major Depressive Disorder Symptoms in Patients Who Have Active Suicidal Ideation With Intent: Double-Blind, Randomized Study (ASPIRE I). *J Clin Psychiatry*. 2020;81(3).
23. Ionescu DF, Fu DJ, Qiu X, et al. Esketamine Nasal Spray for Rapid Reduction of Depressive Symptoms in Patients With Major Depressive Disorder Who Have Active Suicide Ideation With Intent: Results of a Phase 3, Double-Blind, Randomized Study (ASPIRE II). *Int J Neuropsychopharmacol*. 2021;24(1):22-31.
24. Singh B, Kung S, Pazdernik V, et al. Comparative effectiveness of intravenous ketamine and intranasal esketamine in clinical practice among patients with treatment-refractory depression: an observational study. *The Journal of clinical psychiatry*. 2023;84(2):45331.
25. Atlas S, Agboola F, Fazioli K, Kumar V, Adair E, Rind D. Esketamine for the Treatment of Treatment-Resistant Depression: Effectiveness and Value. *Institute for Clinical and Economic Review*. 2019.
26. Brendle M, Robison R, Malone DC. EE51 Cost-Effectiveness of Esketamine Nasal Spray Compared to Intravenous Ketamine for Patients with Treatment-Resistant Depression in the US Utilizing Clinical Trial Efficacy and Real-World Effectiveness Estimates. *Value in Health*. 2022;25(7):S345.
27. Coukell AJ, Markham A. Clopidogrel. *Drugs*. 1997;54(5):745-750; discussion 751.
28. Dean L, Kane M. *Clopidogrel Therapy and CYP2C19 Genotype*. National Center for Biotechnology Information (US), Bethesda (MD); 2012.
29. Fricke-Galindo I, Céspedes-Garro C, Rodrigues-Soares F, et al. Interethnic variation of CYP2C19 alleles, 'predicted' phenotypes and 'measured' metabolic phenotypes across world populations. *The Pharmacogenomics Journal*. 2016;16(2):113-123.
30. Ford NF, Taubert D. Clopidogrel, CYP2C19, and a Black Box. *The Journal of Clinical Pharmacology*. 2013;53(3):241-248.

APPENDIX

RELEVANT AMA POLICY

Patient Access to Treatments Prescribed by Their Physicians H-120.988

1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary.
2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.
3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.
4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).
5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.
6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.

Comparative Effectiveness Research D-460.973

Our AMA will solicit from our members and others articles or postings about current clinical topics where comparative effectiveness research should be conducted and will periodically invite AMA members to recommend topics where the need for comparative effectiveness research is most pressing, and the results will be forwarded to the Patient-Centered Outcomes Research Institute (PCORI) once it is established, or to another relevant federal agency.

Res. 221, A-11. Reaffirmed: BOT Rep. 7, A-21

Comparative Effectiveness Research H-460.909

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

PRINCIPLES FOR CREATING A CENTRALIZED COMPARATIVE EFFECTIVENESS RESEARCH ENTITY:

- A. Value. Value can be thought of as the best balance between benefits and costs, and better value as improved clinical outcomes, quality, and/or patient satisfaction per dollar spent. Improving value in the US health care system will require both clinical and cost information. Quality comparative clinical effectiveness research (CER) will improve health care value by enhancing physician clinical judgment and fostering the delivery of patient-centered care.
- B. Independence. A federally sponsored CER entity should be an objective, independent authority that produces valid, scientifically rigorous research.
- C. Stable Funding. The entity should have secure and sufficient funding in order to maintain the necessary infrastructure and resources to produce quality CER. Funding source(s) must safeguard the independence of a federally sponsored CER entity.
- D. Rigorous Scientifically Sound Methodology. CER should be conducted using rigorous scientific methods to ensure that conclusions from such research are evidence-based and valid for the population studied. The primary responsibility for the conduct of CER and selection of CER methodologies must rest with physicians and researchers.
- E. Transparent Process. The processes for setting research priorities, establishing accepted methodologies, selecting researchers or research organizations, and disseminating findings must be transparent and provide physicians and researchers a central and significant role.
- F. Significant Patient and Physician Oversight Role. The oversight body of the CER entity must provide patients, physicians (MD, DO), including clinical practice physicians, and independent scientific researchers with substantial representation and a central decision-making role(s). Both physicians and patients are uniquely motivated to provide/receive quality care while maximizing value.

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

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

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

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

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

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

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 4-A-24

Subject: Sex and Gender Differences in Medical Research

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee E

1 INTRODUCTION

2
3 At the 2023 Annual meeting of the American Medical Association (AMA’s) House of Delegates,
4 subclause 7 of Resolution 004 was referred. It stated that “[our AMA encourage] the [U.S. Food
5 and Drug Administration (FDA)] to internally develop criteria for identifying medication and
6 medical devices seeking FDA approval that were developed based on research that did not include
7 adequate participation of women, and sexual and gender minorities [SGM].” Testimony at the
8 meeting cited concern with this being too prescriptive of an approach for the AMA to take with the
9 FDA on this topic. This report serves as the Council on Science and Public Health’s response.

11 METHODS

12
13 English language articles were selected from searches of PubMed and Google Scholar using the
14 search terms “gender bias AND clinical trials”, “sex bias AND clinical trials”, “gender differences
15 AND adverse events”, and “sex differences AND adverse events”. Additional articles were
16 identified by manual review of the reference lists of pertinent publications. Web sites managed by
17 government agencies and applicable organizations were also reviewed for relevant information.

19 BACKGROUND

20
21 There has been a long and unfortunately exclusionary history for women, and sex and gender
22 minorities (SGM) participating in clinical trials. Women participating in clinical trials became a
23 topic of intense discussion in the United States and Europe after the tragic discovery of birth
24 defects caused by thalidomide in the 1950s.¹ In response, Congress passed the Kefauver-Harris
25 amendment to the Food, Drug, and Cosmetics Act in 1962 which dramatically expanded the role of
26 the FDA beyond evaluating safety, but also effectiveness, resulting in the modern phased clinical
27 trial model we know today.² By 1977, however, fears of another teratogen like thalidomide resulted
28 in the FDA introducing regulations which functionally barred all women “of child-bearing age”
29 from participating in clinical trials outside of life-saving drugs.³

30
31 After these regulations, the scientific community quickly recognized the impact that excluding
32 women from clinical trials had on health equity, including a call from the U.S. Public Health
33 Service Task Force on Women’s Health to improve women’s participation in clinical trials.⁴ In
34 1993, the FDA repealed their 1977 rule, and Congress passed a mandate that all studies funded by
35 the National Institute of Health (NIH) include women and assess differences amongst sexes.^{5,6}

36
37 However, despite the changes in the regulatory environment, inequities in clinical trial participation
38 and outcomes persist. These inequities have previously been studied in detail by the Council, and

1 can be found in the 2016 report “An Expanded Definition of Women’s Health.”⁷ This report
2 outlined the ways in which health differences experienced by women are not just associated with
3 reproductive health, and includes biological and socioeconomic factors that impact the risk and
4 severity of conditions such as cardiovascular disease, autoimmune disease, Alzheimer’s disease,
5 and substance use disorders. Further, women’s participation in research (both as participants and as
6 investigators), was discussed, including the lack of female animals used in preclinical research
7 impacting the ability to predict pharmacokinetic or pharmacodynamic differences using biologic
8 sex as a variable.

9
10 Briefly, examination of clinical trials find that enrollment of women is still lower than expected –
11 for example, in 740 clinical trials for cardiovascular disease (N = 862,652 adults), only 38 percent
12 were women.⁸ This trend is also observed across disease state, including psychiatric conditions and
13 cancer.⁹

14
15 Reasons for this gap are multi-factorial, and include concerns related to side effects, impact on
16 fertility, lack of women researchers, and the inability to take time for multiple site visits.¹⁰ At the
17 request of Congress, the National Academy of Sciences, Engineering, and Mathematics released a
18 2022 consensus study towards building equity in women and underrepresented groups in
19 research.¹¹ In its recommendations, the report recommends a variety of strategies: starting with
20 intention, establishing a foundation of trust, being proactive about removing barriers, being
21 flexible, maintaining a strong network of interested groups, being cognizant of social and
22 professional expectations, working in a representative team, and prioritizing resources for equity.

23
24 Participation of SGM in clinical trials is even less representative of the population. SGM, which
25 may include individuals identifying as gay, lesbian, transgender, gender non-binary, or gender
26 expansive, have historically been omitted entirely as a category for clinical research, even when
27 they are a high-risk population. For example, surveys have found that individuals identifying as
28 gay or lesbian have an approximately 61 percent prevalence of a substance use disorder compared
29 to 24 percent for individuals identifying as heterosexual.¹² Yet despite the higher risk of substance
30 use disorders, one analysis found that typically less than 5 percent of substance use disorder studies
31 from 2007 to 2012 reported sexual orientation as a relevant participant demographic.¹³ Similarly, a
32 review of 764 cancer clinical trials from 1991 to 2017 (N = 462,449 patients) found that no trial
33 reported sexual identity, and only two patients were reported as anything other than male or female
34 – and in those instances, they were listed as the non-actionable categories “not reported” and
35 “unknown.”¹⁴ Despite the lack of recognition in studies, SGM are at higher risk for developing
36 cancers related to human immunodeficiency virus and human papillomavirus, or hormone-
37 dependent cancers such as breast cancer in individuals receiving hormone therapy.^{15,16}

38
39 The lack of participation of women and the lack of even tracking SGM in clinical trials has clear
40 impacts on the care those populations subsequently receive. One commonly cited statistic is that
41 women experience adverse drug reactions (ADRs) approximately twice as often as men, with the
42 underlying reason being that lack of women’s participation in clinical trials has led to poor
43 understanding of the influence of sex on pharmacokinetics.¹⁷ In an analysis of NIH-funded clinical
44 trials performed in 2015, only 26 percent of studies explicitly used sex as a variable in their
45 analysis, 72 percent made no mention of sex at all, and many studies with low enrollment of
46 women still represented their data to suggest that it is generalizable across sexes.¹⁸ For SGM, lack
47 of interest by the research community contributes to the ongoing feelings of invisibility and
48 mistrust of physicians.¹⁹

1 THE REGULATORY RESPONSE

2
3 The originally proposed resolution calls for the FDA to develop criteria for identifying medication
4 and devices which did not adequately include women and SGM in clinical trials. In recent years,
5 there have been several efforts at the FDA to improve diversity in clinical trials, in part driven by
6 the Food and Drug Administration Safety and Innovation Act of 2012 (FDASIA) and the Food and
7 Drug Omnibus Reform Act of 2022 (FDORA).

8
9 Under Section 907 of FDASIA, FDA was tasked with evaluating clinical trial participation based
10 on sex, age, race, and ethnicity. The “Section 907 report” included a 2014 action plan for enhanced
11 collection, and included recommendations on more robust demographic information, training for
12 reviewers to be more scrutinizing of demographic data, and tackling barriers for enrollment for
13 certain subpopulations.²⁰

14
15 Per FDORA, all drug and device sponsors are required to consider racial and ethnic diversity
16 through the use of a Diversity Action Plan, to be submitted at the same time as their study
17 protocol.²¹ These plans require drug and device sponsors to describe their rationale for enrollment,
18 broken down by age, sex, racial, and ethnic characteristics, and a specific plan for how they intend
19 on achieving these goals, including specific outreach. As of this writing (January 2024), the
20 guidance has not been finalized, but it is expected to be public before the AMA 2024 Annual
21 Meeting.

22
23 In August 2023, the FDA released an additional draft Guidance for Industry, “Postmarketing
24 Approaches to Obtain Data on Populations Underrepresented in Clinical Trials for Drugs and
25 Biological Products”, which would allow the FDA to require post-market studies as a condition for
26 approval for drugs or devices which did not have adequately diverse populations in the clinical
27 trials.²² Populations explicitly cited in the guidance include (but are not limited to): race, ethnicity,
28 sex, age, gender identity, disability, pregnancy status, and lactation status. These post-market
29 studies may include single-arm trials, randomized trials, real-world data collection, or pooled
30 studies to assess pharmacokinetics and/or pharmacodynamics in populations understudied in the
31 initial trials.

32
33 Finally, post-market studies do not always need to be conducted by the drug sponsor. While post-
34 approval agreements may be strong incentives for drug sponsors with named drugs to maintain
35 their approval while on-patent, many commonly used drugs that are currently off-patent and
36 available as generics were developed without representative women or SGM participation in their
37 clinical trials. As such, there is a distinct possibility that post-market trial requirements for generic
38 drugs could result in lower cost medications simply leaving the marketplace. In those instances,
39 targeted studies for medications at higher-risk for sex- and gender-specific adverse events may be
40 well-suited for federal or academic entities.

41
42 EXISTING AMA POLICY

43
44 The AMA maintains a plethora of policies seeking to improve equity in both patient outcomes and
45 workforce representation. Specific to this report, the AMA has policy recognizing the differences
46 in health outcomes for women in cardiovascular disease (H-525.975, “Heart Disease in Women”),
47 substance use (H-30.943, “Alcohol Use Disorder and Unhealthy Alcohol Use Among Women”),
48 pharmacological response (D-525.993, “Education on Sex-Based Response to Opioids”), and even
49 pharmaceutical advertising (D-105.996, “Impact of Pharmaceutical Advertising on Women's
50 Health”). The AMA maintains policy specific to the health care needs of other gender identities,
51 including a recognition of the higher risk for cancer in this population (H-160.991, “Health Care

1 Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations”), and the need for improved
2 gender identity and sexual orientation documentation in medical trials (H-315.967, “Promoting
3 Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation”). Additionally,
4 it is the policy of the AMA that the FDA perform regular surveillance of research trial participants,
5 and to adequately fund activities that increase participant diversity in trials (H-460.911, “Increasing
6 Minority, Female, and other Underrepresented Group Participation in Clinical Research”).
7

8 CONCLUSION

9

10 The lack of women and SGM participation in clinical trials has resulted in health inequities.
11 Although it may have started as a well-intentioned response to teratogenic medication adverse
12 events, legislative and regulatory actions have contributed to a drug and device development
13 environment with limited inclusion and information on women and sex and gender minorities.
14 Since the early 1990s, there have been changes to the regulatory landscape and efforts to improve
15 the diversity of the research and development workforce, but progress is slow. The FDA has
16 demonstrated a commitment to improving diversity in clinical trials which should be applauded,
17 supported, and promptly strengthened.
18

19 RECOMMENDATIONS

20

21 The Council on Science and Public Health recommends that the following be adopted and the
22 remainder of the report be filed:
23

24 That policy H-525.988, “Sex and Gender Differences in Medical Research” be amended by
25 addition and deletion to read as follows:

26 Our AMA:

- 27 (1) reaffirms that gender exclusion in broad medical studies questions the validity of the
28 studies' impact on the health care of society at large;
- 29 (2) affirms the need to include all genders in studies that involve the health of society at
30 large and publicize its policies;
- 31 (3) supports increased funding into areas of women's health and sexual and gender
32 minority health research;
- 33 (4) supports increased research on women's health and sexual and gender minority health
34 and the participation of women and sexual and gender minorities in clinical trials, the
35 results of which will permit development of evidence-based prevention and treatment
36 strategies for all women and sexual and gender minorities from diverse cultural and ethnic
37 groups, geographic locations, and socioeconomic status;
- 38 (5) recommends that all medical/scientific journal editors require, where appropriate, a sex-
39 based and gender-based analysis of data, even if such
40 comparisons are negative; and
- 41 (6) recommends that medical and scientific journals diversify their review processes to
42 better represent women and sexual and gender minorities; and
- 43 (7) supports the FDA's requirement of actionable clinical trial diversity action plans from
44 drug and device sponsors that include women, and sex and gender minorities; and
- 45 (8) supports the FDA's efforts in conditioning drug and device approvals on post-marketing
46 studies which evaluate the efficacy and safety of those products in women and sex and
47 gender minorities when those groups were not adequately represented in clinical trials; and
- 48 (9) supports and encourages the National Institute of Health and other grant-making
49 entities to fund post-market research investigating pharmacodynamics and
50 pharmacokinetics for generic drugs that did not adequately enroll women, and sex and

1 gender minorities in their clinical trials, prioritizing instances when those populations
2 represent a significant portion of patients or reported adverse drug events. (Amend HOD
3 Policy)

Fiscal note: less than \$1,000

CITED AMA POLICY

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 all genders in studies that involve the health of society at large and publicize its policies;
- (3) supports increased funding into areas of women's health and sexual and gender minority health research;
- (4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minorities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minorities from diverse cultural and ethnic groups, geographic locations, and socioeconomic status;
- (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; and
- (6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minorities.

An Expanded Definition of Women's Health H-525.976

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

Inclusion of Women in Clinical Trials H-525.991

Our AMA: (1) encourages the inclusion of women, including pregnant women when appropriate, in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women alike; (2) supports the National Institutes of Health policy requiring investigators to account for the possible role of sex as a biological variable in vertebrate animal and human studies; and (3) encourages translation of important research results into practice.

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

1. Our AMA advocates that:

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

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

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

Heart Disease in Women H-525.975

1. Our AMA supports increased awareness and education on preventive measures for heart disease in women and encourages comprehensive care of heart disease in women.

2. Our AMA urges research to address the gaps in knowledge related to coronary pathophysiology and diagnostic, treatment, and interventional strategies for heart disease in women; and to better understand the role of demographic, socioeconomic, and psychological factors in the onset of heart disease in women.

Alcohol Use Disorder and Unhealthy Alcohol Use Among Women H-30.943

The AMA recognizes the prevalence of unhealthy use of alcohol among women, as well as current barriers to diagnosis and treatment. The AMA urges physicians to be alert to the presence of alcohol-related problems among women and to screen all patients for alcohol use disorder and dependence. The AMA encourages physicians to educate women of all ages about their increased risk of damage to the nervous system, liver and heart disease from alcohol and about the effect of alcohol on the developing fetus. The AMA encourages adequate funding for research to explore the nature and extent of alcohol use disorder and unhealthy alcohol use among women, effective treatment modalities for women with alcohol use disorder and unhealthy alcohol use, and variations in alcohol use among ethnic and other subpopulations. The AMA encourages all medical education programs to provide greater coverage on alcohol as a significant source of morbidity and mortality in women.

Education on Sex-Based Response to Opioids D-525.993

Our AMA will include educational materials for physicians regarding sex-based differences in their resources related to the opioid epidemic. These sex-based differences include the perception of pain, the impact of co-morbid conditions, response to opioids, risks for opioid use disorder, issues with access, and outcomes of addiction treatment programs among women.

Impact of Pharmaceutical Advertising on Women's Health D-105.996

1. Our AMA urges the US Food and Drug Administration (FDA) to assure that all direct-to-consumer advertising of pharmaceuticals includes information regarding differing effects and risks between the sexes.
2. Our AMA urges the FDA to assure that advertising of pharmaceuticals to health care professionals includes specifics outlining whether testing of drugs prescribed to both sexes has included sufficient numbers of women to assure safe use in this population and whether such testing has identified needs to modify dosages based on sex.

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.

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

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, preferred gender pronoun(s), preferred name, and clinically relevant, sex specific anatomy in medical documentation, and related forms, including in electronic health records, in a culturally-sensitive and voluntary manner; (2) will advocate for collection of patient data in medical documentation and in medical research studies, according to current best practices, that is inclusive of sexual orientation, gender identity, and other sexual and gender minority traits for the purposes of research into patient and population health; (3) will research the problems related to the handling of sex and gender

within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; (4) will investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and (5) will advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians.

REFERENCES

1. Florence AL. *Is Thalidomide to Blame?* : Br Med J. 1960 Dec 31;2(5217):1954.
2. Greene JA, Podolsky SH. Reform, regulation, and pharmaceuticals--the Kefauver-Harris Amendments at 50. *N Engl J Med*. 2012;367(16):1481-1483.
3. U.S. Food and Drug Administration. General Considerations for the Clinical Evaluation of Drugs. <https://www.fda.gov/media/71495/download>. Published 1977. Accessed January 23, 2024.
4. Women's health. Report of the Public Health Service Task Force on Women's Health Issues. *Public Health Rep*. 1985;100(1):73-106.
5. U.S. Food and Drug Administration. Study and Evaluation of Gender Differences in the Clinical Evaluation of Drugs. <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/study-and-evaluation-gender-differences-clinical-evaluation-drugs>. Published 1993. Accessed January 23, 2024.
6. Bennett JC. Inclusion of women in clinical trials--policies for population subgroups. *New England Journal of Medicine*. 1993;329(4):288-292.
7. Council on Science and Public Health. An Expanded Definition of Women's Health. https://policysearch.ama-assn.org/councilreports/downloadreport?uri=/councilreports/a16_csaph5.pdf. Published 2016. Accessed.
8. Jin X, Chandramouli C, Allocco B, Gong E, Lam CSP, Yan LL. Women's Participation in Cardiovascular Clinical Trials From 2010 to 2017. *Circulation*. 2020;141(7):540-548.
9. Sosinsky AZ, Rich-Edwards JW, Wiley A, Wright K, Spagnolo PA, Joffe H. Enrollment of female participants in United States drug and device phase 1–3 clinical trials between 2016 and 2019. *Contemporary Clinical Trials*. 2022;115:106718.
10. A Multicenter Investigation of Factors Influencing Women's Participation in Clinical Trials. *Journal of Women's Health*. 2018;27(3):258-270.
11. Bibbins-Domingo K, Helman A, National Academies of Sciences E, Medicine. Improving Representativeness in Clinical Trials and Research: Facilitators to Recruitment and Retention of Underrepresented Groups. In: *Improving Representation in Clinical Trials and Research: Building Research Equity for Women and Underrepresented Groups*. National Academies Press (US); 2022.
12. McCabe SE, West BT, Hughes TL, Boyd CJ. Sexual orientation and substance abuse treatment utilization in the United States: Results from a national survey. *Journal of Substance Abuse Treatment*. 2013;44(1):4-12.
13. Flentje A, Bacca CL, Cochran BN. Missing data in substance abuse research? Researchers' reporting practices of sexual orientation and gender identity. *Drug and Alcohol Dependence*. 2015;147:280-284.
14. Ludmir EB, Espinoza AF, Jethanandani A, et al. Reporting and exclusion of sexual and gender minorities in cancer clinical trials. *International Journal of Cancer*. 2020;146(8):2360-2361.
15. Saunders CL, Meads C, Abel GA, Lyratzopoulos G. Associations Between Sexual Orientation and Overall and Site-Specific Diagnosis of Cancer: Evidence From Two National Patient Surveys in England. *J Clin Oncol*. 2017;35(32):3654-3661.
16. Blok CJMd, Wiepjes CM, Nota NM, et al. Breast cancer risk in transgender people receiving hormone treatment: nationwide cohort study in the Netherlands. *BMJ*. 2019;365:11652.
17. Zucker I, Prendergast BJ. Sex differences in pharmacokinetics predict adverse drug reactions in women. *Biology of Sex Differences*. 2020;11(1):32.
18. Geller SE, Koch AR, Roesch P, Filut A, Hallgren E, Carnes M. The More Things Change, the More They Stay the Same: A Study to Evaluate Compliance With Inclusion and

- Assessment of Women and Minorities in Randomized Controlled Trials. *Acad Med.* 2018;93(4):630-635.
19. Fuzzell L, Fedesco HN, Alexander SC, Fortenberry JD, Shields CG. "I just think that doctors need to ask more questions": Sexual minority and majority adolescents' experiences talking about sexuality with healthcare providers. *Patient Education and Counseling.* 2016;99(9):1467-1472.
 20. Administration USFaD. FDA Action Plan to Enhance the Collection and Availability of Demographic Subgroup Data. <https://www.fda.gov/media/89307/download>. Published 2014. Accessed 2024, January 31.
 21. U.S. Food and Drug Administration. Diversity Plans to Improve Enrollment of Participants from Underrepresented Racial and Ethnic Populations in Clinical Trials. <https://www.fda.gov/media/157635/download>. Published 2022. Accessed January 23, 2024.
 22. U.S. Food and Drug Administration. Postmarketing Approaches to Obtain Data on Populations Underrepresented in Clinical Trials for Drugs and Biological Products. <https://www.fda.gov/media/170899/download>. Published 2023. Accessed January 23, 2024.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 5-A-24

Subject: Biosimilar/Interchangeable Terminology

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee E

1 INTRODUCTION

2
3 Resolution 245-A-23, which was referred by the American Medical Association’s (AMA) House of
4 Delegates, stated as follows:

5
6 That our American Medical Association repeal policy H-125.976, Biosimilar
7 Interchangeability Pathway (Rescind HOD Policy);

8
9 That our AMA advocate for state and federal laws and regulations that support
10 patient and physician choice of biosimilars and remove the “interchangeable”
11 designation from the FDA’s regulatory framework. (Directive to Take Action)

12
13 This report serves as the Council on Science and Public Health’s findings and recommendations
14 after review of the evidence surrounding the “interchangeable” designation for biosimilar
15 medications.

16
17 METHODS

18
19 English language articles were selected from searches of PubMed and Google Scholar using the
20 search terms “biosimilar AND interchangeable.” Additional articles were identified by manual
21 review of the reference lists of pertinent publications. Web sites managed by government agencies
22 and applicable organizations were also reviewed for relevant information.

23
24 BACKGROUND

25
26 This report deals with several technical terms, including discussion as to how they overlap and
27 differ. As such, definitions are provided in Appendix 1 of this report for the following terms:
28 biologic drug, small molecule drug, generic drug, biosimilar, and interchangeable.

29
30 Biosimilars are a classification of biologic medical products (such as recombinant proteins and
31 gene therapies) which are nearly identical to an existing U.S. Food Drug and Administration (FDA)
32 -approved biologic medicine (called the reference product or innovator product). In that sense, they
33 are often thought of as the equivalent to the “generic” designation for small-molecule drugs,
34 however they have several key differences which will be discussed later in this report.

35 Biosimilars are a relatively new class of large molecule medication, with the first follow-on (i.e., a
36 new medication approved in an already established drug class) protein, Omnitrope (somatropin),

1 not receiving FDA approval until 2005.¹ However, the FDA has not had a dedicated regulatory
2 pathway for approving biosimilars until passage of the Patient Protection and Affordable Care Act
3 of 2010, which resulted in the first true biosimilar being approved in 2015, when the leukocyte
4 growth factor Zarxio (filgrastim-sndz) was deemed to be biosimilar to Neupogen (filgrastim).² As
5 of December 2023, there have been 45 biosimilars approved by the FDA, including products such
6 as biosimilars for Humira (adalimumab), Avastin (bevacizumab), and Lantus (insulin glargine).

7
8 Biosimilars have a unique naming convention compared to other classes of drugs. First, all biologic
9 drugs are branded, even if they are a biosimilar. To distinguish between two biologic products, a 4-
10 letter suffix is added to the non-proprietary name. For example, filgrastim is a recombinant form of
11 granulocyte colony-stimulating factor. The first biologic drug product in this class was produced by
12 Amgen under the trade name Neupogen (filgrastim). Once Neupogen lost its market exclusivity,
13 biosimilars such as Zarxio (filgrastim-sndz), Nivestym (filgrastim-aafi), and Releuko (filgrastim-
14 ayow) were approved by the FDA. These were all found by the FDA to have similar efficacy and
15 function to Neupogen but have their own brand name and suffix. This naming strategy is intended
16 to convey that biosimilars such as Zarxio and Nivestym are *similar*, but not identical to Neupogen,
17 and allows for easier pharmacovigilance in the event that those differences result in adverse event
18 profile differences. For biologic drugs approved after March 23, 2020, the originator product also
19 contains a 4-letter suffix.

20
21 Similar to the generic drug market, approvals of biosimilars are generally thought to lead to
22 increased access and lower costs for expensive medications on the market. Per one analysis from
23 2016 (before nearly all biosimilars entered the market) biologic drugs comprised less than one
24 percent of prescriptions in the United States, but accounted for over 28 percent of drug
25 expenditures.³ Since then, one study estimates that biosimilars saved patients \$56 billion in
26 medication spending, and account for approximately 60 percent of a given biologic drug's sales
27 volume when biosimilar competition exists.⁴ It should be noted, however, that the introduction of a
28 biosimilar is not a guaranteed method for reducing cost and increasing access – somatropin, the
29 first biologic drug to have a biosimilar approved, has actually had a nearly 20 percent increase in
30 the reference product unit price since the introduction of follow-on competition, even though the
31 follow-on product is markedly cheaper.⁵

32 33 *Distinctions with Generic Drugs*

34
35 As described above, many often think of biosimilars as the “generic drug” version of biologic
36 medicines. However, there are several key differences, which are also summarized in Appendix 2.⁶
37 The first major distinction between biosimilar large molecule drugs and generic small molecules
38 drugs is the complexity of the underlying medicine. Small molecule drugs generally consist of
39 relatively simple organic chemical structures with atom counts on the scale of 10s, and atomic
40 weights on the scale of 100s of Daltons (Da). For example, acetylsalicylic acid (aspirin) has the
41 chemical formula of C₉H₈O₄ (21 total atoms), and a molecular weight of 180 Da. Biologic drugs,
42 by comparison, typically consist of thousands of atoms – adalimumab, a monoclonal antibody used
43 for autoimmune disorders, has a molecular formula of C₆₄₂₈H₉₉₁₂N₁₆₉₄O₁₉₈₇S₄₆ (20,067 total atoms)
44 and a molecular weight of 144,190 Da.

45
46 Biologic drug efficacy is very sensitive to the secondary, tertiary, and even quaternary structure,
47 which describes how the molecule is folded and packed into shape.⁷ For example, many biosimilars
48 are antibody-based drugs, which require very specific folding patterns to generate the receptor
49 binding affinity needed to provide the drugs action in the body. The “active” portion of the
50 biosimilar may be a tiny fraction of the overall molecule while they also may contain several large
51 components that do not contribute meaningfully to the efficacy of the medication. As such,

1 biosimilars may have different chemical structures than their reference product, but if the
2 difference only exists in non-active portions of the structure and does not impact other elements
3 such as folding or polarity, then in theory they will retain similar efficacy.
4

5 To produce such complex moieties, biologic drugs are manufactured using unique strategies such
6 as bioreactors. Rather than pursuing traditional chemical synthesis, manufacturers leverage living
7 cells such as yeast or E. coli that are genetically modified to produce the desired product. Due to
8 the relative lack of control over bioreactor manufacturing, there can be high levels of both inter-
9 and intra-batch variability resulting in changes in protein sequence, higher order structure,
10 aggregation, charge heterogeneity, oxidation, and any byproducts from the bioreactor organism
11 that may impact drug function and immunogenicity.⁸ Additionally, since the organisms responsible
12 for producing the biologic drug are their own living system, they evolve and mutate over time,
13 meaning that the output will slowly, irreversibly drift over time.⁹ As such, there is significant
14 effort, from industry and regulators, dedicated to monitoring and probing biologic drug
15 manufacturing to ensure drug safety and efficacy are preserved in these manufacturing conditions.⁸
16 Differences in manufacturing of biologics and small molecule drugs result in another key
17 distinction – biosimilars are designed to have *similar* function and efficacy, but it is an impossible
18 task to ever perfectly reproduce composition and structure.
19

20 Considering their unique composition, mechanism of action, and manufacturing, biosimilars and
21 their approvals are regulated via their own distinct pathway by the FDA. Established by the
22 Biologics Price Competition and Innovation Act of 2009 (BPCIA, passed within the broader
23 Affordable Care Act), biosimilars are approved via an abbreviated 351(k) pathway compared to the
24 505(j) pathway for other small molecule generic drugs. Per the Hatch-Waxman Act, generic small
25 molecule drug manufacturers are only required to establish bioequivalence for FDA approval.¹⁰
26 Compared to small molecule generic drugs, biosimilar manufacturers are required to prove that
27 their product utilizes the same mechanism of action, analytical studies proving similarity of the
28 biologically active components, animal studies assessing toxicity, and clinical studies assessing
29 efficacy, immunogenicity, pharmacokinetics, and pharmacodynamics.¹¹ As a result, the cost
30 associated with developing, testing, and seeking approval for a biosimilar is significantly higher
31 than that of a generic drug – with some estimates as high as nine years and \$300 million per
32 biosimilar.^{12,13}
33

34 *Interchangeability*

35

36 There is a continuing tension in how to best describe biosimilars. On the one hand, biosimilar
37 naming and terminology needs to convey that they have been found to perform the same as the
38 reference product. Yet on the other hand, it needs to convey that they are chemically *similar* – not
39 identical. Due to the relative infancy of the field, the clinical implications have yet to be fully
40 understood, especially when there can be significant molecule structural or compositional
41 differences between biologic products that otherwise perform similarly.¹⁴⁻¹⁸
42

43 One of the primary sources of tension around communicating biosimilar drugs similarity and
44 differences is the utilization of the term “interchangeable.” As alluded to by the original Resolution
45 245-A-23, there are additional distinctions and implications between biosimilars and small
46 molecule generic drugs when it comes to interchangeability and pharmacy-level substitutions. Per
47 the BPCIA, “interchangeable” is an additional designation that can be given to biosimilars that
48 allows for pharmacists to perform a substitution of two biologic drugs, if allowed by their state
49 pharmacy laws, similar to generic small molecule drugs for their brand name product. Per the
50 Public Health Service Act, “the [term interchangeable in] reference to a biological product [...]

1 means that the biological product may be substituted for the reference product without the
2 intervention of the health care professional who prescribed the reference product.”¹⁹

3 Beyond the baseline evidence that manufacturers provide for biosimilar approval, to be deemed
4 “interchangeable” manufacturers must perform a switching study or interchangeable trial -- a two-
5 arm clinical trial in which one arm receives the reference product continuously, and the other
6 switches from the reference product to the biosimilar and back again. If there are no substantive
7 differences in efficacy or immunogenicity upon switching back and forth between biosimilar and
8 the reference product, the biosimilar may be deemed “interchangeable.” It should be noted that to
9 receive the initial FDA approval as a biosimilar, the drug must already have proven to have similar
10 efficacy and immunogenicity to the reference product. Instead, interchangeable trials are meant to
11 assess if there are any changes in efficacy and immunogenicity caused by the act of switching itself
12 after a patient has already initiated treatment.

13
14 The “interchangeable” designation is therefore used primarily by pharmacists for performing
15 medication substitutions. These medication substitutions are often required due to formulary
16 restrictions by pharmacy benefits managers, cost-savings to the patient or available stock, among
17 others. State laws vary greatly for how pharmacists may substitute biosimilars and other generic
18 small molecule drugs.²⁰ For example, in Illinois, a pharmacist may substitute a biologic product
19 with an approved interchangeable biosimilar after alerting the prescriber and the patient. In North
20 Carolina, however, pharmacists may only substitute interchangeable biologics if it will result in
21 cost savings for the patient, but they are not required to communicate this to the prescriber.

22
23 The international approach to biosimilar substitutions is mixed, which may be expected for a
24 relatively new class of highly complex medicines.²¹ The European Union’s regulatory arm, the
25 European Medicines Agency (EMA), does not have an additional category or testing requirements
26 for substitutions and deems all biosimilars approved by the EMA to be interchangeable. However,
27 individual member countries may have their own regulations.²²

28
29 Beyond its role in state-level pharmacy laws, the interchangeable designation is often one of
30 frustration for physicians, patients, and pharmacists. Due to their similarity to another drug,
31 patients may expect that a biosimilar can be substituted at the pharmacy like other generic small
32 molecule drugs, barring formulary restrictions. However, the interchangeability requirements leave
33 patients confused, bring added work for physicians and pharmacists to communicate access
34 challenges and mediate procurement of the appropriate agent to the patient. Further, educating
35 patients on the regulatory nuance between biosimilar and interchangeability can leave everyone
36 frustrated and confused with the process and potentially lead to treatment delays.

37
38 From a manufacturer’s perspective, the interchangeable designation is a highly desirable one. The
39 price of many biologic drugs is substantial, and being made available for pharmacy-level
40 substitutions may be a significant competitive advantage in a growing marketplace. In one instance,
41 the interchangeable designation of Semglee (insulin glargine-yfgn) resulted in the removal of the
42 reference product, Lantus (insulin glargine), entirely from major pharmacy benefit managers’ drug
43 formularies.²³ To further incentivize biosimilar developers to pursue interchangeable status, the
44 FDA allows for the first interchangeable biosimilar of a drug to obtain market exclusivity status for
45 a year.²⁴ However, given the high cost of bringing a biosimilar to market, performing an additional
46 clinical trial to evaluate switching may be an additional barrier to entry for smaller biosimilar
47 sponsors. Additionally, biologic drugs which have a biosimilar competitor available will be exempt
48 from Medicare drug price negotiations with the newly founded Drug Price Negotiation Program.²⁵

1 From a regulator’s perspective, the interchangeable designation likely seems to be a cautious step
2 towards regulating a new class of drugs where immunogenicity concerns are high. However, it is
3 unclear if those concerns have been realized. Additionally, much of the interchangeable framework
4 is directly outlined in the BPCIA, meaning it would require an act of Congress to significantly
5 change it.

6 7 REGULATORY MOVEMENT

8
9 According to the FDA’s Purple Book Database at the time of writing, there have been 45 biosimilar
10 products approved in the United States, and seven have received the interchangeable designation.²⁶
11 Clinical trial data for failed studies is generally not published, but there have been no indications
12 that any biosimilar which has pursued the interchangeable study has failed to achieve the
13 interchangeable designation.

14
15 In late 2023, scientists from the FDA’s Center for Drug Evaluation and Research published a meta-
16 analysis evaluating the outcomes of 44 treatment switches across 21 different biosimilars, with a
17 total of 5252 patients. In their review, they found that “no differences in terms of major safety
18 parameters such as deaths, [non-fatal serious adverse events], and discontinuations were observed
19 when patients are switched (to or from a biosimilar and its reference biologic) or not switched.”²⁷
20 This supports the findings of European regulators, which stated “[the] EMA has approved 86
21 biosimilar medicines since 2006. These medicines have been thoroughly reviewed and monitored
22 over the past 15 years and the experience from clinical practice has shown that in terms of efficacy,
23 safety and immunogenicity they are comparable to their reference products and are therefore
24 interchangeable.”²⁸

25
26 The above-mentioned FDA study appears to be part of a larger movement within the federal
27 government more broadly to re-evaluate the role of interchangeable status. In September 2023, the
28 FDA published a draft guidance to change the labeling for biosimilars.²⁹ Prior to this guidance,
29 biologic medicine labeling had two distinct sections: a “biosimilarity statement” and an
30 “interchangeability statement,” where if not deemed interchangeable, the statement would be
31 blank. Under the new guidance, the two are combined into a single statement to allow for those
32 who are legally required to understand interchangeability status to be easily able to find it on
33 product labeling, while prescribers or patients do not feel that their medication is of lower quality
34 when seeing a blank interchangeability statement.

35
36 These movements by the FDA away from the interchangeable designation are matched by other
37 federal entities. In a March 2022 report from the Office of the Inspector General (OIG), they found
38 that Medicare was over-spending on biologic medicines by not fully incorporating biosimilars into
39 their offerings, and instead focusing too heavily on reference products.³⁰ OIG estimated that
40 Medicare Part D spending on biologics could be decreased by 18 percent (\$84 million) annually,
41 and out-of-pocket spending on these products for Medicare beneficiaries could decrease by 12
42 percent (\$1.8 million) annually, if biosimilars were more broadly used.

43
44 Under current regulations, biosimilars may only be substituted with those deemed interchangeable,
45 and only after explicit approval by the Centers for Medicare & Medicaid Service (CMS). In
46 November 2023, CMS proposed rule changes to Medicare Advantage and Medicare Part D that
47 would allow for plans to immediately substitute all biosimilars, including those not deemed
48 interchangeable, for the reference product.³¹ On January 4th, 2024, the AMA submitted comment to
49 CMS on this proposed change, and cited concern that CMS movement was premature barring
50 regulatory changes from the FDA, and that patients currently receiving the reference product
51 should be exempt from substitutions without approval from their physician.

1 In March 2024, the Biden Administration released its draft budget for fiscal year 2025, which
2 included a policy proposal to allow for all biosimilars, regardless of interchangeability status, be
3 eligible for pharmacy level substitutions.³² At the time of this report’s writing (March 2024), it is
4 unclear if this policy will be included in the final, approved budget for fiscal year 2025, but it is
5 generally consistent with the direction federal regulations on biosimilar interchangeability has
6 taken in recent years.

7 8 CURRENT AMA POLICY

9
10 The AMA currently has several policies regarding biosimilars, particularly around reimbursement
11 and cost coverage. Of particular relevance to this report are two policies (full text of policies found
12 at the end of this report): (1) H-125.976 “Biosimilar Interchangeability Pathway,” states amongst
13 other clauses, that “[the AMA] strongly support the pathway for demonstrating biosimilar
14 interchangeability”; and (2) D-125.989 “Substitution of Biosimilar Medicines and Related Medical
15 Products,” which urges State Pharmacy Practice Acts to limit the authority of pharmacists to
16 substitute biosimilars only when they have been deemed interchangeable by the FDA.

17 18 CONCLUSION

19
20 At the crux of this issue is balancing patient access to medications against the unknown risks of a
21 newer class of highly complex medicines. Given the current state of the published evidence
22 between the European Union and FDA reviews, it appears that the previous concerns over toxicity
23 and immune response of switching biosimilars have not been realized. However, it is important to
24 recognize that the evidence on interchangeability is still limited and that the field of biosimilars is
25 in its infancy compared to our knowledge of generic small molecule drugs. Additionally, the term
26 interchangeable, however flawed, is utilized by several entities beyond the FDA, including for
27 Medicare reimbursement and state pharmacy laws. Therefore, the Council recommends that an
28 approach be taken to retain the FDA’s ability to assess and monitor potential risks of switching
29 without placing an outsized importance and advantage in the marketplace on the completion of
30 additional switching trials that have yet to yield value for patients and physicians.

31 32 RECOMMENDATIONS

33
34 The Council on Science and Public Health recommends that the following be adopted and the
35 remainder of the report be filed:

- 36
37 1. That Policy H-125.976, “Biosimilar Interchangeability Pathway” be rescinded. (Rescind
38 HOD Policy)
39 2. That our AMA encourage the FDA to continually collect data and critically evaluate
40 biosimilar utilization including the appropriateness of the term “interchangeable” in
41 regulatory activities. (Directive to Take Action)
42 3. That Policy D-125.989 “Substitution of Biosimilar Medicines and Related Medical
43 Products” be amended by addition and deletion to read as follows:

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 a biologic or biosimilar product; (3) limit the authority of pharmacists to automatically substitute only those biosimilar products that are deemed interchangeable by the FDA. in the absence of express physician authorization to the contrary, allow substitution of the biologic or biosimilar product when (a) the biologic product is highly similar to the reference product.

notwithstanding minor differences in clinically inactive components; and (b) there are no data indicating clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product. (Modify Current HOD Policy)

4. That Policy D-125.987, “Biosimilar Product Naming and Labeling” be reaffirmed. (Reaffirm HOD Policy)

Fiscal note: less than \$1,000

REFERENCES

1. Barlas S. Opening the door to follow-on proteins? *Biotechnol Healthc.* 2006;3(5):47-54.
2. Raedler LA. Zarxio (Filgrastim-sndz): First Biosimilar Approved in the United States. *Am Health Drug Benefits.* 2016;9(Spec Feature):150-154.
3. Scott Morton FM, Stern AD, Stern S. The Impact of the Entry of Biosimilars: Evidence from Europe. *Review of Industrial Organization.* 2018;53(1):173-210.
4. The IQVIA Institute. Biosimilars in the United States 2023-2027. <https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/biosimilars-in-the-united-states-2023-2027>. Published 2023. Accessed January 9, 2024.
5. Biosimilars And Follow-On Products In The United States: Adoption, Prices, And Users. *Health Affairs.* 2021;40(6):989-999.
6. Triplitt C, Hinnen D, Valentine V. How Similar Are Biosimilars? What Do Clinicians Need to Know About Biosimilar and Follow-On Insulins? *Clin Diabetes.* 2017;35(4):209-216.
7. Sullivan PM, DiGrazia LM. Analytic characterization of biosimilars. *American Journal of Health-System Pharmacy.* 2017;74(8):568-579.
8. Vulto AG, Jaquez OA. The process defines the product: what really matters in biosimilar design and production? *Rheumatology.* 2017;56(suppl_4):iv14-iv29.
9. Ramanan S, Grampp G. Drift, evolution, and divergence in biologics and biosimilars manufacturing. *BioDrugs.* 2014;28:363-372.
10. Boehm G, Yao L, Han L, Zheng Q. Development of the generic drug industry in the US after the Hatch-Waxman Act of 1984. *Acta Pharmaceutica Sinica B.* 2013;3(5):297-311.
11. U.S. Food and Drug Administration. Overview of the Regulatory Framework and FDA's Guidance for the Development and Approval of Biosimilar and Interchangeable Products in the US. <https://www.fda.gov/media/113820/download>. Accessed January 9, 2024.
12. Grabowski HG, Guha R, Salgado M. Regulatory and cost barriers are likely to limit biosimilar development and expected savings in the near future. *Health Affairs.* 2014;33(6):1048-1057.
13. Fontanillo M, Kors B, Monnard A. Three imperatives for R&D in biosimilars. <https://www.mckinsey.com/industries/life-sciences/our-insights/three-imperatives-for-r-and-d-in-biosimilars>. Published 2022. Accessed January 11, 2024.
14. Hassett B, Scheinberg M, Castañeda-Hernández G, et al. Variability of intended copies for etanercept (Enbrel®): Data on multiple batches of seven products. *mAbs.* 2018;10(1):166-176.
15. Cho IH, Lee N, Song D, et al. Evaluation of the structural, physicochemical, and biological characteristics of SB4, a biosimilar of etanercept. *mAbs.* 2016;8(6):1136-1155.
16. Lee J, Kang HA, Bae JS, et al. Evaluation of analytical similarity between trastuzumab biosimilar CT-P6 and reference product using statistical analyses. *mAbs.* 2018;10(4):547-571.
17. Nupur N, Joshi S, Gulliarne D, Rathore AS. Analytical similarity assessment of biosimilars: global regulatory landscape, recent studies and major advancements in orthogonal platforms. *Frontiers in Bioengineering and Biotechnology.* 2022;10:832059.
18. Alsamil AM, Giezen TJ, Egberts TC, et al. Reporting of quality attributes in scientific publications presenting biosimilarity assessments of (intended) biosimilars: a systematic literature review. *European Journal of Pharmaceutical Sciences.* 2020;154:105501.
19. U.S. Food and Drug Administration. Biosimilar and Interchangeable Products: The U.S. FDA Perspective. <https://www.fda.gov/media/112818/download>. Published 2018. Accessed January 10, 2024.

20. Cardinal Health. Biosimilar Interchangeability Laws. <https://www.cardinalhealth.com/content/dam/corp/web/documents/publication/Cardinal-Health-Biosimilar-Interchangeability-Laws-by-State.pdf>. Accessed January 9, 2024.
21. Kang HN, Thorpe R, Knezevic I, et al. Regulatory challenges with biosimilars: an update from 20 countries. *Ann N Y Acad Sci*. 2021;1491(1):42-59.
22. O’Callaghan J, Barry SP, Bermingham M, Morris JM, Griffin BT. Regulation of biosimilar medicines and current perspectives on interchangeability and policy. *European Journal of Clinical Pharmacology*. 2019;75(1):1-11.
23. Minemyer P. Express Scripts puts insulin biosimilar Semglee on preferred formulary. *Fierce Healthcare*. October 20, 2021, 2021.
24. Gaudry KS. Exclusivity Strategies and Opportunities in view of the Biologics Price Competition and Innovation Act. *Food and Drug Law Journal*. 2011;66(4):587-630.
25. U.S. Centers for Medicare and Medicaid Services. Medicare Drug Price Negotiation Program: Selected Drugs for Initial Price Applicability Year 2026. <https://www.cms.gov/files/document/fact-sheet-medicare-selected-drug-negotiation-list-ipay-2026.pdf>. Published 2023. Accessed January 10, 2024.
26. U.S. Food and Drug Administration. Biosimilar Product Information. <https://www.fda.gov/drugs/biosimilars/biosimilar-product-information>. Published 2023. Accessed January 9, 2024.
27. Herndon TM, Ausin C, Brahme NN, et al. Safety outcomes when switching between biosimilars and reference biologics: A systematic review and meta-analysis. *PLOS ONE*. 2023;18(10):e0292231.
28. European Medicines Agency. Biosimilar medicines can be interchanged. <https://www.ema.europa.eu/en/news/biosimilar-medicines-can-be-interchanged>. Published 2022. Accessed January 10, 2024.
29. U.S. Food and Drug Administration. Updated FDA Labeling Recommendations for Biosimilar and Interchangeable Biosimilar Products. <https://www.fda.gov/drugs/our-perspective/updated-fda-labeling-recommendations-biosimilar-and-interchangeable-biosimilar-products>. Published 2023. Accessed January 9, 2024.
30. U.S. Office of the Inspector General. Medicare Part D and Beneficiaries Could Realize Significant Spending Reductions With Increased Biosimilar Use. <https://oig.hhs.gov/oei/reports/OEI-05-20-00480.asp>. Published 2022. Accessed January 10, 2024.
31. U.S. Centers for Medicare and Medicaid Services. Contract Year 2025 Policy and Technical Changes to the Medicare Advantage Plan Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, and Health Information Technology Standards. <https://www.cms.gov/newsroom/fact-sheets/contract-year-2025-policy-and-technical-changes-medicare-advantage-plan-program-medicare>. Published 2023. Accessed January 10, 2024.
32. Karins J. President’s Budget Calls For Unrestricted Biosimilar Switching. *InsideHealthPolicy*. March 11, 2024.

CITED AMA POLICIES

Biosimilar Interchangeability Pathway H-125.976

Our AMA will: (1) strongly support the pathway for demonstrating biosimilar interchangeability that was proposed in draft guidance by the FDA in 2017, including requiring manufacturers to use studies to determine whether alternating between a reference product and the proposed interchangeable biosimilar multiple times impacts the safety or efficacy of the drug; and (2) issue a request to the FDA that the agency finalize the biosimilars interchangeability pathway outlined in its draft guidance “Considerations in Demonstrating Interchangeability With a Reference 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

Substitution of Biosimilar Medicines and Related Medical Products D-125.989

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.

Biosimilar Product Naming and Labeling D-125.987

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

APPENDIX 1

Definitions of key terms:

Biologic drug (or large molecule drugs): a classification of drugs which are produced by living organisms (such as human or animal cells, yeast, or bacteria), rather than by chemical synthesis. As such, this class of drug tends to replicate or mimic common biologic entities. For example, antibody- or protein-based drugs are common examples of biologic drugs.

Small molecule drug: A classification of drugs based on the number of atoms (typically <100) in their structure. Small molecule drugs are generally prepared using chemical synthesis techniques. Small molecule drugs are estimated to represent over 90 percent of all pharmaceuticals used in the clinic today. Typically, small molecule drugs function by binding to a biological entity (protein, receptor, etc.) and altering its function.

Generic drug: A drug produced by a second manufacturer after the patent or other market protections have expired, allowing for manufacturers to be able to produce their own products with the same chemical substance as a branded drug. The term generic drug only applies to small molecule drugs, with few exceptions.

Biosimilar: A biologic drug that has a very similar structure and function to a branded biologic drug after its patent or market protections have expired. Unlike generic drugs, biosimilars are not required to be the same chemical compound, but they are required to have the same chemical structure to act on the body and efficacy.

Interchangeable: An additional designation provided for biosimilar drugs by the FDA. This designation is not required for market approval and indicates that a biosimilar has successfully demonstrated no changes in efficacy or immunogenicity when the biosimilar is substituted for the reference product after a patient has already initiated treatment with the reference product. This designation has implications for reimbursement, and state regulations around pharmacist practice.

APPENDIX 2

Table 1: Comparison of follow-on products for small molecule vs. biologic medicines.

Type of Medicine	<u>Small Molecule</u>	<u>Biologic</u>
<i>Name of Follow-on Product</i>	Generic	Biosimilar
<i>Drug Molecule Complexity</i>	Low	High
<i>Size</i>	Small (10s of Dalton)	Very Large (1000s of Dalton)
<i>Manufacturing Process</i>	Chemical synthesis	Bioreactor
<i>Characterization</i>	Simple	Complex
<i>Batch-to-Batch Variability</i>	Low	High, with potential for permanent formulation drift over time
<i>Regulatory Pathway</i>	Abbreviated New Drug Application	Abbreviated Biologics Licensing Agreement
<i>Can Pharmacist Make Substitution?</i>	Yes, if state pharmacy practice laws allow	Yes, if manufacturer successfully completes additional clinical trial where patients switch back and forth between reference and follow-on product AND state pharmacy practice laws allow
<i>Nonproprietary Name</i>	Same as reference product	Same as reference product with additional 4 letter suffix

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 7-A-24

Subject: Androgen Deprivation in Incarceration

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee E

NOTE FROM THE COUNCIL: This report discusses sexual crimes, including against minors. The policy question posed in this report centers on the medical treatment and rehabilitation of those who have been convicted of sexual crimes, often against minors. Please use caution when reading, discussing, disseminating, and debating the contents of this report as they may be re-traumatizing or triggering.

1 INTRODUCTION

2
3 Resolution 501-A-23, “AMA Study of Chemical Castration in Incarceration” was adopted and
4 states that “our AMA study the use of chemical castration in the treatment of incarcerated
5 individuals with paraphilic disorders and for other individuals who commit sexual offenses,
6 including ethical concerns over coercion in its use as an alternative to incarceration and in
7 probation and parole proceedings.”
8

9 This report serves as the Council on Science and Public Health’s response to this charge. For the
10 purposes of this report, the term “androgen deprivation” (AD) will be substituted for “chemical
11 castration” to be more consistent with scientific literature, and to avoid the potential confusion of
12 reversible AD with irreversible surgical castration, typically performed by surgical removal of the
13 testes (orchiectomy).
14

15 METHODS

16
17 English language articles were selected from searches of PubMed and Google Scholar using the
18 search terms “chemical castration”, “androgen deprivation”, “chemical castration AND
19 incarceration”, and “androgen deprivation AND incarceration”. Additional articles were identified
20 by manual review of the reference lists of pertinent publications. Web sites managed by
21 government agencies and applicable organizations were also reviewed for relevant information.
22

23 BACKGROUND

24
25 Sexual crimes can cause significant trauma in their victims. Survivors can be subject to a lifetime
26 of psychological trauma including self-blame, post-traumatic stress disorder, suicidal ideation, and
27 structural changes in the brain.¹⁻⁴ This may be further challenging for those who experience this
28 abuse at a younger age. However, incident rates of child sexual abuse may be difficult to properly
29 assess due to the nature of the victims – e.g., victims may not understand they have been the
30 victims of a crime, or they may rely on their assailant for their basic needs. One study estimates
31 that up to 27 percent of girls and eight percent of boys experience childhood sexual assault in the

1 United States.⁵ Per the U.S. Sentencing Commission, approximately 1,000 cases per year in Federal
2 courts involve sexual abuse, with 94 percent of offenders being men.⁶

3
4 The public perception of perpetrators of sexual crimes is extremely negative, resulting in the
5 feeling that actions against these offenders should be more punitive and less rehabilitative
6 compared to those who have committed non-sexual offenses.⁷ Due to the prevalence and the
7 severity of these crimes, along with the social outrage, public officials often seek non-traditional
8 approaches for dissuading future sexual abuse, such as sexual offender registries, which are outside
9 of the scope of this report.

10
11 One of the approaches, currently utilized in seven states (see Appendix 1), is the use of drugs to
12 lower testosterone levels, with the belief that lower testosterone will reduce the likelihood of an
13 individual committing a sexual crime. This report seeks to describe the current science in the
14 diagnosis and management of paraphilic disorders, examine the utilization of AD in the criminal
15 justice system, and discuss the ethical issues presented by legal mandates for AD in a carceral
16 setting.

17 18 PARAPHILIC DISORDERS, STIGMA, AND THE CRIMINAL JUSTICE SYSTEM

19
20 It is important to distinguish the difference between paraphilias and paraphilic disorders. Per the
21 Diagnostic and Statistical Manual of Mental Disorders (DSM), a paraphilia is “any intense and
22 persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling
23 with phenotypically normal, physically mature, consenting human partners.”⁸ Examples of
24 paraphilic disorders included in the DSM are exhibitionistic disorder, voyeuristic disorder,
25 pedophilic disorder, and frotteuristic disorder. If the paraphilia is causing distress or impairment to
26 either the individual or another person, it may be classified as a paraphilic disorder. The presence
27 of a paraphilia itself does not necessarily warrant clinical intervention or a paraphilic disorder
28 diagnosis. Additionally, it is critical to distinguish between paraphilic thoughts and paraphilic
29 behaviors. This distinction is especially important when discussing criminal acts. Many individuals
30 with paraphilic disorders do not act upon their desires, but they are still distressing and the
31 individual would benefit from clinical support.⁹

32
33 Individuals with paraphilic disorders are subject to intense social stigma, which often results in
34 feelings of guilt, shame, and self-loathing.¹⁰ Clinically, this presents multiple issues, such as
35 individuals being less likely to seek care, and making it more difficult to recruit patients for clinical
36 trials of new treatments. This is particularly true in instances where individuals could be required to
37 disclose that they are experiencing urges to perform criminal acts, even if they do not act upon
38 them. As such, blanket approaches, particularly in the form of legal mandates, should be
39 approached with skepticism as to whether they are truly informed by research and best practices, or
40 a manifestation of the social stigma and bias towards punitive measures for those convicted of
41 sexual offenses. Many of those with paraphilic disorders are themselves survivors of abuse, often
42 experienced in childhood.¹¹

43
44 Treatment for paraphilic disorders is difficult and nuanced. Paraphilic disorders are highly
45 heterogeneous in their manifestation and presentation, ranging from urges to actions, which is
46 further complicated by the social stigma preventing many from seeking care. AD seeks to reduce
47 testosterone, and thus arousal. While this may be effective for some, many convicted of sexual
48 crimes report that they were not seeking sexual gratification, but rather acted out of grievance,
49 impulsivity, or a desire to exert control.¹² This highlights the intersection of many paraphilic
50 disorders with other psychological conditions, emphasizing the importance of consistent,

1 adjunctive psychotherapy, and why many pharmacotherapy approaches for paraphilic disorders go
2 beyond just AD, often including antidepressants, anxiolytics, and mood stabilizers.¹³⁻¹⁶

3 4 ANDROGEN DEPRIVATION IN A CLINICAL SETTING

5
6 AD therapy is a commonly accepted medical treatment approach for managing prostate cancers,
7 where hormones such as testosterone are required for cancer cell growth and proliferation.¹⁷
8 Medications used for AD regimens vary and include leuprorelin, goserelin, and triptorelin, but
9 generally the mechanism of AD action is either as an agonist or antagonist against luteinizing
10 hormone-releasing hormone (LHRH), resulting in a reduction of testosterone production. Patients
11 receiving AD for prostate cancer report loss of libido (up to 91 percent) and erectile dysfunction
12 (up to 95 percent).¹⁸ The high prevalence of sexual dysfunction, as well as the decrease in systemic
13 testosterone levels (and thus presumed decrease in behaviors associated with testosterone, such as
14 aggression) have led to the theoretical utility of AD for managing some types of paraphilic
15 disorders.

16
17 As AD influences hormones, the level of side effects particularly in long-term use can be serious.
18 In a long-term study of men with paraphilic disorders being administered triptorelin, 11 of 18 men
19 saw decreases in bone density, with other reported side effects including persistent hot flashes,
20 diffuse pain, and erectile dysfunction with age-appropriate sexual partners.¹⁹ Depot
21 medroxyprogesterone acetate (DMPA), which is the required medication for AD in the carceral
22 context in California (described below), is contraindicated for people with adrenal disease, severe
23 hypertension, risk of thromboembolic disease, diabetes mellitus, severe depressive disorder,
24 pituitary disease, and meningioma. These side effects often result in high rates of discontinuation,
25 which in the context of most state laws described later, would require the individual to return to
26 prison.²⁰ Due to the side effect profile, the duration of treatment is a critical component. In the
27 oncology setting, the duration of treatment is often on the scale of months, and there is some
28 interest in an intermittent approach (where patients cycle on and off treatment) to better manage
29 side effects.²¹ Patients with paraphilic disorders may receive AD for years, thus subjecting them to
30 more serious side effects.²²

31
32 The evidence base for AD as a treatment for paraphilic disorders primarily comprises of case
33 reports, small cohort, or uncontrolled studies. With those caveats, the current published works
34 generally support that AD may be effective for treating some people with paraphilic disorders. In
35 one study, 29 men previously convicted of sexual crimes and presenting with paraphilic behaviors
36 (child molestation, exhibitionism, or frottage) were treated with DMPA for six months.²³ In that
37 period, one reported committing a sexual crime, while most described a near complete suppression
38 of criminal sexual thoughts and activities. Another study of 46 male patients with paraphilic
39 disorders undergoing group psychotherapy found that patients receiving DMPA in conjunction
40 with psychotherapy had a lower relapse rate (15 percent) compared to those using psychotherapy
41 alone (68 percent).²⁴ These findings are generally observed across the literature, with a meta-
42 analysis (N = 22,181 persons across 69 total studies) finding that hormonal medication had an odds
43 ratio of 3.08 for remission (thoughts, actions, or both) compared to an odds ratio of 1.45 for
44 cognitive-behavioral therapy alone, with the caveat that most hormonal medication included in
45 their analysis was administered in conjunction with cognitive-behavioral therapy.²⁵

46
47 Finally, studies nearly universally focus on the impact of AD on men. While sexual crimes are
48 disproportionately committed by men (97 percent of arrests for rape and 93 percent of arrests for
49 other sexual crimes in 2019 were men), there is a noted lack of research available for treatment of
50 women and people of other gender identities with paraphilic disorders, particularly those which
51 may be utilizing hormone therapy for gender affirming care.²⁶

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ANDROGEN DEPRIVATION THERAPY IN THE CARCERAL SETTING

As of this writing, there are seven states (California, Florida, Iowa, Louisiana, Montana, Wisconsin, and Alabama) which use AD in some component of their judicial response to sexual crimes. A summary of state approaches is provided in Appendix 1 of this report. State approaches to AD generally vary over the level of discretion over who receives it, the duration, and whether it is tied to parole and/or probation.

In California, if an individual is convicted of a crime that is sexual in nature against a victim under the age of 13, a long-acting injection of DMPA may be a condition of their parole. If the individual has two convictions for sexual crimes against a minor, this injection is mandatory as a condition to receive parole.²⁷

In Florida, all individuals convicted of sexual assault (regardless of age of victim) may be required, at the discretion of the presiding judge, to receive AD upon completion of their prison sentence after consulting a medical professional, not necessarily a physician.²⁸ The judge can decide the duration of AD, which can be lifelong. If an individual does not appear for their court-mandated AD administration, they are charged with an additional felony. Similar to California, AD in Florida becomes mandatory upon a second conviction.

Alabama, which adopted its AD statute in 2019, allows judges to decide if someone convicted of sexual crimes against a victim under 12 years old will receive AD after their first offense. Additionally, those convicted in Alabama are required to pay for their AD for an indeterminate period of time, but inability to pay may not be used as the basis to deny parole. It is unclear at this time if court-mandated AD would be reimbursed by insurance.

Interestingly, there does not appear to be a clear trend in the recent actions of states and AD laws. For example, Alabama enacted its statute in 2019, while a legislator in New Mexico introduced an AD bill in 2021 but it failed to pass. Meanwhile, Oregon (2001) and Georgia (2006) both had AD statutes that have since been repealed. In Oregon, the law was a time-limited pilot program that was not renewed upon its conclusion.²⁹ In Georgia, references to AD were removed from laws as an unspecified “policy decision,” with no other public justification provided.³⁰

When trying to measure if AD laws are effective at reducing recidivism, it is critical to appreciate the difficulty in recruiting, retaining, and measuring behavioral outcomes in populations of those convicted of sexual crimes. This is a highly stigmatized population, and studies often require self-reporting of thoughts and actions and may involve confessing to a crime or thoughts that they feel deep shame towards. Efforts to measure recidivism as an endpoint are incredibly difficult to assess accurately due to the previously described factors which cause sexual violence to be underreported. This is especially true if AD is administered as a mandatory condition of parole. Individuals receiving parole are already a self-selecting population – they have indicated that they do not want to be incarcerated any more, meaning that incarceration is a deterrent for them. As such, individuals who receive AD as a condition of parole may already be a population less likely to re-offend, and the effect of AD on recidivism rates versus the fear of being incarcerated may be impossible to disentangle.

1 ETHICAL AND CONSTITUTIONAL CONCERNS

2
3 AD laws have been constitutionally challenged in state courts. For example, in 1984, a Michigan
4 man convicted of rape was sentenced to one year in prison and five years of probation only if he
5 received DMPA for AD.³¹ The Michigan Court of Appeals found in *People v. Gauntlett*, this
6 approach to be unconstitutional, with the rationale that DMPA was not FDA-approved for AD, and
7 that the individual could not provide informed consent if this was court-mandated administration.³²

8
9 While many AD laws in other states have not been challenged in courts, the outcome in Michigan
10 highlights several of the criticisms against AD laws. Beyond concerns of drug efficacy, safety, and
11 consent, there are additional concerns around the constitutionality of AD laws. For example, some
12 have argued that AD violates the Eighth Amendment’s protection against cruel and unusual
13 punishment, or even that government intervention and mandating behavior-altering drugs may
14 violate an individual’s First Amendment rights to have freedom of thought or mental autonomy.³³

15
16 Even in instances where an individual is provided a choice to receive AD, it is unlikely that this
17 would truly be free from coercion. The social stigma of those with paraphilic disorders can be
18 magnified in the carceral setting, and often results in those convicted of sexual crimes being
19 targeted for violence. One study, for example, found that individuals convicted of sexual crimes
20 made up 15 percent of an inmate population, but were the victims for over 30 percent of homicides
21 in prison.³⁴

22
23 Finally, while AD laws are intended to reduce the likelihood of committing additional sexual
24 crimes, they do impact fertility and selective enforcement harkens back to America’s dark history
25 of eugenics. In the 1920s, dozens of states enacted eugenic sterilization laws, resulting in the
26 forceful sterilization of populations deemed undesirable – often inmates, and disproportionately
27 used against Black men and women.³⁵ Particularly in instances where the use of AD is at the
28 discretion of the court, legal scholars worry that racist stereotypes of hyper-sexual Black men will
29 result in disproportionately higher rates of AD administered to marginalized and minoritized
30 groups, which could serve as a modern eugenics law.³⁶

31
32 A review of the available literature was unable to identify analysis of the rate at which AD is used
33 in the carceral setting, nor the demographics of those receiving it.

34
35 CURRENT AMA POLICY

36
37 The AMA, through both its policy and administration of the Code of Medical Ethics, has a strong
38 history of opposing the use of medicine as punishment. Of particular relevance is Opinion 9.7.2,
39 “Court-Initiated Medical Treatment in Criminal Cases” (full text available at end of report), which
40 notes such treatments “raise important questions as to the rights of prisoners, the powers of judges,
41 and the ethical obligations of physicians” and that “medical ethics do not require a physician to
42 carry out civic duties [i.e., court-initiated medical treatments like AD] that contradict fundamental
43 principles of medical ethics.” The Code states that physicians who participate in court-initiated
44 medical treatments should only do so “if the procedure being mandated is therapeutically
45 efficacious” and is “not a form of punishment.” Additionally, the Code explains that physicians
46 should “[t]reat patients based on sound medical diagnoses, not court defined behaviors” and that
47 they should “[d]ecline to provide treatment that is not scientifically validated.”

48
49 As of this writing, it is likely that state laws imposing AD fail to meet the standards set forth by the
50 Code of Medical Ethics. States either utilize automatic mandates or rely solely on the discretion of
51 the courts for deciding who requires AD, removing physician discretion and clinical judgement, as

1 well as eliminating the ability for the patient to provide consent. Additionally, some statutes
2 specifically cite that AD must be performed using DMPA, which has not been FDA-approved for
3 AD nor is it known to be included in any clinical guidelines for AD in the context of prostate
4 cancer or paraphilic disorder treatment.¹⁸ Finally, instances where AD may be optional as a
5 condition for parole or probation likely violate patient voluntariness, in that a patient is forced to
6 choose between extended incarceration or receiving a medicine, thus producing a highly coercive
7 situation.

8
9 CONCLUSION

10
11 Sexual crimes can cause significant trauma in their victims and survivors may experience a lifetime
12 of psychological trauma including self-blame, post-traumatic stress disorder, suicidal ideation, and
13 structural changes in the brain. The public perception of perpetrators of sexual crimes is extremely
14 negative, resulting in the feeling that actions against these offenders should be more punitive and
15 less rehabilitative. While policymakers have sought non-traditional approaches to reduce the
16 prevalence of sexual crimes in their communities, current state laws which remove physicians and
17 instead mandate AD for convicted sex offenders are not supported by science and are contrary to
18 the Code of Medical Ethics. AD should be viewed as a single tool in the physician's toolbox for
19 treating some paraphilic disorders and should only be initiated using informed consent and a
20 physician's best clinical judgement for a given patient and their circumstances, regardless of
21 whether the examination occurs in a prison or a clinic.

22
23 RECOMMENDATIONS

24
25 The Council on Science and Public Health recommends that the following be adopted and the
26 remainder of the report be filed:

- 27
28 1. That Policy H-430.977, "AMA Study of Chemical Castration in Incarceration" be
29 rescinded. (Rescind HOD Policy)
30
31 2. That our AMA:
32
33 a. Opposes laws, regulations, and actions of the court which remove physician
34 autonomy and clinical judgement from treatment decisions regarding androgen
35 deprivation (also known as chemical castration) for those convicted of sexual
36 crimes.
37 b. Opposes linkages of criminal sentencing, parole, or probation to court-mandated
38 androgen deprivation.
39 c. Encourages data collection on the utilization, court mandates, duration of therapy,
40 and clinical outcomes of androgen deprivation in the carceral setting.
41 d. Supports continued research for effective treatments for paraphilic disorders,
42 including efforts to reduce stigma and recruit patients with paraphilic disorders
43 into clinical trials. (New HOD Policy)
44
45 3. That Policies D-430.997, "Support for Health Care Services to Incarcerated Persons," H-
46 430.978 "Improving Care to Lower the Rate of Recidivism," and H-345.981 "Access to
47 Mental Health Services" be reaffirmed. (Reaffirm HOD Policy)

Fiscal note: less than \$1,000

APPENDIX 1

Table 1: Summary of state laws regarding androgen deprivation therapy (as of January 2024)

State	Code	Mandatory?	Age for victims and applications	Duration	Notes
Alabama	Section 15-22-27.4: Parole of persons convicted of sex offense involving person under 13 years of age	Discretion of court as a condition of parole	Sex crime with a victim under the age of 13	Can continue until the department of corrections deem no longer necessary	
California	CA Penal Code Section 645	First conviction: At court's discretion Second or subsequent conviction: Required	Any sex crimes against someone 13 years or younger	Continued until the Department of Corrections deems treatment no longer necessary	Specifically requires the use of medroxyprogesterone acetate.
Florida	Florida Statute 794.0235	First conviction: At court's discretion Second or subsequent conviction: Required	Applies to sexual battery convictions (adult or minors)	Duration will be determined by court and can be up to the life of the offender.	Requires a court appointed medical expert determination that defendant is appropriate candidate for treatment.
Iowa	903B.10 Hormonal intervention therapy	First conviction: At court's discretion Second or subsequent conviction: Required unless court or board of parole determines the treatment would not be effective	For "serious sex offenses" with a minor under the age of 12 (sexual abuse of all degrees, assault, and sexual exploitation)	Treatment will continue until the agency in charge of supervision deems no longer necessary.	Offenders have to pay a "reasonable fee" to pay for the costs of treatment
Georgia	Formerly Ga. Code Ann. § 16-6-4 (2002) and Ga. Code Ann. § 42-9-44.2 (2002)	n/a	n/a	n/a	Repealed in 2006
Louisiana	RS 14:43:6	First conviction: At court's discretion Second or subsequent conviction: Required	All cases of first- or second-degree rape, OR sexual battery and molestation when the victim is under 13	Court will specify the duration of treatment, up to the life of the defendant.	Requires a court appointed medical expert determination that defendant is appropriate candidate for treatment

State	Code	Mandatory?	Age for victims and applications	Duration	Notes
Montana	45-5-212 Assault on minor	First conviction: At court's discretion Second or subsequent conviction: Required	Applies to all convictions (adult or minors) of: -Sexual assault -Rape -Incest	Can continue until the department of corrections deem no longer necessary	
Oregon	Formerly Ore. Rev. Stat. § 144.625 (2001), Ore. Rev. Stat. § 144.627 (2001), Ore. Rev. Stat. § 144.629 (2001), Ore. Rev. Stat. § 144.631 (2001)	n/a	n/a	n/a	Repealed in 2001
Wisconsin	Wisconsin Statutes, Section 302.11(1)(b)2 Wisconsin Legislative Council IM-2021-07: Requirement for chemical castration	Discretion of Department of Corrections of Parole Commission	Sex crimes with a victim below the age of 13	Unspecified	

CITED AMA POLICY

Opinion 9.7.2, “Court-Initiated Medical Treatment in Criminal Cases”

Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.

In limited circumstances physicians can ethically participate in court-initiated medical treatments. Individual physicians who provide care under court order should:

- (1) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.
- (2) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physician’s diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.
- (3) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.
- (4) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.

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.

Improving Care to Lower the Rate of Recidivism H-430.978

Our American Medical Association will advocate and encourage (1) federal, state, and local legislators and officials to increase access to community mental health facilities, community drug rehabilitation facilities, appropriate clinical care, and social support services (e.g., housing, transportation, employment, etc.) to meet the needs of indigent, homeless, and released previously incarcerated persons; and (2) federal, state, and local legislators and officials to advocate prompt reinstatement in governmental medical programs and insurance for those being released from incarceration facilities.

Access to Mental Health Services H-345.981

Our AMA advocates the following steps to remove barriers that keep Americans from seeking and obtaining treatment for mental illness:

- (1) reducing the stigma of mental illness by dispelling myths and providing accurate knowledge to ensure a more informed public;
- (2) improving public awareness of effective treatment for mental illness;
- (3) ensuring the supply of psychiatrists and other well trained mental health professionals, especially in rural areas and those serving children and adolescents;
- (4) tailoring diagnosis and treatment of mental illness to age, gender, race, culture and other characteristics that shape a person's identity;
- (5) facilitating entry into treatment by first-line contacts recognizing mental illness, and making proper referrals and/or to addressing problems effectively themselves; and
- (6) reducing financial barriers to treatment.

REFERENCES

1. Alix S, Cossette L, Cyr M, Frappier J-Y, Caron P-O, Hébert M. Self-blame, shame, avoidance, and suicidal ideation in sexually abused adolescent girls: a longitudinal study. *Journal of child sexual abuse*. 2020;29(4):432-447.
2. Maalouf O, Daigneault I, Dargan S, McDuff P, Frappier J-Y. Relationship between child sexual abuse, psychiatric disorders and infectious diseases: a matched-cohort study. *Journal of child sexual abuse*. 2020;29(7):749-768.
3. Gokten ES, Uyulan C. Prediction of the development of depression and post-traumatic stress disorder in sexually abused children using a random forest classifier. *Journal of Affective Disorders*. 2021;279:256-265.
4. Rinne-Albers MA, Boateng CP, van der Werff SJ, et al. Preserved cortical thickness, surface area and volume in adolescents with PTSD after childhood sexual abuse. *Scientific reports*. 2020;10(1):3266.
5. Finkelhor D, Shattuck A, Turner HA, Hamby SL. The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence. *Journal of Adolescent Health*. 2014;55(3):329-333.
6. U.S. Sentencing Commission. Quick Facts: Sexual Abuse Offenders (FY 2021). https://www.ussc.gov/sites/default/files/pdf/research-and-publications/quick-facts/Sexual_Abuse_FY21.pdf. Accessed.
7. Rogers DL, Ferguson CJ. Punishment and rehabilitation attitudes toward sex offenders versus nonsexual offenders. *Journal of Aggression, Maltreatment & Trauma*. 2011;20(4):395-414.
8. American Psychiatric Association D, Association AP. *Diagnostic and statistical manual of mental disorders: DSM-5*. Vol 5: American psychiatric association Washington, DC; 2013.
9. Molen LV, Ronis ST, Benoit AA. Paraphilic Interests Versus Behaviors: Factors that Distinguish Individuals Who Act on Paraphilic Interests From Individuals Who Refrain. *Sexual Abuse*. 2022;35(4):403-427.
10. Yakeley J, Wood H. Paraphilias and paraphilic disorders: Diagnosis, assessment and management. *Advances in psychiatric treatment*. 2014;20(3):202-213.
11. Longpré N, Galiano CB, Guay J-P. The impact of childhood trauma, personality, and sexuality on the development of paraphilias. *Journal of Criminal Justice*. 2022;82:101981.
12. Mann RE, Hollin CR. Sexual offenders' explanations for their offending. *Journal of Sexual Aggression*. 2007;13(1):3-9.
13. Kafka MP, Hennen J. Psychostimulant augmentation during treatment with selective serotonin reuptake inhibitors in men with paraphilias and paraphilia-related disorders: a case series. *Journal of Clinical Psychiatry*. 2000;61(9):664-670.
14. Galli VB, Raute NJ, McConville BJ, McElroy SL. An Adolescent Male with Multiple Paraphilias Successfully Treated with Fluoxetine. *Journal of Child and Adolescent Psychopharmacology*. 1998;8(3):195-197.
15. Greenberg DM, Bradford JM, Curry S, O'Rourke A. A comparison of treatment of paraphilias with three serotonin reuptake inhibitors: a retrospective study. *Journal of the American Academy of Psychiatry and the Law Online*. 1996;24(4):525-532.
16. Kafka MP, Hennen J. A DSM-IV Axis I Comorbidity Study of Males (n = 120) with Paraphilias and Paraphilia-Related Disorders. *Sexual Abuse: A Journal of Research and Treatment*. 2002;14(4):349-366.
17. Perlmutter MA, Lepor H. Androgen deprivation therapy in the treatment of advanced prostate cancer. *Rev Urol*. 2007;9 Suppl 1(Suppl 1):S3-8.
18. Rhee H, Gunter JH, Heathcote P, et al. Adverse effects of androgen-deprivation therapy in prostate cancer and their management. *BJU International*. 2015;115(S5):3-13.

19. Rösler A, Witztum E. Treatment of Men with Paraphilia with a Long-Acting Analogue of Gonadotropin-Releasing Hormone. *New England Journal of Medicine*. 1998;338(7):416-422.
20. Thibaut F, Cosyns P, Fedoroff JP, Briken P, Goethals K, Bradford JMW. The World Federation of Societies of Biological Psychiatry (WFSBP) 2020 guidelines for the pharmacological treatment of paraphilic disorders. *The World Journal of Biological Psychiatry*. 2020;21(6):412-490.
21. Magnan S, Zarychanski R, Pilote L, et al. Intermittent vs Continuous Androgen Deprivation Therapy for Prostate Cancer: A Systematic Review and Meta-analysis. *JAMA Oncology*. 2015;1(9):1261-1269.
22. De Landtsheer A, Bekaert L, David K, et al. The impact of androgen deprivation therapy on bone mineral density in men treated for paraphilic disorder: A retrospective cohort study. *Andrology*. 2022;10(3):545-550.
23. Kravitz HM, Haywood TW, Kelly J, Wahlstrom C, Liles S, Cavanaugh JL. Medroxyprogesterone treatment for paraphiliacs. *Journal of the American Academy of Psychiatry and the Law Online*. 1995;23(1):19-33.
24. Fedoroff JP, Wisner-Carlson R, Berlin FS, Dean S. Medroxy-Pregesterone Acetate in the Treatment of Paraphilic Sexual Disorders. *Journal of Offender Rehabilitation*. 1992;18(3-4):109-124.
25. Lösel F, Schmucker M. The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology*. 2005;1:117-146.
26. U.S. Department of Justice. Crime in the United States (2019). <https://ucr.fbi.gov/crime-in-the-u.s/2019/crime-in-the-u.s.-2019/tables/table-42/table-42.xls>. Published 2019. Accessed January 18, 2023.
27. Henderson PJ. Section 645 of the California Penal Code: California's Chemical Castration Law-A Panacea or Cruel and Unusual Punishment. *USFL Rev*. 1997;32:653.
28. Simpson T. If Your Hand Causes You to Sin...: Florida's Chemical Castration Statute Misses the Mark. *Fla St UL Rev*. 2006;34:1221.
29. Daley MV. A flawed solution to the sex offenders situation in the United States: The legality of chemical castration for sex offenders. *Ind Health L Rev*. 2008;5:87.
30. Stinneford JF. Incapacitation through maiming: Chemical castration, the Eighth Amendment, and the denial of human dignity. *U St Thomas LJ*. 2005;3:559.
31. Peters KA. Chemical castration: An alternative to incarceration. *Duq L Rev*. 1992;31:307.
32. Keesling L. Practicing medicine without a license: Legislative attempts to mandate chemical castration for repeat sex offenders. *J Marshall L Rev*. 1998;32:381.
33. Green W. Depo-Provera, castration, and the probation of rape offenders: Statutory and constitutional issues. *U Dayton L Rev*. 1986;12:1.
34. Thompson D. Many sex offenders killed in California prison. *Associated Press*. February 16, 2015.
35. Kevles DJ. Eugenics and human rights. *Bmj*. 1999;319(7207):435-438.
36. Richeson MP. Sex, Drugs, and... Race-to-Castrate: A Black Box Warning of Chemical Castration's Potential Racial Side Effects. *Harv BlackLetter LJ*. 2009;25:95.

Subject: Decreasing Regulatory Barriers to Appropriate Testosterone Prescribing

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee E

1 INTRODUCTION

2
3 Our American Medical Association (AMA) House of Delegates referred the second Resolve of
4 Resolution 519-A-23, “Decreasing Regulatory Barriers to Appropriate Testosterone Prescribing.”
5 The referred resolve asked that our AMA study the outcomes of expanding access to testosterone
6 through decreasing state and health insurer regulatory requirements. In addition to the process
7 limitations, other barriers to care for testosterone prescribing include prescription drug monitoring
8 program (PDMP) state database reporting, telehealth, 30-day supply, and mail delivery limitations.
9

10 METHODS

11
12 English-language reports were selected from a PubMed and Google Scholar search through
13 January 2024, using the text terms “testosterone,” “prescribing,” “barriers,” and “regulations.”
14 Additional articles were identified by manual review of the references cited in these publications.
15 Further information was obtained from the Internet sites of medical specialty societies, federal and
16 state agencies, human rights organizations, legal organizations, among others to identify regulatory
17 and legal barriers to testosterone treatments, prescribing, and access when medically indicated.
18

19 BACKGROUND

20
21 Testosterone is a hormone that is naturally produced in the body of all individuals. Testosterone
22 replacement therapy (TRT) has been explored as a therapy for a variety of conditions, including
23 low serum testosterone levels, hypogonadism, erectile dysfunction, osteoporosis, diabetes mellitus,
24 and hypoactive sexual desire disorder.¹⁻⁷ Synthetic testosterone is classified as an anabolic-
25 androgenic steroid designed to mimic natural testosterone.
26

27 Testosterone is also a vital component of gender affirming hormone therapy (GAHT) for
28 transgender, non-binary, and/or gender diverse (TND) individuals, aiding in the development of
29 secondary sex characteristics aligning with their gender identity including physical changes such as
30 increased muscle mass and strength, fat redistribution, cessation of menstrual periods, heightened
31 sex drive, facial and body hair growth, deepening of voice, and clitoral enlargement, among
32 others.^{8,9} These effects may begin within 1-6 months, while some may take up to 2-5 years after
33 initiating therapy. The effects may significantly alleviate gender dysphoria, depression,
34 psychological symptoms, and suicidality while enhancing overall quality of life, interpersonal
35 functioning, psychological adjustment, sexual function, body satisfaction, and self-esteem among
36 TND individuals.^{8,10,11} GAHT is often maintained throughout life, and discontinuation of hormone
37 therapy can lead to bone loss in TND individuals, particularly those who have undergone gonad
38 removal, which highlights the importance for access to this therapy.¹²

1 Testosterone, when prescribed as part of medically monitored GAHT, is generally considered safe,
2 with severe side effects being exceptionally rare.¹³ Concerns regarding associations between
3 testosterone and severe adverse effects, including mood alterations and cardiovascular disease,
4 stem from administering multiple testosterone derivatives at doses ranging from 10 to 100 times
5 higher than the normal physiologic levels. Individuals using high doses of testosterone have
6 reported withdrawal symptoms, such as depression, fatigue, irritability, loss of appetite, decreased
7 libido, and insomnia.¹⁴ TRT, as compared to performance enhancing use, includes testosterone
8 prescriptions within the physiological dosage range which is considered safe. Studies consistently
9 demonstrate significant positive effects on various aspects of mental health and well-being among
10 patients on TRT.^{13,15} However, health care experts have called for further research into the long-
11 term risks associated with testosterone products, including its potential impact on cardiovascular
12 health and the occurrence of breast/chest and endometrial cancers.^{16, 13,17-19}

13 14 DISCUSSION

15 16 *Policy Affecting Appropriate Testosterone Prescribing in the United States*

17
18 Recently, there has been a significant increase in state laws banning gender affirming care (GAC)
19 including GAHT for TND people. Across the nation, state legislatures, governors, and
20 administrative agencies are increasingly implementing measures to limit access to gender-affirming
21 care, particularly targeting youth. GAC is supported by all major medical associations representing
22 over 1.3 million U.S. physicians, including the AMA.²⁰

23
24 Since 2021, 23 states have enacted laws that prohibit healthcare professionals from providing
25 gender-affirming medical interventions, including hormone therapy and surgeries, to minor
26 patients.²¹ These legislative measures effectively ban evidence-based care for TND youth by
27 imposing legal and professional penalties on health care professionals who provide GAC.²² Some
28 states have also taken steps to limit access to GAC for adults.²³ In addition to limiting access to
29 medically necessary care, providers of GAC have also been threatened with violence, jeopardizing
30 physician safety and practice.²⁴

31
32 On a national level, in 2021, U.S. Department of Health and Human Services (HHS), Office for
33 Civil Rights (OCR) expanded its interpretation and enforcement of Section 1557 of the Affordable
34 Care Act (ACA) and Title IX of the Civil Rights Act, to include protection against discrimination
35 based on sexual orientation and gender identity, ensuring access to GAC.²⁵ This was reiterated in
36 2022, when HHS issued a notice affirming its support for TND youths' access to gender-affirming
37 care.²⁶

38 39 *Regulatory Barriers to Appropriate Testosterone Prescribing*

40
41 The primary regulatory obstacle to appropriate testosterone prescribing, in addition to state-based
42 laws restricting care for TND patients, is its controlled substance scheduling status. Testosterone is
43 currently categorized as a Schedule III drug under the Controlled Substances Act (CSA). Such
44 classification indicates a potential for misuse, in addition to a potential to lead to physical
45 dependence or psychological dependence.²⁷ Uniquely, testosterone was added to the Controlled
46 Substances Act by the Anabolic Steroids Control Act of 1990, which classified all anabolic steroids
47 as schedule III-controlled substances, with the aim to stop chemical performance enhancement in
48 sports.²⁸ Congress effectively circumvented FDA's regulatory authority, by bypassing the typical
49 scientific and evidence review to inform scheduling.²⁹ The act faced opposition from the AMA, the
50 FDA, and the National Institute on Drug Abuse and despite this opposition was enacted by
51 Congress.²⁹⁻³¹

1 As a Schedule III controlled substance, testosterone is subject to more stringent regulations
2 compared to other prescription medications. Regulations on controlled substances include shorter
3 validity periods for prescriptions (physicians must rewrite prescriptions every 6 months),
4 limitations on refill quantities (limited to 30-day supplies), and potential exclusions from telehealth
5 and mail-order services of testosterone. Testosterone restrictions necessitate frequent
6 communication between individuals using testosterone and their prescriber to maintain a
7 continuous supply.²⁹ Amid the COVID-19 pandemic, temporary adjustments in regulations enabled
8 individuals to acquire 100-day medication supplies via mail services, however testosterone
9 remained exempt from these alterations due to its classification as a controlled substance.^{29,32}

10 *Prescription Drug Monitoring Programs*

11 PDMPs are state-level electronic databases intended for public health surveillance, prescription
12 monitoring, and to inform clinical decision-making. PDMPs track dispensed prescriptions based on
13 the schedule level designated in the state controlled substances act (CSA). As of 2023, eight states
14 monitor schedule II – IV via their PDMP, 45 states, territories, and districts monitor Schedules II
15 through V, 32 states track “drugs of concern” (i.e., drugs not scheduled under their state CSA), and
16 one state monitors all prescription medications.³³ Currently, testosterone is a monitored substance
17 in all state PDMPs. Patients have raised concerns regarding the surveillance of medications,
18 including fears of being outed by their health care professionals, pharmacists, law enforcement and
19 others with access to their states’ PDMP data.³⁴

20 Almost all PDMPs can be used by court officials, probation and parole officers, and law
21 enforcement agencies to prevent controlled substance diversion or monitor a patient’s prescription
22 use with a court order, search warrant, or subpoena.³⁵ Law enforcement permission to access
23 PDMPs varies by state. As of 2022, 25 states require an active investigation or “official duties,” 18
24 require a subpoena, 17 require a court order, and 11 require a search warrant to view PDMP
25 records.^{36,37} (See Table 1) Some states have multiple forms of law enforcement access requirements
26 that are accepted.⁵⁵ As GAC becomes criminalized in some states, access to this data by law
27 enforcement could be devastating for patients.

28 HIPAA’s Privacy Rule regulates the use and disclosure of protected health information (PHI) by
29 covered entities, but it does not specifically include PDMP data. In December 2023 members of
30 Congress urged HHS to revise the Health Insurance Portability and Accountability Act (HIPAA)
31 regulations to include PDMPs, after briefings with major pharmacies revealed that law enforcement
32 agencies were secretly obtaining thousands of prescription records without a warrant.³⁸ All eight
33 major pharmacy chains reported that “they do not require a warrant prior to sharing pharmacy
34 records with law enforcement agents, unless there is a state law that dictates otherwise.”³⁸ Gaps in
35 federal privacy coverage of both medical, prescription, and PDMP data raises concerns to deter
36 physician prescribing, pharmacist dispensing, and patients procuring medically indicated
37 testosterone.³⁹ Ongoing research is essential to investigate the unintended consequences associated
38 with granting law enforcement access to medical prescription histories, especially in the absence of
39 a court order.

40 *Insurer or Payer Barriers to Testosterone Prescribing and Access*

41 Many transgender individuals do not have health insurance. Those with health insurance often
42 encounter challenges with public and private insurers denying coverage for GAC, leaving patients
43 with large out-of-pocket cost.^{40–42} Findings from a 2022 nationally representative survey by the
44 Center for American Progress show that over 25 percent of transgender participants faced denials
45 for hormone therapy by health insurance providers.⁴³ According to the 2022 Employee Benefits

1 Survey, among the 30 percent of U.S employer-provided health plans providing GAC, only 25
2 percent cover GAC-related prescription drug therapy.⁴⁴ Moreover, only 26 percent include
3 physician visits for GAC and only 21 percent cover GAC-related lab tests, both of which are
4 typically necessary to be prescribed testosterone.⁴⁴

5
6 Even though a large number of insurance companies now provide coverage to TND individuals
7 because of federally mandated laws, many continue to deny coverage.⁴⁵ In 2021, 13 states reported
8 that coverage of GAHT is not addressed in their states' statute or policy, and 2 states exclude
9 coverage of GAHT.⁴⁶ The U.S. Transgender Survey reports that of adults utilizing GAHT, 21
10 percent (2,526 insured patients) of treatment claims have been denied.⁴⁷ Beyond these denials,
11 TND individuals report various insurance-related hurdles, such as difficulties in obtaining coverage
12 for GAC and other medical services, updating health insurance records, and issues related to
13 network adequacy.⁴³ For example, individuals with insurance often need to obtain prior
14 authorization before testosterone can be covered, delaying care up to 7 business days or more.⁴⁸
15 Among TND individuals, nonprescription hormone use is significantly higher among those whose
16 claims were denied or were uninsured.⁴⁷

17
18 Testosterone access is further complicated by insurance industry formulary drug tiers, in which
19 "non-preferred" testosterone products are restricted via prior authorization or higher cost-sharing
20 requirements.⁴⁶ In 2021, 34 out of 51 state Medicaid programs covered GAHT, while nine states
21 and two territories did not provide coverage.⁴⁹ Confirmation regarding GAHT coverage could not
22 be verified for eight states and three territories.⁴⁹

23
24 There have been some successful initiatives to improve GAC accessibility through the expansion of
25 state Medicaid essential health benefit plans and the explicit inclusion of GAC, including GAHT,
26 in state Medicaid coverage laws.⁵⁰ For instance, in 2023 Colorado became the first state to
27 explicitly integrate gender-affirming care to treat gender dysphoria, encompassing surgical
28 procedures, hormone therapy, and mental and behavioral health services, into its benchmark health
29 insurance plan for essential health benefits.⁵¹ While further studies are needed to assess the impact
30 of Colorado's expanded care, the coverage of GAC contributes to improved health outcomes while
31 reducing gender dysphoria, depression, anxiety, and suicidality among TND Coloradans.^{52,53}

32 33 AMA POLICY AND ADVOCACY

34
35 The AMA has robust policy regarding gender-affirming care, patient privacy, health equity,
36 medical necessity, protecting the provider-patient relationship, telehealth, and prior authorization.
37 Of particular relevance to this report is AMA Policy H-185.927, "Clarification of Evidence-Based
38 Gender-Affirming Care," which emphasizes the importance of evidence-based gender-affirming
39 care as determined through shared decision making between patients and physicians. This policy
40 instructs our AMA to "oppose laws and policies that criminalize, prohibit or otherwise impede the
41 provision of evidence-based, gender-affirming care" and to "advocate for federal, state, and local
42 laws and policies to protect access to evidence-based care for gender dysphoria and gender
43 incongruence." Additionally, our AMA advocates for equitable coverage of gender-affirming care
44 by health insurance providers, both public and private, through Policy H-185.950, "Removing
45 Financial Barriers to Care for Transgender Patients."

46
47 AMA policy H-315.983, "Patient Privacy and Confidentiality," affirms that HIPAA should be the
48 minimal standard for protecting client-patient privilege, and that law enforcement agencies
49 requesting private medical information should only be given access through a court order granted
50 through clear and convincing evidence, with the records subject to stringent security measures.

51

1 Further, Policy G-605.009 directs the AMA to convene experts and stakeholders to “identify issues
2 with physician payment and reimbursement for gender-affirming care and recommend solutions to
3 address these barriers to care.” The Task Force to Preserve the Patient-Physician Relationship
4 When Evidence-Based, Appropriate Care Is Banned or Restricted has invited interested Federation
5 partners to participate and is in the process of implementing this policy.
6

7 Protecting access to GAC has been a priority for the AMA for many years. Since the legislative
8 attempts to ban GAC first emerged, the AMA has been working closely with state medical
9 associations to oppose these inappropriate intrusions in the practice of medicine. The AMA has
10 submitted testimony and sent letters to legislators in several states and has assisted behind-the-
11 scenes in many more states. In 2021, the AMA also publicly urged governors across the country to
12 reject state legislation aimed at prohibiting medically necessary gender affirming care for minor
13 patients.⁵⁴ AMA advocacy has also supported state “shield laws” to protect physicians who provide
14 GAC and their patients from interstate enforcement of GAC bans and promote telehealth access to
15 GAC. The AMA has also been very active in litigation and has submitted numerous amicus briefs
16 urging courts to overturn laws that ban GAC.
17

18 Additionally, in 2019 the AMA published an issue brief with GLMA emphasizing the importance
19 of health insurance coverage for transgender patients and asserting the medical community's duty
20 to advocate for evidence-based care, reiterating that medical decisions should be made by patients,
21 their relatives and health care professionals, not politicians.⁵⁵ Lastly, in response to policy that was
22 adopted at the 2023 Annual Meeting Annual, D-270.983, “Decreasing Regulatory Barriers to
23 Appropriate Testosterone Prescribing,” the AMA asked the FDA to review the evidence on
24 testosterone, with the possibility of updating recommendations to send to the DEA regarding its
25 scheduling. In this letter the AMA conveyed concerns to the FDA Commissioner about the current
26 scheduling of testosterone-containing drug products, suggesting that the existing schedule may
27 unnecessarily restrict access to care for patients in critical need.⁵⁶
28

29 CONCLUSION

30

31 Addressing regulatory obstacles to appropriate testosterone prescribing requires a multifaceted
32 approach that encompasses both physician and patient perspectives. Initiatives such as rescheduling
33 testosterone to expand access through telehealth and reducing regulation on dispensing are crucial
34 steps toward ensuring equitable access to care. These measures not only enhance the availability of
35 testosterone therapy but also promote patient-centered care by facilitating access to qualified health
36 care professionals regardless of geographic location. Legislative and regulatory efforts must focus
37 on addressing barriers such as the lack of confidentiality, privacy, and security of medical health
38 data, which can undermine patient trust and deter individuals from seeking necessary care.
39

40 RECOMMENDATIONS

41

42 The Council on Science and Public Health recommends that the following be adopted, and the
43 remainder of the report be filed:
44

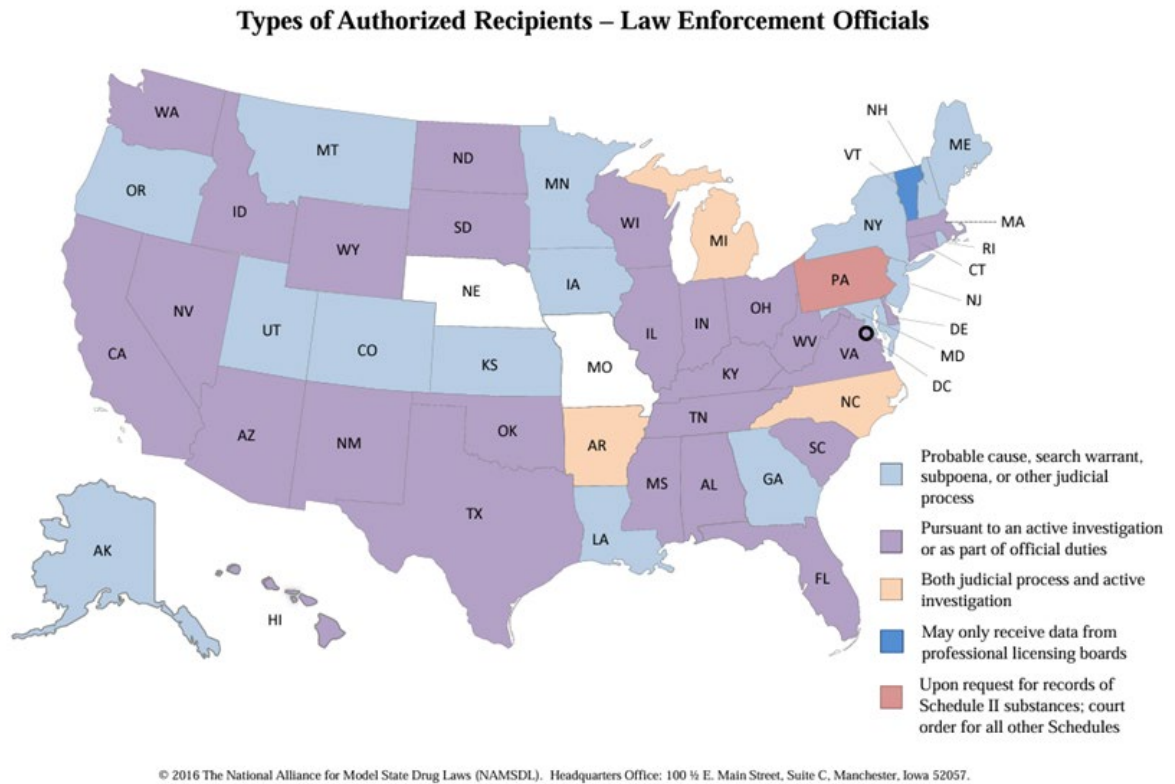
- 45 1. That policy D-270.983, “Decreasing Regulatory Barriers to Appropriate Testosterone
46 Prescribing,” be amended by addition to read as follows:
47
 - 48 A. Our AMA will ask the FDA to review the available evidence and other data on
49 testosterone and submit updated recommendations, if warranted, to the DEA, for its
50 consideration of the scheduling of testosterone-containing drug products.
51

- 1 B. Our AMA supports policies to remove barriers that delay or impede patient access to
2 prescribed testosterone. (New HOD Policy)
3
4 C. Our AMA will continue to work alongside our partner organizations to promote
5 advocacy and physician education on testosterone prescribing. (New HOD Policy)
6
7 2. That Policies H-65.976, “Nondiscriminatory Policy for the Health Care Needs of LGBTQ
8 Populations,” H-140.824, “Healthcare Equity Through Informed Consent and a
9 Collaborative Healthcare Model for the Gender Diverse Population,” H-160.991, “Health
10 Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations,” H-185.927
11 “Clarification of Evidence-Based Gender-Affirming Care,” H-95.946, “Prescription Drug
12 Monitoring Program Confidentiality,” H-315.983, “Patient Privacy and Confidentiality,”
13 D-185.981, “Addressing Discriminatory Health Plan Exclusions or Problematic Benefit
14 Substitutions for Essential Health Benefits Under the Affordable Care Act,” and D-
15 480.964, “Established Patient Relationships and Telemedicine” be reaffirmed. (Reaffirm
16 HOD Policy)

Fiscal Note: less than \$1,000

TABLE 1. The National Alliance for Model State Drug Laws Map of The Types of Authorized Recipients of PDMP Information – Law Enforcement Officials

The National Alliance for Model State Drug Laws. *Compilation of Prescription Monitoring Program Maps*. The National Alliance for Model State Drug Laws; 2016. Accessed January 31, 2024. <https://namsdl.org/wp-content/uploads/Compilation-of-Prescription-Monitoring-Program-Maps.pdf>



Note: As of 2019, Nebraska requires a subpoena, court order or approval, and a written request.⁵⁷ As of 2021, Missouri requires a subpoena, court order or approval for law enforcement to access their state PDMP.⁵⁸

REFERENCES

1. Baillargeon J, Urban RJ, Kuo YF, et al. Screening and monitoring in men prescribed testosterone therapy in the U.S., 2001-2010. *Public Health Rep.* 2015;130(2):143-152. doi:10.1177/003335491513000207
2. McAdams E, Cross Z, Bosch C, Rodriguez JE, Nashelsky J. Treatments for Postmenopausal Hypoactive Sexual Desire Disorder. *afp.* 2020;101(3):182-183.
3. Zhou CK, Advani S, Chaloux M, et al. Trends and Patterns of Testosterone Therapy Among US Male Medicare Beneficiaries, 1999-2014. *J Urol.* 2020;203(6):1184-1190. doi:10.1097/JU.0000000000000744
4. Wang N, Wang L, Huang C. Association of total testosterone status with bone mineral density in adults aged 40-60 years. *Journal of Orthopaedic Surgery and Research.* 2021;16(1):612. doi:10.1186/s13018-021-02714-w
5. Shigehara K, Izumi K, Kadono Y, Mizokami A. Testosterone and Bone Health in Men: A Narrative Review. *J Clin Med.* 2021;10(3):530. doi:10.3390/jcm10030530
6. Wittert G, Bracken K, Robledo KP, et al. Testosterone treatment to prevent or revert type 2 diabetes in men enrolled in a lifestyle programme (T4DM): a randomised, double-blind, placebo-controlled, 2-year, phase 3b trial. *The Lancet Diabetes & Endocrinology.* 2021;9(1):32-45. doi:10.1016/S2213-8587(20)30367-3
7. Parish SJ, Simon JA, Davis SR, et al. International Society for the Study of Women's Sexual Health Clinical Practice Guideline for the Use of Systemic Testosterone for Hypoactive Sexual Desire Disorder in Women. *The Journal of Sexual Medicine.* 2021;18(5):849-867. doi:10.1016/j.jsxm.2020.10.009
8. Whitman-Walker Health. *Hormone Resource Guide - Testosterone.*; 2021. Accessed January 25, 2023. <https://www.whitman-walker.org/wp-content/uploads/2021/10/Hormone-Resource-Guide-Testosterone.pdf>
9. D'hoore L, T'Sjoen G. Gender-affirming hormone therapy: An updated literature review with an eye on the future. *Journal of Internal Medicine.* 2022;291(5):574-592. doi:10.1111/joim.13441
10. Nolan BJ, Zwickl S, Locke P, Zajac JD, Cheung AS. Early Access to Testosterone Therapy in Transgender and Gender-Diverse Adults Seeking Masculinization: A Randomized Clinical Trial. *JAMA Network Open.* 2023;6(9):e2331919. doi:10.1001/jamanetworkopen.2023.31919
11. Committee on Understanding the Well-Being of Sexual and Gender Diverse Populations, Committee on Population, Division of Behavioral and Social Sciences and Education, National Academies of Sciences, Engineering, and Medicine. *Understanding the Well-Being of LGBTIQ+ Populations.* (Patterson CJ, Sepúlveda MJ, White J, eds.). National Academies Press; 2020:25877. doi:10.17226/25877
12. Wiepjes CM, de Blok CJ, Staphorsius AS, et al. Fracture Risk in Trans Women and Trans Men Using Long-Term Gender-Affirming Hormonal Treatment: A Nationwide Cohort Study. *J Bone Miner Res.* 2020;35(1):64-70. doi:10.1002/jbmr.3862
13. Kim HH, Goetz TG, Grieve V, Keuroghlian AS. Psychopharmacological Considerations for Gender-Affirming Hormone Therapy. *Harv Rev Psychiatry.* 2023;31(4):183-194. doi:10.1097/HRP.0000000000000373
14. Basaria S, Coviello AD, Travison TG, et al. Adverse events associated with testosterone administration. *N Engl J Med.* 2010;363(2):109-122. doi:10.1056/NEJMoa1000485
15. World Professional Association for Transgender Health. *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People.*; 2012. <https://www.wpath.org/publications/soc>
16. ACOG. Compounded Bioidentical Menopausal Hormone Therapy. Published November 2023. Accessed January 25, 2024. <https://www.acog.org/clinical/clinical-guidance/clinical-consensus/articles/2023/11/compounded-bioidentical-menopausal-hormone-therapy>

17. Coleman E, Radix AE, Bouman WP, et al. Standards of Care for the Health of Transgender and Gender Diverse People, Version 8. *International Journal of Transgender Health*. 2022;23(sup1):S1-S259. doi:10.1080/26895269.2022.2100644
18. Johnson JM, Nachtigall LB, Stern TA. The effect of testosterone levels on mood in men: a review. *Psychosomatics*. 2013;54(6):509-514. doi:10.1016/j.psym.2013.06.018
19. Davis SA, St. Amand C. Effects of Testosterone Treatment and Chest Reconstruction Surgery on Mental Health and Sexuality in Female-To-Male Transgender People. *International Journal of Sexual Health*. 2014;26(2):113-128. doi:10.1080/19317611.2013.833152
20. Medical Organization Statements on Transgender Health Care. Transgender Legal Defense and Education Fund Trans Health Project. Published n.d. Accessed January 30, 2024. <https://transhealthproject.org/resources/medical-organization-statements/>
21. Trans Legislation Tracker. Tracking the rise of anti-trans bills in the U.S. Published 2024. Accessed January 31, 2024. <https://translegislation.com/learn>
22. Human Rights Campaign. BREAKING: Florida Senate Passes Extreme Gender-Affirming Care Ban. Human Rights Campaign. Published April 4, 2023. Accessed January 29, 2024. <https://www.hrc.org/press-releases/breaking-florida-senate-passes-extreme-gender-affirming-care-ban>
23. Hollingsworth H, Ballentine S. ACLU sues to block Missouri rule on transgender health care. AP News. Published April 24, 2023. Accessed January 29, 2024. <https://apnews.com/article/transgender-health-care-missouri-attorney-general-ef30b41658d95b7206535c5fd67513ae>
24. Human Rights Campaign. New Human Rights Campaign Foundation Report: Online Hate & Real World Violence Are Inextricably Linked. Human Rights Campaign. Published December 13, 2022. Accessed January 31, 2024. <https://www.hrc.org/press-releases/new-human-rights-campaign-foundation-report-online-hate-real-world-violence-are-inextricably-linked>
25. U.S Department of Health and Human Services. Access to Health Care. Published January 20, 2023. Accessed January 25, 2024. <https://www.hhs.gov/programs/topic-sites/lgbtqi/accesstohealthcare/index.html>
26. U.S Department of Health and Human Services. HHS Notice and Guidance on Gender Affirming Care, Civil Rights, and Patient Privacy. Published online March 2, 2022. Accessed January 25, 2024. <https://www.hhs.gov/sites/default/files/hhs-ocr-notice-and-guidance-gender-affirming-care.pdf>
27. 21 USC 812: Schedules of controlled substances. Published 1970. Accessed January 30, 2024. [https://uscode.house.gov/view.xhtml?req=\(title:21%20section:812%20edition:prelim\)](https://uscode.house.gov/view.xhtml?req=(title:21%20section:812%20edition:prelim))
28. Rep. Hughes WJ [D N 2. *Anabolic Steroids Control Act of 1990.*; 1990. Accessed January 30, 2024. <https://www.congress.gov/bill/101st-congress/house-bill/4658>
29. Rosellini S, Coursolle A. Increasing Access to Testosterone for improve the lives of Transmasculine People. National Health Law Program. Published November 29, 2021. Accessed January 25, 2024. <https://healthlaw.org/increasing-access-to-testosterone-to-improve-the-lives-of-transmasculine-people/>
30. McGrew RJ. Raising the Bar: Why the Anabolic Seroid Control Acts Should be Repealed and Replaced. *15 Houston Journal of Health Law and Policy*. 2015;(233):233-252.
31. Council on Scientific Affairs. Medical and Nonmedical Uses of Anabolic-Androgenic Steroids. *JAMA*. 1990;264(22):2923-2927. doi:10.1001/jama.1990.03450220089029
32. Turner W, Coursolle A, Coursolle WT Abigail. Ensuring People Have Access to Prescription Drugs During the COVID-19 Pandemic. National Health Law Program. Published March 18, 2020. Accessed January 29, 2024. <https://healthlaw.org/ensuring-people-have-access-to-prescription-drugs-during-the-covid-19-pandemic/>
33. U.S Department of Justice, Institute for Intergovernmental Research. PDMP Policies and Capabilities. Maps and Tables. Published 2023. Accessed January 31, 2024. <https://www.pdmpassist.org/Policies/Maps>

34. Corcione A. How the Criminalization of Testosterone Attacks Gender Variant People. Filter. Published December 2, 2021. Accessed January 30, 2024. <https://filtermag.org/testosterone-criminalization/>
35. U.S Department of Justice. *Overview of Prescription Drug Monitoring Programs (PDMPs)*. U.S Department of Justice Bureau of Justice Assistance; 2023. Accessed January 20, 2023. https://www.pdmpassist.org/pdf/resources/PDMPs_Overview_2023.pdf
36. Prescription Drug Monitoring Programs. Center for Health Policy and Law - The Action Lab at Northeastern University. Published 2022. Accessed January 30, 2024. <https://www.healthinjustice.org/copy-of-prescription-drug-monitoring>
37. The National Alliance for Model State Drug Laws. *Compilation of Prescription Monitoring Program Maps*. The National Alliance for Model State Drug Laws; 2016. Accessed January 31, 2024. <https://namsdl.org/wp-content/uploads/Compilation-of-Prescription-Monitoring-Program-Maps.pdf>
38. United States Senate Finance Committee. HHS Pharmacy Surveillance Letter. Published online December 12, 2023. Accessed February 8, 2024. https://www.finance.senate.gov/imo/media/doc/hhs_pharmacy_surveillance_letter_signed.pdf
39. U. S. Government Accountability Office. *Prescription Drug Monitoring Programs: Views on Usefulness and Challenges of Programs* | U.S. GAO.; 2020. Accessed January 30, 2024. <https://www.gao.gov/products/gao-21-22>
40. Medina C. Fact Sheet: Protecting and Advancing Health Care for Transgender Adult Communities. Center for American Progress. Published August 25, 2021. Accessed January 25, 2024. <https://www.americanprogress.org/article/fact-sheet-protecting-advancing-health-care-transgender-adult-communities/>
41. Koma W, Rae M, Ramaswamy A, Neuman T, Kates J, Published LD. Demographics, Insurance Coverage, and Access to Care Among Transgender Adults. *KFF*. <https://www.kff.org/affordable-care-act/issue-brief/demographics-insurance-coverage-and-access-to-care-among-transgender-adults/>. Published October 21, 2020. Accessed January 29, 2024.
42. Downing J, Lawley KA, McDowell A. Prevalence of private and public health insurance among transgender and gender diverse adults. *Med Care*. 2022;60(4):311-315. doi:10.1097/MLR.0000000000001693
43. Medina C, Mahowald L. *Advancing Health Care Nondiscrimination Protections for LGBTQI+ Communities*. Center for American Progress; 2022. Accessed January 26, 2024. <https://www.americanprogress.org/article/advancing-health-care-nondiscrimination-protections-for-lgbtqi-communities/>
44. Patterson A. The Rise of Gender-Affirmation Health Care Benefits. International Foundations of Employee Benefit Plans - Word on Benefits. Published October 18, 2023. Accessed January 30, 2024. <https://blog.ifebp.org/the-rise-of-gender-affirmation-health-care-benefits/>
45. Lerner JE, Martin JI, Gorsky GS. More than an Apple a Day: Factors Associated with Avoidance of Doctor Visits Among Transgender, Gender Nonconforming, and Nonbinary People in the USA. *Sex Res Soc Policy*. 2021;18(2):409-426. doi:10.1007/s13178-020-00469-3
46. Gomez I, Ranji U, Salganicoff A, et al. Update on Medicaid Coverage of Gender-Affirming Health Services - Issue Brief - 10019. KFF. Published October 11, 2022. Accessed January 30, 2024. <https://www.kff.org/report-section/update-on-medicaid-coverage-of-gender-affirming-health-services-issue-brief/>
47. Stroumsa D, Crissman HP, Dalton VK, Kolenic G, Richardson CR. Insurance Coverage and Use of Hormones Among Transgender Respondents to a National Survey. *The Annals of Family Medicine*. 2020;18(6):528-534. doi:10.1370/afm.2586
48. Planned Parenthood of Central and Western New York. Hormone Prescriptions at the Pharmacy. Published n.d. Accessed January 30, 2024.

- <https://www.plannedparenthood.org/planned-parenthood-central-western-new-york/patient-resources/our-services/gender-affirming-care/hormone-prescriptions-at-the-pharmacy>
49. Zaliznyak M, Jung EE, Bresee C, Garcia MM. Which U.S. States' Medicaid Programs Provide Coverage for Gender-Affirming Hormone Therapy and Gender-Affirming Genital Surgery for Transgender Patients?: A State-by-State Review, and a Study Detailing the Patient Experience to Confirm Coverage of Services. *The Journal of Sexual Medicine*. 2021;18(2):410-422. doi:10.1016/j.jsxm.2020.11.016
 50. Baugher AR, Olansky E, Sutter L, et al. Prevalence of Discrimination and the Association Between Employment Discrimination and Health Care Access and Use - National HIV Behavioral Surveillance Among Transgender Women, Seven Urban Areas, United States, 2019-2020. *MMWR Suppl*. 2024;73(1):51-60. doi:10.15585/mmwr.su7301a6
 51. Colorado Department of Regulatory Agencies. Gender-Affirming Care Coverage Guide. Colorado Division of Insurance. Published 2023. Accessed January 30, 2024. <https://doi.colorado.gov/for-consumers/consumer-resources/special-insurance-topics/lgbtq-health-care-rights/gender-affirming>
 52. White Hughto JM, Reisner SL. A Systematic Review of the Effects of Hormone Therapy on Psychological Functioning and Quality of Life in Transgender Individuals. *Transgender Health*. 2016;1(1):21-31. doi:10.1089/trgh.2015.0008
 53. Kesselheim AS, Huybrechts KF, Choudhry NK, et al. Prescription Drug Insurance Coverage and Patient Health Outcomes: A Systematic Review. *Am J Public Health*. 2015;105(2):e17-e30. doi:10.2105/AJPH.2014.302240
 54. AMA to states: Stop interfering in health care of transgender children. American Medical Association. Published April 26, 2021. Accessed February 1, 2024. <https://www.ama-assn.org/press-center/press-releases/ama-states-stop-interfering-health-care-transgender-children>
 55. American Medical Association. *Issue Brief: Health Insurance Coverage for Gender-Affirming Care of Transgender Patients.*; 2019. <https://www.ama-assn.org/system/files/2019-03/transgender-coverage-issue-brief.pdf>
 56. American Medical Association. Re: Testosterone Scheduling. Published online October 20, 2023.
 57. Office of Justice Programs, Brandeis University. Prescription Drug Monitoring Program: Nebraska State Profile. Published 2018. Accessed February 6, 2024. <https://www.ojp.gov/ncjrs/virtual-library/abstracts/prescription-drug-monitoring-program-nebraska-state-profile>
 58. Bureau of Justice Assistance. Prescription Drug Monitoring Program: Missouri State Profile. Published 2021. Accessed February 6, 2024. <https://bja.ojp.gov/library/publications/prescription-drug-monitoring-program-missouri-state-profile-2021>

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 12-A-24

Subject: Universal Screening for Substance Use and Substance Use Disorders during Pregnancy

Presented by: David J. Welsh, MD, MBA, Chair

Referred to: Reference Committee E

1 INTRODUCTION

2

3 American Medical Association (AMA) Policy H-95.906, “De-Stigmatization and Management of
4 Substance Use Disorders” as adopted at the 2023 Annual Meeting asks that our AMA study the
5 feasibility, potential methodologies, and implications of early universal screening for substance use
6 and substance use disorders during pregnancy.

7

8 At the meeting, robust testimony was heard regarding screening with concerns being raised
9 regarding the complexity of screening when paired with mandatory reporting requirements. This
10 report investigates the implications, feasibility, and methodology of universal screening for
11 substance use and substance use disorders during pregnancy. This report serves as the Council on
12 Science and Public Health’s (CSAPH) findings and recommendations regarding universal
13 screening for substance use and substance use disorders during pregnancy.

14

15 METHODS

16

17 English-language reports were selected from a PubMed and Google Scholar search through
18 November 2023, using the text terms “screening”, “universal screening”, “pregnancy”, and
19 “substance use.” Additional articles were identified by manual review of the references cited in
20 these publications. Further information was obtained from the Internet sites of specialty physician
21 societies, federal and state agencies, U.S. Department of Health and Human Services (HHS), and
22 U.S. Preventive Services Task Force (USPSTF) to identify validated screening tools,
23 recommendations, clinical guidelines, and position statements.

24

25 BACKGROUND

26

27 Nationally, one in five people use illicit substances during pregnancy.¹ Polysubstance use, which is
28 defined as the use of two or more substances, is also common during pregnancy.² Data suggests
29 that 38.2 percent of pregnant women who drink alcohol also report using one or more substance,
30 the most common being tobacco and cannabis.² Overdose rates during pregnancy and the
31 postpartum period increased 81 percent (from 6.56 to 11.85 per 100,000) from 2017 to 2020.³ This
32 trend has been exacerbated by the COVID-19 pandemic, leading to a surge in overdose-related
33 deaths and intensifying concerns about pregnancy-associated substance use, primarily driven by
34 synthetic opioids and psychostimulants (e.g., fentanyl, methamphetamine, cocaine).³⁻⁵ In an
35 analysis of data from 2017-2019 by the Centers of Disease Control, mental health conditions,
36 including overdose and poisoning related to substance use disorder (SUD), were the leading causes
37 of pregnancy-related death.⁶

1 Despite pregnancy offering a critical window for engaging individuals in medical care, pregnant
2 individuals with SUD, particularly opioid use disorder (OUD), often avoid both prenatal and
3 preventive health care due to stigma, discrimination, inaccessibility of services, and prosecution or
4 loss of infant custody.^{7,8} Compounding these barriers, pregnant individuals with SUD face
5 substantial complications linked to poorer obstetric and neonatal health outcomes including the
6 pregnant persons' mortality, poor fetal growth, preterm birth, neonatal abstinence syndrome, and
7 other conditions.⁹ Even for those who are receiving treatment, returning to substance use in the
8 postpartum period is prominent and can often result in fatal overdose due to decreased tolerance. In
9 the postpartum period, overdose rates peak 7 to 12 months post-delivery for pregnant people who
10 use substances.^{10,11} During this critical period, treatment adherence is further complicated by the
11 physical need of the infant for maternal bonding.¹²

12
13 Persistent racial disparities in perinatal OUD treatment contribute to significant challenges. Studies
14 indicate that Black and Hispanic women are less likely to receive medications for opioid use
15 disorder (MOUD) compared to their White counterparts.^{13,14} Moreover, these challenges are
16 compounded by further racial disparities, particularly affecting individuals of color, notably
17 American Indian and Alaskan Native women, who encounter discrimination within both the health
18 care system and the family regulation system.^{15,16} Rural communities, despite experiencing higher
19 rates of substance exposure in utero, encounter additional barriers in accessing essential care.^{8,17}
20 These disparities are indicative of broader social and economic inequities, including heightened
21 obstacles to reproductive health care, underscoring the urgent need for targeted interventions and
22 systemic changes.

23 24 DISCUSSION

25
26 Identification of substance use at any point during a pregnancy can support improved patient
27 outcomes within the parent-infant dyad. AMA policy H-320.953, "Definitions of 'Screening' and
28 'Medical Necessity,'" defines screening as "health care services or products provided to an
29 individual without apparent signs or symptoms of an illness, injury or disease for the purpose of
30 identifying or excluding an undiagnosed illness, disease, or condition." Screening can be conducted
31 using brief, in-depth, written, verbal, or computerized screening instruments and does not include
32 biological specimens, such as urine or blood.¹⁸ Universal screening, involving the screening of
33 every pregnant individual, is designed to minimize clinician bias in individualized screening
34 decisions and promote more standardized care while also destigmatizing substance use disorders.

35
36 Clinical screening tools recommended for prenatal substance use include the Prenatal Substance
37 Abuse Screen for Alcohol and Drugs also known as the "4Ps" which stands for Parents, Partner,
38 Past, and Present.¹⁹ The 4Ps and the 4Ps Plus, which includes additional questions about depression
39 and domestic violence are the only validated behavioral health screening instruments designed
40 specifically for pregnant women.²⁰ The 4Ps Plus screener is one of the only validated tools for
41 substance use during pregnancy demonstrating overall reliability of 0.62, relatively high sensitivity
42 (87 percent), and specificity (76 percent).²¹ Additionally, the CRAFFT instrument is recommended
43 for screening substance use in adolescents and young adults, generally from ages 12 to 21.²² The
44 CRAFFT instrument has shown efficacy in detecting adolescent substance use, but it has not been
45 thoroughly evaluated for use during pregnancy. Lastly, the National Institute on Drug Abuse
46 (NIDA) Quick Screen is validated for screening for substance use in adults, but has not been
47 validated for screening for pregnant individuals.²³ Despite screening instruments demonstrating
48 strong performance on certain metrics, none exhibit consistently adequate performance across all
49 studied measures. For example, in one study the NIDA Quick Screen exhibited notable specificity
50 (0.99) across all substances but displayed very poor sensitivity (0.10–0.27). Often, screening
51 instruments exhibit significant variations based on race, prenatal clinic, and economic status.²³

1 Future research endeavors should aim to identify the most effective screening instrument for
2 substance use during pregnancy.²⁴

3
4 Current clinical guidelines address screening for substance use. The American Society of Addiction
5 Medicine (ASAM) and American College for Obstetricians and Gynecologists (ACOG)
6 recommend early universal screening for substance use during the first prenatal visit using a
7 validated screening to improve maternal and infant outcomes, advising early universal screening,
8 brief intervention, and referral for treatment (SBIRT) model for the treatment of pregnant patients
9 with OUD.²⁵ The SBIRT model has demonstrated effectiveness for reducing substance use.²⁶
10 Universal screening for opioid use is recommended instead of screening based factors such as
11 “poor adherence to prenatal care or prior adverse pregnancy outcomes” to minimize missed cases
12 of substance use as well as provider stereotyping and stigmatization of patients.²⁵ ASAM and
13 ACOG committee opinion stresses the importance of a coordinated multidisciplinary approach
14 without criminal sanctions for optimal support of the parent-infant dyad, discouraging health care
15 professionals from separating the parent-infant dyad based solely on screening or SUD diagnosis,
16 and emphasizing that screening should be done in partnership with pregnant people.²⁵ Further, the
17 committee recommendations address clinical practices for chronic pain management,
18 pharmacotherapy, monitoring infants for neonatal abstinence syndrome, opioid prescriptions during
19 pregnancy, breastfeeding, postpartum supportive services, and the integration of contraceptive
20 counseling into SUD treatment for people of reproductive age.²⁵

21
22 In 2020 the U.S Preventive Services Task Force (USPSTF) updated their 2008 recommendation on
23 screening for unhealthy drug use for adults and adolescents, conducting two commissioned reviews
24 of the evidence on screening (i.e., asking questions about unhealthy drug use). Unhealthy drug use
25 is defined as “the use of illegal drugs and the nonmedical use of prescription psychoactive
26 medications (i.e., use of medications for reasons, for duration, in amounts, or with frequency other
27 than prescribed or use by persons other than the prescribed individual,” this definition does not
28 include alcohol or tobacco products.²⁷ The USPSTF concluded that there is insufficient evidence to
29 assess the balance of benefits and harms of screening for unhealthy drug use in adolescents.
30 However, for adults 18 years and older, the USPSTF denoted a B grade recommendation,
31 concluding that screening has a moderate net benefit when services for accurate diagnosis, effective
32 treatment, and appropriate care can be offered or referred.²⁷

33
34 Of the 30 identified screening tools many had a sensitivity of 75 percent for detecting unhealthy
35 drug use, misuse, dependence, or use disorders.²⁷ In this recommendation there are no tools
36 suggested for screening during pregnancy, with the USPSTF only reviewing 12 studies that
37 assessed the accuracy of 15 screening tools in nonpregnant people.²⁷ The majority of studies had
38 varying definitions of the reference standard (i.e., drug use, misuse, abuse, dependence, and
39 disorders) and no studies directly addressed the benefits or harms of screening on reducing drug
40 use, drug-related health, social, or legal outcomes in adults or adolescents.²⁷ Lastly, the USPSTF
41 noted several areas where further research is needed to develop recommendations. These include
42 the effectiveness of screening in adolescents; optimal screening intervals; accuracy of screening
43 tools; harms associated with punitive screening results; and strategies to improve access to
44 pharmacotherapy and psychosocial interventions.²⁷

45
46 The USPSTF commissioned two systematic reviews to evaluate the potential benefits and harms of
47 substance use screening, psychosocial interventions, pharmacotherapy, and the accuracy of
48 screening tools.²⁸ They found that despite the availability of validated screening tools, there are no
49 direct studies on the benefits or harms of universal screening for adults or adolescents.²⁸
50 Psychosocial and pharmacotherapy interventions often do not show statistically significant
51 improvement for screen-identified populations, except for those with OUD seeking treatment.²⁸

1 While physicians are crucial in addressing SUD, universal screening may not be justified without
2 sufficient evidence for its benefits across all types of unhealthy drug use due to the lack of
3 available treatment and local resources.²⁸ Physicians must carefully consider the consequences of
4 screening in their clinical setting and the availability of treatment resources before implementing
5 screening programs for SUDs. An examination conducted through a systematic review of research
6 on involuntary substance use treatment revealed no evidence supporting the benefits of this practice
7 and underscored a clear potential for harm.²⁹

8
9 Overall, available medical society and health care organization statements regarding the efficacy of
10 universal screening are mixed. While the Substance Abuse and Mental Health Services
11 Administration recommends universal screening during pregnancy as a part of SBIRT in routine
12 health care settings, the U.S. Department of Defense, Veterans Affairs, and the American Academy
13 of Family Physicians indicate that evidence is insufficient to recommend routine screening for
14 illicit drug use.^{27,29-32} Additionally, the American Psychiatric Association position statement
15 advocates for health care professionals to implement universal evidence-based screening methods
16 for substance use and co-occurring mental health disorders among pregnant and lactating women,
17 ensuring consistency and non-discrimination.³³ Screening during pregnancy should aim to enhance
18 access to evidence-based treatment for substance use, as well as optimize medical, obstetric, and
19 psychiatric care; emphasizing that screening should not be punitive in nature.³³ Thus, consensus
20 regarding universal screening for substance use during pregnancy varies and depends on the patient
21 subpopulation.

22 23 *Substance Use in Pregnancy and Reporting Implications*

24
25 The Child Abuse Prevention and Treatment Act initially enacted in 1974 and updated with the
26 Comprehensive Addiction Recovery Act in 2016 (CAPTA/CARA), is a federal law that mandates
27 the establishment of Plans of Safe Care to ensure the well-being and safety of newborns affected
28 by substance use, as well as their families or caregivers.³⁴ While physicians must notify the state
29 when a newborn has been exposed to substances per CAPTA/CARA, they are not required to file a
30 report of suspected child abuse or neglect unless stipulated by state law.³⁵ The notification
31 requirement necessitates the submission of deidentified, aggregate data on the number of children
32 falling within relevant categories.³⁶ Research shows that over 80 percent of health care
33 professionals are not familiar with CAPTA/CARA.³⁷ Even though the notification requirement
34 itself does not mandate the inclusion of patient-identifying information, there can still be adverse
35 consequences for the parent-infant dyad.³⁶

36
37 Beyond federal standards, many states have implemented additional notification and reporting
38 requirements for substance use in pregnancy. Twenty-four states and the District of Columbia (DC)
39 have passed laws classifying prenatal drug use as child abuse or neglect. Thirty-seven states and
40 DC mandate reporting of “suspected” prenatal drug use to the state.³⁸ “Suspected” drug use
41 involves assumptions or indications based on behavior or symptoms, whereas confirmatory
42 laboratory results directly detect the presence of drugs in the body through analytical testing. Some
43 states go further by requiring health care professionals to conduct prenatal substance use tests if
44 they suspect substance use.¹⁶ These measures compel health care professionals to report pregnant
45 or postpartum individuals for alleged child abuse, in some states this includes receiving MOUD.
46 Additionally, certain states have enacted legislation aimed at prosecuting pregnant individuals who
47 use substances. This legislation usually involves labeling such behavior as fetal assault, chemical
48 endangerment, and even murder.³⁹ The consequences of these laws and reports can be profound,
49 including resulting in family separation, arrests, criminal charges, and incarceration, creating a
50 cascade of adverse health outcomes that extend beyond the parent and infant. State-level policies
51 concerning child abuse and mandatory reporting are associated with reduced utilization of prenatal

1 and postpartum care among women who engage in substance use during pregnancy.⁴⁰ More
2 information is needed regarding the health outcomes and equity implications related to these
3 reporting laws. To alleviate potential adverse effects, including legal consequences tied to inquiring
4 about substance use and documenting and reporting responses, clinicians should be well-versed in
5 state requirements and adhere to best practices regarding informed consent for screening, recording
6 screening results in medical records, reporting results to medico-legal authorities, and ensuring
7 confidentiality protection.⁴¹

8 9 *Challenges in Universal Screening*

10
11 Physician confidence in conducting screening and brief interventions with pregnant patients varies.
12 A survey of 1,500 U.S. adult medicine clinicians found that almost all (95 percent) of those who
13 conducted screening and brief interventions in their practice reported implementing these measures
14 with pregnant patients for alcohol use.⁴² However, less than half (46.5 percent) of these clinicians
15 felt confident in their screening practices.⁴² In a study examining patient experiences and analyzing
16 data from 103,608 people in the Pregnancy Risk Assessment Monitoring System between 2016 and
17 2018, around 95 percent of individuals reported being asked about cigarette or alcohol use during
18 prenatal care, and 80 percent reported being asked about drug use.⁴³ The study reveals disparities in
19 substance use screening during prenatal care appointments.⁴³ Further research is needed to
20 understand the impact of screening approaches on outcomes in prenatal care settings.

21
22 A 1990 study in Pinellas County, Florida found profound racial disparities in child protective
23 services (CPS) reporting during delivery against a background of universal screening for alcohol
24 and illicit drug use in public and private prenatal care.⁴⁴ Around 15 percent of both Black and
25 White mothers identified as using substances, with Black mothers exhibiting significantly higher
26 rates of entering treatment compared to White mothers.⁴⁴ Despite higher treatment rates, Black
27 mothers using substances were referred to CPS at much higher rates than their White counterparts
28 using substances.⁴⁴ The researchers wrote, “we conclude that the use of illicit drugs is common
29 among pregnant women regardless of race and socioeconomic status. If legally mandated reporting
30 is to be free of racial or economic bias, it must be based on objective medical criteria.”⁴⁴ A 2012
31 article that drew heavily on the Florida study showed that, despite nearly universal screening for
32 prenatal drug use among Medicaid patients in one California county, and similar results among
33 racial groups enrolled in Medicaid, overall CPS referrals for Black mothers occurred at nearly four
34 times the rate of White mothers.¹⁵ The authors caution that we cannot count on universal screening
35 to promote equity, either through making referrals more objective or through improved treatment
36 participation rates.¹⁵

37
38 Lastly, in a study examining primary care physicians' implementation of screening, several barriers
39 were identified.⁴⁵ Time constraints, challenges related to parental involvement (for adolescents),
40 perceived ineffectiveness of brief intervention services, and a lack of training in providing brief
41 intervention were among the obstacles to screening and brief intervention.⁴⁵ Physicians
42 recommended boosting screening rates through increased reimbursement and the allocation of
43 dedicated resources.⁴⁵

44 45 **AMA POLICY AND ADVOCACY**

46
47 Our AMA maintains comprehensive policies addressing substance use during pregnancy. AMA
48 Policy H-420.969, “Legal Interventions During Pregnancy,” states that criminal sanctions or civil
49 liability for harmful behavior by the pregnant woman toward her fetus are inappropriate; that
50 pregnant [people who use substances or have a substance use disorder] should be provided with
51 rehabilitative treatment appropriate to their specific physiological and psychological needs; and

1 that in order to minimize the risk of legal action by a pregnant patient or an injured fetus, the
2 physician should document medical recommendations made including the consequences of failure
3 to comply with the physician's recommendation. Policy H-420.962, "Perinatal Addiction - Issues in
4 Care and Prevention," encourages the federal government to expand funding allocated to drug
5 treatment, prevention, and education to establish and make broadly available specialized treatment
6 programs for [pregnant people with substance use disorder] and breastfeeding people wherever
7 possible.

8
9 AMA Policy H-420.950, "Substance Use Disorders During Pregnancy," reiterates our AMA's
10 support of brief interventions and referral for early comprehensive treatment using a coordinated
11 multidisciplinary approach without criminal sanctions. Additionally, this policy opposes any efforts
12 to imply that a positive verbal substance use screen, a positive toxicology test, or the diagnosis of
13 substance use disorder during pregnancy automatically represents child abuse and opposes the
14 filing of a child protective services report or the removal of infants from their mothers solely based
15 on a single positive prenatal drug screen without appropriate evaluation. Our AMA further
16 advocates for appropriate medical evaluation prior to the removal of a child and advocates that
17 state and federal child protection laws be amended so that pregnant people who use substances
18 and/or have a SUD are only reported to child welfare agencies when protective concerns are
19 identified by the clinical team, rather than through automatic or mandated reporting of all pregnant
20 people with a positive toxicology test, positive verbal substance use screen, or diagnosis of a SUD.
21 This policy position is reiterated in D-95.983, "Mandatory Drug Screening Reporting," which
22 states that our AMA will work with appropriate state and specialty medical societies and with state
23 legislative bodies to ensure that physicians not be required to report patients with [positive] urine
24 drug test results to the police; and continue to promote education of physicians regarding the
25 importance of referring patients found to have [positive] urine drug tests for appropriate medical
26 treatment.

27
28 Additionally, in 2022 our AMA and several other medical societies jointly formulated model state
29 legislation to facilitate the "enhancement of access to evidence-based, non-judgmental, and non-
30 punitive maternal treatment."⁴⁶ The proposed legislation, titled "An Act to Create and Implement
31 Family Care Plans for Infants, Children, and Families," underscores the significance of establishing
32 and defining "plans of family care."⁴⁶ These plans aim to provide "supportive care and fulfillment
33 of needs for pregnant, postpartum, and parenting individuals, newborns, children, and families."⁴⁶

34 35 CONCLUSION

36
37 In theory, universal screening for substance use in pregnancy presents a potential avenue for
38 enhancing health outcomes for pregnant individuals who use substances and their infants as well as
39 preserving the parent-infant dyad. However, amidst the backdrop of stringent state policies,
40 mandatory reporting, and obstacles in accessing evidence-based care, universal screening may have
41 unintended consequences. Additional research on the impacts of mandatory reporting laws of
42 substance use in pregnant people needs to be addressed to reduce bias, inequities in care, and fear
43 of pregnant people to access the care they need.

44 45 RECOMMENDATIONS

46
47 The Council on Science and Public Health recommends that the following be adopted, and the
48 remainder of the report be filed:

- 49
50 1. That our AMA:

51

- 1 A. Encourage ongoing research on the benefits and risks of universal screening for
2 substance use during pregnancy including the impact of mandatory reporting laws,
3 evaluation of patient outcomes, effectiveness across different age groups, optimal
4 screening intervals, equity considerations, and efficacy of different screening tools.
5
6 B. Support the development and dissemination of physician education and training on
7 federal and state laws governing mandatory notification and reporting of substance
8 use during pregnancy, and the benefits and consequences of screening
9 implementation in health care settings on a state-by-state basis. (New HOD Policy)
10
11 2. That AMA policy H-420.950, "Substance Use Disorders During Pregnancy," be amended
12 by addition and deletion to read as follows:

13 Our AMA will:

- 14 (1) support brief interventions (such as engaging a patient in a short conversation,
15 providing feedback and advice) and referral for early comprehensive treatment of pregnant
16 individuals with opioid use and opioid use disorder (including naloxone or other overdose
17 reversal medication education and distribution) using a coordinated multidisciplinary
18 approach without criminal sanctions;
19
20 (2) acknowledges the health benefits of identifying substance use during pregnancy and
21 opposes any efforts, including mandatory reporting laws, that to imply that a positive
22 verbal substance use screen, a positive toxicology test, or the diagnosis of substance use
23 disorder during pregnancy automatically represents child abuse or neglect;
24 (3) support legislative and other appropriate efforts for the expansion and improved access
25 to evidence-based treatment for substance use disorders during pregnancy;
26 (4) oppose the filing of a child protective services report or the removal of infants from
27 their ~~mothers~~ parent(s) solely based on a ~~single positive~~ prenatal drug screen and/or
28 biological test(s) for substance use without appropriate evaluation;
29 (5) advocate for appropriate medical evaluation prior to the removal of a child, which takes
30 into account (a) the desire to preserve the individual's family structure, (b) the patient's
31 treatment status, and (c) current impairment status when substance use is suspected or
32 confirmed; and
33 (6) advocate that state and federal child protection laws be amended so that pregnant
34 people with substance use and substance use disorders are only reported to child welfare
35 agencies when protective concerns are identified by the clinical team, rather than through
36 automatic or mandated reporting of all pregnant people with a positive toxicology test,
37 positive verbal substance use screen, ~~or~~ diagnosis of a substance use disorder, or use of
38 evidence-based treatments for substance use disorder. (Modify Current HOD Policy)
39
40 3. That current AMA policies H-420.969, "Legal Interventions During Pregnancy," and D-
41 95.983, "Mandatory Drug Screening Reporting" be reaffirmed. (Reaffirm HOD Policy)
42

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

REFERENCES

1. Board A, D'Angelo DV, Salvesen von Essen B, et al. Polysubstance use during pregnancy: The importance of screening, patient education, and integrating a harm reduction perspective. *Drug and Alcohol Dependence*. 2023;247:109872. doi:10.1016/j.drugalcdep.2023.109872
2. England LJ. Alcohol Use and Co-Use of Other Substances Among Pregnant Females Aged 12–44 Years — United States, 2015–2018. *MMWR Morb Mortal Wkly Rep*. 2020;69. doi:10.15585/mmwr.mm6931a1
3. Bruzelius E, Martins SS. US Trends in Drug Overdose Mortality Among Pregnant and Postpartum Persons, 2017–2020. *JAMA*. 2022;328(21):2159–2161. doi:10.1001/jama.2022.17045
4. Lien J, Hayes T, Liu-Smith F, Rana D. Comparing maternal substance use and perinatal outcomes before and during the COVID-19 pandemic. *J Perinatol*. 2023;43(5):664–669. doi:10.1038/s41372-023-01613-8
5. Spencer M, Miniño A, Warner M. *Drug Overdose Deaths in the United States, 2001–2021*. National Center for Health Statistics (U.S.); 2022. doi:10.15620/cdc:122556
6. CDC. Four in 5 pregnancy-related deaths in the U.S. are preventable. CDC Newsroom. Published September 19, 2022. Accessed January 24, 2024. <https://www.cdc.gov/media/releases/2022/p0919-pregnancy-related-deaths.html>
7. Jackson A, Shannon L. Barriers to receiving substance abuse treatment among rural pregnant women in Kentucky. *Matern Child Health J*. 2012;16(9):1762–1770. doi:10.1007/s10995-011-0923-5
8. Villapiano NLG, Winkelman TNA, Kozhimannil KB, Davis MM, Patrick SW. Rural and Urban Differences in Neonatal Abstinence Syndrome and Maternal Opioid Use, 2004 to 2013. *JAMA Pediatrics*. 2017;171(2):194–196. doi:10.1001/jamapediatrics.2016.3750
9. CDC. Basics About Opioid Use During Pregnancy. Centers for Disease Control and Prevention. Published November 28, 2022. Accessed December 20, 2023. <https://www.cdc.gov/pregnancy/opioids/basics.html>
10. Schiff DM, Nielsen T, Terplan M, et al. Fatal and Nonfatal Overdose Among Pregnant and Postpartum Women in Massachusetts. *Obstet Gynecol*. 2018;132(2):466–474. doi:10.1097/AOG.0000000000002734
11. Smid MC, Stone NM, Baksh L, et al. Pregnancy-Associated Death in Utah: Contribution of Drug-Induced Deaths. *Obstet Gynecol*. 2019;133(6):1131–1140. doi:10.1097/AOG.0000000000003279
12. Prince MK, Daley SF, Ayers D. Substance Use in Pregnancy. In: *StatPearls*. StatPearls Publishing; 2023. Accessed January 10, 2024. <http://www.ncbi.nlm.nih.gov/books/NBK542330/>
13. Short VL, Hand DJ, MacAfee L, Abatemarco DJ, Terplan M. Trends and disparities in receipt of pharmacotherapy among pregnant women in publically funded treatment programs for opioid

use disorder in the United States. *J Subst Abuse Treat.* 2018;89:67-74.
doi:10.1016/j.jsat.2018.04.003

14. Schiff DM, Nielsen T, Hoepfner BB, et al. Assessment of Racial and Ethnic Disparities in the Use of Medication to Treat Opioid Use Disorder Among Pregnant Women in Massachusetts. *JAMA Netw Open.* 2020;3(5):e205734. doi:10.1001/jamanetworkopen.2020.5734
15. Roberts SCM, Nuru-Jeter A. Universal Screening for Alcohol and Drug Use and Racial Disparities in Child Protective Services Reporting. *J Behav Health Serv Res.* 2012;39(1):3-16. doi:10.1007/s11414-011-9247-x
16. Simon R, Giroux J, Chor J. Effects of Substance Use Disorder Criminalization on American Indian Pregnant Individuals. *AMA Journal of Ethics.* 2020;22(10):862-867. doi:10.1001/amajethics.2020.862
17. Jumah NA. Rural, Pregnant, and Opioid Dependent: A Systematic Review. *Subst Abuse.* 2016;10(Suppl 1):35-41. doi:10.4137/SART.S34547
18. Center for Substance Abuse Treatment. *Screening for Substance Use Disorders.* Substance Abuse and Mental Health Services Administration (US); 1997. Accessed January 10, 2024. <https://www.ncbi.nlm.nih.gov/books/NBK64820/>
19. ACOG Committee on Obstetric Practice. Opioid Use and Opioid Use Disorder in Pregnancy - Committee Opinion 711. Published August 2017. Accessed January 18, 2024. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy>
20. NTI Upstream. About the 4P's Plus. Published n.d. Accessed March 18, 2024. <https://www.ntiupstream.com/4psabout>
21. Chasnoff IJ, Wells AM, McGourty RF, Bailey LK. Validation of the 4P's Plus screen for substance use in pregnancy validation of the 4P's Plus. *J Perinatol.* 2007;27(12):744-748. doi:10.1038/sj.jp.7211823
22. About the CRAFFT. CRAFFT. Published 2018. Accessed January 18, 2024. <https://crafft.org/about-the-crafft/>
23. Ondersma SJ, Chang G, Blake-Lamb T, et al. Accuracy of five self-report screening instruments for substance use in pregnancy. *Addiction.* 2019;114(9):1683-1693. doi:10.1111/add.14651
24. Ecker J, Abuhamad A, Hill W, et al. Substance use disorders in pregnancy: clinical, ethical, and research imperatives of the opioid epidemic: a report of a joint workshop of the Society for Maternal-Fetal Medicine, American College of Obstetricians and Gynecologists, and American Society of Addiction Medicine. *American Journal of Obstetrics & Gynecology.* 2019;221(1):B5-B28. doi:10.1016/j.ajog.2019.03.022
25. ACOG Committee on Health Care for Underserved Women, American Society of Addiction Medicine. *Opioid Abuse, Dependence, and Addiction in Pregnancy.*; 2012. Accessed January 18, 2024. <https://www.asam.org/docs/default-source/public-policy-statements/1-opioids-in-pregnancy---joint-acog-4-12.pdf?sfvrsn=2>

26. Agerwala SM, McCance-Katz EF. Integrating Screening, Brief Intervention, and Referral to Treatment (SBIRT) into Clinical Practice Settings: A Brief Review. *J Psychoactive Drugs*. 2012;44(4):307-317.
27. US Preventive Services Task Force, Krist AH, Davidson KW, et al. Screening for Unhealthy Drug Use: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2020;323(22):2301. doi:10.1001/jama.2020.8020
28. Coles S, Vosooney A. Evidence Lacking to Support Universal Unhealthy Drug Use Screening. *afp*. 2021;103(2):72-73.
29. Werb D, Kamarulzaman A, Meacham MC, et al. The effectiveness of compulsory drug treatment: A systematic review. *International Journal of Drug Policy*. 2016;28:1-9. doi:10.1016/j.drugpo.2015.12.005
30. Patnode CD, Perdue LA, Rushkin M, et al. Screening for Unhealthy Drug Use: Updated Evidence Report and Systematic Review for the US Preventive Services Task Force. *JAMA*. 2020;323(22):2310. doi:10.1001/jama.2019.21381
31. Center for Substance Abuse Treatment. *A Guide to Substance Abuse Services for Primary Care Clinicians*. Substance Abuse and Mental Health Services Administration (US); 1997. Accessed March 5, 2024. <http://www.ncbi.nlm.nih.gov/books/NBK64827/>
32. Department of Veterans Affairs, Department of Defense. *VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders.*; 2015. Accessed February 15, 2024. <https://www.healthquality.va.gov/guidelines/MH/sud/VADoDSUDCPGRevised22216.pdf>
33. American Psychiatric Association. *Position Statement on Assuring the Appropriate Care of Pregnant and Newly-Delivered Women with Substance Use Disorders.*; 2019. Accessed January 2, 2024. <https://www.psychiatry.org/getattachment/d0fe00fd-8b78-47e2-9098-63dc6917e1d4/Position-Assuring-Appropriate-Care-of-Pregnant-and-Newly-Delivered-Women-with-SUDs.pdf>
34. New York State Department of Health. New York State CAPTA CARA Information and Resources. Published July 2022. Accessed January 19, 2024. <https://health.ny.gov/prevention/captacara/index.htm>
35. The Administration for Children and Families. Child Welfare Policy Manual. CW Policy Database. Published October 11, 2016. Accessed January 24, 2024. https://www.acf.hhs.gov/cwpm/public_html/programs/cb/laws_policies/laws/cwpm/policy_dsp_pf.jsp?id=2
36. Pregnancy Justice. *Confronting Pregnancy Criminalization.*; 2022. https://www.pregnancyjusticeus.org/wp-content/uploads/2023/09/1.Confronting-Pregnancy-Criminalization_6.22.23.pdf
37. Chasnoff IJ, Barber G, Brook J, Akin BA. Child Abuse Prevention and Treatment Act: Knowledge of Health Care and Legal Professionals. *Child Welfare*. 96(3):41-58.

38. McCourt AD, White SA, Bandara S, et al. Development and Implementation of State and Federal Child Welfare Laws Related to Drug Use in Pregnancy. *Milbank Q.* 2022;100(4):1076-1120. doi:10.1111/1468-0009.12591
39. USA: Criminalizing pregnancy: policing pregnant women who use drugs in the USA. Amnesty International. Published May 22, 2017. Accessed September 14, 2023. <https://www.amnesty.org/en/documents/amr51/6203/2017/en/>
40. Austin AE, Naumann RB, Simmons E. Association of State Child Abuse Policies and Mandated Reporting Policies With Prenatal and Postpartum Care Among Women Who Engaged in Substance Use During Pregnancy. *JAMA Pediatrics.* 2022;176(11):1123-1130. doi:10.1001/jamapediatrics.2022.3396
41. Screening for Unhealthy Drug Use: Recommendation Statement. *afp.* 2021;103(2):107-112.
42. Green C. Screening and Brief Interventions for Alcohol Use During Pregnancy: Practices Among US Primary Care Clinicians, DocStyles 2019. *Prev Chronic Dis.* 2023;20. doi:10.5888/pcd20.220226
43. Patel E, Bandara S, Saloner B, et al. Heterogeneity in prenatal substance use screening despite universal screening recommendations: findings from the Pregnancy Risk Assessment Monitoring System, 2016–2018. *American Journal of Obstetrics & Gynecology MFM.* 2021;3(5). doi:10.1016/j.ajogmf.2021.100419
44. Chasnoff IJ, Landress HJ, Barrett ME. The Prevalence of Illicit-Drug or Alcohol Use during Pregnancy and Discrepancies in Mandatory Reporting in Pinellas County, Florida. *New England Journal of Medicine.* 1990;322(17):1202-1206. doi:10.1056/NEJM199004263221706
45. Palmer A, Karakus M, Mark T. Barriers Faced by Physicians in Screening for Substance Use Disorders Among Adolescents. *PS.* 2019;70(5):409-412. doi:10.1176/appi.ps.201800427
46. Legislative Analysis and Public Policy Association. *Substance Use During Pregnancy and Family Care Plans.*; 2022. Accessed January 18, 2024. <https://legislativeanalysis.org/substance-use-during-pregnancy-and-family-care-plans/>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 501
(A-24)

Introduced by: Medical Student Section

Subject: Fragrance Regulation

Referred to: Reference Committee E

1 Whereas, fragrances include many contact allergens, irritants, cross-reactors, or other substance
2 or natural extract often found in personal care products, cosmetics, household products, drugs,
3 and wound care products¹⁻¹¹; and
4

5 Whereas, individuals with fragrance sensitivity experience adverse effects after exposure,
6 especially patients with allergies, asthma, eczema, lung disease, and migraine^{1,2-26}; and
7

8 Whereas, due to wide use, fragrances are the most common cause of contact allergy and lead
9 to debilitating systemic dermatologic, neurologic, and immunologic side effects¹²⁻¹⁶; and
10

11 Whereas, large surveys show that over 30% of individuals may experience fragrance sensitivity,
12 50% prefer that healthcare facilities be fragrance-free, and 7% lose workdays due to workplace
13 fragrance exposure^{1,11-14}; and
14

15 Whereas, fragranced products can lower both indoor and outdoor air quality by releasing
16 hazardous air pollutants that contribute to diseases and illness^{1,5,8,14,22}; and
17

18 Whereas, the severity of fragrance sensitivity often meets Americans with Disabilities Act (ADA)
19 criteria for a disability (“physical or mental impairment that substantially limits one or more major
20 life activities”) and may be considered an “invisible disability” (“impairment...not always obvious
21 to the onlooker”)³⁰⁻³²; and
22

23 Whereas, *Core v. Champaign County Board of County Commissioners* (2012) and *McBride v. the*
24 *City of Detroit* (2009) found that severe fragrance sensitivity can be an invisible disability, leading
25 Detroit to add a fragrance-free policy to their employee ADA handbook³³⁻³⁴; and
26

27 Whereas, fragrance-free policies are recommended by the Centers for Disease Control and
28 Prevention, the American Lung Association, and the US Department of Labor Office of Disability
29 Employment Policy and are in place in multiple healthcare facilities, workplaces, schools, and
30 other organizations across the US³⁵⁻³⁹; and
31

32 Whereas, the US Food and Drug Administration and US Consumer Product Safety Commission
33 do not currently regulate fragrances^{2,40-45}; and
34

35 Whereas, the European Union has already banned nearly 1,400 chemicals from cosmetics and
36 required premarket safety assessments, mandatory registration, and government authorization
37 for the use of certain materials, compared to only 30 chemicals in the US⁴⁶⁻⁴⁸; therefore be it

1 RESOLVED, that our American Medical Association recognize fragrance sensitivity as a
2 disability where the presence of fragranced products can limit accessibility of healthcare settings
3 (New HOD Policy); and be it further
4

5 RESOLVED, that our AMA encourage all hospitals, outpatient clinics, urgent cares, and other
6 patient care areas inclusive of medical schools to adopt a fragrance-free policy that pertains to
7 employees, patients, and visitors of any kind (New HOD Policy); and be it further
8

9 RESOLVED, that our AMA work with relevant parties to advocate for governmental regulatory
10 bodies, including but not limited to the Occupational Safety and Health Administration (OSHA),
11 the Centers for Disease Control and Prevention (CDC), and the National Institute for
12 Occupational Safety and Health (NIOSH) to recommend fragrance-free policies in all medical
13 offices, buildings, and places of patient care (Directive to Take Action); and be it further
14

15 RESOLVED, that our AMA work with relevant parties to support the appropriate labeling of
16 fragrance-containing personal care products, cosmetics, and drugs with warnings about
17 possible allergic reactions or adverse events due to the fragrance, and advocates for increased
18 categorization in the use of a “fragrance free” designation (Directive to Take Action); and be it
19 further
20

21 RESOLVED, that our AMA support increased identification of hazardous chemicals in fragrance
22 compounds, as well as research focused on fragrance sensitivity in order to remove these
23 allergens from products applied to one’s body. (New HOD Policy)
24

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 3/28/2024

REFERENCES

1. Steinemann A. International prevalence of fragrance sensitivity. *Air Qual Atmosphere Health*. 2019;12(8):891-897. doi:10.1007/s11869-019-00699-4
2. Pastor-Nieto MA, Gatica-Ortega ME. Ubiquity, Hazardous Effects, and Risk Assessment of Fragrances in Consumer Products. *Curr Treat Options Allergy*. 2021;8(1):21-41. doi:10.1007/s40521-020-00275-7
3. Shawa H, Wu PA, Dahle S, Isseroff RR, Sood A. Potential Allergens in Wound Care Products. *Dermat Contact Atopic Occup Drug*. 2023;34(1):51-55. doi:10.1089/DERM.0000000000000946
4. Ravichandran J, Karthikeyan BS, Jost J, Samal A. An atlas of fragrance chemicals in children’s products. *Sci Total Environ*. 2022;818:151682. doi:10.1016/j.scitotenv.2021.151682
5. Rádis-Baptista G. Do Synthetic Fragrances in Personal Care and Household Products Impact Indoor Air Quality and Pose Health Risks? *J Xenobiotics*. 2023;13(1):121-131. doi:10.3390/jox13010010
6. Wieck S, Olsson O, Kümmerer K, Klaschka U. Fragrance allergens in household detergents. *Regul Toxicol Pharmacol RTP*. 2018;97:163-169. doi:10.1016/j.yrtph.2018.06.015
7. Couteau C, Morin T, Diarra H, Coiffard L. Influence of Cosmetic Type and Distribution Channel on the Presence of Regulated Fragrance Allergens: Study of 2044 Commercial Products. *Clin Rev Allergy Immunol*. 2020;59(1):101-108. doi:10.1007/s12016-020-08790-w
8. Steinemann A, Nematollahi N, Rismanchi B, Goodman N, Kolev SD. Pandemic products and volatile chemical emissions. *Air Qual Atmosphere Health*. 2021;14(1):47-53. doi:10.1007/s11869-020-00912-9
9. Kumar M, Devi A, Sharma M, Kaur P, Mandal UK. Review on perfume and present status of its associated allergens. *J Cosmet Dermatol*. 2021;20(2):391-399. doi:10.1111/jocd.13507
10. Panico A, Serio F, Bagordo F, et al. Skin safety and health prevention: an overview of chemicals in cosmetic products. *J Prev Med Hyg*. 2019;60(1):E50-E57. doi:10.15167/2421-4248/jpmh2019.60.1.1080
11. Uter W, Werfel T, Lepoittevin JP, White IR. Contact Allergy-Emerging Allergens and Public Health Impact. *Int J Environ Res Public Health*. 2020;17(7):2404. doi:10.3390/ijerph17072404
12. Silvestre JF, Mercader P, González-Pérez R, et al. Sensitization to fragrances in Spain: A 5-year multicentre study (2011-2015). *Contact Dermatitis*. 2019;80(2):94-100. doi:10.1111/cod.13152
13. Pastor-Nieto MA, Gatica-Ortega ME. Ubiquity, hazardous effects, and risk assessment of fragrances in consumer products. *Curr Treat Options Allergy*. 2021;8(1):21-41. doi: 10.1007/s40521-020-00275-7 [doi].
14. Nematollahi N, Doronila A, Mornane PJ, Duan A, Kolev SD, Steinemann A. Volatile chemical emissions from fragranced baby products. *Air Qual Atmos Health*. 2018;11(7):785-790. doi: 10.1007/s11869-018-0593-1 [doi].

15. Tam I, Yu J. Allergic contact dermatitis in children: Recommendations for patch testing. *Current Allergy and Asthma Reports*. 2020;20(9):41. <https://doi.org/10.1007/s11882-020-00939-z>. doi: 10.1007/s11882-020-00939-z.
16. Warshaw EM, Schlarbaum JP, Silverberg JI, et al. Contact dermatitis to personal care products is increasing (but different!) in males and females: North American contact dermatitis group data, 1996-2016. *Journal of the American Academy of Dermatology*. 2021;85(6):1446-1455. <https://www.sciencedirect.com/science/article/pii/S0190962220327547>. doi: <https://doi.org/10.1016/j.jaad.2020.10.003>.
17. de Groot AC. Fragrances: Contact allergy and other adverse effects. *Dermatitis*. 2020;31(1). https://journals.lww.com/dermatitis/Fulltext/2020/01000/Fragrances__Contact_Allergy_and_Other_Adverse.3.aspx.
18. Johansen JD, Werfel T. Highlights in allergic contact dermatitis 2018/2019. *Current Opinion in Allergy and Clinical Immunology*. 2019;19(4). https://journals.lww.com/co-allergy/Fulltext/2019/08000/Highlights_in_allergic_contact_dermatitis.11.aspx.
19. Zhou J, Tierney NK, McCarthy TJ, Black KG, Hernandez M, Weisel CP. Estimating infants' and toddlers' inhalation exposure to fragrance ingredients in baby personal care products. *Int J Occup Environ Health*. 2017;23(4):291-298. doi: 10.1080/10773525.2018.1475446
20. Herz RS, Larsson M, Trujillo R, et al. A three-factor benefits framework for understanding consumer preference for scented household products: psychological interactions and implications for future development. *Cogn Res Princ Implic*. 2022;7(1):28. doi:10.1186/s41235-022-00378-6
21. Nassau S, Fonacier L. Allergic Contact Dermatitis. *Med Clin North Am*. 2020;104(1):61-76. doi:10.1016/j.mcna.2019.08.012
22. Nematollahi N, Kolev SD, Steinemann A. Volatile chemical emissions from 134 common consumer products. *Air Qual Atmosphere Health*. 2019;12(11):1259-1265. doi:10.1007/s11869-019-00754-0
23. Steinemann A, Nematollahi N. Migraine headaches and fragranced consumer products: an international population-based study. *Air Qual Atmosphere Health*. 2020;13(4):387-390. doi:10.1007/s11869-020-00807-9
24. Steinemann A. Ten questions concerning fragrance-free policies and indoor environments. *Build Environ*. 2019;159:106054. doi:10.1016/j.buildenv.2019.03.052
25. Warshaw EM, Schlarbaum JP, Silverberg JI, et al. Contact dermatitis to personal care products is increasing (but different!) in males and females: North American Contact Dermatitis Group data, 1996-2016. *J Am Acad Dermatol*. 2021;85(6):1446-1455. doi:10.1016/j.jaad.2020.10.003
26. Johansen JD, Werfel T. Highlights in allergic contact dermatitis 2018/2019. *Curr Opin Allergy Clin Immunol*. 2019;19(4):334. doi:10.1097/ACI.0000000000000552
27. Maung TZ, Bishop JE, Holt E, Turner AM, Pfrang C. Indoor Air Pollution and the Health of Vulnerable Groups: A Systematic Review Focused on Particulate Matter (PM), Volatile Organic Compounds (VOCs) and Their Effects on Children and People with Pre-Existing Lung Disease. *Int J Environ Res Public Health*. 2022;19(14):8752. doi:10.3390/ijerph19148752
28. Vardoulakis S, Giagloglou E, Steinle S, et al. Indoor Exposure to Selected Air Pollutants in the Home Environment: A Systematic Review. *Int J Environ Res Public Health*. 2020;17(23):8972. doi:10.3390/ijerph17238972
29. Nematollahi N, Doronila A, Mornane PJ, Duan A, Kolev SD, Steinemann A. Volatile chemical emissions from fragranced baby products. *Air Qual Atmosphere Health*. 2018;11(7):785-790. doi:10.1007/s11869-018-0593-1
30. Rossi S, Pitidis A. Multiple Chemical Sensitivity: Review of the State of the Art in Epidemiology, Diagnosis, and Future Perspectives. *J Occup Environ Med*. 2018;60(2):138-146. doi:10.1097/JOM.0000000000001215
31. Steinemann, A., Health and societal effects from exposure to fragranced consumer products. *Preventive medicine reports*, 2016. 5: p. 45-47.
32. Why go fragrance free? Invisible Disabilities® Association. (2021, January 11). Retrieved March 16, 2022, from <https://invisibledisabilities.org/publications/chemicalsensitivities/whygofragrancefree>
33. Town Hall meeting transcript for Chicago. U.S. Equal Employment Opportunity Commission. (n.d.). Retrieved March 17, 2022, from <https://www.eeoc.gov/town-hall-meeting-transcript-chicago>
34. "Core v. Champaign County Board of County Commissioners, No. 3:2011CV00166 - Document 51 (S.D. Ohio 2012)." *Justia Law*, <https://law.justia.com/cases/federal/district-courts/ohio/ohsdc/3:2011cv00166/146509/51/>.
35. Accommodation and Compliance: Fragrance Sensitivity. Job Accommodation Network. <https://askjan.org/disabilities/Fragrance-Sensitivity.cfm>. Accessed March 17, 2022.
36. Centers For Disease Control and Prevention, Department of Health and Human Services. (2009, June 22). CDC1 indoor environmental quality policy. Retrieved March 17, 2022, from https://irp-cdn.multiscreensite.com/c4e267ab/files/uploaded/DskIT9BfRF6ZwAsibvxq_CDC_Indoor%20Environmental%20Quality%20Policy_2009.pdf
37. "Indoor Environmental Quality: Chemicals and Odors." Centers for Disease Control and Prevention, Centers for Disease Control and Prevention, 25 Feb. 2022, <https://www.cdc.gov/niosh/topics/indoorenv/chemicalsodors.html>.
38. "Department of Labor Logo United States department of Labor." Indoor Air Quality - Overview | Occupational Safety and Health Administration, <https://www.osha.gov/indoor-air-quality>.
39. Consumer Products Smog. California Air Resources Board. (n.d.). Retrieved March 20, 2022, from <https://ww2.arb.ca.gov/our-work/programs/consumer-products-program/consumer-products-smog>
40. FDA regulation of cosmetics and personal care products. Congressional Research Service. 2022:1-33.
41. Nutrition, Center for Food Safety and Applied. Is it a cosmetic, a drug, or both? (or is it soap?). FDA. 2022. <https://www.fda.gov/cosmetics/cosmetics-laws-regulations/it-cosmetic-drug-or-both-or-it-soap>. Accessed Aug 31, 2022.
42. Affairs OoR. Are all "personal care products" regulated as cosmetics? FDA. 2022. <https://www.fda.gov/industry/fda-basics-industry/are-all-personal-care-products-regulated-cosmetics>. Accessed Aug 31, 2022.
43. Nutrition, Center for Food Safety and Applied. Cosmetics guidance & regulation. FDA Web site. <https://www.fda.gov/cosmetics/cosmetics-guidance-regulation>. Updated 2022. Accessed Aug 31, 2022.
44. Nutrition, Center for Food Safety and Applied. FDA authority over cosmetics: How cosmetics are not FDA-approved, but are FDA-regulated. FDA Web site. <https://www.fda.gov/cosmetics/cosmetics-laws-regulations/fda-authority-over-cosmetics-how-cosmetics-are-not-fda-approved-are-fda-regulated>. Updated 2013. Accessed Aug 31, 2022.

45. Boozalis E, Patel S. Clinical utility of marketing terms used for over-the-counter dermatologic products. *J Dermatol Treat.* 2018;29(8):841-845. <https://doi.org/10.1080/09546634.2018.1467540>. doi: 10.1080/09546634.2018.1467540.
46. EUR-Lex - 32009R1223 - EN - EUR-Lex. Accessed September 16, 2023. <https://eur-lex.europa.eu/eli/reg/2009/1223/oj>
47. Klaschka, U., Between attraction and avoidance: from perfume application to fragrance-free policies. *Environmental Sciences Europe*, 2020. 32(1): p. 98.
48. Scientific Committee on Consumer Safety (SCCS). Accessed September 16, 2023. https://health.ec.europa.eu/scientific-committees/scientific-committee-consumer-safety-sccs_en

RELEVANT AMA POLICY

H-440.855 National Cosmetics Registry and Regulation

1. Our AMA: (a) supports the creation of a publicly available registry of all cosmetics and their ingredients in a manner which does not substantially affect the manufacturers' proprietary interests and (b) supports providing the Food and Drug Administration with sufficient authority to recall cosmetic products that it deems to be harmful.
2. Our AMA will monitor the progress of HR 759 (Food and Drug Administration Globalization Act of 2009) and respond as appropriate. [BOT Action in response to referred for decision Res. 907, I-09; Reaffirmed in lieu of: Res. 502, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:502
(A-24)

Introduced by: Medical Student Section

Subject: Tribally-Directed Precision Medicine Research

Referred to: Reference Committee E

1 Whereas, an estimated 80% of data used in precision medicine is from people with European
2 ancestry, limiting generalizability of research and possibly exacerbating health inequities¹⁻⁶; and
3
4 Whereas, effects of ongoing cultural genocide and colonization increase chronic disease burden
5 and reduce quality of care for American Indian and Alaska Native (AI/AN) persons^{3,7-11}; and
6
7 Whereas, a 2021 study found that AI/AN persons are underrepresented at only 0.3% of
8 research participants while comprising 3% of the US population, while non-Hispanic whites were
9 overrepresented at 82% while comprising 59% of the US population^{2,4,6,9,12}; and
10
11 Whereas, a National Institutes of Health (NIH) report on AI/AN engagement in the All of Us
12 Research Program noted a need for comanagement of precision medicine research with AI/AN
13 communities and consideration of the distinct ethical, legal, and social contexts when engaging
14 AI/AN communities in research, including their status as political entities¹³⁻¹⁶; and
15
16 Whereas, AI/AN researchers have developed specific models to recruit AI/AN persons for
17 clinical trials that account for the complex geopolitical climates of sovereign governments that
18 extend far beyond considerations of race and ethnicity, such as the principles for engaging in
19 ethical research with Indigenous people by Claw et al. and the Circle of Trust^{9,14,17-19}; and
20
21 Whereas, the Indian Health Service does not have the resources or facilities to support
22 precision medicine research without institutional partnerships²⁰; and
23
24 Whereas, a 2022 White House Office of Science and Technology Policy memorandum
25 recognized the value of Indigenous knowledge in scientific advances and created a working
26 group to include Indigenous perspectives in federal decisions and grantmaking²¹; therefore be it
27
28 RESOLVED, that our American Medical Association support clinical funding supplements to the
29 National Institutes of Health, the U.S. Food and Drug Administration, and the Indian Health
30 Service to promote greater participation of the Indian Health Service, Tribal, and Urban Indian
31 Health Programs in clinical research. (Directive to Take Action)

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

Received: 4/5/2024

REFERENCES

1. Overview of Precision Medicine - US. Accessed August 27, 2023. <https://www.thermofisher.com/us/en/home/clinical/precision-medicine/precision-medicine-learning-center/precision-medicine-resource-library/precision-medicine-articles/overview-precision-medicine.html>
2. Lee SSJ, Fullerton SM, McMahon CE, et al. Targeting Representation: Interpreting Calls for Diversity in Precision Medicine Research. *Yale J Biol Med*. 2022;95(3):317-326.
3. Vigil D, Sinai N, Karp B. American Indian and Alaska Native Enrollment in Clinical Studies in the National Institutes of Health's Intramural Research Program. *Ethics Hum Res*. 2021;43(3):2-9. doi:10.1002/eahr.500090
4. Aldrighetti CM, Niemierko A, Van Allen E, Willers H, Kamran SC. Racial and Ethnic Disparities Among Participants in Precision Oncology Clinical Studies. *JAMA Netw Open*. 2021;4(11):e2133205. doi:10.1001/jamanetworkopen.2021.33205
5. Commissioner O of the. Collection of Race and Ethnicity Data in Clinical Trials. Published August 10, 2023. Accessed August 27, 2023. <https://www.fda.gov/regulatory-information/search-fda-guidance-documents/collection-race-and-ethnicity-data-clinical-trials>
6. Khoury MJ, Bowen S, Dotson WD, et al. Health equity in the implementation of genomics and precision medicine: A public health imperative. *Genet Med Off J Am Coll Med Genet*. 2022;24(8):1630-1639. doi:10.1016/j.gim.2022.04.009
7. Farrell J, Burow PB, McConnell K, Bayham J, Whyte K, Koss G. Effects of land dispossession and forced migration on Indigenous peoples in North America. *Science*. 2021;374(6567):eabe4943. doi:10.1126/science.abe4943
8. Adakai M. Health Disparities Among American Indians/Alaska Natives — Arizona, 2017. *MMWR Morb Mortal Wkly Rep*. 2018;67. doi:10.15585/mmwr.mm6747a4
9. Skewes MC, Gonzalez VM, Gameon JA, et al. Health Disparities Research with American Indian Communities: The Importance of Trust and Transparency. *Am J Community Psychol*. Published online July 11, 2020:10.1002/ajcp.12445. doi:10.1002/ajcp.12445
10. Solomon TGA, Starks RRB, Attakai A, et al. The Generational Impact Of Racism On Health: Voices From American Indian Communities. *Health Aff (Millwood)*. 2022;41(2):281-288. doi:10.1377/hlthaff.2021.01419
11. Trinidad SB, Blacksher E, Woodbury RB, et al. Precision medicine research with American Indian and Alaska Native communities: Results of a deliberative engagement with tribal leaders. *Genet Med Off J Am Coll Med Genet*. 2022;24(3):622-630. doi:10.1016/j.gim.2021.11.003
12. U.S. Census Bureau QuickFacts: United States. Accessed August 27, 2023. <https://www.census.gov/quickfacts/fact/table/US/PST045222>
13. Bentley AR, Callier S, Rotimi CN. Diversity and inclusion in genomic research: why the uneven progress? *J Community Genet*. 2017;8(4):255-266. doi:10.1007/s12687-017-0316-6
14. Mainous AG, Kelliher A, Warne D. Recruiting Indigenous Patients Into Clinical Trials: A Circle of Trust. *Ann Fam Med*. 2023;21(1):54-56. doi:10.1370/afm.2901
15. All of Us Tribal Engagement. All of Us Research Program | NIH. Published September 14, 2020. Accessed August 27, 2023. <https://allofus.nih.gov/about/diversity-and-inclusion/tribal-engagement>
16. All of Us Research Program Tribal Consultation Final Report. All of Us Research Program | NIH. Published March 16, 2021. Accessed August 27, 2023. <https://allofus.nih.gov/all-us-research-program-tribal-consultation-final-report>
17. Claw KG, Anderson MZ, Begay RL, Tsosie KS, Fox K, Garrison NA. A framework for enhancing ethical genomic research with Indigenous communities. *Nat Commun*. 2018;9:2957. doi:10.1038/s41467-018-05188-3
18. H-460.884 Indigenous Data Sovereignty | AMA. Accessed August 27, 2023. <https://policysearch.ama-assn.org/policyfinder/detail/%22Indigenous%20Data%20Sovereignty%20H-460.884%22?uri=%2FAMADoc%2FHOD.xml-H-460.884.xml>
19. Pacheco CM, Daley SM, Brown T, Filippi M, Greiner KA, Daley CM. Moving Forward: Breaking the Cycle of Mistrust Between American Indians and Researchers. *Am J Public Health*. 2013;103(12):2152-2159. doi:10.2105/AJPH.2013.301480
20. Requirements: Priorities of Care | Eligibility. Purchased/Referred Care (PRC). Accessed August 27, 2023. <https://www.ihs.gov/prc/eligibility/requirements-priorities-of-care/>
21. OSTP-CEQ-IK-Guidance.pdf. Accessed August 27, 2023. <https://www.whitehouse.gov/wp-content/uploads/2022/12/OSTP-CEQ-IK-Guidance.pdf>
22. Disparities | Fact Sheets. Newsroom. Published January 1, 2013. Accessed August 27, 2023. <https://www.ihs.gov/newsroom/factsheets/disparities>

RELEVANT AMA Policy

H-460.884 Indigenous Data Sovereignty

Our AMA: (1) recognizes that American Indian and Alaska Native (AI/AN) Tribes and Villages are sovereign governments that should be consulted before the conduct of research specific to their members, lands, and properties; (2) supports that AI/AN Tribes and Villages' Institutional Review Boards (IRBs) and research departments retain the right to oversee and regulate the collection, ownership, and management of research data with the consent of their members, and that individual members of AI/AN Tribes and Villages retain their autonomy and privacy regarding research data shared with researchers, AI/AN Tribes and Villages, and governments, consistent with existing protections under 45 CFR 46; and (3) encourages: (a) the use and regular review of data-sharing agreements for all studies between academic medical centers and AI/AN Tribes and Villages be mutually agreed upon and aligned with AI/AN Tribes' and Villages' preferences, and (b) the National Institutes of Health and other stakeholders to provide flexible funding to AI/AN Tribes and Villages for research efforts, including the creation and maintenance of IRBs. [Res. 003, I-22]

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

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 Rep. 4, A-06; Reaffirmed: CSAPH Rep. 4, A-10; Reaffirmed: CSAPH Rep. 01, A-20]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 503
(A-24)

Introduced by: Albert L. Hsu, MD

Subject: Unregulated Hemp-Derived Intoxicating Cannabinoids, and Derived Psychoactive Cannabis Products (DPCPs)

Referred to: Reference Committee E

- 1 Whereas, hemp was taken off the controlled substances list in 2018 by the Agriculture
2 Improvement Act;^{1,2} and
3
- 4 Whereas, the 2018 Farm Bill legalized hemp but included “derivatives” and “isomers” of the
5 plant in the definition of hemp, as long as content of delta-9 THC by weight is less than 0.3%;^{1,2}
6 and
7
- 8 Whereas, since 2018, processes have been developed to chemically derive over a dozen
9 different intoxicating cannabinoids from hemp at varying potency levels;^{1,2} and
10
- 11 Whereas, the recent amplified availability and use of Hemp-Driven Intoxicating Cannabinoids
12 (e.g. delta-8 tetrahydrocannabinol (THC) and over a dozen others) pose significant health risks,
13 particularly to youth;^{1,2} and
14
- 15 Whereas, reporting of adverse reactions to consumption of products containing Hemp-Derived
16 Intoxicating Cannabinoids has increased;^{1,2} and
17
- 18 Whereas, these products are marketed progressively and assertively in eye-catching ways to
19 attract public consumption, particularly that of young consumers;^{1,2} and
20
- 21 Whereas, there are no regulations imposing age restrictions on intoxicating hemp-derived
22 products, which are widely available online and in brick-and-mortar establishments like gas
23 stations, grocery stores, and convenience stores;^{1,2} and
24
- 25 Whereas, some of these intoxicating hemp-derived products intentionally mimic commercial
26 food products that appeal to children;^{1,2} and
27
- 28 Whereas, many of these products are mislabeled, alleging inaccurate potency, and not
29 disclosing presence of combinations of intoxicating cannabinoids or other toxic byproducts or
30 contaminants;^{1,2} and
31
- 32 Whereas, direct effects of these particular cannabinoids on the body include (but are not limited
33 to): impairment of cognitive function, memory and judgment; hallucinations; anxiety; nausea,
34 vomiting; dizziness, tremor; loss of consciousness, death; dependency (and prolonged use may
35 result in dependency, leading to addiction and withdrawal symptoms);^{1,2} and
36
- 37 Whereas, “Derived Psychoactive Cannabis Products” (DPCPs) have psychoactive properties
38 similar to cannabis, but are chemically derived and not grown;² and

1 Whereas, DPCPs have been available in every state, including those that have banned Δ -8
2 THC, because the loophole allows for engineering of new DPCPs, including Δ -6 THC, Δ -10
3 THC, Δ -11 THC, THC-A, THC-O, THC-P, THC-V, THC-JD, PHC, HHC, HHC-P, and HXC;^{1,2}
4 and

5
6 Whereas, DPCPs are very new (unknown and unproven and uncharacterized), and we have
7 minimal data on short- and long-term risks from use;² and

8
9 Whereas, DPCP use has been associated with psychiatric, lung, chest, and heart disorders, as
10 well as injuries and poisonings;² and

11
12 Whereas, DPCPs have been consumed accidentally by children, partly due to lack of age laws
13 in many states, poor labeling, lack of childproof containers, and marketing to young people
14 (including product packaging mimicking well-known food brands that appeal to children,
15 including Cap'n Crunch, Cocoa Puffs, Froot Loops, Starbursts and Sour Patch Kids);² and

16
17 Whereas, DPCPs have been marketed in ways to attract children, such as added in candy,
18 chips, and chocolates. DPCPs are also inexpensive (sometimes < \$5) and stores are
19 disproportionately located in low-income areas;² and

20
21 Whereas, most states do not require testing for chemical contaminants, even though DPCPs
22 are commonly synthesized using hash solvents known to be hazardous to human health;² and

23
24 Whereas, potency limits are rare, despite conclusive evidence that more potent products carry
25 higher risk of harms;² and

26
27 Whereas, there is a complex interplay between the endocannabinoid system and the estrogen
28 system in the central nervous system, raising concerns about how use of these products may
29 impact fertility, pregnancy, breastfeeding, and contraception; therefore, be it

30
31 RESOLVED, that our American Medical Association work with other interested organizations to
32 increase public awareness and promote education on the dangers of Derived Psychoactive
33 Cannabis Products (DPCPs) and Hemp-Derived Intoxicating Cannabinoids (Directive to Take
34 Action); and be it further

35
36 RESOLVED, that our AMA work with other interested organizations to advocate to close the
37 loophole in the 2018 Farm bill that allows Derived Psychoactive Cannabis Products (DPCPs)
38 and Hemp-Derived Intoxicating Cannabinoids to be regulated as hemp (Directive to Take
39 Action); and be it further

40
41 RESOLVED, that our AMA work with other interested organizations to advocate for prohibition
42 of Derived Psychoactive Cannabis Products (DPCPs) and Hemp-Derived Intoxicating
43 Cannabinoids (unless and until properly tested in humans) (Directive to Take Action); and be it
44 further

45
46 RESOLVED, that our AMA work with other interested organizations to advocate for further
47 research on the health impacts of Derived Psychoactive Cannabis Products (DPCPs) and
48 Hemp-Derived Intoxicating Cannabinoids, including the potential dangers of these products to
49 children, pregnant women and other vulnerable populations (Directive to Take Action); and be it
50 further

1 RESOLVED, that our AMA report back on this issue at A-25. (Directive to Take Action)

2

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

Received: 4/23/2024

References:

1. "Health Risks Associated with Hemp-Derived Intoxicating Cannabinoids." Health Advisory by the Missouri Department of Health and Senior Services (DHSS), 18 April 2024. PDF at: <https://health.mo.gov/emergencies/ert/alerts/advisories/pdf/advisory041824.pdf>, accessed 4/19/24
2. University of North Texas Health Science Center at Fort Worth School of Public Health – Dr. Matthew Rossheim <https://www.unthsc.edu/school-of-public-health/derived-psychoactive-cannabis-products-dpcps/>
3. MO DHSS: <https://health.mo.gov/safety/cannabis/pdf/hemp-derived-cannabinoids.pdf>
4. CDC: Increases in Availability of Cannabis Products Containing Delta-8 THC and Reported Cases of Adverse Events. https://emergency.cdc.gov/han/2021/pdf/CDC_HAN_451.pdf
5. DEA: https://www.dea.gov/sites/default/files/2020-06/Marijuana-Cannabis-2020_0.pdf
6. FDA: 5 Things to Know about Delta-8 Tetrahydrocannabinol – Delta-8 THC <https://www.fda.gov/consumers/consumer-updates/5-things-know-about-delta-8-tetrahydrocannabinol-delta-8-thc>
7. Harlow AF, Miech RA, Leventhal AM. Adolescent Δ8 -THC and Marijuana Use in the US. JAMA. 2024;331(10):861–865. doi:10.1001/jama.2024.0865
8. Rossheim, Matthew & Tillett, Kayla & Vasilev, Viktor & Loparco, Cassidy & Berg, Carla & Trangenstein, Pamela & Yockey, Andrew & Sussman, Steve & Siegel, Michael & Jernigan, David. (2024). Types and Brands of Derived Psychoactive Cannabis Products: An Online Retail Assessment, 2023. Cannabis and cannabinoid research. 10.1089/can.2023.0266.
9. LoParco, C.R., Rossheim, M.E., Walters, S. T., Zhou, Z., Olsson, S., & Sussman, S. (2023). Delta-8 tetrahydrocannabinol: a scoping review and commentary. *Addiction*, 118(6):1011–28. doi: 10.1111/add.16142 |
10. Rossheim, M.E., LoParco, C., Henry, D., Trangenstein, P.J., & Walters, S.T. (2023). Delta-8, Delta-10, HHC, THC-O, THCP, and THCV: What should we call these products? *Journal of Studies on Alcohol and Drugs*. doi: 10.15288/jsad.23-00008 |
11. Livingston, M.D., Walker, A., Cannell, M.B., & Rossheim, M.E. (2022). Popularity of Delta-8 THC on the Internet Across US States, 2021. *American Journal of Public Health*, 112(2), 296–299. doi: 10.2105/AJPH.2021.306586. |
12. Livne, O., Budney, A., Borodovsky, J., Walsh, C., Shmulewitz, D., Fink, D.S., Struble, C.A., Habib, M., Aharonovich, E., & Hasin, D.S. (2022). Delta-8 THC use in US adults: Sociodemographic characteristics and correlates. *Addictive Behaviors*, 133, 107374. doi: 10.1016/j.addbeh.2022.107374 |
13. Leas, E.C., Harati, R.M., Satybaldiyeva, N., Morales, N.E., Huaker, S.L., Mejorado, T., & Grant, I. (2023). Self-reported adverse events associated with Delta-8-Tetrahydrocannabinol (Delta-8-THC) Use. *Journal of Cannabis Research*, 5(15). doi: 10.1186/s42238-023-00191-y |
14. United States Food and Drug Administration (FDA). (2022). 5 Things to Know about Delta-8 Tetrahydrocannabinol – Delta-8 THC. <https://www.fda.gov/consumers/consumer-updates/5-things-know-about-delta-8-tetrahydrocannabinol-delta-8-thc> |
15. Bozman, M.E., Manoharan, S.V.R.R., Vasavada, T. (2022). Marijuana variant of concern: Delta 8-tetrahydrocannabinol (Delta-8-THC, Delta-8-THC). *Psychiatry Research Case Reports*, 1(2). doi: 10.1016/j.psycr.2022.100028. |
16. Egan, K.L., Villani, S., & Soule, E.K. (2023). Absence of Age Verification for Online Purchases of Cannabidiol and Delta-8: Implications for Youth Access. *Journal of Adolescent Health*. doi: 10.1016/j.jadohealth.2023.01.020. |
17. Rossheim, M.E., LoParco, C.R., Walker, A., Livingston, M.D., Trangenstein, P.J., Olsson, S., McDonald, K.K., Yockey, R.A., Lunningham, J.M., Kong, A.Y., Henry, D., Walters, S.T., Thombs, D.L., & Jernigan, D.H. (2022). Delta-8 THC Retail Availability, Price, and Minimum Purchase Age. *Cannabis and Cannabinoid Research*. doi: 10.1089/can.2022.0079 |
18. <https://www.fda.gov/food/alerts-advisories-safety-information/fda-warns-consumers-about-accidental-ingestion-children-food-products-containing-th>
19. American College of Obstetricians and Gynecologists Committee on Obstetric Practice. Committee Opinion No. 637: Marijuana Use During Pregnancy and Lactation. *Obstet Gynecol*. 2015 Jul;126(1):234-8. doi: 10.1097/01.AOG.0000467192.89321.a6. PMID: 26241291.
20. AMA Council on Science and Public Health (CSAPH) report 6 (I-23) on "Marketing Guardrails for the 'Over-Medicalization' of Cannabis Use"

Relevant AMA policy:

Regulation of Cannabidiol Products H-120.926

Our AMA will: (1) encourage state controlled substance authorities, boards of pharmacy, and legislative bodies to take the necessary steps including regulation and legislation to reschedule U.S. Food and Drug Administration (FDA)-approved cannabidiol products, or make any other necessary regulatory or legislative change, as expeditiously as possible so that they will be available to patients immediately after approval by the FDA and rescheduling by the U.S. Drug Enforcement Administration; (2) advocate that an FDA-approved cannabidiol medication should be governed only by the federal and state regulatory provisions that apply to other prescription-only products, such as dispensing through pharmacies, rather than by these various state laws applicable to unapproved **cannabis** products; and (3) support

comprehensive FDA regulation of cannabidiol products and practices necessary to ensure product quality, including identity, purity, and potency.

Cannabis Product Safety D-95.956

Our American Medical Association will draft state model legislation to help states implement the provisions of AMA policies H-95.924, **Cannabis** Legalization for Adult Use and H-95.936, **Cannabis** Warnings for Pregnant and Breastfeeding Women that currently do not have such model language, including regulation of retail sales, marketing and promotion (especially those aimed at children), misleading health claims, and product labeling regarding dangers of use during pregnancy and breastfeeding.

Marketing Guardrails for the "Over-Medicalization" of Cannabis Use D-95.958

Our AMA will: (1) send a formal letter to the Food and Drug Administration and Federal Trade Commission requesting more direct oversight of the marketing of **cannabis** for medical use; (2) generate a formal letter for use by state medical societies requesting more direct oversight by state government of the marketing of **cannabis**; (3) support and encourage federal, state, and private sector research on the effects of **cannabis** marketing to identify best practices in protecting vulnerable populations, as well as the benefits of safety campaigns such as preventing impaired driving or dangerous use; (4) encourage state regulatory bodies to enforce **cannabis**-related marketing laws and to publicize and make publicly available the results of such enforcement activities; (5) encourage social media platforms to set a threshold age of 21 years for exposure to **cannabis** advertising and marketing and improve age verification practices on social media platforms; (6) encourage regulatory agencies to research how marketing best practices learned from tobacco and alcohol policies can be adopted or applied to **cannabis** marketing; and (7) support using existing AMA channels to educate physicians and the public on the health risks of **cannabis** to children and potential health risks of **cannabis** to people who are pregnant or lactating.

Cannabis Warnings for Pregnant and Breastfeeding Women H-95.936

Our AMA advocates for regulations requiring point-of-sale warnings and product labeling for **cannabis** and **cannabis**-based products regarding the potential dangers of use during pregnancy and breastfeeding wherever these products are sold or distributed.

Taxes on Cannabis Products H-95.923

Our AMA encourages states and territories to allocate a substantial portion of their **cannabis** tax revenue for public health purposes, including: substance abuse prevention and treatment programs, **cannabis**-related educational campaigns, scientifically rigorous research on the health effects of **cannabis**, and public health surveillance efforts.

Cannabis and Cannabinoid Research H-95.952

1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.
2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical **cannabis** programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of **cannabis** meets the current standards for a prescription drug product.
3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving **cannabis** and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for **cannabis** clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of **cannabis** for clinical research purposes; c) confirming that **cannabis** of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.

4. Our AMA supports research to determine the consequences of long-term **cannabis** use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.
5. Our AMA urges legislatures to delay initiating the legalization of **cannabis** for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.
6. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to **cannabis** and cannabinoids.
7. Our AMA will create a **Cannabis** Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924

Our AMA: (1) believes that **cannabis** is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of **cannabis** for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages **cannabis** use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized **cannabis** (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of **cannabis** extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized **cannabis** use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of **cannabis**, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including **cannabis** use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing **cannabis** for personal use; (8) encourages research on the impact of legalization and decriminalization of **cannabis** in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of **cannabis**; (10) will advocate for stronger public health messaging on the health effects of **cannabis** and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of **cannabis** use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding **cannabis**-impaired driving; (11) supports social equity programs to address the impacts of **cannabis** prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of **cannabis** on human health and on methods for counseling and educating patients on the use **cannabis** and cannabinoids.

Cannabis Legalization for Medicinal Use D-95.969

Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential **cannabis** products for medical use; (2) believes that **cannabis** for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all **cannabis** products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend **cannabis** in accordance with their state's laws; (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; (6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians; and (7) encourages hospitals and health systems to: (a) not recommend patient use of non-FDA approved **cannabis** or **cannabis** derived products within healthcare facilities until such time as federal laws or regulations permit its use; and (b) educate medical staffs on **cannabis** use, effects and **cannabis** withdrawal syndrome.

Medical Marijuana License Safety D-95.959

1. Our AMA supports efforts to include medical **cannabis** license certification in states' prescription drug monitoring programs when consistent with AMA principles safeguarding patient privacy and confidentiality.
2. Our AMA will continue its monitoring of state legislation relating to the inclusion of **cannabis** and related information in state PDMPs.
3. Our AMA will review existing state laws that require information about medical **cannabis** to be shared with or entered into a state prescription drug monitoring program. The review should address impacts on patients, physicians and availability of information including types, forms, THC concentration, quantity, recommended usage, and other medical **cannabis** details that may be available from a dispensary.

Cannabis Intoxication as a Criminal Defense H-95.997

Our AMA believes a plea of **cannabis** intoxication not be a defense in any criminal proceedings.

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

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

Preventing the Elimination of Cannabis from Occupational and Municipal Drug Testing Programs H-95.902

Our American Medical Association supports the continued inclusion of **cannabis** metabolite analysis in relevant drug testing analysis performed for occupational and municipal purposes (pre-employment, post-accident, random and for-cause).

Alcohol and Drug Use and Addiction Education H-170.992

Our AMA: (1) supports continued encouragement for increased educational programs relating to use of and addiction involving alcohol, **cannabis** and controlled substances; (2) supports the implementation of alcohol and **cannabis** education in comprehensive health education curricula, kindergarten through grade twelve; and (3) encourages state medical societies to work with the appropriate agencies to develop a state-funded educational campaign to counteract pressures on young people to use alcohol, **cannabis** products, and controlled substances.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 504
(A-24)

Introduced by: California
Subject: FDA Regulation of Biosimilars
Referred to: Reference Committee E

1 Whereas, biologics drugs account for 2% of pharmaceutical prescriptions by volume, but
2 account for 37-43% of current U.S. pharmaceutical spending and 90% of net pharmaceutical
3 spending growth over the past decade;¹⁻⁶ and
4
5 Whereas, biologic drugs, typically recombinant proteins or monoclonal antibodies, are
6 significantly more expensive than small molecule drugs; prices average ~\$10,000-\$40,000 per
7 patient per year, and can be as costly as \$250,000 per patient per year;¹⁻⁶ and
8
9 Whereas, biosimilar medications are defined by the Food and Drug Administration (FDA) and
10 European Medicines Agency (EMA) as “highly similar to and have no clinically meaningful
11 differences in terms of safety, purity, and potency when compared to an originator biologic that
12 is already approved;”⁷ and
13
14 Whereas, under the 2010 Biologics and Price Competition Act, the FDA created a licensure
15 pathway (called the 351(k) pathway) for approving biosimilars of originator biologics; the first
16 biosimilar was approved by the FDA in 2015;⁷ and
17
18 Whereas, the approval process is more stringent for a biosimilar in comparison with a generic
19 small molecule, requiring approval through the Biologics License Application Pathway and post-
20 marketing surveillance;⁸ and
21
22 Whereas, in 2018, the FDA standardized requirements for approving “interchangeable
23 biologics”, defined as a biosimilar that meets additional requirements that allow it to be
24 substituted for an originator biologic without the intervention of the health care professional who
25 prescribed the reference product, much like how generic drugs are routinely substituted for
26 brand name drugs, i.e., “pharmacy-level substitution;”⁹ and
27
28 Whereas, existing regulations allow physicians to specify when a pharmacy-level substitution is
29 not clinically appropriate, such as for reasons of allergies or concern for adverse reactions to
30 inactive ingredients; and
31
32 Whereas, U.S. regulatory requirements to designate a biosimilar as ‘interchangeable’ are
33 significantly more stringent than those in Europe; to demonstrate ‘interchangeability’ the FDA
34 requires a Phase 3 switching non-inferiority trial, in which patients are repeatedly switched
35 between the biosimilar and reference biologic agent, whereas the EMA considers biosimilars as
36 ‘interchangeable’ without the need for additional crossover “switching” studies;¹⁰⁻¹⁶ and
37
38 Whereas, long-term clinical studies of biosimilars in European countries have not demonstrated
39 any notable difference in the efficacy or safety of biosimilar products relative to originators,
40 which challenges the necessity for these switching studies;¹⁵⁻¹⁶ and

1 Whereas, the FDA requirements to achieving an “interchangeable” designation in the U.S. are
2 another reason that uptake of biosimilars has been lower in the U.S. than in other Organization
3 for Economic Cooperation and Development (OECD) countries;¹⁰⁻²⁵ and
4

5 Whereas, pharmaceutical companies have made huge investments in the U.S. to market
6 biologics as superior to their biosimilar counterparts; which may explain why biosimilars only
7 have an average market penetration rate of 20%, compared with 80% in Europe;¹⁷⁻²⁵ and
8

9 Whereas, a survey of 510 U.S. community oncologists illustrated significant knowledge gaps in
10 the use of biosimilars and this translated into hesitancy in prescribing biosimilars;²⁶ and
11

12 Whereas, a recent American Society of Clinical Oncology (ASCO) policy statement recognized
13 that “biosimilars and reference products can be considered equally efficacious for the purpose
14 of inclusion in ASCO clinical practice guidelines,” regardless of its FDA designation as
15 “interchangeable”, and supports removal of this distinction;^{27,28} therefore be it
16

17 RESOLVED, that our American Medical Association recognize that, by definition, Biosimilar
18 medications are clinically equivalent to their reference Biologic and therefore do not need a
19 designation of “interchangeability;” (New HOD Policy); and be it further
20

21 RESOLVED, that our AMA support a rigorous approval process for Biosimilar medications and
22 oppose the application of the redundant designation of “interchangeability” with the reference
23 biologic drug (New HOD Policy); and it be further
24

25 RESOLVED, that AMA support the development of a model and a process for biologic and
26 biosimilar medication prescribing that protects physician decision-making when a pharmacy-
27 level substitution is not clinically appropriate (New HOD Policy); and be it further
28

29 RESOLVED, that our AMA support physician education on the clinical equivalence of
30 Biosimilars, the FDA approval process and the post-market surveillance that is required. (New
31 HOD Policy)

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

Received: 4/23/2024

References:

1. Medicare Payment Advisory Commission, “Prescription Drugs.” *Health Care Spending and the Medicare Program: Data Book*, July 2021. https://www.medpac.gov/wp-content/uploads/2021/10/July2021_MedPAC_DataBook_Sec10_SEC.pdf.
2. Tichy EM, Hoffman JM, Suda KJ, et al. National trends in prescription drug expenditures and projections for 2022. *Am J Health Syst Pharm*. 2022;79(14):1158-1172. doi:10.1093/ajhp/zxac102
3. IQVIA Institute for Human Data and Science, Biosimilars in the United States 2020-2024: Competition, Savings and Sustainability (September 29, 2020), <https://www.iqvia.com/insights/the-iqvia-institute/reports/biosimilars-in-theunited-states-2020-2024>.
4. Mulchachy et al. Projected US Savings From Biosimilars, 2021-2025. 2022. *Am J Manag Care*. 2022;28(7):329-335.
5. Roy, A. Biologic Medicines: The Biggest Driver of Rising Drug Prices. *Forbes*, <https://www.forbes.com/sites/theapothecary/2019/03/08/biologic-medicines-the-biggest-driver-of-rising-drug-prices/?sh=72e153a118b0>. March 8, 2019, Accessed August 28, 2022.
6. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Medicare Part B Drugs: Trends in Spending and Utilization, 2006-2017, (ASPE, November 2020), <https://aspe.hhs.gov/system/files/pdf/264416/Part-B-Drugs-Trends-Issue-Brief.pdf>.
7. FDA. Biological Product Innovation and Competition Act. <https://www.fda.gov/drugs/biosimilars/biological-product-innovation-and-competition#:~:text=The%20Biologics%20Price%20Competition%20and,safe%20and%20effective%20biological%20products>.
8. Scientific considerations in demonstrating biosimilarity to a reference product: guidance for industry. FDA. April 2015. <https://www.fda.gov/media/82647/download>
9. Zachary Brennan. 2019. Updated: Interchangeable Biosimilars: FDA Finalizes Guidance. *Regulatory Focus*. <https://www.raps.org/news-and-articles/news-articles/2019/5/interchangeable-biosimilars-fda-finalizes-guidanc>

10. Elena Wolff-Holz et al., "Evolution of the EU Biosimilar Framework: Past and Future," *BioDrugs* 33, (September 20, 2019): 621–34. <https://doi.org/10.1007/s40259-019-00377-y>.
11. Mielke et al., "An Update on the Clinical Evidence That Supports Biosimilar Approvals in Europe."
12. Marie-Christine Bielsky et al., "Streamlined Approval of Biosimilars: Moving on from the Confirmatory Efficacy Trial," *Drug Discovery Today* 25, no. 11 (November 1, 2020): 1910–18. <https://doi.org/10.1016/j.drudis.2020.09.006>.
13. Sarfaraz Niazi, "Do we need comparative efficacy testing for biosimilars?" *Biosimilar Development*, April 7, 2020, <https://www.biosimilardevelopment.com/doc/do-we-need-comparative-clinical-efficacy-testing-for-biosimilars0001>
14. Hans C. Ebbers, Huub Schellekens, "Are we ready to close the discussion on the interchangeability of biosimilars?," *Drug Discovery Today*, Volume 24, Issue 10 (October 2019): 1963-67. <https://doi.org/10.1016/j.drudis.2019.06.016>
15. Anna La Noce and Marcin Ernst, "Switching from Reference to Biosimilar Products: An Overview of the European Approach and Real-World Experience So Far", *European Medical Journal*, EMJ. 2018;3[3]:74-81. (September 2018). <https://www.emjreviews.com/rheumatology/article/switching-from-reference-to-biosimilar-products-anoverview-of-the-european-approach-and-real-world-experience-so-far/>.
16. Pekka Kurki et al., "Interchangeability of biosimilars: A European perspective," *BioDrugs*, 31(2), 83-91 (April 2017), doi:<http://dx.doi.org.proxy.lib.duke.edu/10.1007/s40259-017-0210-0>
17. Michael S. Reilly and Phillip J. Schneider. "Policy Recommendations for a Sustainable Biosimilars Market: Lessons from Europe" *Generics and Biosimilars Initiative Journal* 9, no. 2 (February 2020): 76–83. <https://doi.org/10.5639/gabij.2020.0902.013>.
18. Uptake of Biosimilars in Different Countries Varies," *Generics and Biosimilars Initiative*, August 11, 2019. <https://www.gabionline.net/Reports/Uptake-of-biosimilars-in-different-countries-varies>
19. "Humira Biosimilars Available at up to 80 Percent Discount in Europe: AbbVie," *Reuters*, November 2, 2018, <https://www.reuters.com/article/us-abbvie-results-humira-idUSKCN1N71NZ>.
20. IQVIA Institute for Human Data and Science, *Biosimilars in the United States 2020-2024: Competition, Savings and Sustainability* (September 29, 2020), <https://www.iqvia.com/insights/the-iqvia-institute/reports/biosimilars-in-theunited-states-2020-2024>.
21. San-Juan-Rodriguez et al. 2019. Trends in List Prices, Net Prices, and Discounts for Originator Biologics Facing Biosimilar Competition. *JAMA Netw Open*. 2019;2(12):e1917379.
22. Benjamin Yu. 2016. Greater Potential Cost Savings With Biosimilar Use. *Am J Manag Care*. 2016;22(5):378
23. Mulchachy et al. Projected US Savings From Biosimilars, 2021-2025. 2022. *Am J Manag Care*. 2022;28(7):329-335.
24. Kay J. The Dawn of the Biosimilars in the Management of IMiDs: Understanding and Integrating Biosimilar Data into Informed Collaborative Care. Presented at: IAS 2018; April 27-29, 2018; Boston.
25. Scott Morton et al. 2018. The Impact of the Entry of Biosimilars: Evidence from Europe. *Review of Industrial Organization*. <https://link.springer.com/article/10.1007/s11151-018-9630-3#Sec14>
26. Nabhan C, Valley A, Feinberg BA. Barriers to Oncology Biosimilars Uptake in the United States. *Oncologist*. 2018;23(11):1261-1265. doi:10.1634/theoncologist. 2018-0066
27. Rodriguez R, Mancuso J, Lyman G et al. ASCO Policy Statement on Biosimilar and Interchangeable Products in Oncology. April, 2023. *JCO Oncol Pract* 19:411-419 <https://ascopubs.org/doi/full/10.1200/OP.22.00783>
28. <https://www.ama-assn.org/system/files/a23-245.pdf>

RELEVANT AMA POLICY

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.

[Modified: CSAPH Rep. 4, A-14; Modified: CSAPH Rep. 1, 1-11; Reaffirmation A-11; Res. 220, A-09.]

H-125.976 Biosimilar Interchangeability Pathway

Our AMA will: (1) strongly support the pathway for demonstrating biosimilar interchangeability that was proposed in draft guidance by the FDA in 2017, including requiring manufacturers to use studies to determine whether alternating between a reference product and the proposed interchangeable biosimilar multiple times impacts the safety or efficacy of the drug; and (2) issue a request to the FDA that the agency finalize the biosimilars interchangeability pathway outlined in its draft guidance "Considerations in Demonstrating Interchangeability With a Reference 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]

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. [Modified: CSAPH Rep. 4, A-14, Modified: CSAPH Rep. 1, 1-11; Res. 918, I-08]

D-330.960 Cuts in Medicare Outpatient Infusion Services

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. [Reaffirmation: I-18; Reaffirmed: CMS Rep. 10, A-16; Reaffirmation A-15; Reaffirmed and Modified: CMS Rep. 3, I-08; Res. 926, I-03]

D-330.904 Opposition to the CMS Medicare Part B Drug Payment Model

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.
[Res. 241, A-16]

H-110.983 Medicare Part B Competitive Acquisition Program (CAP)

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.

[Reaffirmed: CMS Rep. 4, A-22; Reaffirmed: CMS Rep. 4, I-19; Res. 216, I-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 505
(A-24)

Introduced by: Medical Student Section

Subject: Mitigating the Harms of Colorism and Skin Bleaching Agents

Referred to: Reference Committee E

1 Whereas, colorism is defined as discrimination which treats people with lighter skin more
2 favorably than those with darker skin, including within a given racial or ethnic group,
3 distinguishing it from racism;¹⁻⁴ and
4

5 Whereas, studies associate colorism with differences in health outcomes, treatment in clinical
6 settings, income, education, housing, and marital status;¹⁻¹³ and
7

8 Whereas, due to the social value of lighter skin entrenched in colorism and the implicit
9 understanding that lighter skin tone lessens discrimination, practices such as depigmentation
10 and skin bleaching have increased;^{2,7} and
11

12 Whereas, skin bleaching or lightening aims to lighten someone's skin in either specific areas
13 ('dark spots') or their overall skin tone, with creams serving as a common agent;¹⁵⁻¹⁹ and
14

15 Whereas, some skin lightening agents are evidence-based medical treatments for
16 dermatological conditions such as pigmentation disorders, when prescribed, instructed, and
17 supervised by a physician such as a dermatologist;²⁰⁻²⁷ and
18

19 Whereas, unsupervised skin lightening is an alarming public health concern due to associated
20 adverse effects and the large global supply of unregulated products, widely available over-the-
21 counter via online shopping such as Amazon and social media such as Tik Tok;¹⁵⁻³¹ and
22

23 Whereas, the three most common components in skin lightening agents that have faced
24 scrutiny from the medical and scientific communities are hydroquinone, mercury, and topical
25 corticosteroids, with the Food and Drug Administration (FDA) listing 22 specific products
26 confirmed to have unsafe levels of hydroquinone and mercury;³²⁻⁴² and
27

28 Whereas, the FDA and other public health agencies have raised concerns about the lack of
29 effective regulation of skin lightening agents due to illegal shipments into the US, their over-the-
30 counter availability despite lack of FDA approval, and marketing and sales tactics targeting
31 communities of color, immigrants, and people with darker skin;⁴³⁻⁴⁶ and
32

33 Whereas, the Personal Care Products Safety Act and the Cosmetic Safety Enhancement Act
34 would both improve regulation of cosmetic products such as skin lightening agents by
35 increasing safety tests, verifying international suppliers, and investigating counterfeits;⁴⁷⁻⁴⁸ and
36

37 Whereas, the long history and psychological harms of colorism and the widespread pressures to
38 engage in unsupervised skin bleaching result in many individuals starting in adolescence,
39 experiencing depression due to discrimination, and wanting to "acquire beauty," "appear more

1 white or European,” enhance their social mobility or romantic life, and even “avoid police
2 encounters,” highlighting the intersecting effects of colorism and racism;^{20-27,49-53} and
3

4 Whereas, recent pieces in the *Journal of the American Academy of Dermatology* have raised
5 concern about the public health impacts of colorism and skin bleaching;⁵⁴⁻⁵⁵ and
6

7 Whereas, the international implications of the skin bleaching product market, especially for
8 communities of color and immigrants in the US, suggest the potential for partnerships at the
9 international level with the World Medical Association and other parties; therefore be it

10
11 RESOLVED, that our American Medical Association support efforts to reduce the unsupervised
12 use of skin lightening agents, especially due to colorism or social stigma, that do not limit
13 evidence-based use by qualified clinicians (New HOD Policy); and be it further
14

15 RESOLVED, that our AMA work with the World Medical Association and other interested parties
16 to mitigate the harms of colorism and unsupervised use of skin lightening agents. (Directive to
17 Take Action)
18

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

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REFERENCES

1. Hunter M. The Persistent Problem of Colorism: Skin Tone, Status, and Inequality: The Persistent Problem of Colorism: Skin Tone, Status, and Inequality. *Sociol Compass*. 2007;1(1):237-254. doi:10.1111/j.1751-9020.2007.00006.x
2. Daftary K, Krishnam NS, Kundu RV. Uncovering the roots of skin bleaching: Colorism and its detrimental effects. *J Cosmet Dermatol*. 2023;22(1):337-338. doi:10.1111/jocd.15049
3. Navata A, Ocholski C, Anaya-Lopez M, Martinez C, Dennis J. Colonial mentality and colorism among Filipinx Americans. *Asian Am J Psychol*. Published online February 13, 2023. doi:10.1037/aap0000311
4. Noe-Bustamante L, Gonzalez-Barrera A, Edwards K, Mora, Lopez M. Majority of Latinos Say Skin Color Impacts Opportunity in America and Shapes Daily Life. Pew Research Center; 2021. Accessed September 16, 2023. <https://www.pewresearch.org/hispanic/2021/11/04/majority-of-latinos-say-skin-color-impacts-opportunity-in-america-and-shapes-daily-life/>
5. Landor AM, McNeil Smith S. Skin-Tone Trauma: Historical and Contemporary Influences on the Health and Interpersonal Outcomes of African Americans. *Perspect Psychol Sci*. 2019;14(5):797-815. doi:10.1177/1745691619851781
6. Nguyen JK. Racial discrimination in non-fungible token (NFT) prices? CryptoPunk sales and skin tone. *Econ Lett*. 2022;218:110727. doi:10.1016/j.econlet.2022.110727
7. Keyes L, Small E, Nikolova S. The complex relationship between colorism and poor health outcomes with African Americans: A systematic review. *Anal Soc Issues Public Policy*. 2020;20(1):676-697. doi:10.1111/asap.12223
8. Hargrove TW. Light Privilege? Skin Tone Stratification in Health among African Americans. *Sociol Race Ethn*. 2019;5(3):370-387. doi:10.1177/2332649218793670
9. Campos-Vazquez RM, Medina-Cortina EM. Skin Color and Social Mobility: Evidence From Mexico. *Demography*. 2019;56(1):321-343. doi:10.1007/s13524-018-0734-z
10. Hall JC. No Longer Invisible: Understanding the Psychosocial Impact of Skin Color Stratification in the Lives of African American Women. *Health Soc Work*. 2017;42(2):71-78. doi:10.1093/hsw/hlx001
11. Stewart QT, Cobb RJ, Keith VM. The color of death: race, observed skin tone, and all-cause mortality in the United States. *Ethn Health*. 2020;25(7):1018-1040. doi:10.1080/13557858.2018.1469735
12. DeAngelis RT, Hargrove TW, Hummer RA. Skin Tone and the Health Returns to Higher Status. *Demography*. 2022;59(5):1791-1819. doi:10.1215/00703370-10191675
13. Uzogara EE. Who desires in-group neighbors? Associations of skin tone biases and discrimination with Latinas' segregation preferences. *Group Process Intergroup Relat*. 2019;22(8):1196-1214. doi:10.1177/1368430218788154
14. Perreira KM, Telles EE. The color of health: Skin color, ethnoracial classification, and discrimination in the health of Latin Americans. *Soc Sci Med*. 2014;116:241-250. doi:10.1016/j.socscimed.2014.05.054
15. Lewis MB. Who is the fairest of them all? Race, attractiveness and skin color sexual dimorphism. *Personal Individ Differ*. 2011;50(2):159-162. doi:10.1016/j.paid.2010.09.018
16. Pollock S, Taylor S, Oyerinde O, et al. The dark side of skin lightening: An international collaboration and review of a public health issue affecting dermatology. *Int J Womens Dermatol*. 2021;7(2):158-164. doi:10.1016/j.ijwd.2020.09.006
17. Bellew SG, Alster TS. Treatment of Exogenous Ochronosis With a Q-Switched Alexandrite (755 nm) Laser. *Dermatol Surg*. 2004;30(4):555-558. doi:10.1097/00042728-200404000-00022
18. Maneli MH, Wiesner L, Tinguely C, et al. Combinations of potent topical steroids, mercury and hydroquinone are common in internationally manufactured skin-lightening products: a spectroscopic study. *Clin Exp Dermatol*. 2016;41(2):196-201. doi:10.1111/ced.12720
19. Bastiansz A, Ewald J, Rodríguez Saldaña V, Santa-Rios A, Basu N. A Systematic Review of Mercury Exposures from Skin-Lightening Products. *Environ Health Perspect*. 2022;130(11):116002. doi:10.1289/EHP10808

20. Vijaya RM. The New Economics of Colorism in the Skin Whitening Industry: Case of India and Nigeria. In: Johnson GD, Thomas KD, Harrison AK, Grier SA, eds. *Race in the Marketplace*. Springer International Publishing; 2019:227-244. doi:10.1007/978-3-030-11711-5_14
21. Adbi A, Chatterjee C, Cortland C, Kinias Z, Singh J. Women's Disempowerment and Preferences for Skin Lightening Products That Reinforce Colorism: Experimental Evidence From India. *Psychol Women Q*. 2021;45(2):178-193. doi:10.1177/0361684321993796
22. Glenn EN. Yearning for Lightness: Transnational Circuits in the Marketing and Consumption of Skin Lighteners. *GenD Soc*. 2008;22(3):281-302. doi:10.1177/0891243208316089
23. Sagoe D, Pallesen S, Dlova NC, Lartey M, Ezzedine K, Dadzie O. The global prevalence and correlates of skin bleaching: a meta-analysis and meta-regression analysis. *Int J Dermatol*. 2019;58(1):24-44. doi:10.1111/ijd.14052
24. Dorman J. Skin Bleach And Civilization: The Racial Formation of Blackness in 1920s Harlem. *J Pan Afr Stud*. 2011;4(4). <http://jpanafrican.org/docs/vol4no4/Dorman%20Skin%20Bleach%20And%20Civilization.pdf>
25. Hill ME. Skin Color and the Perception of Attractiveness among African Americans: Does Gender Make a Difference? *Soc Psychol Q*. 2002;65(1):77. doi:10.2307/3090169
26. Laidley T, Domingue B, Sinsub P, Harris KM, Conley D. New Evidence of Skin Color Bias and Health Outcomes Using Sibling Difference Models: A Research Note. *Demography*. 2019;56(2):753-762. doi:10.1007/s13524-018-0756-6
27. Slaughter-Acey JC, Sneed D, Parker L, Keith VM, Lee NL, Misra DP. Skin Tone Matters: Racial Microaggressions and Delayed Prenatal Care. *Am J Prev Med*. 2019;57(3):321-329. doi:10.1016/j.amepre.2019.04.014
28. Michalek IM, Pintro K, Benn EKT, Liu B, Caetano Dos Santos FL. An analysis of skin lightening products' violations reported in four U.S. databases in 2002–2020: In hunt of surveillance quality enhancement, not just an assessment of the magnitude of the problem. *Regul Toxicol Pharmacol*. 2020;116:104731. doi:10.1016/j.yrtph.2020.104731
29. Cramer M. Johnson & Johnson Will Stop Selling Skin-Whitening Lotions. *The New York Times*. <https://www.nytimes.com/2020/06/19/business/johnson-and-johnson-skin-whitening-cream.html>. Published June 25, 2020.
30. Senthilingam M, Muni P, Offiong V. Skin whitening: What is it, what are the risks and who profits? <https://www.cnn.com/2022/01/25/world/as-equals-skin-whitening-global-market-explainer-intl-cmd/index.html>. Published June 25, 2020.
31. Cheng AD, De La Garza H, Maymone MBC, Johansen VM, Vashi NA. Skin-Lightening Products: Consumer Preferences and Costs. *Cureus*. Published online August 17, 2021. doi:10.7759/cureus.17245
32. TRI-LUMA Cream. U.S. Food and Drug Administration; 2013. Accessed September 13, 2023. https://www.accessdata.fda.gov/drugsatfda_docs/label/2013/021112s006lbl.pdf
33. Harris JE. Chemical-Induced Vitiligo. *Dermatol Clin*. 2017;35(2):151-161. doi:10.1016/j.det.2016.11.006
34. Schwartz C, Jan A, Zito PM. Hydroquinone. In: *StatPearls*. StatPearls Publishing; 2023. Accessed September 15, 2023. <http://www.ncbi.nlm.nih.gov/books/NBK539693/>
35. Hydroquinone. In: *American Conference of Governmental Industrial Hygienists*; 2022. Accessed April 30, 2023. <https://www.acgih.org/hydroquinone/>
36. O'Donoghue JL. Hydroquinone and its analogues in dermatology ? a risk-benefit viewpoint. *J Cosmet Dermatol*. 2006;5(3):196-203. doi:10.1111/j.1473-2165.2006.00253.x
37. Agorku ES, Kwaansa-Ansah EE, Voegborlo RB, Amegbletor P, Opoku F. Mercury and hydroquinone content of skin toning creams and cosmetic soaps, and the potential risks to the health of Ghanaian women. *SpringerPlus*. 2016;5(1):319. doi:10.1186/s40064-016-1967-1
38. Hamann CR, Boonchai W, Wen L, et al. Spectrometric analysis of mercury content in 549 skin-lightening products: Is mercury toxicity a hidden global health hazard? *J Am Acad Dermatol*. 2014;70(2):281-287.e3. doi:10.1016/j.jaad.2013.09.050
39. Ricketts P, Knight C, Gordon A, Boischio A, Voutchkov M. Mercury Exposure Associated with Use of Skin Lightening Products in Jamaica. *J Health Pollut*. 2020;10(26):200601. doi:10.5696/2156-9614-10.26.200601
40. Coondoo A, Phiske M, Verma S, Lahiri K. Side-effects of topical steroids: A long overdue revisit. *Indian Dermatol Online J*. 2014;5(4):416. doi:10.4103/2229-5178.142483
41. Olumide YM, Akinkugbe AO, Altraide D, et al. Complications of chronic use of skin lightening cosmetics. *Int J Dermatol*. 2008;47(4):344-353. doi:10.1111/j.1365-4632.2008.02719.x
42. Perret JL, Sane M, Gning S, Ba K, Rohou G. [Hypothalamo-hypophyseal-adrenal hypofunction caused by the use of bleaching cosmetics in Senegal]. *Bull Soc Pathol Exot* 1990. 2001;94(3):249-252.
43. Summary of Cosmetic Labeling Requirements. U.S. Food and Drug Administration; 2022. Accessed February 19, 2023. <https://www.fda.gov/cosmetics/cosmetics-labeling-regulations/summary-cosmetics-labeling-requirements#Declaration>
44. FDA works to protect consumers from potentially harmful OTC skin lightening products. Food and Drug Administration. <https://www.fda.gov/drugs/drug-safety-and-availability/fda-works-protect-consumers-potentially-harmful-otc-skin-lightening-products#:~:text=All%20OTC%20skin%20lightening%20products>. Published May 10, 2022. Accessed September 22, 2022.
45. Skin Lightening Products Found to Contain Mercury. Minnesota Department of Health. <https://www.health.state.mn.us/communities/environment/skin/index.html>. Published October 30, 2022.
46. Skin Product Safety. U.S. Food and Drug Administration. <https://www.fda.gov/consumers/skin-facts-what-you-need-know-about-skin-lightening-products/skin-product-safety>. Published October 27, 2022. Accessed February 19, 2023.
47. Personal Care Products Safety Act. Vol 5. U.S. Government Publishing Office; 2019:552a, 552, 552. Accessed September 17, 2023. <https://www.govinfo.gov/app/details/BILLS-116s726is>
48. Rep. Pallone F. H.R.5279 - 116th Congress (2019-2020): Cosmetic Safety Enhancement Act of 2019. Published March 11, 2020. Accessed September 17, 2023. <https://www.congress.gov/bill/116th-congress/house-bill/5279>
49. Alrayyes SF, Alrayyes SF, Farooq UD. Skin-lightening patterns among female students: A cross-sectional study in Saudi Arabia. *Int J Womens Dermatol*. 2019;5(4):246-250. doi:10.1016/j.ijwd.2019.04.026
50. Peltzer K, Pengpid S, James C. The globalization of whitening: prevalence of skin lighteners (or bleachers) use and its social correlates among university students in 26 countries. *Int J Dermatol*. 2016;55(2):165-172. doi:10.1111/ijd.12860
51. Gwaravanda ET. Shona Proverbial Implications on Skin Bleaching: Some Philosophical Insights. *J Pan Afr Stud*. 2011;4(4):195-218.
52. Craddock N, Dlova N, Diedrichs PC. Colourism: a global adolescent health concern. *Curr Opin Pediatr*. 2018;30(4):472-477. doi:10.1097/MOP.0000000000000638

53. Charles CAD, McLean SK. Body image disturbance and skin bleaching. *Br J Psychol.* 2017;108(4):783-796. doi:10.1111/bjop.12241
54. Desai SR, Khanna R. The skin bleaching epidemic: Reply to "Regulation of skin lightening agents in the United States and implications for public health." *Journal of the American Academy of Dermatology.* 2021;85(6):e413. doi:10.1016/j.jaad.2021.05.076
55. Liu Y, Krueger LD, Nguyen HP. Regulation of skin lightening agents in the United States and implications for public health. *Journal of the American Academy of Dermatology.* 2021;85(6):1608-1610. doi:10.1016/j.jaad.2020.12.007

RELEVANT AMA Policy

Racism as a Public Health Threat H-65.952

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies. [Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22]

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]

Pulse Oximetry in Patients with Pigmented Skin D-480.957

Our AMA recognizes that pulse oximeters may not accurately measure oxygen saturation in all skin tones and will continue to urge the US Food and Drug Administration to (1) ensure pulse oximeters provide accurate and reliable readings for patients with diverse degrees of skin pigmentation and (2) ensure health care personnel and the public are educated on the limitations of pulse oximeter technology so they can account for measurement error. [Res. 915, I-22]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 506
(A-24)

Introduced by: Medical Student Section

Subject: Screening for Image Manipulation in Research Publications

Referred to: Reference Committee E

1 Whereas, the scientific community has raised alarm regarding research misconduct involving
2 image manipulation, leading some journals to implement AI-based screening tools to detect
3 alterations indistinguishable to humans and sometimes themselves generated by AI;¹⁻² and
4

5 Whereas, the American Association of Cancer Research's AI-based Proofig is now used by
6 multiple journal publishers and has demonstrated improved efficacy in detecting image
7 manipulation compared to human analysts to reject publications;³⁻⁶ and
8

9 Whereas, image screening will likely lag behind advancements in image manipulation, such as
10 generative adversarial networks (GANs), a type of machine learning algorithm specifically
11 designed to deceive or evade other AI tools; and
12

13 Whereas, efforts to improve image screening tools therefore depend on as much data from
14 manipulated images as possible; therefore be it
15

16 RESOLVED, that our American Medical Association support the creation of a nationally
17 collaborative database of manipulated images from retracted publications to provide a test bank
18 for researchers developing augmented intelligence-integrated image screening tools. (New
19 HOD Policy)
20

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REFERENCES

1. Wang, L., Zhou, L., Yang, W., & Yu, R. (2022). Deepfakes: A new threat to image fabrication in scientific publications? *Patterns*, 3(5), 100509. doi:10.1016/j.patter.2022.100509
2. Qi, C., Zhang, J., & Luo, P. (2021). Emerging Concern of Scientific Fraud: Deep Learning and Image Manipulation. *BioRxiv*, 2020.11.24.395319. doi:10.1101/2020.11.24.395319
3. About Us: Proofig Ltd.: Software image integrity. proofig. (n.d.). Retrieved March 19, 2023, from <https://www.proofig.com/about-us>
4. Jackson S, Williams CL, Collins KL, McNally EM. Data we can trust. *J Clin Invest*. 2022 Aug 1;132(15):e162884. doi: 10.1172/JCI162884. PMID: 35912864; PMCID: PMC9337817.
5. Van Noorden, R. (2021, December 21). Journals adopt AI to spot duplicated images in manuscripts. *Nature News*. Retrieved March 19, 2023, from <https://www.nature.com/articles/d41586-021-03807-6>
6. Gu, J., Wang, X., Li, C., Zhao, J., Fu, W., Liang, G., & Qiu, J. (2022). AI-enabled image fraud in scientific publications. *Patterns*, 3(7), 100511. doi:10.1016/j.patter.2022.100511

RELEVANT AMA Policy

7.1.5 Misconduct in Research

Biomedical and health research is intended to advance medical knowledge to benefit future patients. To achieve those goals physicians who are involved in such research maintain the highest standards of professionalism and scientific integrity.

Physicians with oversight responsibilities in biomedical or health research have a responsibility to ensure that allegations of scientific misconduct are addressed promptly and fairly. They should ensure that procedures to resolve such allegations:

- (a) Do not damage science.
- (b) Resolve charges expeditiously.
- (c) Treat all parties fairly and justly. Review procedures should be sensitive to parties' reputations and vulnerabilities.
- (d) Maintain the integrity of the process. Real or perceived conflicts of interest must be avoided.
- (e) Maintain accurate and thorough documentation throughout the process.
- (f) Maintain the highest degree of confidentiality.
- (g) Take appropriate action to discharge responsibilities to all individuals involved, as well as to the public, research sponsors, the scientific literature, and the scientific community.

AMA Principles of Medical Ethics: I,III,V [Issued: 2016]

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]

Assessing the Potentially Dangerous Intersection Between AI and Misinformation H-480.935

Our American Medical Association will: (1) study and develop recommendations on the benefits and unforeseen consequences to the medical profession of large language models (LLM) such as, generative pretrained transformers (GPTs), and other augmented intelligence-generated medical advice or content, and that our AMA propose appropriate state and federal regulations with a report back at A-24; (2) work with the federal government and other appropriate organizations to protect patients from false or misleading AI-generated medical advice; (3) encourage physicians to educate our patients about the benefits and risks of consumers facing LLMs including GPTs; and (4) support publishing groups and scientific journals to establish guidelines to regulate the use of augmented intelligence in scientific publications that include detailing the use of augmented intelligence in the methods, exclusion of augmented intelligence systems as authors, and the responsibility of authors to validate the veracity of any text generated by augmented intelligence. [Res. 247, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 507
(A-24)

Introduced by: Illinois

Subject: Ban on Dual Ownership, Investment, Marketing or Distribution of
Recreational Cannabis by Medical Cannabis Companies

Referred to: Reference Committee E

1 Whereas, recreational cannabis legislation is often linked to perceived medical cannabis
2 acceptance. As the industry matures, there is significantly less time from when medical
3 cannabis is first legalized, to the first recreational sale. According to Marijuana Business
4 Daily, California took 7,308 days from medical to recreational to the state's first sale.
5 Massachusetts took just 1,463 days (<https://mjbizdaily.com/letter-of-the-law/> also see
6 reference 9); and

7
8 Whereas, national recreational cannabis sales account for over 60% of all legal cannabis
9 sales (and increasing) in 2020 ([https://mjbizdaily.com/chart-nationwide-sales-of-adult-use-
10 cannabis-further-eclipse-those-of-medical-marijuana/](https://mjbizdaily.com/chart-nationwide-sales-of-adult-use-cannabis-further-eclipse-those-of-medical-marijuana/)) with medical cannabis sales either
11 plateauing or declining; and

12
13 Whereas, national recreational cannabis sales are projected to account for approximately
14 75% of all legal retail cannabis sales in 2028 ([https://mjbizdaily.com/us-cannabis-sales-
15 estimates/](https://mjbizdaily.com/us-cannabis-sales-estimates/)); and

16
17 Whereas, for example, the number of medical cannabis patients in Oregon has been in a
18 freefall since adult-use cannabis sales began, down 65% from October 2015 to July 2019
19 ([https://mjbizdaily.com/chart-how-medical-cannabis-programs-fare-in-states-with-
20 recreational-markets/](https://mjbizdaily.com/chart-how-medical-cannabis-programs-fare-in-states-with-recreational-markets/)); and

21
22 Whereas, according to Americans for Safe Access (ASA): “After combing through thousands
23 of data points on the state programs, it is clear that, with a few exceptions, states that have
24 added recreational/adult-use markets are forgetting the needs of patients”
25 (<https://www.safeaccessnow.org/sos22>); and

26
27 Whereas, ASA concludes that medical cannabis companies are moving to recreational use;
28 and

29
30 Whereas, cannabis companies are broadening their offering to get a piece of both the
31 medical and recreational pie ([https://www.adweek.com/brand-marketing/marketing-cannabis-
32 within-the-confines-of-recreational-and-medical/](https://www.adweek.com/brand-marketing/marketing-cannabis-within-the-confines-of-recreational-and-medical/)); and

33
34 Whereas, a recent JAMA study noted that as “Cannabis legalization is expanding, making
35 understanding how cannabis companies legitimize themselves critical. Industry motivation to
36 increase consumption makes policies difficult to modify once established. Public health
37 actors have been wary of industry CSR activities, given research demonstrating such
38 programs are ineffectual by design and advance corporate interest;” and

1 Whereas, similar to tobacco companies, cannabis companies appear to use corporate social
2 responsibility (CSR) practices activities that normalize and legitimize the industry for the goal
3 to open markets and influence regulation (Wakefield T, Glantz SA, Apollonio DE. Content
4 Analysis of the Corporate Social Responsibility Practices of 9 Major Cannabis Companies in
5 Canada and the US. JAMA Network Open. 2022;5(8): e2228088.
6 doi:10.1001/jamanetworkopen.2022.28088); and
7

8 Whereas, industry motivation to increase consumption makes policies difficult to modify once
9 established (Room R, Cisneros Örnberg J. Government monopoly as an instrument for
10 public health and welfare: lessons for cannabis from experience with alcohol monopolies. Int
11 J Drug Policy. 2019;74:223-228. doi:10.1016/j.drugpo.2019.10.008); and
12

13 Whereas, there is volatility in the cannabis industry: In 2021, there were around 306 merger
14 and acquisition deals in the cannabis industry across North America, more than triple the
15 number in the previous year ([https://www.statista.com/statistics/1336787/mergers-and-
16 acquisitions-cannabis-industry-north-america/](https://www.statista.com/statistics/1336787/mergers-and-acquisitions-cannabis-industry-north-america/)); and
17

18 Whereas, if any traditional medical pharmaceutical company owned, invested, promoted or
19 distributed their addictive medication for recreational purposes (even indirectly), severe
20 criticism and ethical questions would ensue; and
21

22 Whereas, in Maryland, medical cannabis companies are prohibited from selling a controlling
23 interest within five years after converting to adult-use sales
24 ([https://mmcc.maryland.gov/Documents/2023%20 PDF Files/Adult-
25 Use%20Cannabis%20Legalization/COMAR%2014.17.01-.22%205.19.23 Watermarked.pdf](https://mmcc.maryland.gov/Documents/2023%20PDF%20Files/Adult-Use%20Cannabis%20Legalization/COMAR%2014.17.01-.22%205.19.23%20Watermarked.pdf));
26 and
27

28 Whereas, dual ownership of medical/recreational cannabis companies also can represent a
29 conflict of interest that can harm medical cannabis patients (i.e. diversion of cannabis
30 products when scarce to recreational dispensaries); and
31

32 Whereas, a survey by University of Chicago in 2019 found that seventy percent of those with
33 personal experience with opioid addiction say pharmaceutical firms are responsible for the
34 problem of opioid addiction, along with 59% of those without any opioid addiction among
35 their family or friends ([https://apnorc.org/projects/pharmaceutical-companies-and-drug-users-
36 most-often-blamed-for-opioid-crisis/](https://apnorc.org/projects/pharmaceutical-companies-and-drug-users-most-often-blamed-for-opioid-crisis/)); and
37

38 Whereas, initiating THC use at a potency of 12% is associated with almost a five-fold higher
39 risk for progression to cannabis use disorder symptom onset within a year; and
40

41 Whereas THC exhibits adverse cardiac, neurological and psychiatric effects (see
42 references); therefore be it
43

44 RESOLVED, that our American Medical Association support a permanent ban on medical
45 cannabis companies (and its related holding conglomerates) from owning, investing in,
46 distributing, or promoting recreational (or “adult use”) cannabis or any other activity relating
47 to recreational use of cannabis. (New HOD Policy)

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REFERENCES

1. Scroyer, J.: Marijuana foes seek to impose THC potency caps to curb industry's growth. *MJBizDaily*, March 25, 2021
2. Rebik, D.: Despite pandemic, 2020 was the deadliest for Illinois Roads in 13 years. *WGNTV.com* March 4, 2021
3. Johnson, T.: Fatal Road Crashes involving marijuana double after states legalizes drug. *Newsroom.aaa.com*, May 2016
4. Arterberry, B.J., Padovano, H.T., Foster, K.T., et al: Higher average potency across the United States is associated with progression to first cannabis use disorder symptoms, *Drug Alcohol Depend* 2019;195:186-192
5. Pierre, J.M., Gandal, M., Son M.: Cannabis – induced psychosis associated with high potency “wax dabs”; *Schizophr Res* 2016: 172 (1-3): 211-212
6. Cerne K.: Toxicological Properties of Delta 9 – tetrahydrocannabinol and cannabidiol. *Aeh Hig Rada Toksikol*, 2020: 71 (1): 1-11
7. Temple L, Lampert S, Ewigman B. Barriers to achieving optimal success with medical cannabis in IL: opportunities for quality improvement. *J Alt Compl Med*. 2018. [Doi.org/10.1089/acm.2018.0250](https://doi.org/10.1089/acm.2018.0250)
8. Wen H, Hockenberry J. Association of medical and adult-use marijuana laws with opioid prescribing for Medicaid enrollees. *JAMA Internal Medicine*. 2018; 178(5): 673-679
9. Chhabra N, Leikin JB. Analysis of medical marijuana laws in states transitioning to recreational marijuana –a legislatively gateway drug policy? Presented at the North American Congress of Clinical Toxicology; Vancouver BC. October 2017.
10. Mowery JB, Spyker DA, Brooks DE, et al. 2015 Annual Report of the American Association of Poison Control Centers' National Poison Data System (NPDS): 33rd Annual Report. *Clin Toxicol*. 2016; 54(10): 924-1109
11. Leikin JB, Amusina O. Use of dexmedetomidine to treat delirium primarily caused by cannabis. *Am J Emerg Med*. 2017; 35:80: e5 -801.e6
12. Arterberry BJ, Treloar-Padovano H, Foster K. Higher average potency across the United States is associated with progression to first cannabis use disorder symptom. *Drug Alcohol Depend*. 2018, Dec.
13. Neauyn MJ, Blohm E, Babu KM, Bird SM. Medical marijuana and driving: a review. *J Medical Toxicol*. 2014; 10:269-279
14. Grontenhemin F, Russo E, Zuardi AW. Even high doses of oral cannabidiol do not cause THC-like effects in humans: comment on Merrick et al cannabis and cannabinoid research. *Cannabis and Cannabinoid Research*. 2017; 2(1):1-4
15. Zhu H, Wu L-T. Sex differences in cannabis use disorder diagnosis involved hospitalizations in the United States. *Journal of Addiction Medicine*. 2017; 11(5): 357-367
16. Betholet N, Cheng DM, Patfai TP, et al. Anxiety, depression, and pain symptoms: associations with the course of marijuana use and drug use consequences among urban primary care patients. *Journal of Addiction Medicine*. 2018; 12(1): 45-52
17. Mark K, Gryczynski J, Axenfeld E, et al. Pregnant women's current and intended cannabis use in relation to their views toward legalization and knowledge of potential harm. *Journal of Addiction Medicine*. 2017; 11(3): 211-216
18. Oliviera P, Morais AS, Madeira N. Synthetic cannabis analogues and suicidal behavior: case report. *Journal of Addiction Medicine*. 2017; 11(5): 408-410
19. Lammert S, Harrison K, Tosun N, et al. Menstrual cycle in women who co-use marijuana and tobacco. *Journal of Addiction Medicine*. 2018; 12(3):207-211
20. Caputi TL, Humphrey K. Medical marijuana users are more likely to use prescription drugs medically and non-medically. *Journal of Addiction Medicine*. 2018; 12(4) 295-299
21. Bagra I, Krishnan V, Rao R, et al. Does cannabis use influence opioid outcomes and quality of life among buprenorphine maintained patients? A cross-sectional comparative study. *Journal of Addiction Medicine*. 2018; 12(4): 315-320
22. Koppel BS, Brust JC, Fife T. Systemic review: efficacy and safety of medical marijuana in selected neurological disorders: report of the guideline development subcommittee of the American Academy of Neurology. *Neurology*. 2014; 82:1556-1563
23. Houser W, Fitzcharles MA, Radbrunch L, Petzke F. Cannabinoids in pain management and palliative medicine. *Disch Arztebl Int*. 2017; 114 (38): 627-634
24. Finnerup NB, Attal N, Haroutounian S, et al. Pharmacotherapy for neuropathic pain in adults: a systemic review and meta-analysis. *Lancet Neurol*. 2015; 14(2): 162-173
25. Jensen B, Chen J, Furnish T, Wallace M. Medical marijuana and chronic pain: a review of basic science and clinical evidence. *Curr Pain Headache Rep*. 2015; 19 (10):50. [Doi 10.1007/S11916-015-0524-x](https://doi.org/10.1007/S11916-015-0524-x)
26. Nielsen S, Sabioni P, Trigo JM, et al. Opioid-sparing effect of cannabinoids: a systemic review and meta-analysis. *Neuropsychopharmacology*. 2017; 42(9):1752-1765
27. Johnson LD, Miech RA, O'Malley PM, et al. Monitoring the future national survey results on drug use 1975-2017: overview key findings on adolescent drug use. *Ann Arbor: Institute for Social Research; the University of Michigan*. 2018: 1-3
28. Abrams DI, Vizoso HP, Shade SB, et al. Vaporization as a smokeless cannabis delivery system: a pilot study. *Clin Pharmacol Ther*. 2007; 82(5): 572-578
29. D'Souza DC, Ranganathan M. Medical marijuana: is the cart before the horse? *JAMA*. 2015; 313(24): 2431-2432
30. Whiting PF, Wolff RF, Deshpande S, et al. Cannabinoids for medical use: a systemic review and meta-analysis. *JAMA*. 313(24): 2456-2473
31. Caulley L, Caplan B, Ross E. Medical marijuana for chronic pain. *N Engl J Med*. 2018; 379: 1575-1577
32. Greydanus DE, Kaplan G, Baxter Sr LE, et al. Cannabis: the never-ending, nefarious mepenthe of the 21st century: what should the clinician know? *Disease-a-Month*. 2015; 61(4): 118-175
33. MacCoun RJ, Mello MM. Half-baked-the retail promotion of marijuana edibles. *N Engl J Med*. 2015; 372(11): 989-991

34. Richards JR, Smith NE, Moulin AK. Unintentional Cannabis Ingestion in Children: A Systemic Review. *Journal of Pediatrics*. 2017; 190: 142-152
35. Benjamin DM, Fossler MJ. Edible Cannabis Products: It is Time for FDA Oversight. *J Clin Pharmacology*. 2016; 56(9): 1045-1047
36. Kim HS, Monte AA. Colorado Cannabis Legalization and its Effect on Emergency Care. *Ann Emerg Med*. 2016; 68(1): 71-75
37. Ammerman SD, Ryan SA, Adelman WP. American Academy of Pediatrics: The Impact of Marijuana Policies on Youth: Clinical Research and Legal Update. *Pediatrics*. 2015; 135(3): e769-e785
38. Ryan SA, Ammerman SD, O'Connor ME. Marijuana Use During Pregnancy and Breastfeeding: Implications for Neonatal and Childhood Outcomes. *Pediatrics*. 2018;142. DOI:10.1542/peds.2018-1889
39. Wang GS. Pediatric Concerns Due to Expanded Cannabis Use: Unintended Consequences of Legalization. *J Med Toxicology*. 2017; 13(1): 99-105
40. Scragg RK, Mitchell EA, Ford RP, et al. Maternal Cannabis Use in the Sudden Death Syndrome. *Acta Paediatr*. 2001; 90(1):57-60
41. Klonoff-Cohen H, Lam-Kruglick P. Maternal and Paternal Recreational Drug Use and Sudden Infant Death Syndrome. *Acta Paediatr Adolesc Med*. 2001;155(7): 765-770
42. Leung J, Chiu C, Sjepanic D, Hall W. Has the Legalization of Medical and Recreational Cannabis Use in the USA Affected the Prevalence of Cannabis Use and Cannabis Use Disorder? *Current Addiction Reports*. 2018; 5(4): 403-417
43. Temple LM, Leikin JB. (2019): Tetrahydrocannabinol – friend or foe? – Debate, *Clinical Toxicology*, May 7, 2019 (<https://doi/full/10.1080/15563650.2019.1610567>); 2020; 58(2):75-81
44. Kennedy J, Leikin JB. Pulmonary Disease Related to E-Cigarette Use. *New England Journal of Medicine*. August 2020, Vol 383 (8): p.792
45. Cordova J, Biank VF, Black EG, Leikin JB. Urinary Cannabis Metabolite Concentrations in Cannabinoid Hyperemesis Syndrome. Presented to the Great Lakes Gut Club, Rosemont, IL. July 2019

Relevant AMA Policy

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924

Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids.

Marketing Guardrails for the "Over-Medicalization" of Cannabis Use D-95.958

Our AMA will: (1) send a formal letter to the Food and Drug Administration and Federal Trade Commission requesting more direct oversight of the marketing of cannabis for medical use; (2) generate a formal letter for use by state medical societies requesting more direct oversight by state government of the marketing of cannabis; and (3) study marketing practices of cannabis, cannabis products and cannabis paraphernalia that influence vulnerable populations, such as children or pregnant people.

Cannabis Legalization for Medicinal Use D-95.969

Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; (6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians; and (7) encourages hospitals and health systems to: (a) not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use; and (b) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 508
(A-24)

Introduced by: Mississippi

Subject: AMA to support regulations to decrease overdoses in children due to ingestion of edible cannabis

Referred to: Reference Committee E

1 Whereas, the American Association of Poison Control Centers shows more than 7,000
2 confirmed cases of kids younger than six years old who have eaten marijuana edibles were
3 reported to the nation's poison control centers between 2017 and 2021; and
4

5 Whereas, edibles are often packaged to look like candy or cookies and children unaware of the
6 risks may find them appealing; and
7

8 Whereas, consuming too much cannabis can lead to serious health problems in children
9 including confusion, hallucinations, tachycardia and vomiting, and in severe cases children can
10 experience trouble breathing or even coma; therefore be it
11

12 RESOLVED, that our American Medical Association work with the Food and Drug
13 Administration to strengthen how marijuana manufacturers can advertise their products,
14 including regulations that ensure the packaging does not appeal to children (Directive to Take
15 Action); and be it further
16

17 RESOLVED, that our AMA propose public awareness campaigns aimed at informing the
18 general population, especially parents and guardians, about the risks associated with edible
19 cannabis and the importance of safe storage and handling (Directive to Take Action); and be it
20 further
21

22 RESOLVED, that our AMA emphasize the importance of childproof packaging for all cannabis
23 products, along with advocating for stricter regulations to enforce this requirement. (New HOD
24 Policy)
25

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

Received: 4/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution:509
(A-24)

Introduced by: Senior Physicians Section

Subject: Addressing Sarcopenia and its Impact on Quality of Life

Referred to: Reference Committee E

1 Whereas, sarcopenia, the progressive loss of skeletal muscle mass, strength, and function
2 typically associated with aging, poses significant health challenges to the rapidly growing senior
3 population¹; and
4

5 Whereas, sarcopenia contributes to increased risk of falls, fractures, disability, decreased
6 mobility, increased cardiovascular morbidity and mortality, cognitive decline, diminished length
7 and quality of life and increased healthcare costs^{2,3,4}; and
8

9 Whereas, sarcopenia is estimated to affect 10-16% of persons worldwide, especially the elderly
10 and malnourished⁵; and
11

12 Whereas, the prevalence of sarcopenia will predictably continue to rise in the aging population,
13 necessitating proactive measure to mitigate its impact; and
14

15 Whereas, sarcopenia is a potentially modifiable, multifactorial condition influenced by factors
16 such as inadequate nutrition, sedentary lifestyle, chronic diseases, hormonal changes and
17 inflammation⁶; and
18

19 Whereas, early detection, prevention, and management strategies are crucial measures in
20 addressing sarcopenia and its adverse consequences; therefore be it
21

22 RESOLVED, that our American Medical Association collaborate with appropriate entities to
23 develop and implement educational awareness targeting healthcare professionals, caregivers,
24 and the elderly population to increase knowledge about sarcopenia, its risk factors and
25 consequences, in order to facilitate prevention, early recognition and evidence-based
26 management as a routine part of clinical practice with elderly patients (Directive to Take Action);
27 and be it further
28

29 RESOLVED, that our AMA (1) support nutritional interventions aimed at optimizing protein
30 intake, essential amino acids, and micronutrients; (2) promote regular physical activity, including
31 resistance training, aerobic exercise, and balance exercises, tailored to individual capabilities
32 and preferences (New HOD Policy); and be it further
33

34 RESOLVED, that our AMA support allocation of resources for research initiatives aimed at
35 advancing our understanding of sarcopenia, its pathophysiology, risk factors, and treatment
36 modalities (New HOD Policy); and be it further
37

38 RESOLVED, that our AMA advocate for policy changes to support reimbursement for
39 sarcopenia screening, diagnosis, and interventions (Directive to Take Action); and be it further

- 1 RESOLVED, that our AMA collaborate with all stakeholders to integrate sarcopenia prevention
2 and management into public health agendas and aging-related initiatives. (Directive to Take
3 Action)

Fiscal Note: \$101,420: Contract with third parties to develop educational content and advertise beyond standard AMA channels.

Received: 5/2/2024

REFERENCES

1. Colón, C. J. P., Molina-Vicenty, I. L., Frontera-Rodríguez, M., García-Ferré, A., Rivera, B. P., Cintrón-Vélez, G., & Frontera-Rodríguez, S. (2018). Muscle and Bone Mass Loss in the Elderly Population: Advances in diagnosis and treatment. *Journal of Biomedicine (Sydney, NSW)*, 3, 40.
2. Damluji, A. A., Alfaraidhy, M., AlHajri, N., Rohant, N. N., Kumar, M., Al Malouf, C., ... & Goyal, P. (2023). Sarcopenia and cardiovascular diseases. *Circulation*, 147(20), 1534-1553.
3. Yuan, S., & Larsson, S. C. (2023). Epidemiology of sarcopenia: Prevalence, risk factors, and consequences. *Metabolism*, 155533.
4. Hida, T., Harada, A., Imagama, S., & Ishiguro, N. (2014). Managing sarcopenia and its related-fractures to improve quality of life in geriatric populations. *Aging and disease*, 5(4), 226.
5. Yuan, S., & Larsson, S. C. (2023). Epidemiology of sarcopenia: Prevalence, risk factors, and consequences. *Metabolism*, 155533.
6. Gao, Q., Hu, K., Yan, C., Zhao, B., Mei, F., Chen, F., ... & Ma, B. (2021). Associated factors of sarcopenia in community-dwelling older adults: a systematic review and meta-analysis. *Nutrients*, 13(12), 4291.

RELEVANT AMA POLICY

H-425.994 Medical Evaluations of Healthy Persons

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.

[CSA Rep. D, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13; Reaffirmed: CMS Rep. 03, I-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 510
(A-24)

Introduced by: New Jersey

Subject: Study to investigate the validity of claims made by the manufacturers of OTC Vitamins, Supplements and "Natural Cures"

Referred to: Reference Committee E

- 1 Whereas, over 50 billion dollars are spent every year by vulnerable patients on advertised OTC
2 vitamins, supplements, and natural health cures; and
3
4 Whereas, cures are reported for diseases and conditions such as Diabetes, Hypertension, Liver
5 Disease, Prostate, ED, Neuropathy, Arthritis, Loss of Memory, Weight loss, and even Vision
6 Problems; and
7
8 Whereas, it is illegal to make false claims on the efficacy of medications, vitamins, supplements,
9 and "natural remedies"; and
10
11 Whereas, patients are advised that they can throw away their prescribed medications; and
12
13 Whereas, they accuse the pharmaceutical industry of a conspiracy to protect their profits while
14 hiding the truth about these "Natural" cures; and
15
16 Whereas, discontinuing medication without involvement of their Physician or Health Care
17 Provider could be deleterious to the patient's health; and
18
19 Whereas, in the advertisements, there are no peer reviewed scientific evidence is provided, only
20 inferences to scientific studies done at a "prestigious" university or a scientific breakthrough
21 discovered by a well know celebrity; and
22
23 Whereas, the FDA is overwhelmed with the number of these products which seem to appear
24 daily; therefore be it
25
26 RESOLVED, that our American Medical Association study the growing problem of
27 advertisements on OTC Vitamins, Supplements, and "Natural Cures" that claim health benefits
28 and cures. With report back at A-25 (Directive to Take Action); and be it further
29
30 RESOLVED, that our AMA collaborate with all the specialties which are affected by these claims
31 and gather scientific evidence showing benefits and false claims (Directive to Take Action); and
32 be it further
33
34 RESOLVED, that our AMA request that the FDA exercise its full scope of authority to protect our
35 patients by removing all the advertisements containing false claims of medical cures. (Directive
36 to Take Action)

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

Received: 5/3/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 511
(A-24)

Introduced by: New England, American Academy of Allergy, Asthma, and Immunology
(AAAAI)

Subject: National Penicillin Allergy Day and Penicillin Allergy Evaluation & Appropriate
Delabeling

Referred to: Reference Committee E

- 1 Whereas, the American Medical Association has no policy on this resolution topic; and
2
3 Whereas, National Penicillin Allergy Day is the anniversary of Dr. Alexander Fleming's discovery
4 of penicillin on September 28, 1928; and
5
6 Whereas, more than 1 in 10 US persons report a prior allergy to a penicillin antibiotic but more
7 than 9 in 10 of these individuals do not have a confirmed allergy after appropriate investigation¹;
8 and
9
10 Whereas, a penicillin allergy label is associated with adverse consequences for individuals and
11 public health, such as a higher risk of treatment failures, C. diff colitis, antibiotic resistance,
12 surgical site infections, healthcare utilization, and death²⁻⁵; and
13
14 Whereas, most penicillin allergies are side effects or low risk reactions that do not prevent safe
15 use of penicillins and other beta-lactam therapeutics^{1,6}; and
16
17 Whereas, testing for penicillin allergy is safe and may include a skin test and/or administration of
18 a penicillin dose under observation (a drug "challenge" or "test" dose)⁶; and
19
20 Whereas, history-only evaluations with improved documentation or use in clinical decision rules
21 can result in a penicillin allergy delabeling⁷⁻¹⁰; therefore be it
22
23 RESOLVED, that National Penicillin Allergy Day, September 28, be recognized by the American
24 Medical Association (New HOD Policy); and be it further
25
26 RESOLVED, that our AMA promote penicillin allergy evaluation and appropriate delabeling.
27 (New HOD Policy)
28

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

Received: 5/7/2024

REFERENCES

1. Shenoy ES, Macy E, Rowe T, Blumenthal KG. Evaluation and Management of Penicillin Allergy: A Review. *JAMA*. 2019 Jan 15;321(2):188-199. doi: 10.1001/jama.2018.19283. PMID: 30644987.
2. MacFadden DR, LaDelfa A, Leen J, Gold WL, Daneman N, Weber E, Al-Busaidi I, Petrescu D, Saltzman I, Devlin M, Andany N, Leis JA. Impact of Reported Beta-Lactam Allergy on Inpatient Outcomes: A Multicenter Prospective Cohort Study. *Clin Infect Dis*. 2016 Oct 1;63(7):904-910. doi: 10.1093/cid/ciw462. Epub 2016 Jul 11. PMID: 27402820.
3. Blumenthal KG, Ryan EE, Li Y, Lee H, Kuhlen JL, Shenoy ES. The Impact of a Reported Penicillin Allergy on Surgical Site Infection Risk. *Clin Infect Dis*. 2018 Jan 18;66(3):329-336. doi: 10.1093/cid/cix794. PMID: 29361015; PMCID: PMC5850334.
4. Blumenthal KG, Lu N, Zhang Y, Walensky RP, Choi HK. Recorded Penicillin Allergy and Risk of Mortality: a Population-Based Matched Cohort Study. *J Gen Intern Med*. 2019 Sep;34(9):1685-1687. doi: 10.1007/s11606-019-04991-y. PMID: 31011962; PMCID: PMC6712108.
5. Blumenthal KG, Lu N, Zhang Y, Li Y, Walensky RP, Choi HK. Risk of meticillin resistant *Staphylococcus aureus* and *Clostridium difficile* in patients with a documented penicillin allergy: population based matched cohort study. *BMJ*. 2018 Jun 27;361:k2400. doi: 10.1136/bmj.k2400. PMID: 29950489; PMCID: PMC6019853.
6. Khan DA, Banerji A, Blumenthal KG, Phillips EJ, Solensky R, White AA, Bernstein JA, Chu DK, Ellis AK, Golden DBK, Greenhawt MJ, Horner CC, Ledford D, Lieberman JA, Oppenheimer J, Rank MA, Shaker MS, Stukus DR, Wallace D, Wang J; Chief Editor(s): Khan DA, Golden DBK, Shaker M, Stukus DR; Workgroup Contributors: Khan DA, Banerji A, Blumenthal KG, Phillips EJ, Solensky R, White AA; Joint Task Force on Practice Parameters Reviewers: Bernstein JA, Chu DK, Ellis AK, Golden DBK, Greenhawt MJ, Horner CC, Ledford D, Lieberman JA, Oppenheimer J, Rank MA, Shaker MS, Stukus DR, Wallace D, Wang J. Drug allergy: A 2022 practice parameter update. *J Allergy Clin Immunol*. 2022 Dec;150(6):1333-1393. doi: 10.1016/j.jaci.2022.08.028. Epub 2022 Sep 17. PMID: 36122788.
7. du Plessis T, Walls G, Jordan A, Holland DJ. Implementation of a pharmacist-led penicillin allergy de-labelling service in a public hospital. *J Antimicrob Chemother*. 2019;74(5):1438-46. doi: 10.1093/jac/dky575. PMID: 30753497.
8. Stone CA Jr, Trubiano J, Coleman DT, Rukasin CRF, Phillips EJ. The challenge of de-labeling penicillin allergy. *Allergy*. 2020;75(2):273-88. doi: 10.1111/all.13848. PMID: 31049971; PMCID: PMC6824919.
9. Trubiano JA, Vogrin S, Chua KYL, Bourke J, Yun J, Douglas A, et al. Development and validation of a penicillin allergy clinical decision rule. *JAMA Intern Med*. 2020;180(5):745-52. doi: 10.1001/jamainternmed.2020.0403. PMID: 32176248; PMCID: PMC7076536.
10. Shah NS, Ridgway JP, Pettit N, Fahrenbach J, Robicsek A. Documenting Penicillin Allergy: The Impact of Inconsistency. *PLoS One*. 2016 Mar 16;11(3):e0150514. doi: 10.1371/journal.pone.0150514. PMID: 26981866; PMCID: PMC4794183.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 512
(A-24)

Introduced by: New York

Subject: Opioid Overdose Reversal Agents Where AED's Are Located

Referred to: Reference Committee E

1 Whereas, the number of overdose deaths in the US has continued to rise year by year for over
2 20 years, with nearly 110,000 dying by overdose in the year 2022, and opioids such as fentanyl
3 alone or in combination with other substances involved in the majority of overdose deaths¹; and
4

5 Whereas, naloxone is a mu opioid competitive antagonist which is effective in reversing opioid
6 overdose when administered intravenously or intranasally, has no abuse potential, has few side
7 effects or adverse events when administered to someone who has overdosed, is easy to
8 administer with little training required²⁻⁶; and
9

10 Whereas, the World Health Organization and the CDC have recommended widespread
11 availability of naloxone to reverse opioid overdoses^{7,8}; and
12

13 Whereas, expansion of the availability of naloxone is not associated with compensatory
14 increases in substance use or risk taking^{9,10}; and
15

16 Whereas, one modelling study conservatively estimated that in Alleghany County,
17 Pennsylvania, 16% of naloxone administrations occur within 200 yards of an AED location¹¹;
18 which would suggest that an additional 1/7 opioid overdoses could be reversed and potential
19 lives saved; therefore be it
20

21 RESOLVED, that our American Medical Association support the expansion of naloxone
22 availability through colocation of intranasal naloxone with AEDs in public locations. (New HOD
23 Policy)

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

Received: 5/8/2024

REFERENCES

NIDA. Drug Overdose Death Rates. 30 June 2023. Accessed 20 October 2023 at: <https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates>

NIDA. Naloxone for Opioid Overdose: Life-Saving Science. National Institute on Drug Abuse website.

<https://nida.nih.gov/publications/naloxone-opioid-overdose-life-saving-science>. March 30, 2017 Accessed October 20, 2023.

Rzasa Lynn R, Galinkin JL. Naloxone dosage for opioid reversal: current evidence and clinical implications. *Ther Adv drug Saf*. 2018;9(1):63-88. doi:10.1177/2042098617744161

Davis CS, Carr D. Legal changes to increase access to naloxone for opioid overdose reversal in the United States. *Drug Alcohol Depend*. 2015;157:112-120. doi:10.1016/j.drugalcdep.2015.10.013

Wermeling DP. Review of naloxone safety for opioid overdose: practical considerations for new technology and expanded public access. *Ther Adv drug Saf*. 2015;6(1):20-31. doi:10.1177/2042098614564776

Jauncey ME, Nielsen S. Community use of naloxone for opioid overdose. *Aust Prescr*. 2017;40(4):137-140

World Health Organization. Opioid Overdose. 29 August 2023. Accessed 21 October 2023 at: <https://www.who.int/news-room/fact-sheets/detail/opioid-overdose#:~:text=WHO%20recommends%20that%20naloxone%20be,assisting%20ventilation%20and%20administering%20naloxone>

Center for Disease Control: Lifesaving Naloxone. Updated 21 April 2023. Accessed at:

<https://www.cdc.gov/stopoverdose/naloxone/index.html>

Bazazi AR, Zaller ND, Fu JJ, Rich JD. Preventing opiate overdose deaths: examining objections to take-home naloxone. *J Health Care Poor Underserved*. 2010 Nov;21(4):1108-13. doi: 10.1353/hpu.2010.0935. PMID: 21099064; PMCID: PMC3008773.

Jones JD, Campbell A, Metz VE, Comer SD. No evidence of compensatory drug use risk behavior among heroin users after receiving take-home naloxone. *Addict Behav*. 2017;71:104-106. doi:10.1016/j.addbeh.2017.03.008

Salerno JE, Weiss LS, Salcido DD. Simulation of the Effects of Co-Locating Naloxone with Automated External Defibrillators.

Prehosp Emerg Care. 2018 Sep-Oct;22(5):565-570. doi: 10.1080/10903127.2018.1439128. Epub 2018 Mar 1. PMID: 29494776; PMCID: PMC6777719.

RELEVANT AMA POLICY

Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal Medications H-95.932

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone and other safe and effective overdose reversal medications, 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 and other safe and effective overdose reversal medications delivery.
2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone and other safe and effective overdose reversal medications .
3. Our AMA encourages physicians to co-prescribe naloxone and other safe and effective overdose reversal medications 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 and other safe and effective overdose reversal medications on their preferred drug lists and formularies with minimal or no cost sharing.
5. Our AMA supports liability protections for physicians and other healthcare professionals and others who are authorized to prescribe, dispense and/or administer naloxone and other safe and effective overdose reversal medications pursuant to state law.
6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone and other safe and effective overdose reversal medications 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 and other safe and effective overdose reversal medications with the Food and Drug Administration.
8. Our AMA supports the widespread implementation of easily accessible naloxone and other safe and effective overdose reversal medications rescue stations (public availability of naloxone and other safe and effective overdose reversal medications 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 and other safe and effective overdose reversal medications 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 overdose reversal medications, including naloxone, to help prevent opioid-related overdose, especially in vulnerable populations, including but not limited to underserved communities and American Indian reservation populations.

BOT Rep. 22, A-16 Modified: Res. 231, A-17 Modified: Speakers Rep. 01, A-17 Appended: Res. 909, I-17 Reaffirmed: BOT Rep. 17, A-18 Modified: Res. 524, A-19 Reaffirmed: BOT 09, I-19 Reaffirmed: Res. 219, A-21 Modified: Res. 505, A-23

Oppose Tracking of People who Purchase Naloxone D-120.930

Our AMA will: (1) oppose any policies, regulations, or laws that require personally identifiable information associated with naloxone prescriptions or purchases to be tracked, monitored, or utilized for non-clinical or non-public health care purposes; and (2) advocate for availability of naloxone as an over-the-counter medication.

Res. 219, A-21

Implementing Naloxone Training into the Basic Life Support (BLS) Certification Program D-130.961

Our AMA will collaborate with the American Heart Association and other interested parties to include naloxone use in training in BLS instruction.

Res. 530, A-19

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

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 safe and effective overdose reversal medications 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 safe and effective overdose reversal medications 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) 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 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.

Res. 526, A-06 Modified in lieu of Res. 503, A-12 Appended: Res. 909, I-12 Reaffirmed: BOT Rep. 22, A-16 Modified: Res. 511, A-18 Reaffirmed: Res. 235, I-18 Modified: Res. 506, I-21 Appended: Res. 513, A-22 Modified: Res. 211, I-22 Appended: Res. 221, A-23 Reaffirmation: A-23 Modified: Res. 505, A-23

Substance Use Disorders During Pregnancy H-420.950

Our AMA will:

- (1) support brief interventions (such as engaging a patient in a short conversation, providing feedback and advice) and referral for early comprehensive treatment of pregnant individuals with opioid use and opioid use disorder (including naloxone or other overdose reversal medication education and distribution) using a coordinated multidisciplinary approach without criminal sanctions;
- (2) oppose any efforts to imply that a positive verbal substance use screen, a positive toxicology test, or the diagnosis of substance use disorder during pregnancy automatically represents child abuse;
- (3) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy;
- (4) oppose the filing of a child protective services report or the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation;
- (5) 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
- (6) advocate that state and federal child protection laws be amended so that pregnant people with substance use and substance use disorders are only reported to child welfare agencies when protective concerns are identified by the clinical team, rather than through automatic or mandated reporting of all pregnant people with a positive toxicology test, positive verbal substance use screen, or diagnosis of a substance use disorder.

Res. 209, A-18 Modified: Res. 520, A-19 Modified: Res. 505, A-23

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-2

American Medical Association House of Delegates

Resolution: 513
(A-24)

Introduced by: New York
Subject: Biotin Supplement Packaging Disclaimer
Referred to: Reference Committee E

1 Whereas, although the use of biotin supplementation has become widespread for its supposed
2 stimulation of hair and nail growth, there is a sparsity in the scientific data supporting these
3 claims; and

4
5 Whereas, the FDA defines the recommended daily allowance of biotin to be 30 mcg per day for
6 an adult, the majority of biotin supplement brands have daily dosages ranging between 600-
7 10,000mcg; and

8
9 Whereas, there are no apparent negative side effects to taking megadosages of biotin, there is
10 evidence supporting its interference with many laboratory tests. In particular, excess biotin
11 may cause falsely low troponin levels, resulting in missed or delayed myocardial infarction
12 diagnoses, or false thyroid function tests leading to false diagnoses of Graves' disease;
13 therefore be it

14
15 RESOLVED, that our American Medical Association support efforts to have over-the-counter
16 biotin supplements provide a clear disclaimer on the bottle that states the possibility of lab test
17 interference (New HOD Policy); and be it further

18
19 RESOLVED, that our AMA advocates for greater awareness among both patients and
20 physicians in regards to biotin megadose interference. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 5/7/2024

REFERENCES

1. Gifford JL, Sadrzadeh SMH, Naugler C. Biotin interference: Underrecognized patient safety risk in laboratory testing. *Can Fam Physician*. 2018 May;64(5):370. PMID: 29760259; PMCID: PMC5951654.
2. Barbesino G. Misdiagnosis of Graves' Disease with Apparent Severe Hyperthyroidism in a Patient Taking Biotin Megadoses. *Thyroid*. 2016 Jun;26(6):860-3. doi: 10.1089/thy.2015.0664. Epub 2016 Apr 28. PMID: 27043844.
3. Li D, Rooney MR, Burmeister LA, Basta NE, Lutsey PL. Trends in Daily Use of Biotin Supplements Among US Adults, 1999-2016. *JAMA*. 2020;324(6):605-607. doi:10.1001/jama.2020.8144

Reference Committee F

Report(s) of the Board of Trustees

- 01 Annual Report
- 04 AMA 2025 Dues
- 21 American Medical Association Meeting Venues and Accessibility
- 23 United States Professional Association for Transgender Health Observer Status in the House of Delegates
- 25 Environmental Sustainability of AMA National Meetings. Supporting Carbon Offset Programs for Travel for AMA Conferences
- 26 Equity and Justice Initiatives for International Medical Graduates
- 28 Encouraging Collaboration Between Physicians and Industry in AI Development
- 33 Employed Physicians

Report(s) of the Council on Constitution and Bylaws and the Council on Long Range Planning and Development

- 01 Joint Council Sunset Review of 2014 House Policies

Report(s) of the Council on Long Range Planning and Development

- 01 Establishment of a LGBTQ+ Section

Report of the House of Delegates Committee on the Compensation of the Officers

- 01 Compensation Committee Report

Report(s) of the Speakers

- 01 Report of the Resolution Modernization Task Force Update

Resolutions

- 601 Annual Holocaust Remembrance Event
- 602 Ranked Choice Voting
- 603 End Attacks on Health and Human Rights in Israel and Palestine
- 604 Confronting Ageism in Medicine
- 605 Walking the Walk of Climate Change
- 606 Creation of an AMA Council with a Focus on Digital Health Technologies and AI
- 607 Appealing to our AMA to add clarity to its mission statement to better meet the need of physicians, the practice of medicine and the public health
- 608 The American Medical Association Diversity Mentorship Program

REPORT OF THE BOARD OF TRUSTEES

B of T Report 01-A-24

Subject: Annual Report

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

-
- 1 The Consolidated Financial Statements for the years ended December 31, 2023 and 2022 and the
 - 2 Independent Auditor's report have been included in the 2023 Annual Report. This is included in
 - 3 the Handbook mailing to members of the House of Delegates and will be discussed at the
 - 4 Reference Committee F hearing.

YOUR P[⚡]WERFUL ALLY IN PATIENT CARE

2023 ANNUAL REPORT

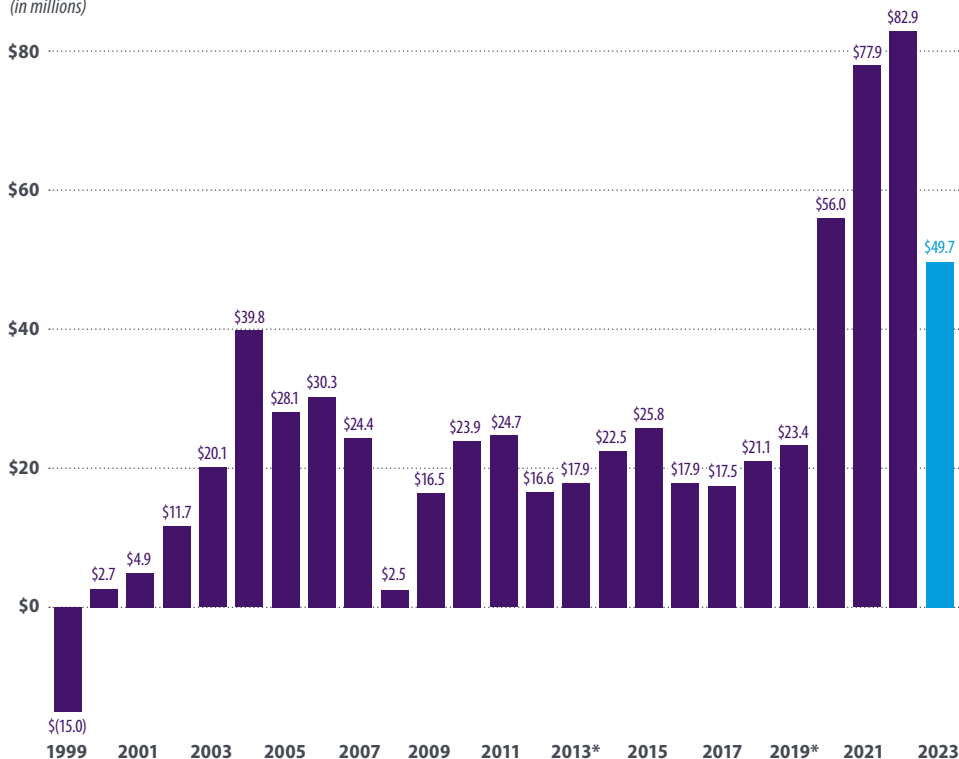


FINANCIAL HIGHLIGHTS

(Dollars in millions)	2023	2022
Revenues	\$ 495.1	\$ 493.4
Cost of products sold and selling expense	27.8	30.6
General and administrative expenses	412.5	375.5
Operating results	49.7	82.9
Non-operating items	101.7	(117.9)
Changes in defined benefit postretirement plans, other than periodic expense, net of tax	(17.3)	29.4
Change in unrestricted equity	134.1	(5.6)
Change in donor restricted equity	(0.1)	0.1
Change in association equity	\$ 134.0	\$ (5.5)
Association equity at year-end	\$ 1,023.4	\$ 889.4
Employees at year-end	1,314	1,267

Association operating results

(in millions)



* Pro forma operating results: 1) 2013 excludes \$33 million in nonrecurring charges relating to AMA's headquarters relocation and 2) 2019 excludes \$36.2 million noncash pension termination expense reclassification from non-operating results.

2020 through 2022 results were impacted by a lack of travel due to the pandemic, as well as a hiring freeze and subsequent tight labor market. These savings were temporary in nature.

The story of the American Medical Association in 2023 was one of collective achievement, resolute leadership and powerful advocacy on behalf of physicians.

The AMA stood up to challenges against physicians and medical practice at the highest levels, including launching a campaign to stop short-term payment cuts to physicians while at the same time calling for significant reform of the overall Medicare physician payment system. The AMA also secured victories to defend scope of practice and reduce burdens from prior authorization—making meaningful progress in our AMA Recovery Plan for America’s Physicians.

In doing so, the AMA reinforced its role as the Physician’s Powerful Ally in Patient Care throughout 2023. We continued to remove obstacles that interfere with patient care and are known to drive physician burnout. We advanced innovative solutions to tackle health care’s most significant challenges while reimagining medical education, training and lifelong learning. And we continued to lead the charge to prevent chronic disease, improve health outcomes and eliminate inequities across health care.

Achieving significant wins for patients in 2023, AMA advocacy yielded more than 100 state-level victories against inappropriate scope of practice expansions by working closely with state medical associations. To advance solutions that promote physician well-being, the AMA recognized 72 hospitals and health systems in its Joy in Medicine™ Health System Recognition Program, which elevates and promotes best practices in caring for physicians and patients.

The AMA proudly announced the launch of the Rise to Health Coalition, a first-of-its-kind national initiative co-led by the AMA and the Institute for Healthcare Improvement and supported by numerous collaborators, including Race Forward. This innovative approach to eliminating historic inequities in health aligns multiple sectors—including health care organizations, physicians and other health care professionals—under a common framework and unified vision.

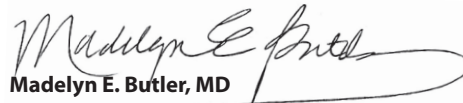
This work was made possible by another strong financial performance in 2023 and an impressive 3.4 percent growth in AMA’s dues-paying members. The hard work of dedicated AMA leadership and talented staff across

the organization continues to shape a vibrant, more fully engaged and more collaborative health care community, and paves the way for continued action and greater strength going forward.

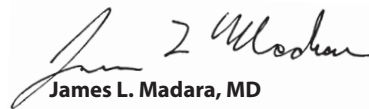
Knocking down obstacles and overcoming challenges is deeply embedded in the AMA’s DNA. With health care rapidly evolving, physicians and patients are looking to us to make sense of these changes and help them find their footing in an unfamiliar landscape. We are committed to this work, to always promoting the art and science of medicine and the betterment of public health, and to always placing the needs of physicians and patients at the core of our efforts and advocacy.




Willie Underwood III, MD, MSc, MPH
Chair, Board of Trustees



Madelyn E. Butler, MD
Finance Committee Chair, Board of Trustees



James L. Madara, MD
CEO and Executive Vice President

On the following pages you'll explore the progress we've made throughout 2023 across all initiatives. To quickly identify our highest priority initiatives related to the AMA Recovery Plan for America's Physicians, look for this symbol: 



**“The AMA has
been a vital asset
to the states.**

The amount of
research the
AMA does is
invaluable.”

Claude Brunson, MD
AMA member since 1984
On scope of practice

YouTube

Consumer price
Practice
Physician update

0%
2001

Medicare payment is broken
988 views · 2 months ago · #AMAUpdate

American Medical Association

10 Share

The video player shows a line graph with three lines: a blue line for 'Consumer price', a green line for 'Practice', and a red line for 'Physician update'. The y-axis is labeled '0%' and the x-axis is labeled '2001'. The graph shows that 'Consumer price' and 'Practice' have increased significantly over time, while 'Physician update' has remained relatively flat. The video title is 'Medicare payment is broken' and it has 988 views and was posted 2 months ago. The video is from the American Medical Association and has 10 likes and a share button.

Help our Medicare
advocacy efforts.
Scan to watch,
then share.

DEFENDING THE PRACTICE OF MEDICINE

In 2023 the AMA vigorously defended medicine across the country to keep care where it belongs: between physicians and their patients.



More than 100 state-level scope of practice wins in partnership with state medical associations and medical specialty societies

Keeping physicians at the center of medical care

Patients deserve care led by physicians. Through research, advocacy and education, the AMA in 2023 continued its work to stop inappropriate scope of practice expansions that threaten patient safety.

We promoted physician-led, team-based care and helped defeat legislation across the country that would have allowed:

- Physician assistants to practice independently without physician oversight.
- Pharmacists to prescribe medications.
- Optometrists to perform surgery.
- Scope of practice expansion for nurse practitioners and other APRNs.

To ensure more transparency in health care, the AMA worked with multiple state medical associations to introduce new or strengthen existing “Truth in Advertising”

laws so that patients know if the person providing care to them is a physician—or not. Two states enacted such laws in 2023.

Reforming the Medicare payment system

Last year the AMA continued to lead efforts to reform the Medicare payment system to eliminate the threat of annual payment reductions and implement solutions that would increase payments in line with annual increases in the cost of providing care. The AMA was able to secure the introduction of a number of bipartisan policies and significantly grew support for those solutions throughout the year.

Opposing efforts to undermine physicians

The AMA has continued to serve as a powerful voice for physicians in federal and state courts around the country on a broad range of issues, including several cases before the U.S. Supreme Court.

Working with state and federal policymakers, the AMA continued to oppose legislation and laws that interfere with the practice of medicine, including cases in which physicians are facing criminal, civil or administrative penalties for providing necessary care.

“I am so grateful that we have an organization that says **‘we’re not going to stand for this.’**”

Rasmeet Kaur Miller, MD
AMA member since 2019
On the crisis of physician burnout



The sold-out 2023 American Conference on Physician Health focused on bringing back the joy in medicine.

Follow us on social!

CHAMPIONING PHYSICIAN WELL-BEING

In a recent survey co-authored by the AMA, nearly 63 percent of physicians reported symptoms of burnout. We know that reducing burnout is integral to the delivery of high-quality patient care and health system sustainability. In 2023 the AMA continued its work to tackle the root causes of burnout and developed effective advocacy, research and resources needed to help physicians increase professional satisfaction and rediscover joy in their work.

Empowering health systems to reduce burnout

The AMA continues to expand its work in promoting physician wellness through the AMA Joy in Medicine™ Health System Recognition Program. This program is committed to advancing the science of physician burnout and recognizes those systems that are dedicated to organizational well-being. In 2023 the AMA recognized 72 health systems—bringing the total number of currently recognized organizations to 96.

Developing evidence-based resources for well-being and resiliency

The AMA is committed to developing evidence-based programs and resources dedicated to improving mental health and resiliency. Last year alone, we provided more than 100 new and updated AMA STEPS Forward® resources—including toolkits, webinars and podcast episodes—focused on reducing physician burnout and improving patient care.



2 million users have accessed the AMA STEPS Forward program to reduce burnout and improve patient care and practice efficiency.

Reducing the stigma of mental illness

Fear of repercussions and stigma associated with seeking care for mental health issues remains a huge barrier to physicians in getting the care they need. The AMA is part of a growing nationwide effort to remove stigmatizing mental health questions from applications for state licensing and credentialing applications used by medical groups, hospitals and health plans. As a direct result of the AMA's education and advocacy, 15 state medical boards, health systems and credentialing bodies removed potentially stigmatizing questions about mental illness from their applications, resulting in a huge step forward for physician well-being.

“The AMA is developing great policy at state and national levels that is making an impact and **improving patient care.**”

Carolynn Francavilla Brown, MD
AMA member since 2007
On prior authorization



AMA Past President Jack Resneck Jr., MD, talks on an episode of AMA Update about the work that led up to our big prior authorization win for physicians.



View this and other interviews on our AMA Update video and podcast series.

REMOVING OBSTACLES TO PATIENT CARE

In 2023 the AMA worked tirelessly to address the burdens that get in the way of patient care. Last year we saw a number of hard-earned results that came from our direct efforts to put the needs of physicians and patients first.

**\$15 BILLION IN SAVINGS
FOR PHYSICIANS**

and getting patients the care they
need without delay
(January 2024 CMS final rule
on prior authorization)

Fixing prior authorization

Prior authorizations often come at the expense of patients and physicians. That's why the AMA stands up to insurance companies to eliminate care delays, relieve physician burdens—and save patients' lives.

As a direct result of AMA advocacy efforts throughout 2023, the Centers for Medicare & Medicaid Services announced a final rule in early January 2024 that requires government-regulated health plans to reduce the timeframes for prior authorization decisions and to publicly report program metrics. This final rule will make important reforms to prior authorization that cut patient care delays and electronically streamline the process for physicians. Together, these changes will save physician practices an estimated \$15 billion over 10 years, according to the U.S. Department of Health and Human Services.

In 2023 we also worked with state medical associations across the country to enact prior authorization reform using AMA model legislation, data, testimony and other resources that resulted in more than 30 states introducing legislation—and at least nine new states enacting prior authorization laws.

Increasing access to life-saving medication

The AMA successfully advocated to make naloxone available over the counter and continued to advocate for responsible pricing and insurance coverage for this life-saving medication. We also advocated for revisions to the CDC's opioid prescribing guidelines that resulted in the CDC removing its dose and quantity thresholds for treating patients experiencing pain.

Maintaining access to care

The AMA successfully advocated to achieve passage of legislation to extend Medicare telehealth coverage through 2024. The 2024 Medicare payment rule preserves key telehealth policies, ensuring Medicare patients throughout the country (not only from rural areas) will continue to receive access to telehealth.

2023 IN REVIEW

The AMA rapidly delivered an educational offering through the AMA Ed Hub™ to help **physicians meet the new DEA MATE requirements** on substance use disorders and addiction. This offering was deployed within 24 hours of the new regulation issuance and significantly contributed to increased AMA Ed Hub engagement as well as membership growth.

 **226,000+**
messages to Congress

from patients and physicians in our **FixMedicareNow.org** grassroots effort

Convened the first annual **JAMA Summit**, bringing together 60+ leaders in medicine to discuss ways to improve the clinical trials enterprise. In early 2024, the pages of **JAMA®** will elaborate on the themes and innovative ideas that emerged from these discussions.

Through its Center for Health Equity, the AMA continued to strengthen physician and health system understanding and engagement around advancing equity. We launched the **National Health Equity Grand Rounds**, resulting in more than 11,000 viewers for important discourse about how to advance health equity, and we continued to publish the **Prioritizing Equity Series**, reaching 47 episodes.

In support of CDC's Project Firstline, the **AMA launched resources on infection prevention and control**, including webinars, podcasts and townhalls, so that frontline health care professionals can protect patients, coworkers and themselves from infectious disease threats.

To better meet the needs of academic researchers, **JAMA optimized the JAMA Express publication pathway** by promising to move select accepted manuscripts to publication within four weeks of submission.

 **37 MILLION**


the record-breaking number of readers, listeners and viewers who consumed **AMA digital content** in 2023 (excluding *JAMA* and AMA Ed Hub)

In 2023 the AMA established the **Firearm Injury Prevention Task Force**. The task force convenes subject matter experts across medical specialties to inform the development of resources for physicians and trainees to increase counseling of high-risk patients and awareness of available interventions.

To help ensure future physicians receive standardized training on how to consistently take accurate blood pressure measurements, the **AMA awarded financial grants** to eight academic institutions representing 18 total training programs for health care professionals including future physicians, nurses, physician assistants and pharmacists.

We held our bi-annual AMA ChangeMedEd® national conference from Sept. 27-29 in Chicago. This event brought together more than 500 leaders and innovators in medical education and related health care fields to catalyze change in medical education and **transform the way future physicians and residents are trained**. Nearly 150 presenters led more than 75 sessions including plenary sessions on educator well-being in medical education, reimagining residency, precision education, and equity, diversity and belonging.

The AMA announced Leelabati Biswas, a Rutgers Robert Wood Johnson Medical School MD/PhD candidate, as the winner of the **2023 AMA Research Challenge** and recipient of a \$10,000 grand prize, presented by Laurel Road. We received nearly 1,200 submissions, with 800 selected to present in our poster symposium. The top 50 scored posters competed in our semifinals and were scored by judges and AMA members, and the top five advanced to the finals and presented to a panel of physician experts.




8.6 million
YouTube views

Thanks to policy guidance provided by the AMA, five states passed bills that mandated Medicaid coverage of self-measured blood pressure devices and clinical support services, **increasing access for many underserved populations** in those states.

The AMA completed and published the inaugural **Health Equity in Organized Medicine survey**, which included responses from 68 organizations within the Federation of Medicine. We also hosted Health Equity Forums at our AMA House of Delegates meetings, reaching more than 680 delegate physicians.

As the application of augmented intelligence (AI) continues to grow and promises to transform health care, the AMA, in partnership with the University of Michigan, created a new online learning series “**AI in Health Care**” that introduces learners to foundational principles in AI and machine-learning.

JAMA also launched a new video and podcast series on “**AI and Clinical Practice**” to keep physicians informed on AI’s promise to transform treatment, training, research and publishing.



125 billion
AMA media
impressions

from more than 40,000 media stories on critical AMA issues

The **AMA Ed Hub**, the AMA’s online education platform, achieved unprecedented growth in users and engagement (compared to 2022):

46% INCREASE SESSIONS INCREASED TO 3.7 MILLION

72% INCREASE EDUCATION ACTIVITY USAGE INCREASED TO 3.6 MILLION

63% INCREASE COURSE ASSESSMENT COMPLETIONS INCREASED TO 615K

120% INCREASE UNIQUE NEW USER REGISTRATIONS UP 125K

In addition the AMA Ed Hub continued to expand its educational offering by signing on 14 new organizations to feature their education on the platform, bringing the total number of partners to 50.

The AMA continues to support faculty development through the **AMA Health Systems Science Scholars program** and the Coaching Implementation Workshop, with each program now having trained more than 200 faculty members from across the United States to advance these innovations in medical schools and residency programs.

The AMA piloted a **new physician credentialing solution** that improves the complex credentialing process for physicians and the health care industry. **VeriCre** addresses inefficiencies in credentialing by providing centralized, trusted and authoritative data that can be used to pre-populate applications and is designed to work with the varied workflows and software solutions within health care systems and institutions.

The AMA **released a how-to guide on integrating behavioral health care** for older adults and a behavioral health coding resource for physicians and care teams to leverage when administering behavioral health preventive services, screening and/or treatment plans.

MANAGEMENT'S DISCUSSION AND ANALYSIS

MANAGEMENT'S DISCUSSION AND ANALYSIS

Introduction

The objective of this section is to help American Medical Association (AMA) members and other readers of our financial statements understand management's views on the AMA's financial condition and results of operations. This discussion should be read in conjunction with the audited consolidated financial statements and notes to the consolidated financial statements.

Improving the health of the nation is at the core of the AMA's work. As the physicians' powerful ally in patient care, the AMA delivers on this mission by representing physicians with a unified voice in courts and legislative bodies across the nation, removing the largest governmental and private sector obstacles that interfere with optimal patient care, leading the charge to prevent chronic disease and confront public health crises, and driving the future of medicine to tackle the biggest challenges in health care and training the leaders of tomorrow. AMA's strategic arcs are supported by improving health outcomes, lifelong medical education and enhancing physician professional satisfaction and practice sustainability. Our advocacy, health equity and innovation initiatives act as accelerators across all arcs. AMA's foundation is built on science, membership, financial performance, marketing and communication, and talent and engagement.

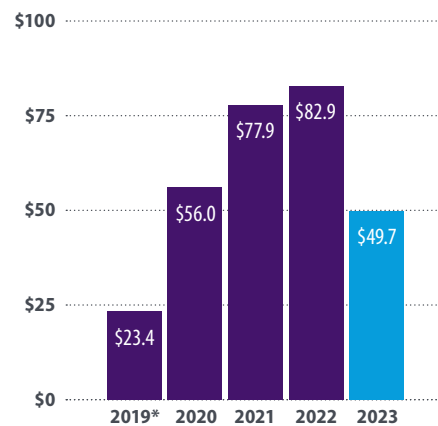
2023 priorities continued to be led by the AMA Recovery Plan for America's Physicians, focusing on five key goals to re-build health care so that it works better for physicians and all those they serve: 1) fixing prior authorization to reduce the burden on practices and minimize care delays for patients; 2) reforming Medicare payment to promote thriving physician practices and innovation; 3) stopping scope creep that threatens patient safety; 4) supporting telehealth to maintain coverage and payment; and 5) reducing physician burnout and addressing the stigma around mental health. For example, through research, advocacy and education, the AMA continued to defend the practice of medicine against scope of practice expansions that threaten patient safety. Through AMA's work with the Center for Medicare & Medicaid Services (CMS), major prior authorization reforms under Medicare Advantage were achieved. The AMA facilitated over 226,000 contacts to Congress from patients and physicians as part of our FixMedicareNow.org grassroots campaign.

The results for 2020 through 2022 were dramatically impacted by the COVID-19 pandemic. Early in 2020, the AMA, like all other organizations, recognized that there was substantial uncertainty about the effects and risk of COVID-19 on our funding, financial condition, and results of operations. As a result, AMA took steps to ensure that programmatic activities and employment levels would be protected during a sustained pandemic, knowing the potential for economic uncertainty. AMA lifted a freeze on hiring

in the spring of 2021, but the level of open positions remained high through 2022 as the job market was very tight. Vacancies and limited travel for most of the three years garnered substantial savings that were temporary in nature resulting in unusually high operating income for AMA. Open positions were at a record high at the end of 2022 and although they dropped substantially by the end of 2023, remained above normal levels, providing over \$15 million in unplanned vacancy savings for 2023.

Pro forma net operating results

(in millions)



*Excluding the \$36.2 million non-cash pension termination charge

Looking forward, the AMA's 2024 budget assumes that vacancies will revert to normal levels and, with expansion of certain programmatic areas, expenses will increase, resulting in operating income at the board approved policy level.

The AMA is committed to its responsibility of ensuring that the organization focuses its finite resources on strategic arcs, accelerators and core mission activities while improving the quality and breadth of products and services for physicians and medical students. Our physicians' and medical students' voices are central to AMA's overall success.

The following pages discuss the 2023 consolidated financial results as compared to 2022. Additional detailed discussion of operating unit results is included in the section titled "Group Operating Results."

Consolidated financial results

Results from operations

Net operating results

(in millions)



As noted above, the unusually tight labor market that adversely impacted hiring and limited travel and in-person meetings through the first half of 2022 were major factors in spending levels running substantially less than budget during 2020 through 2022.

In 2023, AMA revenues were largely unchanged from the prior year, while expenses moved closer to budgeted levels, increasing \$34.2 million, resulting in a substantial decline in operating income compared to 2022.

In 2019, the AMA finalized termination of its defined benefit pension plan, providing lump sum payments to individuals that elected that option and purchasing a group annuity plan for participants that chose to remain in the plan. AMA recorded a \$38.2 million noncash reclassification of prior actuarial losses from non-operating expense to operating expense, titled pension termination expense, as well as reclassifying a \$2 million noncash tax benefit to income tax expense that was previously reported as a non-operating credit.

Excluding the \$36.2 million noncash pension termination expense (net of the \$2 million tax credit), AMA would have reported \$23.4 million in net operating income for 2019, shown as pro forma on the preceding page.

Results discussed below reflect AMA's actual results from operations in 2023 as compared to 2022. Any pro forma charts exclude the impact of the pension termination on 2019 results.

Revenues

In 2023, total revenue increased slightly, up by \$1.7 million over the prior year. Continued growth in AMA's royalties and increased investment income were largely offset by the absence of \$14.3 million in one-time recognition of deferred revenue upon liquidation of a subsidiary company of Health2047, Inc. (Health2047) in 2022 and a decline in publishing print advertising.

Consolidated investment income, which is dividend and interest income, net of management fees, increased in 2023, impacted in large part by higher interest rates. Market gains or losses are not included in investment income and are reported as non-operating results.

The number of AMA dues paying members increased by 3.4 percent in 2023, the 12th year of growth in the past 13 years. During that 13-year period, AMA dues paying membership increased by over 81,000. Dues revenue declined 1.5 percent in 2023 as growth in lower dues paying categories such as group memberships and sponsored memberships partially offset the decline in individual direct member categories.

Most other revenue categories were either slightly down or unchanged for the year.

Cost of products sold and selling expenses

All variable expenses related to the production, distribution and sale of periodicals, books, coding products and licensed products are included in the cost of products sold and selling expense categories. Examples include paper, sales commissions, promotional activities, distribution costs and third-party editorial costs.

In 2023, cost of products sold and selling expenses decreased \$2.8 million from the prior year, mainly due to the prior year inclusion of a \$2.7 million one-time recognition of deferred costs related to the Health2047 subsidiary's liquidation.

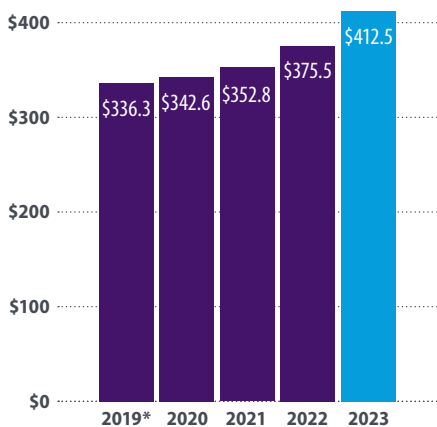
Contribution to general and administrative expenses

Cost of products sold and selling expenses are deducted from revenues to determine the amount of money available for the general and administrative expenses of the organization. Contribution to general and administrative expenses measures the gross margin derived from revenue-producing activities.

The contribution to general and administrative expenses increased \$4.5 million to \$467.3 million in 2023, with a small revenue improvement coupled with the absence of the one-time recognition of the Health2047 subsidiary's deferred costs accounting for most of the change.

Pro forma general and administrative expenses

(in millions)



*Excluding the non-cash pension termination charge

General and administrative expenses rose only \$37 million in 2023, or just under 10 percent, when compared to 2022. This was substantially less than the \$66.5 million budgeted increase for 2023, with over \$27 million in nonrecurring savings related to staffing, professional services and travel still impacting results.

Compensation and benefits increased \$27.3 million in 2023, up over 11 percent. Compensation, including temporary help, was \$17 million higher in 2023, a 7.2 percent increase which was a function of annual merit increases plus filling open positions. Fringe benefit costs increased \$2.8 million in total primarily due to higher medical, 401(k) plan and payroll tax expenses. Incentive compensation increased \$8.1 million after a \$7.8 million decline in 2022, as key performance indicators were achieved or exceeded in 2023.

Occupancy costs were largely unchanged as increased operating costs due to full return to the office were offset by reduced rent expense. In late 2022, AMA exercised a contraction option in the main headquarters lease whereby AMA relinquished one full floor of office space beginning in 2023 upon payment of a termination penalty. In late 2023, AMA negotiated an extension of the current headquarters lease in return for future contraction options and lease incentives. The impact will be amortized over the life of the lease.

Travel and meeting costs increased by \$5.2 million in 2023, as AMA resumed in-person meetings and travel for the full year. Technology costs were up \$4.4 million in 2023, due to cost increases and continued development of major AMA technology platforms for business units such as Publishing, Insurance Agency, and Membership marketing. As more technology moves to the cloud, costs associated with the technology platforms will be reflected in operating expense instead of capitalized as an asset and depreciated. This model has the benefit of reducing the need for in-house development expertise but also exposes AMA to more price risk from vendors.

Marketing and promotion costs remained largely unchanged in 2023. One-time approved marketing and media costs related to the launch of the AMA Recovery Plan for America's Physicians and membership promotion declined \$1.6 million but was offset by a \$1.1 million increase for the Advocacy marketing campaign on Medicare payment reform.

Outside professional services increased \$0.5 million in 2023, primarily in the strategic arcs, accelerators and core mission activities, led by a \$2 million increase in Advocacy related to the Physician Practice Survey and grassroots efforts supporting the Medicare payment reform campaign.

Other operating expenses were largely unchanged in 2023 as a write off of software and costs associated with liquidating a Health2047 affiliate were largely offset by a reduction in online subscription costs.

Operating results before income taxes

The AMA reported \$54.8 million in pre-tax operating income in 2023 compared to \$87.3 million in 2022. The prior year reflects substantially reduced expenses due to pandemic restrictions on travel and meetings, staffing freezes and tight labor markets. The current year results include over \$20 million in savings that is expected to diminish in 2024 as AMA continues to see improvement in recruiting.

Income taxes

Taxes increased \$0.7 million in 2023 when compared to 2022, reflecting higher taxable income in one of the subsidiaries.

Net operating results

Net operating income was \$49.7 million in 2023 compared to \$82.9 million in 2022, driven mainly by expenses starting to return to normal levels.

Non-operating items

The AMA reported a \$105 million gain in the fair value of its portfolio during 2023, recovering much of the \$115.1 million loss from 2022. Additional portfolio performance information is discussed in the group operating results section.

As a result of an accounting standard adopted in 2019 for postretirement benefit plans, non-operating results include \$3.9 million and \$3.5 million in postretirement plan interest expense and recognized actuarial losses and prior service credits for 2023 and 2022, respectively.

Revenue in excess of (less than) expenses

Revenues exceeded expenses by \$151.4 million in 2023, a combination of \$49.7 million in operating income, \$105 million gain in fair value in the portfolio and \$3.3 million in other non-operating expenses. The opposite occurred in 2022, where expenses exceeded revenues by \$35 million, a combination of \$82.9 million in operating income, the \$115.1 million loss in fair value in the portfolio and \$2.8 million in other non-operating expenses.

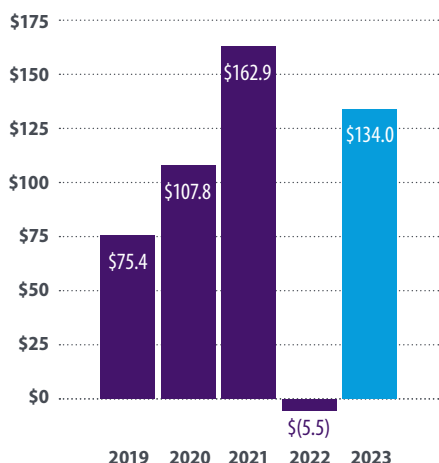
Accounting standards require organizations to recognize deferred actuarial losses and prior service credits or charges for defined benefit postretirement plans as a charge or credit to equity.

In 2023, AMA recorded a \$17.3 million charge to equity reflecting an actuarial loss for the postretirement health care plan, net of a reclassification of actuarial gains to operating expense and income tax. The loss resulted primarily from a change in the initial health care cost trend from 7.0 percent to 8.5 percent and less favorable claims cost experience.

In 2022, AMA recorded a \$29.4 million credit to equity reflecting an actuarial gain for the postretirement health care plan, net of a reclassification of actuarial losses for the plan to operating expense and income tax. The gain resulted primarily from higher interest rates that reduced the present value of plan liabilities.

Change in total association equity

(in millions)



The AMA reported a \$134 million increase in association equity in 2023. This reflects the amount by which revenues exceeded expenses, less the charge to equity for changes in defined benefit postretirement plans discussed above, as well as a small decrease in donor-restricted equity.

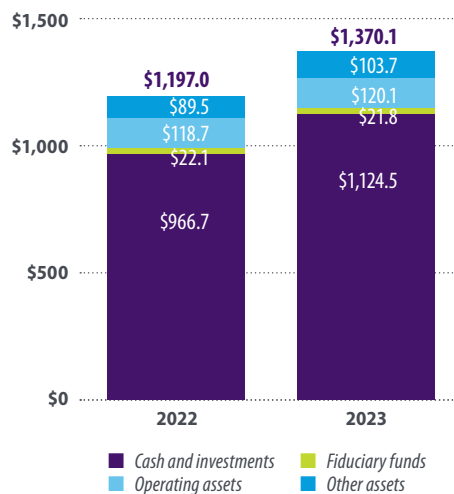
The AMA reported a \$5.5 million decrease in association equity in 2022. This reflects the amount by which expenses exceeded revenues, plus the credit to equity for changes in defined benefit postretirement plans discussed above, as well as a slight increase in donor-restricted equity.

Financial position and cash flows

The AMA's assets include cash, cash equivalents and investments; operating assets such as accounts receivable, inventory and prepaid expenses; fixed capital such as equipment, information technology hardware and software; and other assets. AMA assets are supported by association equity, operating liabilities and deferred revenue.

Assets

(in millions)



The AMA's total assets increased \$173.1 million in 2023. This includes a \$157.8 million increase in cash and investments resulting from \$61.5 million in free cash flow plus a \$105 million gain in the fair value of investment securities less \$8.7 million for investments in affiliates.

Fiduciary funds are premium payments from insurance customers not yet remitted to the carriers and funds held by the AMA for third parties for future use as approved by the third parties. This approximates the offsetting liability titled insurance premiums and other fiduciary funds payable.

Operating assets increased slightly in 2023, primarily due to an increase in accounts receivable. Changes in operating assets from year to year are largely due to timing of cash flows.

Other assets include operating lease right-of-use assets, property and equipment, investment in affiliates and investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Operating lease right-of-use assets increased \$12.2 million in 2023 largely due to the extension of AMA's current headquarters lease in return for contraction rights and lease incentives. Property and equipment net book value decreased as new capital spending was exceeded by annual depreciation and

amortization of existing capital assets while AMA's investment in affiliates increased by \$6.4 million as investments of \$8.7 million were reduced by AMA's share of the affiliates' operating losses.

Operating liabilities increased \$33.3 million in 2023, led by increases in the postretirement health care plan liabilities, lease liability and accrued payroll. The postretirement health care plan liability increase was a function of the impact of a higher projected health care cost trend and adverse claims experience on the actuarially computed present value of plan liabilities. The \$5.8 million lease liability change includes an increase in the present value of the headquarters liability resulting from extending the lease as noted above, reduced by cash payments in excess of rent expense.

Deferred revenue represents funds received during the year that will not be recognized as income until the following year or thereafter. These amounts vary, as well as accounts payable and accrued expenses, depending on the timing of cash receipts and payments.

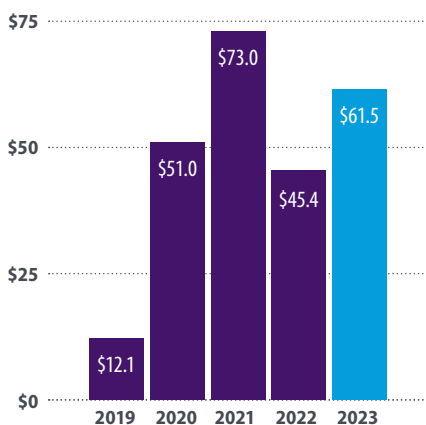
Cash flows

Cash, cash equivalents and donor-restricted cash increased \$2.6 million and \$1.4 million in 2023 and 2022, respectively. This comparison may cause misleading conclusions, as the change in cash and cash equivalents includes reductions for amounts invested in marketable securities, as well as cash inflows from non-operating activities.

Free cash flow measures the AMA's ability to fund operations, capital expenses and major programmatic initiatives from funds generated from operations. This measure excludes non-operating gains and losses.

Free cash

(in millions)

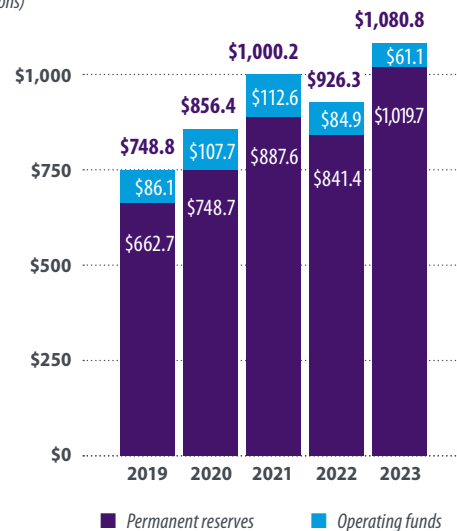


Free cash in 2023 totaled \$61.5 million, \$16.1 million higher than 2022, as changes in operating assets and liabilities more than offset the reduction in cash operating income.

Reserve portfolio

Reserves

(in millions)



The reserves and operating funds above do not include cash and investments in the for-profit subsidiaries and reflect only the not-for-profit entity's cash and investment portfolio values.

As of year-end 2023, the reserve portfolio's value was \$1,019.7 million compared to \$841.4 million in 2022, a \$178.3 million increase. That increase was mainly the result of a \$104.5 million gain in the fair value of the reserve portfolio plus a \$74.2 million transfer of 2022 excess operating funds to reserves. Operating funds totaled \$61.1 million in 2023, down \$23.8 million from 2022.

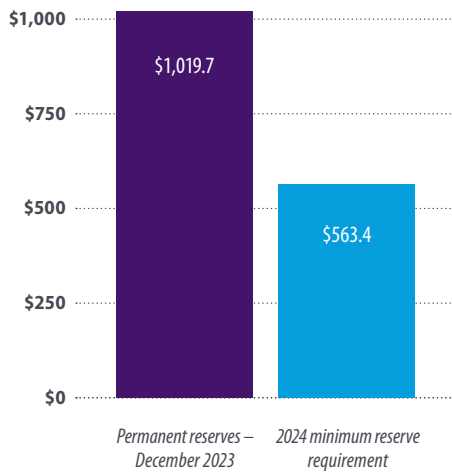
The AMA has established a required minimum reserve investment portfolio level that is adequate to cover 100 percent of annual general and administrative expenses (excluding grant expenses) plus an amount sufficient to pay long-term postretirement and lease liabilities (net of the right-of-use asset value). Operating funds, coupled with operating assets, are to be maintained at a level that allows payment of all operating liabilities.

AMA's reserves provide the backbone for the organization's long-term viability and independence, currently operating as a quasi-endowment fund, with a goal of achieving levels that could generate adequate funding to ensure the long-term future of the organization.

Reserve portfolio funds also provide the AMA with the ability to fund major strategic spending initiatives not within the operating budget. Spending from reserve funds is limited to dollar- or time-limited initiatives and capped at the amount by which reserves exceed the minimum requirement. Reserves may not be used for ongoing operating expenses. The Board of Trustees must authorize any use of reserves.

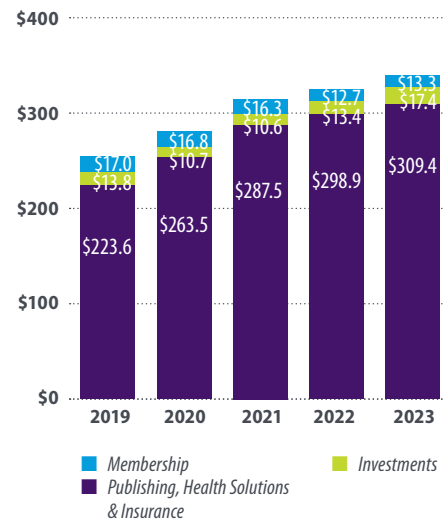
Permanent reserves and minimum reserve requirement

(in millions)



Contribution margin

(in millions)



Group operating results

The AMA is organized into various operating groups: Membership; Publishing, Health Solutions & Insurance; Strategic Arcs, Accelerators & Core Mission Activities; Administration and Operations; Affiliated Organizations; Unallocated Overhead; and Health2047 (including subsidiaries). Revenues and expenses directly attributed to those units are included in the group operating results. A financial summary of group operating results is presented at the end of this section. The prior year financial results have been updated to be consistent with the current year reported results for each group.

Contribution margin (net expenses)

Contribution margin equals individual group revenues minus cost of products sold, selling expenses, and direct general and administrative expenses such as compensation, occupancy, travel and meetings, technology costs and professional services.

Net expenses equals total spending, net of any revenue produced by the group, such as grants or other fee income. Total contribution margin and net expenses equals consolidated operating results before income taxes. The charts below separate groups with contribution margin from groups with net expenses.

The contribution margin generated by Membership; Publishing, Health Solutions & Insurance; as well as Investments, provides the funding for all mission-related activities of the AMA as well as funding for all administration and support operations required to run the organization.

Membership

The Membership group's net membership dues revenue includes the gross dues revenue collected, reduced by any commissions paid to state societies, and equals the membership dues revenue reported on the statement of activities.

In 2023, AMA again reported an increase in the number of dues-paying members, up 3.4 percent from 2022. In 12 of the last 13 years, AMA has reported increases in the number of dues-paying members, a major accomplishment. Membership continues to focus on expanding use of digital tools to engage physicians and retain them as lifelong members, group membership marketing, and expanding AMA's reach to physicians through programmatic activities.

Dues revenue was \$33.3 million, a \$0.4 million decrease from 2022. Although the number of physician members increased, most of the growth was in lower dues paying categories. Membership expenses are down \$1 million as 2022 results included a \$1 million one-time increase in marketing costs related to the launch of the AMA Recovery Plan for America's Physicians that did not recur in 2023. Membership's contribution margin increased \$0.6 million in 2023, as cost decreases more than offset the revenue decline.

Publishing, Health Solutions & Insurance

Publications in the JAMA Network include the *Journal of the American Medical Association (JAMA)* and the JAMA Network specialty journals. In the last decade, the JAMA Network has launched four new journals: *JAMA Oncology* in 2015 and *JAMA Cardiology* in 2016, which are hybrid journals offering open access options for research articles; *JAMA Network Open* in 2018, a fully open access journal; and *JAMA Health Forum* in 2021, a peer-reviewed, open-access, online journal focused on health policy, health care systems, and global and public health.

Publishing revenues are derived from advertising, subscriptions, site licensing, reprints, electronic licensing, open access fees and royalties. Publishing revenues decreased \$2.1 million in 2023, largely a function of a \$2.3 million decline in advertising. The continued drop in advertising revenue necessitated a change in strategy for Publishing as the business unit eliminated distribution of print journals to a controlled population of physicians who were included in measuring journal readership scores, a key indicator for ad placement. This change slightly reduced production and distribution costs and partially offset the advertising drop. It is expected to result in a larger benefit in 2024. Expenses declined \$1 million during 2023, primarily due to vacancy savings from unfilled positions. The contribution margin thus declined by \$1.1 million to \$1 million.

Health Solutions includes two major lines: Database Products, and Books and Digital Content.

Database Products includes royalties from licensed data sales and credentialing products revenue. Revenues increased in 2023, up \$0.8 million when compared to 2022, driven again in large part by a major compliance effort to upgrade existing customer contracts to full licenses. Expenses were up \$1.5 million driven by compensation from filling positions and increased technology costs, of which \$0.6 million relates to development of a new physician credentialing product. This is a credentials wallet that streamlines credentialing by pre-filling physician applications with authoritative, verified AMA data, reducing administrative burden for physicians and medical staff professionals. The resulting contribution margin declined by \$0.7 million in 2023 to \$53.6 million.

AMA-published books and coding products, such as CPT books, workshops, and licensed data files, make up the Books and Digital Content unit. Royalties and digital content sales drove a \$13.4 million revenue increase, as the market for electronic use of digital coding products continues to expand. A three percent price increase, after no increases in the pandemic years, as well as phasing in previous pricing model changes, were also factors. Coding book sales improved slightly in 2023 as the move from print products to digital slowed. Expenses were up slightly in 2023, driven by increased compensation from filling open positions, offset by a reduction in technology costs. The contribution margin increased by \$12.5 million to \$241 million.

The AMA has two active for-profit subsidiaries, the AMA Insurance Agency (Agency) and Health2047. The latter is discussed separately at the end of this discussion and analysis.

The Agency revenues improved by \$0.6 million in 2023, as increased investment income from higher interest rates offset a decline in commissions. The commission reduction was mainly due to continued decreases in commission rates to protect the viability of the plan, which allowed the Agency to avoid charging higher premiums to physician customers. The Agency, as broker, receives a commission on insurance policies sold. Expenses were up \$1.2 million mainly due to filling open positions and technology costs related to development of a new customer-facing platform. The contribution margin decreased to \$17.3 million from \$17.9 million in the prior year.

Other business operations net expenses were down \$0.4 million in 2023, as the prior year included \$0.7 million in one-time costs.

In total, Publishing, Health Solutions & Insurance contribution margin was \$309.4 million, up \$10.5 million from 2022.

Investments (AMA-only)

AMA-only investment income includes dividend and interest earnings on the AMA's portfolio. Investment income in AMA's for-profit subsidiaries is included as part of the group results for Publishing, Health Solutions & Insurance and Health2047.

Investments' revenue was \$18.1 million in 2023, a \$4 million increase over the prior year. Dividend and interest income continued to improve in 2023, impacted in large part by higher interest rates. The contribution margin also increased by \$4 million as expenses were unchanged.

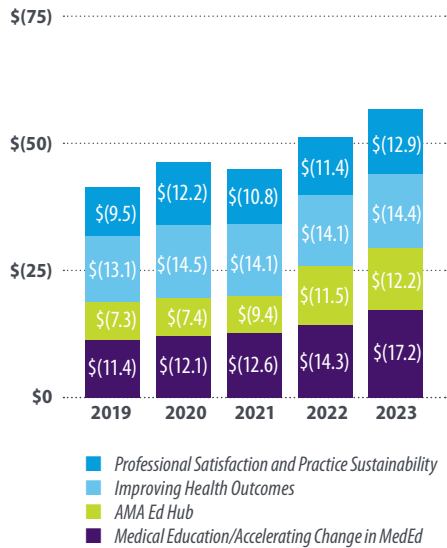
The net gain or loss on the market value of investments is not included in operating results but reported as a non-operating item. This amount is in addition to the investment income discussed above.

In 2023, AMA reported a net gain of \$105 million, compared to a \$115.1 million loss in 2022. The total investment return, including investment income, on the reserve portfolios was 14.9 percent, slightly less than the 15.4 percent gain in the composite benchmark index.

Net expenses

Strategic Arcs

(in millions)



The Strategic Arcs include direct costs associated with the groups for Improving Health Outcomes (IHO), Medical Education/Accelerating Change in Medical Education (ACE), the AMA Ed Hub and Professional Satisfaction and Practice Sustainability (PS2).

IHO focuses on confronting two of the nation’s most prevalent issues: cardiovascular disease and type-2 diabetes, setting a course of innovation and action aimed at reducing the disease and cost burden associated with these selected conditions.

The main focus during 2023 was on hypertension outcome goals as progress continues on implementation of cloud-based MAP BP (a three-step program that works to diagnose and manage patients with hypertension) dashboards at health care organizations (HCOs), providing a visual representation of their performance on five key blood pressure metrics, including stratification by ethnicity, race and gender. To improve the quality of care physicians provide to their patients with hypertension, the AMA collaborated with three channel partners to increase access to AMA MAP Metrics, which help identify gaps, track progress, and support quality improvement efforts. This reached approximately 5.5 million additional patients with hypertension across 683 organizations inclusive of health systems, Federally Qualified Health Centers, community health centers and medical groups. Over 8 million hypertension patients were reached through professionals using one or more individual components of AMA MAP BP. In addition, to help close a gap in blood pressure measurement training that exists within medical schools, the AMA awarded financial grants to eight academic institutions representing 18 total training programs for healthcare professionals allowing them to meaningfully engage in BP Measurement Essentials: Student Edition, AMA’s eLearning series. In 2023, net expenses were largely unchanged.

Advancing Professional Development includes Medical Education/ACE and the AMA Ed Hub.

While the undergraduate medical school consortium grants successfully concluded in 2018, all 32 consortium schools have continued collaboration and the consortium of schools has been substantially expanded. The consortium now acts as a learning collaborative so that best practices can be developed, shared, and implemented in medical schools across the country. The AMA ChangeMedEd® initiative held its bi-annual, national conference in Chicago, bringing together more than 500 leaders and innovators in medical education and related health care fields to catalyze change in medical education and transform the way future physicians and residents are trained. Nearly 150 presenters led over 75 sessions including plenary sessions on educator well-being in medical education, reimagining residency, precision education, and equity, diversity and belonging.

In 2019, the methods and learning from the undergraduate consortium initiative were extended to a new multi-year grant program for graduate medical education, designed to improve the transition from undergraduate to graduate medical education and to maintain and reinforce the positive changes initiated by the undergraduate consortium work.

One of the key outcomes of the ACE consortium was the development of Health Systems Science, a foundational platform and framework for the study and understanding of how care is delivered, how health professionals work together to deliver that care, and how the health system can improve patient care and health care delivery.

In 2023, the AMA advanced a conceptual model for precision education: a system that can leverage technology and data to improve education personalization and learning efficiency across the continuum, in support of students, residents, fellows, physicians, and ultimately the needs of patients. Innovation Grants were awarded to 13 sites applying precision education approaches in medical school, residency and continuing professional development. Medical Education is also responsible for defining or influencing standards for undergraduate, graduate and continuing medical education and providing support for the Council on Medical Education. Net expenses increased \$2.9 million in 2023 reflecting filling open positions, resumption of in-person meetings and travel as well as a \$0.9 million expense increase for precision education.

The AMA Ed Hub, formally launched in 2018, is a platform providing physicians and other health care providers content and educational services that support lifelong professional development. The Ed Hub has unified the AMA education portfolio and has piloted integration of external content providers, launched new content sets, and established internal development plans enterprise wide, including the Health Equity Education Center and the UME Curricular Enrichment Program. The Ed Hub also gives physicians and other health professionals a streamlined way to earn, track and report continuing medical education activities spanning clinical, practice transformation and professionalism topics. The number of external education

providers on the platform grew by ten organizations to 50 organizations and the Ed Hub achieved unprecedented growth in users and engagement in 2023, driven in large part by Ed Hub's rapid delivery of an education offering to help physicians and clinicians meet the new DEA MATE requirements on substance use disorders and addiction. Net expenses were up \$0.7 million in 2023 due largely to filling open positions.

PS2 includes three major streams of work: professional satisfaction/practice transformation, practice sustainability, and digital health, all designed to improve the day-to-day practice and professional experience of physicians and remove obstacles to care. The goals of this group are to promote successful models in both the public and private sectors. This includes expanding research of credible practice science, creating tools and other solutions to help guide physicians, care teams and health system leaders on developing and implementing strategies to optimize practice efficiencies, reduce burnout and improve professional well-being; ensuring the physician perspective is represented in the design, implementation and evaluation of new health care technologies; and shaping the evolution of payment models for sustainability and satisfaction.

In 2023, PS2 published more than 25 peer-reviewed studies on physician and practice issues, and led and funded a variety of research on high impact issues affecting physicians and health systems, such as burnout, workforce and EHR inbox workload. The AMA Joy in Medicine Health System Recognition Program recognized 72 health systems who met the evidenced-based criteria representing their commitment to organizational well-being. Providing over 100 new or updated AMA STEPS Forward® resources (toolkits, webinars, podcasts, and playbooks) helped drive the user growth to over two million. AMA also co-sponsored the 2023 American Conference on Physician Health with Stanford Medicine and Mayo Clinic with a record-breaking attendance of over 600 participants. In 2023, net expenses increased \$1.5 million, driven almost entirely by staffing and travel costs.

Accelerators & Core Mission Activities includes six groups: Advocacy; Health, Science & Ethics; Center for Health Equity (CHE); Integrated Health Model Initiative (IHMI); Enterprise Communications; and Marketing & Member Experience (MMX).

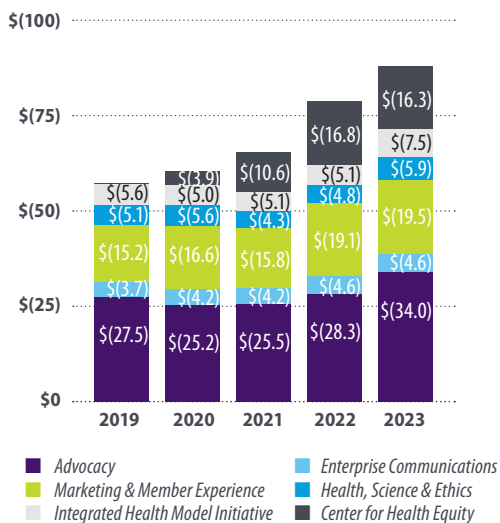
Advocacy includes federal and state level advocacy to enact laws and advance regulations on issues important to patients and physicians; economic, statistical and market research to support advocacy efforts; political education for physicians; grassroots advocacy; and maintaining relations with the federation of medicine. Advocacy led the launch of a major media campaign to urge Congress to address long-term, systemic reform of Medicare payments through the AMA's coalition. Other major initiatives included fighting scope creep by achieving more than 100 state-level scope of practice victories in strong collaboration with Federation partners and introducing or strengthening existing "Truth in Advertising" laws so that patients know if the person providing care is a physician; working with the Center for Medicare & Medicaid Services (CMS) to finalize several major prior authorization reforms under Medicare Advantage; ensuring that AMA's critical voice is represented in federal and state courts around the country on a broad range of issues; working with state and federal policymakers to oppose legislation and laws that interfere with the practice of medicine; and elevating the voice of physician leadership on critical issues of public health. In 2023, Advocacy net spending increased \$5.7 million, with \$2.5 million for compensation expenses and travel and meeting costs as in-person meetings resumed, \$1.9 million in media and professional service costs for the Medicare reform campaign, as well as \$1.5 million for the Physician Practice Survey initiative.

Health, Science & Ethics is involved in developing AMA policies on scientific, public health and ethical issues for the House of Delegates; providing leadership, subject matter expertise and scientifically sound content and evidence that underpins and informs both current and future AMA initiatives in areas such as infectious disease, drug policy and opioid prescribing; overseeing maintenance of the AMA *Code of Medical Ethics* and publication of the *AMA Journal of Ethics*, AMA's online ethics journal; and managing the United States Adopted Names (USAN) program, responsible for selecting generic names for drugs by establishing logical nomenclature classifications based on pharmacological or chemical relationships (reported separately in group operating results). This group launched several major initiatives in 2023 including a new website and learning center for the *AMA Code of Medical Ethics*, new resources on infectious disease and control, and the Firearm Injury Prevention Task Force. Net expenses increased \$1.1 million in 2023, mainly due to higher compensation and travel and meeting expenses.

AMA recognized that a key to long-term success in our strategic arcs is increasing our efforts to reduce health and health care disparities. As a result of a 2018 task force report, the AMA sought leadership to embed health equity initiatives as relevant into all strategic priorities and areas of the organization, creating a new group, the Center for Health Equity. The focus of this group is to elevate AMA's public role and responsibilities to improve health equity. In 2023, CHE expanded its efforts to establish

Accelerators & Core Mission Activities

(in millions)



an AMA presence in the health equity research literature with the publication of 43 Social Justice Education Ed Hub modules, the continuation of the Prioritizing Equity Series and launching the National Health Equity Grand Rounds, engaging over ten thousand viewers.

AMA-Satcher Health Leadership Institute at Morehouse School of Medicine, Medical Justice in Advocacy Fellowship is a unique, first of its kind post-doctoral fellowship designed to enhance physicians' advocacy leadership skills to improve health outcomes and advance health equity in the areas they serve or may serve. The Advocacy Fellowship successfully completed its second cohort of fellows, bringing the total number of fellows to 23.

CHE continued to convene members of the health ecosystem to share knowledge and to build alliances resulting in collaboration opportunities and collective action that advance health equity, including the official launch of the *Rise to Health: A National Coalition for Equity in Health Care* co-led by the Institute of Healthcare Improvement (IHI), uniting organizations toward action and shared solutions for systemic change and structural impact, and establishment of the Truth, Reconciliation, Healing and Transformation Task Force during the first half of 2023. CHE also represented AMA as an anchor mission partner for the collaborative on Chicago's west side, West Side United, and continued building staff capacity to understand concepts surrounding health equity and to operationalize equity in goal and metric setting and developing structural competency learning tools. CHE has largely achieved its planned level of growth and net expenses declined slightly in 2023.

IHMI brings together experts from patient care, medical terminology, and informatics around a common framework for defining and expressing health data. IHMI has been recognized as a leading authority on clinical content standards and is contributing to the development and use of clinical content through collaboration with Health Level 7 (HL7) FHIR (Fast Healthcare Interoperability Resources), the Gravity Project and others. A major initiative in the last several years has focused on development of a Self-Measured Blood Pressure (SMBP) software and services solution, which in 2023 was determined to be difficult for AMA to develop and maintain. As such, AMA decided to cease operations of the development team and focus on the clinical content standards work. IHMI net expenses increased \$2.4 million in 2023, reflecting a full year of development activity as well as costs associated with closing the SMBP program. The data standards team will be transferred to Health Solutions in 2024.

MMX extends the reach and impact of AMA's mission and advocacy initiatives and strengthens the AMA brand. MMX continues to take on increased oversight for managing the quality, timing and relevance of the experience physicians have at each point of interaction through AMA's digital publishing, health system engagement and member programs. MMX creates or packages AMA's content into digital formats and distributes AMA resources and thought leadership to intended audiences through owned and paid channels, raising awareness of AMA initiatives, resources and accomplishments and elevating the

voice of AMA and physicians. In 2023, almost 37 million unique individuals accessed AMA's website, a 5 percent increase over the record number of users in the prior year. The continuation of the AMA Recovery Plan for America's Physicians demonstrated its relevance with more than 80 percent of physicians saying it is important, with awareness of the campaign increasing 26 percent over the prior year. Video programming connected strongly with medical students with more than half the video views on YouTube attributed to the AMA Research Challenge. Net expenses increased slightly in 2023, by \$0.4 million, as higher staffing costs were partially offset by lower media marketing expenses for the Recovery Plan after the initial launch in 2022.

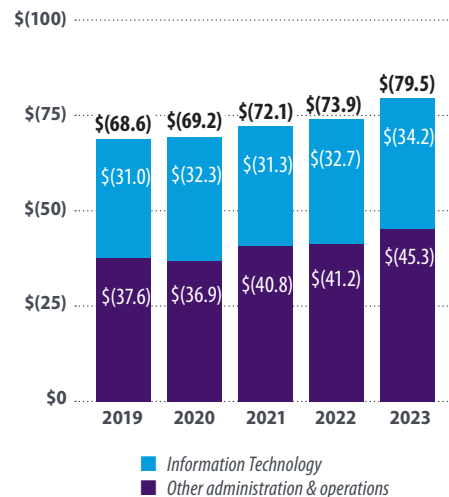
Ongoing responsibilities of the Enterprise Communications area include amplifying the work of individual operating units among their core audiences while providing consistency and alignment with the AMA narrative. Enterprise Communications distinctly communicates AMA's leading voice in science and evidence to embed equity, innovation, and advocacy across the AMA's strategic work throughout health care. Net expenses were unchanged in 2023, as increased staffing and technology costs were largely offset by the absence of costs for activities celebrating AMA's 175th anniversary in 2022.

Governance

Governance includes the Board of Trustees and Officer Services, the House of Delegates (HOD), Sections and Special Constituencies & International units. The Board of Trustees unit includes costs related to governance activities as well as expenses associated with support of the Strategic Arcs, Accelerators and Core Mission Activities. The HOD, Sections and Special Constituencies & International unit includes costs associated with annual and interim meetings, groups, sections and other HOD activities, as well as costs associated with AMA's involvement in the World Medical Association. In 2023, Governance net spending was up \$1.1 million, mainly reflecting the impact of a full year's in-person meeting and travel costs.

Administration and Operations

(in millions)



These units provide administrative and operational support for Publishing & Health Solutions, Membership, Strategic Arcs, Accelerators and Core Mission Activities, as well as other operating groups. Net expenses were up 7.6 percent in 2023, an increase of \$5.6 million, almost entirely due to compensation costs from filling open positions and merit increases.

Affiliated Organizations

Affiliated Organizations represent either grant or in-kind service support provided by the AMA to other foundations and societies. In some cases, the AMA is reimbursed for services provided. No net expenses were reported in 2023.

Unallocated Overhead

The net expenses in this area include costs not allocated back to operating units such as corporate insurance and actuarial services, employee incentive compensation, valuation allowances or other reserves. In 2023, these expenses total \$29.3 million, up from \$18.6 million in 2022. Higher incentive compensation was the main factor in the increase.

Health2047 and Subsidiaries

AMA owns a business formation and commercialization enterprise designed to enhance AMA's ability to define, create, develop and launch, with partners, a portfolio of products and technologies that will have a profound impact on many aspects of the U.S. health care system and population health, with a central goal of helping physicians in practice. The AMA Board of Trustees approved the use of reserves to establish this subsidiary with plans to use third-party resources to assist in funding spinoffs with commercial potential in future years. These liquidity events generally occur somewhere between eight and twelve years after the initial spinoff.

Health2047 funds initial projects and moves those that demonstrate commercial appeal into separate companies, along with necessary seed funding for the new companies. The initial stages generally involve seed money provided by Health2047, after which these companies should command additional investment from third parties to begin commercialization of the product, either through debt or equity financing. For those that achieve third-party funding, at some point in the future, the spinoffs will be sold or liquidated, at which time, AMA would expect to receive a financial return.

Since 2017, Health2047 has spun off or invested in 12 companies, Akiri, Inc. (Akiri), First Mile Care, Inc. (FMC), HXSquare, Inc. (HXS), Zing Health Enterprises, LP (Zing), Medcurio, Inc. (Medcurio), Phenomix Sciences, Inc. (Phenomix), Sitebridge Research, Inc. (Sitebridge), Emergence Healthcare Group, Inc. (Emergence), Heal Security, Inc. (Heal), Evidium, Inc. (previously Recovery Exploration Technologies, Inc.) (Evidium), Scholar Rx, Inc. (Scholar Rx) and IntellixAI, Inc. (IntellixAI).

In 2021 and 2022, Health2047 liquidated two of these companies, Akiri and HXS, as third-party financing efforts were unsuccessful. Upon liquidation of Akiri in 2022, there was an \$11.6 million gain from recognizing deferred revenue and expense for a customer contract entered into and paid in an earlier year. There was no material gain or loss upon the HXS liquidation. In 2023, Health2047 liquidated Emergence and recorded a \$2.2 million loss on liquidation.

As of December 31, 2023, Health2047 has an ownership interest in nine companies, including a consolidated subsidiary, FMC, one company accounted for using the equity method, Heal, and seven companies accounted for using the cost method, Zing, Medcurio, Phenomix, Sitebridge, Evidium, Scholar Rx and IntellixAI. The footnotes to AMA's financial statements include a detailed discussion on accounting for Health2047 spinoff companies. Third-party financing is expected to cover most long-term future costs for many of these companies.

Health2047 revenue in 2023 totaled a negative \$0.3 million, as the \$1.2 million loss in earnings of affiliates was partially offset by investment income and other operating revenue totaling \$0.9 million. In 2022, as result of the Akiri liquidation, Health2047 recognized \$14.3 million in revenue and \$2.7 million in associated costs for creating a custom platform for a customer. Both revenue and expense had been received or incurred in prior years but were deferred until the project was completed or abandoned, which occurred in 2022.

Costs increased by \$0.9 million in 2023 as a \$3.6 million increase was offset by the absence of the prior year \$2.7 million recognition of deferred costs. The gross \$3.6 million increase includes the \$2.2 million loss on liquidation of Emergence, as well as \$1.5 million in increased compensation.

Net expenses increased by \$15.4 million in 2023 mainly due to the cost increases plus the absence of the net \$11.6 million impact from recognizing the deferred revenue and expense that was reported in 2022.

The summary of group operating results is included on the following page.

American Medical Association Group operating results

(in millions)	Revenues		Margin (Expenses)	
	2023	2022	2023	2022
Membership	\$ 33.3	\$ 33.7	\$ 13.3	\$ 12.7
Publishing, Health Solutions & Insurance				
Publishing	63.8	65.9	1.0	2.1
Books and Digital Content	265.5	252.1	241.0	228.5
Database Products	67.7	66.9	53.6	54.3
Insurance Agency/Affinity Products	37.1	36.5	17.3	17.9
Other business operations	-	-	(3.5)	(3.9)
	434.1	421.4	309.4	298.9
Investments (AMA-only)	18.1	14.1	17.4	13.4
Strategic Arcs, Accelerators & Core Mission Activities				
Improving Health Outcomes	-	-	(14.4)	(14.1)
Medical Education/Accelerating Change in Medical Education	0.4	0.3	(17.2)	(14.3)
AMA Ed Hub	0.3	0.4	(12.2)	(11.5)
Professional Satisfaction and Practice Sustainability	0.6	0.4	(12.9)	(11.4)
Advocacy	1.0	0.5	(34.0)	(28.3)
Health, Science & Ethics	2.4	2.7	(5.9)	(4.8)
Center for Health Equity	-	0.1	(16.3)	(16.8)
Integrated Health Model Initiative	-	-	(7.5)	(5.1)
Marketing and Member Experience	-	-	(19.5)	(19.1)
Enterprise Communications	-	-	(4.6)	(4.6)
United States Adopted Names Program	3.4	3.7	2.6	2.9
	8.1	8.1	(141.9)	(127.1)
Governance				
Board of Trustees and Officer Services	-	-	(6.8)	(6.3)
House of Delegates, Sections, Special Constituencies & International	0.1	0.1	(10.9)	(10.3)
	0.1	0.1	(17.7)	(16.6)
Administration and Operations				
Information Technology	-	-	(34.2)	(32.7)
Senior Executive Management	-	-	(7.5)	(5.6)
General Counsel	-	-	(6.3)	(6.9)
Finance & Risk Management	-	-	(9.0)	(7.7)
Human Resources	-	-	(8.2)	(8.1)
Corporate Services	-	-	(6.2)	(5.6)
Customer Service	-	-	(3.6)	(3.4)
Strategic Insights and Planning	-	-	(4.5)	(3.9)
	-	-	(79.5)	(73.9)
Affiliated Organizations	0.1	0.1	-	-
Unallocated Overhead	1.6	1.7	(29.3)	(18.6)
Health2047 & Subsidiaries	(0.3)	14.2	(16.9)	(1.5)
Consolidated revenue and income before tax	\$ 495.1	\$ 493.4	54.8	87.3
Income taxes			(5.1)	(4.4)
Consolidated net operating income			\$ 49.7	\$ 82.9

CONSOLIDATED FINANCIAL STATEMENTS

CONSOLIDATED STATEMENTS OF ACTIVITIES

Years ended December 31

(in millions)	2023	2022
Revenues		
Membership dues	\$ 33.3	\$ 33.8
Advertising	11.0	13.3
Journal print subscription revenues	2.7	2.9
Journal online revenues	31.6	30.8
Other publishing revenue	18.0	17.8
Books, newsletters and online product sales	23.8	24.7
Royalties and credentialing products	308.0	293.1
Insurance commissions	31.6	33.2
Investment income (Note 4)	21.3	15.1
Equity in losses of affiliates (Note 2)	(1.2)	(0.8)
Grants and other income	15.0	29.5
Total revenues	495.1	493.4
Expenses		
Cost of products sold and selling expenses	27.8	30.6
Contribution to general and administrative expenses	467.3	462.8
General and administrative expenses		
Compensation and benefits	262.0	234.7
Occupancy	21.2	21.4
Travel and meetings	19.9	14.7
Technology costs	33.9	29.5
Marketing and promotion	20.7	21.3
Professional services	29.7	29.2
Other operating expenses	25.1	24.7
Total general and administrative expenses	412.5	375.5
Operating results before income taxes	54.8	87.3
Income taxes (Note 9)	5.1	4.4
Net operating results	49.7	82.9
Non-operating items		
Net gain (loss) on investments (Note 4)	105.0	(115.1)
Defined benefit postretirement plan non-service periodic expense (Note 8)	(3.9)	(3.5)
Other non-operating income	0.6	0.7
Total non-operating items	101.7	(117.9)
Revenues in excess of (less than) expenses	151.4	(35.0)
Changes in defined benefit postretirement plans, other than periodic expense, net of tax (Notes 8 and 9)	(17.3)	29.4
Change in association equity	134.1	(5.6)
Change in donor restricted association equity		
Restricted contributions	0.6	0.4
Net assets released from restriction	(0.7)	(0.3)
Change in association equity – donor restricted	(0.1)	0.1
Change in total association equity	134.0	(5.5)
Total association equity at beginning of year	889.4	894.9
Total association equity at end of year	\$ 1,023.4	\$ 889.4

See accompanying notes to the consolidated financial statements.

CONSOLIDATED STATEMENTS OF FINANCIAL POSITION

As of December 31

(in millions)	2023	2022
Assets		
Cash, cash equivalents and donor-restricted cash	\$ 36.1	\$ 33.5
Fiduciary funds (Note 2)	21.8	22.1
Investments in affiliates (Note 2)	15.3	8.9
Accounts receivable and other receivables, net of an allowance for doubtful accounts of \$0.3 in 2023 and 2022	104.5	101.5
Inventories	2.1	2.8
Prepaid expenses and deposits	10.5	11.7
Deferred income taxes (Note 9)	3.0	2.7
Investments (Note 4)	1,088.4	933.2
Property and equipment, net (Note 6)	27.3	33.3
Operating lease right-of-use assets (Note 10)	51.3	39.1
Other assets (Note 5)	9.8	8.2
	\$ 1,370.1	\$ 1,197.0
Liabilities, deferred revenue and association equity		
Liabilities		
Accounts payable, accrued expenses and other liabilities	\$ 15.1	\$ 16.0
Accrued payroll and employee benefits (Note 7)	54.9	45.7
Accrued postretirement health care benefits (Note 8)	107.8	88.1
Insurance premiums and other fiduciary funds payable (Note 2)	21.6	22.1
Operating lease liability (Note 10)	71.1	65.3
	270.5	237.2
Deferred revenue		
Membership dues	13.2	13.9
Subscriptions, licensing, insurance commissions and royalties	59.9	53.9
Grants and other	3.1	2.6
	76.2	70.4
Association equity		
Association equity	1,023.4	889.3
Donor-restricted association equity	-	0.1
Total association equity	1,023.4	889.4
	\$ 1,370.1	\$ 1,197.0

See accompanying notes to the consolidated financial statements.

CONSOLIDATED STATEMENTS OF CASH FLOWS

Years ended December 31

(in millions)	2023	2022
Cash flows from operating activities		
Change in total association equity	\$ 134.0	\$ (5.5)
Adjustments to reconcile change in association equity to net cash provided by operating activities		
Depreciation and amortization	11.7	12.2
Postretirement health care expense	4.4	4.6
Noncash operating lease expense	8.9	9.7
Net (gain) loss on investments	(105.0)	115.1
Equity in losses of affiliates	1.2	0.8
Noncash charge (credit) for changes in defined benefit plans other than periodic expense net of tax	17.3	(29.4)
Noncash loss (gain) upon liquidation of affiliate or subsidiary	2.2	(11.6)
Loss on disposal of property and equipment	1.5	-
Bad debt expense	0.1	0.1
Other	(1.3)	(1.3)
Changes in assets and liabilities		
Accounts receivable and other receivables	(3.1)	(13.1)
Inventories	0.7	(1.1)
Prepaid expenses and deposits	1.2	1.0
Accounts payable, accrued liabilities and income taxes	(8.9)	(22.5)
Accrued postretirement benefit costs	(3.0)	(2.7)
Deferred revenue	5.8	(1.7)
Net cash provided by operating activities	67.7	54.6
Cash flows from investing activities		
Purchase of property and equipment	(6.2)	(9.2)
Investment in affiliates	(8.7)	(2.3)
Purchase of investments	(876.0)	(538.3)
Proceeds from sale of investments	825.8	496.6
Net cash used in investing activities	(65.1)	(53.2)
Net change in cash, cash equivalents and donor restricted cash	2.6	1.4
Cash, cash equivalents and donor restricted cash at beginning of year	33.5	32.1
Cash, cash equivalents and donor restricted cash at end of year	\$ 36.1	\$ 33.5
Noncash operating activities		
Right-of-use assets obtained in exchange for lease obligation	\$ 17.8	\$ 0.5
Noncash investing activities		
Accounts payable for property and equipment additions	\$ 1.3	\$ 0.3

See accompanying notes to the consolidated financial statements.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS

For the years ended December 31, 2023 and 2022
(Columnar amounts in millions)

1. Nature of operations

The American Medical Association (AMA) is a national professional association of physicians with approximately 283 thousand members. The AMA serves the medical community and the public through standard setting and implementation in the areas of science, medical education, improving health outcomes, health equity, delivery and payment systems, ethics, representation and advocacy, policy development, and image and identity building. The AMA provides information and services to hundreds of thousands of physicians and includes journal and book publishing, physician credentialing, database licensing, insurance and other professional services for physicians.

The AMA classifies all operating results as revenues and expenses in the consolidated statements of activities. Non-operating items include net realized and unrealized gains and losses on investments, defined benefit postretirement plan non-service expense and other nonrecurring income or expense.

Donor-restricted association equity includes contributions restricted for use for a scope of practice program which are not available for general use by AMA.

2. Significant accounting policies

Consolidation policy

The accompanying consolidated financial statements include the accounts of the AMA and its subsidiaries, AMA Services, Inc., American Medical Assurance Company and Health2047 Inc. (collectively, the AMA).

AMA, through its wholly owned subsidiary, Health2047 Inc. (Health2047), has investments in nine companies or limited partnerships as of December 31, 2023. Health2047 controls and therefore consolidates the results of one company, First Mile Care, Inc.

The equity method of accounting is used to account for investments in companies or limited partnerships in which the AMA has significant influence but not overall control. The investments are initially recorded at the original amounts paid for common and convertible preferred stock, and subsequently adjusted for the AMA's share of undistributed earnings and losses from the underlying entities from the dates of formation. Each investment will be increased or reduced by any future additional contributions and distributions received, respectively. The cost method of accounting is used to account for investments in companies in which the AMA has neither significant influence nor overall control and where the fair value is not readily determinable.

The companies accounted for under the equity method of accounting during 2023 are Emergence Healthcare Group, Inc. (formed in January 2021 and liquidated in September 2023) and Heal Security, Inc. (formed in February 2021).

At December 31, 2023, AMA ownership interest is 33.3% in Heal Security, Inc. The book value of the investment accounted for under the equity method, net of convertible debt, at December 31, 2023 is \$0.9 million.

In addition, at December 31, 2023, AMA has ownership interest of 3.3% in Zing Health Enterprises, LP (formed in May 2020), 16.7% in Medcurio Inc., (formed in February 2020), 19.1% in Phenomix Sciences, Inc. (formed in August 2020), 11.3% in Evidium, Inc. (formerly Recovery Exploration Technologies, Inc., formed in August 2021), 18.4% in Sitebridge Research, Inc. (formed in January 2021), 6.0% in Scholar Rx, Inc. (formed in December 2022) and 6.1% in IntellixAI, Inc. (formed in May 2023). The investments in these entities are accounted for using the cost method, as AMA holds less than a 20% ownership and does not exercise significant influence over the entities. The book value of the seven investments carried at cost at December 31, 2023 is \$14.4 million.

Health2047 had investments in nine companies or limited partnerships as of December 31, 2022. Health2047 controlled and therefore consolidated the results of two companies, First Mile Care, Inc. and Akiri, Inc. (Akiri). Akiri was liquidated during 2022 resulting in recognition of \$14.3 million of deferred revenue, reported in grants and other income, and \$2.7 million of deferred costs, included in cost of products sold and selling expenses, related to completion of a customer contract entered into during 2017.

The companies accounted for under the equity method of accounting during 2022 were: HXSquare, Inc. (formed in January 2019 and liquidated in February 2022), Emergence Healthcare Group, Inc., Heal Security, Inc., and Evidium, Inc. During 2022, the AMA ceased application of the equity method to account for the investment in Evidium, Inc. as additional third-party investment resulted in AMA no longer exercising significant influence over this entity.

At December 31, 2022, AMA ownership interest was 20.1% in Emergence Healthcare Group, Inc. and 33.3% in Heal Security, Inc. The book value of the two investments accounted for under the equity method, net of convertible debt, at December 31, 2022 was \$1.8 million.

In addition, at December 31, 2022, AMA had an ownership interest of 3.6% in Zing Health Enterprises, LP, 12.1% in Medcurio Inc., 12.6% in Phenomix Sciences, Inc., 11.3% in Evidium, Inc., 18.8% in Sitebridge Research, Inc. and 6.0% in ScholarRx, Inc. The investments in these entities were accounted for using the cost method, as AMA held less than a 20% ownership and did not exercise significant influence over the entities. The book value of the six investments carried at cost at December 31, 2022 was \$7.1 million.

Use of estimates

Preparation of consolidated financial statements in conformity with accounting principles generally accepted (GAAP) in the United States of America requires management to make estimates and assumptions that affect reported amounts of assets, liabilities, revenues and expenses as reflected in the consolidated financial statements. Actual results could differ from estimates.

Cash equivalents

Cash equivalents consist of liquid investments with original maturities of three months or less and are recorded at cost, which approximates fair value.

Fiduciary funds

One of the AMA's subsidiaries, the AMA Insurance Agency, Inc., in its capacity as an insurance broker, collects premiums from the insured and, after deducting its commission, remits the premiums to the underwriter of the insurance coverage. Unremitted insurance premiums are invested on a short-term basis and are held in a fiduciary capacity. The AMA also collects and holds contributions on behalf of separate unincorporated entities with \$2.4 million and \$2.3 million held at December 31, 2023 and 2022, respectively.

Inventories

Inventories, consisting primarily of books and paper for publications, are valued at the lower of cost or net realizable value.

Property and equipment

Property and equipment are carried at cost, less accumulated depreciation and amortization. Depreciation and amortization are computed using the straight-line method over the estimated useful lives of the assets. Furniture and office equipment, hardware and software are depreciated or amortized over three to 10 years. Leasehold improvements are depreciated over the shorter of the estimated useful lives or the remaining lease term.

Revenue recognition

Revenue is recognized upon transfer of control of promised products or services to customers in an amount that reflects the consideration that AMA expects to receive in exchange for those products or services. AMA enters into contracts that generally include only one product or service and as such, are distinct and accounted for as separate performance obligations. Revenue is recognized net of allowances for returns and any taxes collected from customers, which are subsequently remitted to governmental authorities.

Nature of products and services

Membership dues are deferred and recognized as revenue in equal monthly amounts during the applicable membership year, which is a calendar year.

Licensing and subscriptions to scientific journals, site licenses, newsletters or other online products are recognized as revenue

ratably over the terms of the subscriptions or service period. Advertising revenue and direct publication costs are recognized in the period the related journal is issued. Book and product sales are recognized at the time the book or product is shipped or otherwise delivered to the customer. Royalties are recognized as revenue over the royalty term. Insurance brokerage commissions on individual policies are recognized as revenue on the date they become effective or are renewed, to the extent services under the policies are complete. Brokerage commissions or plan rebates on the group products are recognized as revenue ratably over the term of the contract as services are rendered.

Contract balances

AMA records a receivable when the performance obligation is satisfied and revenue is recognized. For agreements covering subscription or service periods, AMA generally records a receivable related to revenue recognized for the subscription, license or royalty period. For sales of books and products, AMA records a receivable at the time the product is shipped or otherwise delivered to the customer. These amounts are included in accounts receivable on the consolidated statements of financial position and the balance, net of allowance for doubtful accounts, was \$98.4 million and \$96.3 million as of December 31, 2023 and 2022, respectively.

The allowance for doubtful accounts reflects AMA's best estimate of probable losses inherent in the accounts receivable balance. The allowance is based on historical experience and other currently available evidence.

Payment terms and conditions vary by contract type, although terms generally include a requirement of payment within 30 to 60 days. Some annual licensing agreements carry longer payment terms. In instances where the timing of revenue recognition differs from the timing of invoicing, AMA has determined that these contracts generally do not include a significant financing component.

Prepaid dues by members are included as deferred membership dues revenue in the consolidated statements of financial position. Prepayments by customers in advance of the subscription, royalty or insurance coverage period are recorded as deferred subscriptions, licensing, insurance commissions and royalty revenue in the consolidated statements of financial position.

Income taxes

The AMA is an exempt organization as defined by Section 501(c)(6) of the Internal Revenue Code and is subject to income taxes only on income determined to be unrelated business taxable income. The AMA's subsidiaries are taxable entities and are subject to income taxes. See note 9.

Changes in presentation

In 2023, AMA realigned its business units to better reflect the current operations of the organization. As a result, the presentation of the functional expenses for 2022 in footnote 14 have been updated to be consistent with the current presentation.

3. New accounting standards update

In August 2020, Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) No. 2020-06, *Debt — Debt with Conversion and Other Options (Subtopic 470-20) and Derivatives and Hedging — Contracts in Entity's Own Equity (Subtopic 815-40) — Accounting for Convertible Instruments and Contracts in an Entity's Own Equity*. The amendments in this update are expected to improve, simplify, and enhance the financial reporting requirements for convertible instruments and contracts in an entity's own equity for all entities, including private companies. The new guidance is effective for the AMA for the year ending December 31, 2024. AMA does not expect there to be a material impact on the consolidated financial statements upon adoption.

In December 2023, FASB issued ASU No. 2023-09, *Improvements to Income Tax Disclosures*. This requires an entity to report the amount of income taxes paid disaggregated by federal, state, and foreign taxes as well as the amount of income taxes paid disaggregated by individual jurisdictions in which income taxes paid is equal to or greater than five percent of total income taxes paid. The new standard is effective for AMA for annual periods beginning after December 15, 2025. The adoption of the standard will expand certain footnote disclosures but will not have an impact on the AMA's consolidated financial statements.

4. Investments

Investments include marketable securities and venture capital and private equity investments that are carried at fair value.

In determining fair value, the AMA uses various valuation approaches. The FASB's Accounting Standards Codification (ASC) Topic 820, *Fair Value Measurements and Disclosures*, establishes a hierarchy for inputs used in measuring fair value that maximizes the use of observable inputs and minimizes the use of unobservable inputs by requiring that the most observable inputs be used when available. Observable inputs are inputs that market participants would use in pricing the asset based on market data obtained from sources independent of the organization. Unobservable inputs are inputs that would reflect an organization's assumptions about the assumptions market participants would use in pricing the asset developed based on the best information available in the circumstances. The hierarchy is broken down into three levels based on the observability of inputs as follows:

Level 1—Valuations based on quoted prices in active markets for identical assets that the organization has the ability to access. Since valuations are based on quoted prices that are readily and regularly available in an active market, valuation of these products does not entail a significant degree of judgment.

Level 2—Valuations based on one or more quoted prices in markets that are not active or for which all significant inputs are observable, either directly or indirectly.

Level 3—Valuations based on inputs that are unobservable and significant to the overall fair value measurement.

The availability of observable inputs can vary from instrument to instrument and is affected by a wide variety of factors, including, for example, the liquidity of markets and other characteristics particular to the transaction. To the extent that valuation is based on models or inputs that are less observable or unobservable in the market, the determination of fair value requires more judgment.

The AMA uses prices and inputs that are current as of the measurement date, obtained through a third-party custodian from independent pricing services.

A description of the valuation techniques applied to the major categories of investments measured at fair value is outlined below.

Exchange-traded equity securities are valued based on quoted prices from the exchange. To the extent these securities are actively traded, valuation adjustments are not applied and they are categorized in Level 1 of the fair value hierarchy.

Mutual funds are open-ended Securities and Exchange Commission (SEC) registered investment funds with a daily net asset value (NAV). The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy.

The fair value of corporate debt securities is estimated using recently executed transactions, market price quotations (where observable) or bond spreads. If the spread data does not reference the issuer, then data that reference a comparable issuer are used. Corporate debt securities are generally categorized in Level 2 of the fair value hierarchy.

U.S. government agency securities consist of two categories of agency issued debt. Non-callable agency issued debt securities are generally valued using dealer quotes. Callable agency issued debt securities are valued by benchmarking model-derived prices to quoted market prices and trade data for identical or comparable securities. Agency issued debt securities are categorized in Level 2 of the fair value hierarchy.

U.S. government securities are valued using quoted prices provided by a vendor or broker-dealer. These securities are categorized in Level 2 of the fair value hierarchy, as it is difficult for the custodian to accurately assess at a security level whether a quoted trade on a bond represents an active market.

Foreign and U.S. state government securities are valued using quoted prices in active markets when available. To the extent quoted prices are not available, fair value is determined based on interest rate yield curves, cross-currency basis index spreads, and country credit spreads for structures similar to the bond in terms of issuer, maturity, and seniority. These investments are generally categorized in Level 2 of the fair value hierarchy.

Investments also include investments in a diversified closed end private equity fund with a focus on buyout and secondary market opportunities in the United States and the European Union, as well as an investment in a venture capital fund focused on companies developing promising health care technologies that can be commercialized into revolutionary products and services that improve the practice of medicine and the delivery and management of health care. The investments are not redeemable and distributions are received through liquidation of the underlying assets of the funds. It is estimated that the underlying assets will be liquidated over the next four to ten years. The fair value estimates of these investments are based on NAV as provided by the investment managers. Unfunded commitments as of December 31, 2023, and 2022 totaled \$81.1 million and \$80.1 million, respectively.

The AMA manages its investments in accordance with Board-approved investment policies that establish investment objectives of real inflation-adjusted growth over the investment time horizon, with diversification to provide a balance between long-term growth objectives and potential liquidity needs.

The following table presents information about the AMA's investments measured at fair value as of December 31. In accordance with ASC Subtopic 820-10, investments that are measured at fair value using the NAV per share (or its equivalent) practical expedient have not been classified in the fair value hierarchy. The fair value amounts presented in this table are intended to permit reconciliation of the fair value hierarchy to the amounts presented in the consolidated statements of financial position.

	2023	2022
Level 1 – Quoted prices in active market for identical securities		
Equity securities	\$ 544.3	\$ 419.9
Fixed-income mutual funds	19.4	27.1
	563.7	447.0
Level 2 – Significant other observable inputs		
Debt securities		
Corporate	126.0	106.7
U.S. government and federal agency	254.3	264.8
Foreign government	28.3	24.7
U.S. state government	0.1	0.1
	408.7	396.3
Other investments measured at NAV – Private equity and venture capital funds		
Investments	\$ 1,088.4	\$ 933.2

Interest and dividends are included in investment income as operating revenue while realized and unrealized gains and losses are included as a component of non-operating items.

Investment income consists of:

	2023	2022
Investment dividend and interest income	\$ 25.0	\$ 18.3
Management fees	(3.7)	(3.2)
	\$ 21.3	\$ 15.1

Investment non-operating items include:

	2023	2022
Realized gains on investments, net	\$ 15.2	\$ 6.4
Unrealized gains (losses) on investments, net	89.8	(121.5)
	\$ 105.0	\$ (115.1)

5. Other assets

Other assets include investments in mutual funds maintained in separate accounts designated for various nonqualified benefit plans that are not available for operations. Mutual funds are open-ended SEC registered investment funds with a daily NAV. The mutual funds allow investors to sell their interests to the fund at the published daily NAV, with no restrictions on redemptions. These mutual funds are categorized in Level 1 of the fair value hierarchy. The investments totaled \$9.8 million and \$8.2 million as of December 31, 2023 and 2022, respectively.

6. Property and equipment

Property and equipment at December 31 consists of:

	2023	2022
Leasehold improvements	\$ 36.2	\$ 39.0
Furniture and office equipment	17.5	19.9
Information technology		
Hardware	11.6	12.9
Software	96.6	94.4
	161.9	166.2
Accumulated depreciation and amortization	(134.6)	(132.9)
Property and equipment, net	\$ 27.3	\$ 33.3

7. Retirement savings plan

The AMA has a 401(k) retirement and savings plan, which allows eligible employees to contribute up to 75 percent of their compensation annually, subject to Internal Revenue Service (IRS) limits. The AMA matches 100 percent of the first three percent and 50 percent of the next two percent of employee contributions. The AMA may, at its discretion, make additional contributions for any year in an amount up to two percent of the compensation for each eligible employee. Compensation is subject to IRS limits and excludes bonuses and severance pay. AMA matching and discretionary contribution expense totaled \$9.2 million and \$8.3 million in 2023 and 2022, respectively.

8. Postretirement health care benefits

The AMA provides health care benefits to retired employees who were employed on or prior to December 31, 2010. After that date, no individual can become a participant in the plan. Generally, qualified employees become eligible for these benefits if they retire in accordance with the plan provisions and are participating in the AMA medical plan at the time of their retirement. The AMA shares the cost of the retiree health care payments with retirees, paying approximately 60 to 80 percent of the expected benefit payments. The AMA has the right to modify or terminate the postretirement benefit plan at any time. Other employers participate in this plan and liabilities are allocated between the AMA and the other employers.

The AMA has applied for and received the federal subsidy to sponsors of retiree health care benefit plans that provides a prescription drug benefit that is actuarially equivalent to Medicare Part D under the *Medicare Prescription Drug, Improvement and Modernization Act of 2003*. In accordance with *ASC Topic 958-715, Compensation-Retirement Benefits*, the AMA initially accounted for the subsidy as an actuarial experience gain to the accumulated postretirement benefit obligation.

The postretirement health care plan is unfunded. In accordance with *ASC Topic 958-715*, the AMA recognizes this liability in its consolidated statements of financial position.

The following reconciles the change in accumulated benefit obligation and the amounts included in the consolidated statements of financial position at December 31:

	2023	2022
Benefit obligation at beginning of year	\$ 88.1	\$ 117.5
Service cost	0.5	1.1
Interest cost	4.4	3.1
Benefits paid	(4.4)	(4.1)
Participant contributions	1.2	1.2
Federal subsidy	0.2	0.2
Actuarial loss (gain)	17.8	(30.9)
Accrued postretirement benefit costs	\$ 107.8	\$ 88.1

The postretirement health care plan accumulated gains or losses not yet recognized as a component of periodic postretirement health care expense, but included as an accumulated charge or credit to equity as of December 31 are:

	2023	2022
Actuarial losses (gains)	\$ 8.6	\$ (9.7)

Actuarial assumptions used in determining the accumulated benefit obligation at December 31 are:

	2023	2022
Discount rate	5.0%	5.2%
Initial health care cost trend	8.5%	7.0%
Ultimate health care cost trend	4.0%	4.0%
Year that the rate reaches the ultimate trend rate	2047	2046

The change in the initial health care cost trend from 7.0% to 8.5% and claims cost experience were the major drivers of the \$17.8 million actuarial loss in 2023. The change in the discount rate from 2.8% at the end of 2021 to 5.2% in 2022 was the major driver of the \$30.9 million actuarial gain in 2022.

AMA recognizes postretirement health care expense in its consolidated statements of activities. The service cost component is included as part of compensation and benefits expense and the other components of expense are recognized as a non-operating item:

	2023	2022
Service cost	\$ 0.5	\$ 1.1
Non-service costs		
Interest cost	4.4	3.1
Amortization of actuarial (gain) loss	(0.5)	0.4
Total non-service costs	3.9	3.5
	\$ 4.4	\$ 4.6

Postretirement health care-related changes, other than periodic expense, that have been included as a charge or credit to unrestricted equity consist of:

	2023	2022
Actuarial (loss) gain arising during period	\$ (17.8)	\$ 30.9
Reclassification adjustment for recognition of actuarial (gain) loss	(0.5)	0.4
Change in association equity	\$ (18.3)	\$ 31.3

Actuarial assumptions used in determining postretirement health care expense are the same assumptions noted in the table above for determining the accumulated benefit obligation, except as follows:

	2023	2022
Discount rate	5.2%	2.8%
Initial health care cost trend	7.0%	6.1%

The following postretirement health care benefit payments are expected to be paid by the AMA, net of contributions by retirees and federal subsidies:

2024	\$ 3.7
2025	4.1
2026	4.5
2027	4.8
2028	5.1
2029 – 2033	30.1

9. Income taxes

The provision for income taxes includes:

	2023	2022
Operating		
Current	\$ 4.4	\$ 4.3
Deferred	(4.6)	(21.4)
Valuation allowance	5.3	21.5
	5.1	4.4
Tax (benefit) expense related to credits or charges to equity		
Deferred	(1.0)	1.9
	\$ 4.1	\$ 6.3

As prescribed under ASC Topic 740, *Income Taxes*, the AMA determines its provision for income taxes using the asset and liability method. Under this method, deferred tax assets and liabilities are recognized for future tax effects of temporary differences between the consolidated financial statement carrying amounts of existing assets and liabilities and their respective tax basis.

The deferred tax benefit or expense from credits or charges to equity represents the estimated tax benefit from recording unrecognized actuarial losses and prior service credits for the postretirement health care plan, pursuant to ASC Topic 958-715.

Valuation allowances are provided to reduce deferred tax assets to an amount that is more likely than not to be realized. The AMA evaluates the likelihood of realizing its deferred tax assets by estimating sources of future taxable income and assessing whether or not it is likely that future taxable income will be adequate for the AMA to realize the deferred tax asset. The valuation allowance reflects the fact that deferred tax assets include future expected benefits, largely related to retiree health care payments, that may not be deductible due to a projected lack of taxable advertising income in future years as well as net operating or capital losses where recoverability will not occur until future taxable income is generated. Increases or decreases in deferred tax assets, where future benefits are considered unlikely, will result in an equal and offsetting change in the valuation reserve. If the AMA were to make a determination in future years that these deferred tax assets would be realized, the related valuation allowance would be reduced and a benefit to earnings recorded.

Deferred tax assets recognized in the consolidated statements of financial position at December 31 are:

	2023	2022
Net operating and capital loss carryforward	\$ 26.5	\$ 21.4
Benefit plans and compensation	5.9	5.2
Other	(0.1)	0.1
	32.3	26.7
Valuation allowance	(29.3)	(24.0)
	\$ 3.0	\$ 2.7

Cash payments for income taxes were \$4.4 million and \$4 million in 2023 and 2022, respectively, net of refunds.

AMA's federal taxes are open to examination by taxing authorities from 2020 through 2023. AMA's state taxes are open to examination for various years depending on the jurisdiction.

10. Leases

AMA leases office space at a number of locations and the initial terms of the office leases range from four years to 15 years. Most office space leases have options to renew at then prevailing market rates, or, in one circumstance, early terminate or contract with appropriate notice and termination payments. As any renewal, termination, or contraction is at the sole discretion of AMA, and at this date is not certain, renewal and termination options are not included in the right-of-use asset (ROU asset) or lease liability. AMA also leases copiers and printers in several locations, with initial terms generally of four years.

The lease agreements do not contain variable lease payments, residual value guarantees or material restrictive covenants. All leases are classified as operating leases.

AMA leases do not provide an implicit interest rate and as such, AMA calculates the lease liability at lease commencement or remeasurement date as the present value of unpaid lease payments using an estimated incremental borrowing rate. The incremental borrowing rate represents the rate of interest that AMA estimates it would have to pay to borrow an amount equal to the lease payments on a collateralized basis over a similar term, based on information available at the time of commencement or remeasurement.

During 2023, AMA extended the term of the main headquarters lease for an additional seven years in return for certain concessions. The ROU asset and lease liability were remeasured as of the modification date and the impact of the extension is a \$17.7 million increase in the ROU asset and corresponding lease liability. In addition, AMA exercised early termination options of two small satellite office leases, with a termination penalty. The impact of the early terminations was not material.

During 2022, AMA exercised a contraction option that reduced the square footage at the main headquarters by approximately 10%, with a contraction penalty. The ROU asset and lease liability were remeasured as of the lease modification date and the impact of the contraction was reflected in the ROU asset and lease liability as of December 31, 2022. ROU assets decreased \$1.3 million, lease liabilities decreased \$2.3 million, with the resulting net gain of \$1 million included as a reduction to other operating expense in 2022.

Operating lease costs totaled \$8.9 million in 2023 and \$9.7 million in 2022. Cash paid for amounts included in the measurement of lease liabilities totaled \$15.3 million in 2023 and \$13.2 million in 2022.

The remaining weighted-average lease term is 11.1 years and 6.3 years as of December 31, 2023 and 2022, respectively. The weighted-average discount rate used for operating leases is 7.2% and 5% for 2023 and 2022, respectively.

The maturity of lease liabilities as of December 31, 2023:

2024	11.5
2025	8.2
2026	1.9
2027	1.9
2028	5.6
2029 and beyond	80.4
Total lease payments	109.5
Less imputed interest	(38.4)
Present value of lease obligations	\$ 71.1

In addition to the above, as of December 31, 2023, AMA entered into a lease for a satellite office that will commence in 2024 with aggregate future lease payments totaling \$4 million.

11. Financial asset availability and liquidity

AMA has a formal reserve policy that defines the reserve investment portfolios as pools of liquid net assets that can be accessed to mitigate the impact of undesirable financial events or to pursue opportunities of strategic importance that may arise, as well as provide a source of capital appreciation. The policy establishes minimum required dollar levels required to be held in the portfolios (defined as an amount equal to one-year's general and administrative operating expenses plus long-term liabilities). The policy also covers the use of dividend and interest income, establishes criteria for use of the funds and outlines the handling of excess operating funds on an annual basis.

Dividend and interest income generated from the reserve portfolios are transferred to operating funds monthly and used to fund operations. The formal reserve policy contemplates use of reserve portfolio funds for board approved time- or dollar-limited strategic outlays, to the extent that the reserve portfolio balances exceed the minimum amount established by policy. All surplus funds generated from operations annually (defined as operating cash plus other current assets minus current liabilities and deferred revenue at year-end) are transferred to the reserve portfolios after year-end. The reserve policy does not cover the for-profit subsidiaries' activities.

AMA invests cash in excess of projected weekly requirements in short-term investments and money market funds. AMA does not maintain any credit facilities as the reserve portfolios provide ample protection against any liquidity needs.

The following reflects AMA's financial assets as of December 31 reduced by amounts not available for general use that have been set aside for long-term investing in the reserve investment portfolios or funds subject to donor restrictions. AMA's financial assets include cash, cash equivalents and donor restricted cash, short-term investments and long-term investments in the reserve portfolios.

	2023	2022
Financial assets	\$ 1,124.5	\$ 966.7
Less assets unavailable for general expenditures:		
Restricted by governing body primarily for long-term investing or for governing body approved outlays	(1,021.2)	(841.4)
Financial assets available to meet cash needs for general expenditures within one year	\$ 103.3	\$ 125.3

In addition to financial assets available to meet general expenditures over the next 12 months, the AMA operates under a policy that requires an annual budget surplus, excluding time- or dollar-limited strategic expenditures approved by the board, and anticipates generating sufficient revenue to cover general ongoing expenditures on an annual basis.

12. Contingencies

In the opinion of management, there are no pending legal actions for which the ultimate liability will have a material effect on the equity of the AMA.

13. Subsequent events

ASC Topic 855, *Subsequent Events*, establishes general standards of accounting for and disclosure of events that occur after the consolidated balance sheet date but before consolidated financial statements are issued or are available to be issued.

For the year ended December 31, 2023, the AMA has evaluated all subsequent events through February 9, 2024, which is the date the consolidated financial statements were available to be issued, and concluded no additional subsequent events have occurred that would require recognition or disclosure in these consolidated financial statements that have not already been accounted for.

14. Functional expenses

The costs of providing program and other activities have been summarized on a functional basis in the consolidated statements of activities. Certain costs have been allocated among the Strategic Arcs and Core Mission Activities, Publishing, Health Solutions and Insurance, Membership and other supporting services.

The expenses that are allocated and the method of allocation include the following: fringe benefits based on percentage of compensation and occupancy based on square footage. All other expenses are direct expenses of each functional area.

	Membership	Publishing, Health Solutions and Insurance	Investments (AMA only)	Strategic Arcs and Core Mission Activities	Governance, Administration and Operations	Health2047 and Subsidiaries	Total
Cost of products sold and selling expense	\$ -	\$ 27.8	\$ -	\$ -	\$ -	\$ -	\$ 27.8
Compensation and benefits	6.7	65.5	-	87.7	93.6	8.5	262.0
Occupancy	0.5	5.5	-	7.0	7.3	0.9	21.2
Travel and meetings	0.1	3.4	-	7.9	8.0	0.5	19.9
Technology costs	1.1	12.1	-	8.4	12.2	0.1	33.9
Marketing and promotion	10.5	1.2	-	8.3	-	0.7	20.7
Professional services	0.2	4.2	0.3	18.5	3.4	3.1	29.7
Other operating expense	0.9	5.0	0.4	12.2	3.8	2.8	25.1
2023 total expense	\$ 20.0	\$ 124.7	\$ 0.7	\$ 150.0	\$ 128.3	\$ 16.6	\$ 440.3
Cost of products sold and selling expense	\$ -	\$ 27.9	\$ -	\$ -	\$ -	\$ 2.7	\$ 30.6
Compensation and benefits	6.4	65.1	-	78.1	78.1	7.0	234.7
Occupancy	0.4	5.7	-	6.9	7.1	1.3	21.4
Travel and meetings	0.1	2.6	-	4.5	7.2	0.3	14.7
Technology costs	1.0	11.0	-	7.1	10.3	0.1	29.5
Marketing and promotion	11.7	0.1	-	8.9	-	0.6	21.3
Professional services	0.4	4.2	0.3	17.6	3.7	3.0	29.2
Other operating expense	1.0	5.9	0.4	12.1	4.6	0.7	24.7
2022 total expense	\$ 21.0	\$ 122.5	\$ 0.7	\$ 135.2	\$ 111.0	\$ 15.7	\$ 406.1

INDEPENDENT AUDITOR'S REPORT

The Board of Trustees of American Medical Association

Opinion

We have audited the consolidated financial statements of American Medical Association (the "AMA") and subsidiaries, which comprise the consolidated statements of financial position as of December 31, 2023 and 2022, and the related consolidated statements of activities and cash flows for the years then ended, and the related notes to the consolidated financial statements (collectively referred to as the "financial statements").

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of the AMA as of December 31, 2023 and 2022, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America (GAAS). Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the AMA and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Responsibilities of Management for the Financial Statements

Management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America, and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for one year after the date that the financial statements are available to be issued.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable

assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with GAAS will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with GAAS, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the AMA's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the AMA's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Deloitte & Touche LLP
Chicago, Illinois
February 9, 2024

WRITTEN STATEMENT OF CERTIFICATION OF CHIEF EXECUTIVE OFFICER AND CHIEF FINANCIAL OFFICER

The undersigned hereby certify that the information contained in the consolidated financial statements of the American Medical Association for the years ended December 31, 2023 and 2022 fairly present, in all material respects, the financial condition and the results of operations of the American Medical Association.

James L. Madara, MD
Executive Vice President and Chief Executive Officer

Denise M. Hagerty
Senior Vice President and Chief Financial Officer

February 9, 2024

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AMA House of Delegates

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- Dr. Mukkamala
- Dr. Koirala
- Dr. Resneck
- Dr. Levin

Note: Drs. Underwood, Suk and Fryhofer serve on all committees, except where otherwise noted, as ex-officio members without vote. Dr. Ehrenfeld serves on all committees as an ex-officio member with vote.



REPORT OF THE BOARD OF TRUSTEES

B of T Report 04-A-24

Subject: AMA 2025 Dues

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

1
2 Our American Medical Association (AMA) last raised its dues in 1994. The AMA continues to
3 invest in improving the value of membership. As our AMA’s membership benefits portfolio is
4 modified and enhanced, management will continuously evaluate dues pricing to ensure
5 optimization of the membership value proposition.

6
7 RECOMMENDATION

8
9 2025 Membership Year

10
11 The Board of Trustees recommends no change to the dues levels for 2024, that the following be
12 adopted and that the remainder of this report be filed:

13

14	Regular Members	\$ 420
15	Physicians in Their Fourth Year of Practice	\$ 315
16	Physicians in Their Third year of Practice	\$ 210
17	Physicians in Their Second Year of Practice	\$ 105
18	Physicians in Their First Year of Practice	\$ 60
19	Physicians in Military Service	\$ 280
20	Semi-Retired Physicians	\$ 210
21	Fully Retired Physicians	\$ 84
22	Physicians in Residency/Fellow Training	\$ 45
23	Medical Students	\$ 20

24
25 (Directive to Take Action)

Fiscal Note: No significant fiscal impact.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 21-A-24

Subject: American Medical Association Meeting Venues and Accessibility
(Board of Trustees Report 12-I-23, RES 602-I-22)

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

1 At the 2023 Interim Meeting, Board of Trustees Report 12 American Medical Association Meeting
2 Venues and Accessibility responded to Resolution 602-I-22 and proposed amendments to Policy
3 G-630.140 which would have expanded options for meeting venues selection. The Report was
4 referred to the 2024 Annual meeting. Policy G-630.140 (4) states:

5
6 4. It is the policy of our AMA not to hold meetings organized and/or primarily sponsored by
7 our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club,
8 restaurant, or other institution, that has exclusionary policies, including, but not limited to,
9 policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex,
10 sexual orientation, gender, gender identity and gender expression, disability, or age unless
11 intended or existing contracts or special circumstances justify an exception to this policy.
12

13 This report responds to referred Board of Trustees Report 12, specifically addressing concerns
14 about assurances and guarantees for personal safety and medical care in an emergency.
15

16 DISCUSSION

17
18 The Board has heard member concerns and recommends that current policy remain in place and be
19 strictly enforced at all AMA meetings of the AMA. It is at the discretion of the House of Delegates
20 to change current policy.
21

22 CONCLUSION

23
24 This principled approach reflects the AMA's ongoing commitment to advocating for policies that
25 safeguard reproductive rights and combat discrimination. The organization remains steadfast in
26 promoting an inclusive and supportive environment for all members and attendees.
27

28 RECOMMENDATION

29
30 The Board therefore recommends Policy G-630.140 be reaffirmed and is strictly enforced as a
31 resolute stance against all forms of discrimination, and support of evidenced-based medicine,
32 underscoring our commitment to fostering an inclusive and safe environment for all attendees. This
33 strategic recommendation places a primary emphasis on prioritizing attendee safety, reflecting the
34 values and principles upheld by the AMA.

1 **Relevant AMA Policy**

2

3 **Policy G-630.140 Lodging, Meeting Venues, and Social Functions**

4 1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size,
5 service, location, cost, and similar factors.

6 2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly
7 Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.

8 3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in
9 a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free
10 worksites and public places (including restaurants and bars), unless intended or existing contracts
11 or special circumstances justify an exception to this policy, and our AMA encourages state and
12 local medical societies, national medical specialty societies, and other health organizations to adopt
13 a similar policy.

14 4. It is the policy of our AMA not to hold meetings organized and/or primarily sponsored by our
15 AMA, in cities, counties, or states, or pay member, officer or employee dues in any club,
16 restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies
17 based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual
18 orientation, gender, gender identity and gender expression, disability, or age unless intended or
19 existing contracts or special circumstances justify an exception to this policy.

20 5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for
21 breastfeeding and breast pumping.

22 6. All future AMA meetings will be structured to provide accommodations for members and
23 invited attendees who are able to physically attend, but who need assistance in order to
24 meaningfully participate.

Fiscal Note: Minimal

REPORT OF THE BOARD OF TRUSTEES

B of T Report 23-A-24

Subject: United States Professional Association for Transgender Health Observer Status in the House of Delegates

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

1 The Board of Trustees has received a request from the United States Professional Association for
2 Transgender Health (USPATH) to be considered for Official Observer status in the House of
3 Delegates (HOD). The USPATH’s request has been thoroughly considered using the criteria below
4 (Policy G-600.025, “Official Observers in Our AMA House”):
5

- 6 1. The organization and the AMA should already have established an informal relationship
7 and have worked together for the mutual benefit of both;
- 8 2. The organization should be national in scope and have similar goals and concerns about
9 health care issues;
- 10 3. The organization is expected to add a unique perspective or bring expertise to the
11 deliberations of the HOD; and
- 12 4. The organization does not represent narrow religious, social, cultural, economic, or
13 regional interests so that formal ties with the AMA would be welcomed universally by
14 AMA members.
15

16 The Board has discussed the USPATH’s request and presents the following report.

17
18 DISCUSSION

19
20 As part of its request, USPATH submitted information on how it has met the criteria for Official
21 Observer status, which is summarized below.
22

23 *Criterion 1. The organization and the AMA should already have established an informal*
24 *relationship and have worked together for the mutual benefit of both.*
25

26 USPATH has established informal relationships with the AMA through member and board
27 member involvement in the AMA Advisory Committee on LGBTQ Issues as well as the business
28 of the AMA HOD. Given their national scope, USPATH shares similar goals and concerns as the
29 AMA in ensuring appropriate access to and practice of evidence-based medicine and the
30 elimination of barriers to care placed between physicians and their patients.
31

32 *Criterion 2. The organization should be national in scope and have similar goals and concerns*
33 *about health care issues.*
34

35 USPATH is regional affiliate organization of the World Professional Association for Transgender
36 Health (WPATH), which is an interdisciplinary professional and educational organization devoted

1 to transgender health. USPATH professional, supporting, and student members engage in clinical
2 and academic research to develop evidence-based medicine and strive to promote a high quality of
3 care for transgender and gender-nonconforming individuals within the US.

4
5 As a national interdisciplinary, professional organization, USPATH works to further the
6 understanding and treatment of gender dysphoria by professionals in medicine, psychology, law,
7 social work, counseling, psychotherapy, family studies, sociology, anthropology, sexology, speech
8 and voice therapy, and additional related fields. USPATH provides opportunities for professionals
9 from various sub-specialties to communicate with each other in the context of research and
10 treatment of gender dysphoria including sponsoring biennial scientific symposia. USPATH is a
11 regional affiliate of WPATH, which publishes the Standards of Care for the Health of Transgender
12 and Gender Diverse People, Version 8, which articulate a professional consensus about the
13 psychiatric, psychological, medical, and surgical management of gender dysphoria and help
14 professionals understand the parameters within which they may aid those with these conditions.
15 The Standards of Care are frequently cited to support current AMA policy regarding gender-
16 affirming care.

17
18 *Criterion 3. The organization is expected to add a unique perspective or bring expertise to the*
19 *deliberations of the HOD.*

20
21 Given their multi-disciplinary membership and focus on a particular area of health care, USPATH
22 will add a unique perspective and bring expertise to the deliberations of the AMA HOD.

23
24 *Criterion 4. The organization does not represent narrow religious, social, cultural, economic, or*
25 *regional interests so that formal ties with the AMA would be welcomed universally by AMA*
26 *members.*

27
28 The USPATH does not represent narrow religious, social, cultural, economic, or regional interests
29 and has already been welcomed to participate in previous AMA activities.

30
31 The Board of Trustees appreciates the previous involvement of USPATH with the AMA Advisory
32 Committee on LGBTQ Issues and believes that the USPATH should be recognized as an Official
33 Observer and welcomed to the House in that capacity.

34
35 RECOMMENDATION

36
37 The Board of Trustees recommends that the United States Professional Association for
38 Transgender Health be admitted as an Official Observer in the House of Delegates, and that the
39 remainder of this report be filed.

Fiscal Note: Under \$500

Appendix - Official Observers to the House of Delegates

Organization	Year Admitted
Accreditation Association for Ambulatory Health Care	1993
Alliance for Continuing Medical Education	1999
Alliance for Regenerative Medicine	2014
Ambulatory Surgery Center Association	2005
American Academy of Physician Assistants	1994
American Association of Medical Assistants	1994
American Board of Medical Specialties	2014
American Dental Association	1982
American Health Quality Association	1987
American Hospital Association	1992
American Nurses Association	1998
American Public Health Association	1990
American Podiatric Medical Association	2019
Association of periOperative Registered Nurses	2000
Association of State and Territorial Health Officials	1990
Commission on Graduates of Foreign Nursing Schools	1999
Council of Medical Specialty Societies	2008
Educational Commission for Foreign Medical Graduates	2011
Federation of State Medical Boards	2000
Federation of State Physician Health Programs	2006
Medical Group Management Association	1988
National Association of County and City Health Officials	1990
National Commission on Correctional Health Care	2000
National Council of State Boards of Nursing	2000
National Indian Health Board	2013
PIAA	2013
Society for Academic Continuing Medical Education	2003
US Pharmacopeia	1998

REPORT OF THE BOARD OF TRUSTEES

B of T Report 25-A-24

Subject: Environmental Sustainability of AMA National Meetings. Supporting Carbon Offset Programs for Travel for AMA Conferences (RES 603-A-23 and 608-A-23)

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

1 At the 2023 Annual Meeting, Resolutions 603- Environmental Sustainability of AMA National
2 Meetings and 608 - Supporting Carbon Offset Programs for travel for AMA Conferences were
3 introduced. Both resolutions received testimony in favor of referral. Testimony also suggested that
4 our American Medical Association (AMA) lead the health care profession by example and that a
5 strategic plan to address environmental sustainability be developed with attention to fiscal impact.
6 This report is in direct response to the two referred resolutions addressing AMA’s commitment to
7 sustainability of AMA National Meetings and exploring supporting carbon offset programs for
8 travel for AMA Conferences
9

10 DISCUSSION

11
12 The AMA recognizes the imperative to lead by example and play a proactive role in promoting
13 environmental stewardship within the health care community. Resolutions 603 and 608 calls for the
14 AMA to commit to reducing carbon emissions and fostering a more sustainable future. Resolution
15 603 calls for the AMA to commit to reaching net-zero emissions for its business operations by
16 2030, and advocates for the reduction of emissions within the broader health care system.
17

18 Resolution 608 focuses on the importance of mitigating carbon emissions related to AMA events
19 and calls for exploring opportunities for attendees to offset their environmental impact. While these
20 resolutions highlight AMA’s dedication to sustainability, it is also crucial to develop a
21 comprehensive plan, considering all related implications and ensuring effective implementation.
22 After initial research and consultation with relevant stakeholders, we are sharing an update on
23 AMA’s progress towards achieving carbon neutrality within our AMA and encouraging similar
24 efforts within the broader health care system. Below is a summary of our findings and the next
25 steps.
26

27 *Net Zero Emissions for Business Operations by 2030*

28
29 AMA is committed to progressing towards reaching net zero emissions for business operations by
30 2030, by continuing to execute against the current initiatives and expanding upon them. Our team
31 has already begun implementing measures to reduce our carbon footprint, including but not limited
32 to:
33

34 Renegotiating the Chicago headquarters’ lease with a LEED-Gold certified building and
35 advocating for sustainable practices with our corporate partner vendors.

1 Making multiple energy efficient upgrades within our facilities:

2
3 New HVAC systems (including Merv-13 filtration) were added on each floor, resulting in a 35
4 percent energy reduction.

5
6 Lighting retrofits, including adding LEDs and a daylight harvesting feature in the lobby to
7 automatically dim the lights according to the amount of sunlight entering the building), produced a
8 savings of two million kilowatt-hours per year, or 70 percent less energy.

9
10 Water conservation programs:

- 11 • A restroom retrofit to incorporate low-flow fixtures (e.g., toilets that use 1.60 gallons
12 of water per minute (gpm), urinals at 1 gpm and faucet aerators at 0.5 gpm).
- 13 • A 20 percent energy savings by re-landscaping with low-water plants like native
14 perennials and sedum.
- 15 • Adding meters on all hoses, and a green-roof water supply to monitor usage and detect
16 leaks.
- 17 • 50 percent of AMA Plaza's roof houses a green vegetable garden, which not only
18 reduces carbon dioxide emissions but also slows the amount of rainfall runoff that goes
19 to Chicago's sewer system. The roof at AMA Plaza is also home to a vegetable garden
20 and bee program, which harvests honey twice a year.

21
22 AMA utilizes a shuttlebus service, bike area, on-site Zipcars and scooter and hybrid vehicle
23 parking: all of which contribute to nine metric tons of carbon emissions reduction (the shuttlebuses
24 alone save an average of 65,000 pounds in carbon dioxide emissions per month).

25
26 AMA's HQ café sources local food and participates in the building's compost program, which
27 collects 70 percent of its waste; AMA staff and visiting members/meeting attendees can charge
28 their electronics using solar-powered benches in AMA plaza.

29
30 AMA reduced its waste generation (paper and otherwise) and implemented enhanced recycling
31 programs.

32
33 Leadership has encouraged telecommuting and virtual meetings to minimize travel emissions.

34 35 *Evaluating Feasibility of Carbon Offsets and Sustainable Meeting Practices*

36
37 Investing in projects to increase AMA's energy efficiency can contribute to reducing AMA's
38 carbon emissions at a relatively low cost. Partnering with vendors that use renewable energy
39 sources can also offer a cost-effective way to offset carbon emissions, and we continue to explore
40 new vendors who generate clean energy, displacing the need for fossil fuel-based electricity and
41 effectively reducing overall carbon emissions.

42
43 Leadership in Energy and Environmental Design (LEED) is the world's most widely used green
44 building rating system, providing a framework for healthy, efficient, cost-effective buildings
45 offering environmental, social, and other benefits. The AMA has tenancy in three locations
46 (Chicago, DC, and Greenville) that have implemented varying sustainability best practices
47 including LEED Green Certification, light sensors, recycling, etc. within their building guidelines.
48 The AMA also instituted a requirement to contract exclusively with LEED-certified conference
49 centers for Annual and Interim meetings in 2030. The Annual and Interim meetings have been
50 contracted through 2029 with Hyatt and Marriott: AMA has committed to Hyatt Regency Chicago,
51 a LEED-certified building, for AMA's Annual meeting through 2029; Hyatt's World of Care

1 program is committed to advancing environmental action. AMA has contracted with Marriott
2 properties through 2029 for Interim meetings; Marriott is integrating sustainability across their
3 properties and is committed to mitigating climate-related risk, reducing environmental impact,
4 building and operating sustainable hotels and sourcing responsibly (Gaylord National Resort and
5 Convention Center in National Harbor, Maryland, recently announced a partnership with Unison
6 Energy to commission a six-megawatt combined heat and power system to reduce its carbon
7 footprint).

8
9 AMA is also pleased to announce that the forthcoming 2027 and 2029 Interim Meetings will be
10 held at the prestigious Gaylord Pacific, currently under construction. Gaylord Pacific is being
11 meticulously designed to adhere to California's stringent energy code Title 24, surpassing even the
12 standards set by LEED certified buildings. The project incorporates all coastal development
13 mandates, positioning it as one of the most sustainable hotel and resort destinations in the United
14 States; this commitment to environmental sustainability aligns seamlessly with the AMA's values
15 and underscores our dedication to hosting events that prioritize sustainability and environmental
16 stewardship.

17 18 CONCLUSION

19
20 In conclusion, the AMA is committed to continuing to execute against our current initiatives, and
21 expanding upon them, to achieve environmental sustainability. These resolutions reflect our
22 proactive stance in reducing carbon emissions and championing sustainability initiatives within our
23 organization and the broader health care sector. Through our efforts, we demonstrate our dedication
24 to mitigating the environmental impact of our business operations. Additionally, our commitment
25 to limiting carbon emissions generated by AMA events and researching opportunities for attendees
26 to offset their environmental impact, highlights our holistic approach to sustainability. Through
27 these initiatives, the AMA reaffirms its commitment to environmental stewardship and welcomes
28 the opportunity to drive meaningful change within the health care ecosystem and beyond.

29
30 RECOMMENDATION: The Board of Trustees recommends that the following be adopted in lieu
31 of Resolutions 603-A-23 and 608-A-23, and the remainder of the report be filed:

- 32
33 1. Our AMA is committed to progression to net zero emissions for its business operations by
34 2030, by continuing and expanding energy efficiency upgrades, waste reduction initiatives, and
35 the transition to renewable energy sources (New HOD Policy).
36
37 2. Our AMA will prioritize sustainable organizational practices to reduce emissions over
38 purchasing carbon offsets (New HOD Policy).
39
40 3. Our AMA will continue to prioritize collaboration within the health care community by sharing
41 the learnings from our sustainability initiative to inspire our peer organizations to follow suit
42 and adopt similar environmentally conscious practices (Directive-to-Take-Action).

Fiscal Note: \$20,000

REPORT OF THE BOARD OF TRUSTEES

B of T Report 26-A-24

Subject: Equity and Justice Initiatives for International Medical Graduates

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

1 BACKGROUND

2

3 At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates (HOD),
4 Resolution 605-A-23, “Equity and Justice Initiatives for International Medical Graduatesⁱ,” sponsored by
5 the International Medical Graduates Section, was referred to the Board of Trustees. Resolution 605-A-23
6 requested:

7

8 1. That our American Medical Association, via the Center for Health Equity, create a yearly session
9 (during the Interim or Annual Meeting) as a part of the equity forum that will be dedicated to
10 international medical graduates (Directive to Take Action); and

11

12 2. That our AMA, via the Center of Health Equity, create an amendment to the health equity plan
13 that will address the issues of equity and justice for international medical graduates. (Directive to
14 Take Action)

15

16 DISCUSSION

17

18 This report seeks to provide clarity to two questions: (1) Whether the AMA should, via the Center for
19 Health Equity, create a yearly session (during the Interim or Annual Meeting) as part of the equity forum
20 that will be dedicated to international medical graduates; and (2) Whether the AMA should, via the
21 Center for Health Equity, create an amendment to the health equity plan that will address the issues of
22 equity and justice for international medical graduates.

23

24 *AMA Health Equity Open Forum*

25

26 In 2022, at the Annual Meeting, the HOD adopted new policy titled “Continuing Equity Education G-
27 600.960”, which instructed AMA to establish an Open Forum on Health Equity, to be held at least
28 annually at a House of Delegates Meeting, for members to directly engage in educational discourse and
29 strengthen organizational capacity to advance and operationalize equity.

30

31 Prior to its adoption, Resolution 611-A-22, as it was known at the time, was discussed openly during the
32 Reference Committee F Hearing. The resulting committee report provided:

33

34 Reference Committee heard supportive testimony acknowledging the importance of
35 prioritizing equity through forums, education sessions, and other programming. Testimony
36 supported changing the frequency of educational opportunities to each House of Delegates
37 meeting, noting that it will increase education and awareness of the effects of bias,
38 prejudice, and racism in medicine. During testimony, it was mentioned that a call for

1 education sessions is made prior to each House of Delegates meeting. For the June 2022
2 meeting, the Center for Health Equity opted to host education sessions in lieu of an open
3 forum. Format and timing of educational sessions at the House of Delegates is at the
4 discretion of the Speakers in consultation with subject matter experts. In addition, the
5 proffered language allows for the potential of additional sessions offered online,
6 asynchronous to the House of Delegates meeting, or even at other AMA sponsored
7 meetings.ⁱⁱ
8

9 The report provides many details, but it appears that delegates and attendees did not discuss specific
10 subject matter to be presented at each open forum, subsequently leaving the policy open to interpretation.
11 This is not an uncommon practice, if one were to skim through AMA policy, they would find that many
12 organizational policies have been adopted in the same manner relying on staff experts to take the lead on
13 executing requested actions.
14

15 If we can infer anything from the HOD's decision to adopt the policy on Continuing Equity Education
16 with its current language, it would be that the HOD reserved the task of making equity-based decisions on
17 content development for the open forum for AMA staff. Since the policy was adopted at the 2022 Annual
18 Meeting, the Center for Health Equity has taken the lead on planning and has successfully hosted two
19 forums. During the planning and development stages, staff consistently prioritizes equity by ensuring
20 diverse perspectives are represented; considering the unique needs and experiences of all potential
21 attendees to create inclusive content that resonates with a wide audience; focusing on time-sensitive
22 topics to operationalize equity; and regularly assessing and adjusting their approach to address any
23 disparities and promote fairness in the planning and development process. To permanently designate a
24 particular topic or group over others would be counterproductive to the ideals of fairness and equity and
25 risks the possibility of harm, creating an atmosphere of resentment and discouragement among those who
26 may feel excluded or unfairly treated. Instead, AMA staff has employed an equitable content planning
27 and development process that balances the consideration of competing recommendations. Since policy
28 does require an equity forum at least once a year, each meeting presents an additional opportunity to
29 educate the House on a variety of equity-based topics, which can include, but is not limited to, issues
30 related to IMGs.
31

32 *AMA Strategic Plan to Embed Racial Justice and Advance Health Equity* 33

34 In 2021, the Center for Health Equity published the AMA Strategic Plan to Embed Racial Justice and
35 Advance Health Equity. The 86-page document is a comprehensive initiative aimed at addressing
36 systemic inequities in healthcare. Rooted in the recognition of historical injustices and social drivers of
37 health, the plan outlines strategic actions to promote equity, diversity, and inclusion within the medical
38 community. It emphasizes the need for culturally competent care, increased representation of minoritized
39 and marginalized individuals in healthcare leadership, and the dismantling of barriers that perpetuate
40 racial and ethnic disparities. The Strategic Plan has sought to accomplish many goals, but the document
41 was also scheduled to sunset in 2023. To continue the work that the first Strategic Plan initiated, the
42 AMA has pushed forward with the development of the next iteration of the Plan. Following the goals
43 outlined in the first Strategic Plan, the second plan will go further by highlighting IMGs specifically, their
44 potential for advancing health equity amid significant challenges in training and working within the U.S.
45 It will also include details related to recent policy developments, accomplishments, and a call to action for
46 AMA. Prior to its release, authors of the Plan have worked closely with AMA IMG Section leadership to
47 thoroughly review and ensure that IMG perspectives are prominent in the document. At the 2024 Annual
48 Meeting, the Health Equity Open Forum will be an overview of the 2024-2025 Strategic Plan with
49 designated time to focus on IMG issues and perspectives. Our AMA will continue to support IMGs by
50 advocating for fair and transparent processes in licensing, protection of all rights and privileges, and
51 recognizing the valuable contributions IMGs make to the U.S. health care system.

1 RECOMMENDATION

2

3 The Board of Trustees recommends that Resolution 605-A-23 not be adopted and that the remainder of
4 this report be filed.

Fiscal Note: None.

ⁱ Resolution 605-A-23, "Equity and Justice Initiatives for International Medical Graduates." <https://www.ama-assn.org/system/files/a23-605.pdf>

ⁱⁱ 2022 Annual Meeting Reference Committee F Report. <https://www.ama-assn.org/system/files/a22-reference-committee-reports.pdf>

EXECUTIVE SUMMARY

At the 2023 Annual Meeting of the House of Delegates (HOD), Resolution 609-A-23, “Encouraging Collaboration Between Physicians and Industry in Augmented Intelligence (AI) Development”, was referred. The directives of the referred resolution ask the American Medical Association (AMA) to address physician-centered innovation, specifically in the field of AI and, enhance physician access to the Physician Innovation Network (PIN) community through matchmaking and an advisor network. The following Board of Trustees Report provides detailed information about the AMA’s efforts to ensure the physician voice is front and center in the design, development and use of technology and innovation, including AI, across healthcare, and outlines various ways the AMA is supporting physicians in the implementation and use of these tools. The AMA’s work includes numerous activities in the following areas:

- Engagement between physicians and the AI industry facilitated by the Physician Innovation Network (PIN);
- Advocacy for legislative oversight of health care AI and the development of principles to guide such advocacy;
- Formation of programs and collaborative partnerships with other medical and professional societies, in addition to other stakeholders in the health care AI space;
- Development of educational tools and resources;
- Publication of reports and research; and
- Adoption of multiple related AMA policies

REPORT OF THE BOARD OF TRUSTEES

B of T Report 28-A-24

Subject: Encouraging Collaboration Between Physicians and Industry in AI Development

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

1 INTRODUCTION

2
3 At the 2023 Annual Meeting, the House of Delegates (HOD) referred Resolution 609-A-23,
4 “Encouraging Collaboration Between Physicians and Industry in Augmented Intelligence (AI)
5 Development”, for report back at the 2024 Annual Meeting. This resolution was introduced by the
6 Medical Student Section and asked that our American Medical Association (AMA):
7

- 8 1. Augment the existing Physician Innovation Network (PIN) through the creation of advisors
9 to specifically link physician members of AMA and its associated specialty societies with
10 companies or individuals working on AI research and development, focusing on:
11
 - 12 a. Expanding recruitment among AMA physician members,
 - 13 b. Advising AMA physician members who are interested in healthcare innovation/AI
14 without knowledge of proper channels to pursue their ideas,
 - 15 c. Increasing outreach from AMA to industry leaders and companies to both further
16 promote the PIN and to understand the needs of specific companies,
 - 17 d. Facilitating communication between companies and physicians with similar
18 interests,
 - 19 e. Matching physicians to projects early in their design and testing stages,
 - 20 f. Decreasing the time and workload spent by individual physicians on finding
21 projects themselves,
 - 22 g. Above all, boosting physician-centered innovation in the field of AI research and
23 development (Directive to Take Action); and
24
- 25 2. Support selection of PIN advisors through an application process where candidates are
26 screened by PIN leadership for interpersonal skills, problem solving, networking abilities,
27 objective decision making and familiarity with industry (New HOD Policy).
28

29 BACKGROUND

30
31 Artificial intelligence focuses on developing smart machines that can perform tasks that otherwise
32 require human intelligence. Augmented intelligence (AI), a subsection of artificial intelligence,
33 depends on machine learning (ML) techniques to extract large amounts of data to assist humans in
34 solving problems.^{1,2} It has been used within a wide array of fields and is responsible for innovations
35 such as web search, targeted content and product recommendations and autonomous vehicles.¹ In
36 2016, AI projects within medicine attracted more investment than AI projects within any other
37 sector of the global economy.³ AI applications within medicine include diagnostics, drug discovery

1 and development, medical documentation and remote treatment. Several recent strides have been
2 made in this area. For instance, Google developed and trained an AI model to classify images as
3 diabetic retinopathy and macular edema for adult patients with diabetes, producing implications for
4 improved detection, diagnosis and treatment of diabetic retinopathy. Additionally, companies have
5 used ML algorithms to identify drugs that treat neurological diseases.¹

6
7 The purpose of AI application to medicine is to supplement—not supplant—the work of health
8 care practitioners and a misunderstanding of this concept is a major deterrent to the adoption of AI
9 innovations by clinicians and health systems.⁴ It is essential that physicians and members of their
10 care teams are included across all stages of the development of AI innovations in health care so
11 such designs best reflect what they find valuable for treating their patients and reducing
12 administrative and other burdens. The integral role physicians play in the development of health
13 care AI enables the refinement of clinical algorithms, testing of new clinical tools and research
14 designed to improve disease management and outcomes.⁵ However, research shows that current AI
15 applications in health care may not sufficiently reflect that they’ve been designed with health care
16 practitioners at the forefront. Despite physicians’ desire to be consulted on tech decisions, many of
17 them lack any significant influence on these decisions.⁶

18
19 It is especially important that efforts to include physicians in the development of health care AI are
20 diverse and comprise marginalized and minoritized physicians so bias that underlies existing data is
21 not further entrenched into AI solutions and health inequities are not exacerbated. Further,
22 equitable inclusion of physicians in the research and development of AI is imperative to its success,
23 as evidenced by literature on racial concordance in medicine. For example, a 2018 Stanford study
24 illustrated how Black physicians were more likely to engage with Black men—a patient group with
25 a historically lower life expectancy—and even collect consent to provide preventive services like
26 cardiovascular screenings and immunizations.⁷ Additionally, research found that a 10% increase in
27 Black primary care physicians was associated with a 30.61-day increase in life expectancy and a
28 decrease in all-cause mortality by 12.71 deaths per 100,000 among Black individuals.⁸ Despite
29 such statistics, only 5.7% of physicians in 2023 identified as Black.⁹ AI can either improve the
30 system by filling these gaps or inadvertently worsen current health inequities by reproducing and
31 normalizing what exists. While increased application of AI in healthcare is expected to reduce bias
32 and promote health equity by improving evidence-based interventions for marginalized and
33 minoritized communities, the voices of these physicians must be integrated early and more often
34 within the development of these tools to truly improve health outcomes for all patients.¹⁰

35 36 DISCUSSION

37
38 The AMA is committed to ensuring that AI can meet its full potential to advance clinical care and
39 improve clinician well-being. As the number of AI-enabled health care tools continue to grow, it is
40 critical they are designed, developed and deployed in a manner that is ethical, equitable and
41 responsible. The use of AI in health care must be transparent to both physicians and patients, and
42 positioning the physician voice front and center is critical.

43 44 *AMA Physician Innovation Network (PIN)*

45
46 To address concerns around the lack of the physician voice in health care innovation, the AMA
47 launched the [Physician Innovation Network](#) (PIN) in 2016. Since then, the network has grown to
48 over 18,000 users and continues to bring together physicians and health tech companies through its
49 various offerings.

1 The PIN platform is available for all physicians to join and connect with other stakeholders across
2 the innovation ecosystem including responding to opportunities posted by digital health and
3 technology companies seeking feedback from subject matter experts. AMA's [PIN "In Real Life"](#)
4 (IRL) events launched in 2022 with the purpose of bringing the online platform to life, encouraging
5 companies to be transparent about their design challenges and hosting diverse physician voices to
6 create an engaging, live PIN experience. Health tech conferences are not usually the events that
7 most practicing physicians attend to advance their professional development. However, such a
8 structure allows physicians to connect with companies live, share clinical problems and expertise
9 and provide feedback on solutions being developed across the health care industry. The PIN IRL
10 events will evolve this structure in an iterative fashion as we continue to evaluate physicians' needs
11 in the changing technological landscape. Further, PIN Community Office Hours occur bi-weekly
12 and provide an opportunity for subject matter experts across the PIN community to connect with
13 digital health solutions focused on optimizing patient experience and minimizing physician
14 burnout.

15
16 The AMA is engaging PIN Physicians to gather feedback and continue iterating on how to help
17 bring better solutions to market together. All AMA members are invited to join PIN and should be
18 ambassadors to their organizations about the platform's ability to link subject matter experts and
19 solution designers. Companies developing health care solutions enabled by AI and ML are
20 interacting on PIN. However, it is the individual physician member's decision how they would like
21 to interact with each company. Some companies post paid opportunities while others are so early in
22 their development that they only have volunteer opportunities posted. Additionally, the AMA is in
23 conversations with the World Medical Association to expand the PIN to a global audience.
24 Applying for PIN IRL engagements is one of the best ways to be involved. As we examine the
25 successes of PIN and the current clinical technology needs of physicians, the PIN strategy is
26 continuously re-evaluated to ensure the program's impact is maximized.

27
28 *Advocacy*

29
30 AI has been an area of focus for AMA advocacy for several years with the first set of advocacy
31 principles developed in 2018. In addition to interfacing with medical devices, AI is increasingly
32 used in health care administration and to reduce physician burden, and policy and guidance for
33 both device and non-device use of health care AI is necessary. Recognizing this, the AMA
34 developed an updated set of advocacy principles that builds on current AI policy. These [new](#)
35 [principles](#) address the development, deployment and use of health care AI, with particular emphasis
36 on:

- 37
38
- 39 • Health care AI oversight;
 - 40 • When and what to disclose to advance AI transparency;
 - 41 • Generative AI policies and governance;
 - 42 • Physician liability for use of AI-enabled technologies;
 - 43 • AI data privacy and cybersecurity; and
 - 44 • Payor use of AI and automated decision-making systems.¹¹

45 The AMA also continues to keep track of AI-related legislation and policy coming from both the
46 congressional bodies, as well as the federal government.

47
48 Additionally, the AMA plans to research state-based AI policies to better understand local
49 approaches to policy and regulation for the use of AI across health care stakeholders, including
50 health care practices, health systems and payers. *AMA research, programs and other resources*

1
2 The AMA is committed to researching the AI landscape in health care and developing resources to
3 support physicians in getting involved in the design, development and deployment of these tools
4 across the industry. In 2023, the AMA completed a [survey](#) to better understand physician
5 sentiments around AI, including opportunities, current use cases and needs around education and
6 support for the implementation and use of AI. Of the 1,081 physicians surveyed, 41% responded
7 that they were both equally excited and concerned about AI. It was also confirmed that physicians
8 are seeking more information in digestible formats that can help them successfully evaluate and use
9 these tools in their clinical environments.⁶

10
11 In February 2024, the AMA released a foundational AI landscape report as part of its Future of
12 Health work titled, [“The Emerging Landscape of Augmented Intelligence in Health Care”](#). The
13 report aims to create a common lexicon for augmented intelligence in health care, explore the risks,
14 identify current and future use cases and provide guidance for physicians looking to leverage these
15 tools in practice. As part of this research, the AMA completed the previously mentioned survey
16 designed to capture physician sentiments around AI, held a set of one-on-one interviews with key
17 stakeholders from across the industry and hosted a specialty society workshop to align on key
18 priorities across specialties. The report lays the foundation for the development of additional
19 educational content into specific areas of AI to further support the implementation and use of AI in
20 practice including, but not limited to:

- 21
- 22 • Practical case studies of where AI is working in practice today.
 - 23 • Issue briefs aimed at deciphering AI policy. For instance, the AMA released a [guide](#) in
24 2023, providing advice for physicians when considering ChatGPT.
 - 25 • Research on areas where AI is impacting clinician well-being (i.e. documentation burden
26 reduction, etc.).
 - 27 • Step-by-step educational materials on creating governance structures that support the
28 successful selection and deployment of AI solutions.
- 29

30 The AMA ChangeMedEd initiative works with partners across the medical education continuum to
31 help produce a physician workforce that meets the needs of patients today and in the future. As part
32 of these efforts, an [Artificial Intelligence in Health Care](#) learning series was recently published on
33 the AMA EdHub. These modules are geared towards medical students and physician learners, and
34 introduce key concepts related to artificial intelligence and ML in health care. These are developed
35 in collaboration with medical education partners from across the nation.

36
37 Further, the AMA and Accreditation Council for Graduate Medical Education (ACGME) have a
38 shared interest in fostering the use of AI to improve education across a physician’s career. The
39 ACGME is aware of the AMA’s conceptual model of Precision Education and has participated in
40 the AMA Accelerating Change in Medical Education Consortium’s National Advisory Panel
41 around planning the next major initiative. Awardees of AMA grant funding also presented their
42 work on leveraging AI to improve residency selection and education at the 2024 ACGME Annual
43 Education Conference.

44
45 Additionally, the AMA is engaged with the American Board of Medical Specialties, National
46 Board of Medical Examiners, Association of American Medical Colleges, Association for Hospital
47 Medical Education, International Association of Medical Science Educators, as well as several
48 specialty societies, medical schools and academic health systems around advancing AI in medical
49 education. AMA staff will also serve on the planning committee for the Macy Foundation’s next
50 conference which will focus on AI in medical education. These conferences are designed to

1 generate national recommendations which are typically published in the journal, *Academic*
2 *Medicine*.

3
4 The AMA has also crafted a [framework](#) to promote the development and use of responsible,
5 evidence-based, unbiased and equitable health care AI. This ethics-evidence-equity framework
6 envisions the use of AI to advance the quadruple aim (enhancing patient care, improving
7 population health and clinician work-life and reducing costs) and defines the responsibilities of
8 developers, health care organizations (deployers) and physicians to put the framework into action.
9 For instance, the framework outlines the responsibility of all three groups to (1) develop a protocol
10 to identify and correct for potential bias, as well as (2) ensure protocols exist for enforcement and
11 accountability, including a system to ensure equitable implementation. Physicians can use the
12 framework to assess if an AI innovation meets the qualifications for ethics, evidence and equity
13 and can therefore be trusted.¹² This framework has also been leveraged to create a companion
14 resource that considers educational applications of AI and addresses the use of AI to facilitate the
15 process of training health professionals.

16
17 Further, the AMA is in the process of creating a physician development curriculum that will cover
18 topics across physician leadership and the business of medicine. The goal of these materials is to
19 empower and support physicians throughout their professional lives by amplifying AMA-wide
20 resources on the health care landscape, leadership and the business of medicine and develop new
21 resources where gaps exist. These materials will be made available for both individual physicians
22 and member organizations.

23
24 Additionally, the AMA developed the [CPT® Developer Program](#) to assist developers in translating
25 ideas into innovations. The program is dedicated to developers' needs and provides them with
26 access to high-quality AMA CPT content and resources.

27
28 As interest grows in the use of AI solutions and tools that address administrative burden and
29 support physicians in their daily tasks, the AMA is committed to ensuring that the evolution of AI
30 in medicine equitably benefits patients, physicians and other health care stakeholders. The AMA
31 intends to continue developing AI principles for the use of AI in health care, advocate for state and
32 federal policies that ensure appropriate oversight and continued innovation in AI, partner with
33 health and technology leaders to ensure physicians have a leading voice in shaping the ethical use
34 of AI in medicine, promote training in AI across the continuum of medical education and provide
35 high-value insights and actionable resources for physicians.

36 37 *Stakeholder engagement*

38
39 The AMA is a convener around many topics important to physicians including AI. As a follow up
40 to the Specialty Society workshop in 2023, the AMA has created an AI Specialty Collaborative
41 with over 15 specialty associations committed to participating. The goal of the collaborative is to
42 ensure the physician voice is leading in a united way as AI in health care continues to expand.
43 Additionally, this group will collectively identify priorities and collaboratively develop resources
44 to advance AI in health care starting in the second quarter of 2024.

45
46 The AMA also continues to stay abreast of the latest developments in AI across the industry
47 through participation in external industry collaboratives. For example, the AMA is currently a non-
48 profit member organization of [VALID AI](#), an execution accelerator dedicated to bridging the gap in
49 coordinated efforts around generative AI while rapidly advancing validation and governance
50 implementation.

1 Furthermore, as a member of the [Health AI Partnership](#)—a collaboration among 14 health care
2 organizations and ecosystem partners—the AMA is encouraging the collaborative development
3 and dissemination of AI best practices. The AMA will continue to work with this partnership and
4 others to develop resources, including a case-based AI ethics training program that will delve into
5 real-world, contemporary challenges that physicians and health care delivery organizations face
6 when using AI.

7
8 The [In Full Health Learning & Action Community to Advance Equitable Health Innovation](#)
9 initiative seeks to advance equitable opportunities in health innovation investment, solution
10 development and purchasing. The AMA has partnered with founding collaborator organizations to
11 support this community with content, tools, resources and opportunities to connect, engage and
12 learn with and from each other to advance equitable health innovation.

13
14 The AMA also has long standing relationship with the innovation accelerator, MATTER. As part
15 of this sponsorship, AMA employees and physician members have access to the MATTER space
16 and programming. AMA physician members can also reach out to [AMA staff contacts](#) to learn
17 more about getting involved with MATTER and other innovation accelerator programs.

18
19 Further, the AMA participated in a joint clinician panel with the Office of the National Coordinator
20 for Health Information Technology in 2020 titled, [“Artificial Intelligence in Health IT- The Good,
21 The Bad, The Ugly”](#) and continues to engage in additional conferences such as HLTH and ViVE,
22 where AMA representatives engage in a variety of topics around health care technology including
23 AI.

24
25 In addition to the efforts outlined above, the AMA has several internal cross-business unit
26 workgroups in place to ensure alignment across the work in innovation and specifically, AI. There
27 is a Future of Health workgroup meeting that occurs monthly to stay aligned on the latest policy,
28 projects and collaborations in progress around innovation and digital health. Additionally, the
29 Advocacy business unit convenes two monthly meetings specifically focused on aligning AI
30 initiatives across the AMA.

31 32 AMA POLICY

33
34 As a leader in American medicine, the AMA has a unique opportunity to ensure that the evolution
35 of AI in medicine benefits patients, physicians and the health care community. The AMA has
36 several policies in place around ensuring the physician voice is reflected in the design and
37 development of AI innovations in health care.

38
39 The AMA will seek to:

- 40
- 41 1. Leverage its ongoing engagement in digital health and other priority areas for improving
42 patient outcomes and physicians’ professional satisfaction to help set priorities for health
43 care AI.
 - 44 2. Identify opportunities to integrate the perspective of practicing physicians into the
45 development, design, validation, and implementation of health care AI.
 - 46 3. Promote development of thoughtfully designed, high-quality, clinically validated health
47 care AI that:
 - 48 a. is designed and evaluated in keeping with best practices in user-centered design,
49 particularly for physicians and other members of the health care team;
 - 50 b. is transparent;
 - 51 c. conforms to leading standards for reproducibility;

- 1 d. identifies and takes steps to address bias and avoids introducing or exacerbating
- 2 health care disparities including when testing or deploying new AI tools on
- 3 vulnerable populations; and
- 4 e. safeguards patients' and other individuals' privacy interests and preserves the
- 5 security and integrity of personal information.
- 6 4. Encourage education for patients, physicians, medical students, other health care
- 7 professionals, and health administrators to promote greater understanding of the promise
- 8 and limitations of health care AI.
- 9 5. Explore the legal implications of health care AI, such as issues of liability or intellectual
- 10 property, and advocate for appropriate professional and governmental oversight for safe,
- 11 effective, and equitable use of and access to health care AI ([Policy H-480.940](#),
- 12 ["Augmented Intelligence in Health Care"](#)).
- 13

14 The AMA also supports the use and payment of AI systems that advance the quadruple aim. AI
15 systems should enhance the patient experience of care and outcomes, improve population health,
16 reduce overall costs for the health care system while increasing value and support the professional
17 satisfaction of physicians and the health care team. To that end our AMA will advocate that:

- 18
- 19 1. Oversight and regulation of health care AI systems must be based on risk of harm and
- 20 benefit accounting for a host of factors, including but not limited to: intended and
- 21 reasonably expected use(s); evidence of safety, efficacy and equity including addressing
- 22 bias; AI system methods; level of automation; transparency; and conditions of deployment.
- 23 2. Payment and coverage for all health care AI systems must be conditioned on complying
- 24 with all appropriate federal and state laws and regulations, including, but not limited to
- 25 those governing patient safety, efficacy, equity, truthful claims, privacy and security as
- 26 well as state medical practice and licensure laws.
- 27 3. Payment and coverage for health care AI systems intended for clinical care must be
- 28 conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is
- 29 familiar to physicians; and (c) high-quality clinical evidence.
- 30 4. Payment and coverage for health care AI systems must (a) be informed by real world
- 31 workflow and human-centered design principles; (b) enable physicians to prepare for and
- 32 transition to new care delivery models; (c) support effective communication and
- 33 engagement between patients, physicians, and the health care team; (d) seamlessly
- 34 integrate clinical, administrative, and population health management functions into
- 35 workflow; and (e) seek end-user feedback to support iterative product improvement.
- 36 5. Payment and coverage policies must advance affordability and access to AI systems that
- 37 are designed for small physician practices and patients and not limited to large practices
- 38 and institutions. Government-conferred exclusivities and intellectual property laws are
- 39 meant to foster innovation, but constitute interventions into the free market, and therefore,
- 40 should be appropriately balanced with the need for competition, access and affordability.
- 41 6. Physicians should not be penalized if they do not use AI systems while regulatory
- 42 oversight, standards, clinical validation, clinical usefulness and standards of care are in
- 43 flux. Furthermore, our AMA opposes:
- 44 a. Policies by payers, hospitals, health systems or governmental entities that mandate
- 45 use of health care AI systems as a condition of licensure, participation, payment, or
- 46 coverage.
- 47 b. The imposition of costs associated with acquisition, implementation, and
- 48 maintenance of healthcare AI systems on physicians without sufficient payment.
- 49 7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best
- 50 positioned to know the AI system risks and best positioned to avert or mitigate harm do so

- 1 through design, development, validation and implementation. Our AMA will further
2 advocate:
- 3 a. Where a mandated use of AI systems prevents mitigation of risk and harm, the
4 individual or entity issuing the mandate must be assigned all applicable liability.
 - 5 b. Developers of autonomous AI systems with clinical applications (screening,
6 diagnosis, treatment) are in the best position to manage issues of liability arising
7 directly from system failure or misdiagnosis and must accept this liability with
8 measures such as maintaining appropriate medical liability insurance and in their
9 agreements with users.
 - 10 c. Health care AI systems that are subject to non-disclosure agreements concerning
11 flaws, malfunctions, or patient harm (referred to as gag clauses) must not be
12 covered or paid and the party initiating or enforcing the gag clause assumes
13 liability for any harm.
- 14 8. The AMA, national medical specialty societies, and state medical associations—
- 15 a. Identify areas of medical practice where AI systems would advance the quadruple
16 aim;
 - 17 b. Leverage existing expertise to ensure clinical validation and clinical assessment of
18 clinical applications of AI systems by medical experts;
 - 19 c. Outline new professional roles and capacities required to aid and guide health care
20 AI systems; and
 - 21 d. Develop practice guidelines for clinical applications of AI systems.
- 22 9. There should be federal and state interagency collaboration with participation of the
23 physician community and other stakeholders in order to advance the broader infrastructural
24 capabilities and requirements necessary for AI solutions in health care to be sufficiently
25 inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD
26 Policy)
- 27 10. AI is designed to enhance human intelligence and the patient-physician relationship rather
28 than replace it ([Policy H-480.939, “Augmented Intelligence in Health Care”](#)).

29
30 CONCLUSION

31
32 The AMA has various existing initiatives, research, policy, advocacy efforts, educational material
33 and other resources that are aligned with the desire to boost physician-centered innovation in the
34 field of AI research and development. As such, much of the work that Resolution 609-A-23 asks
35 the AMA to conduct is already ongoing.

36
37 The PIN serves as one source of connecting physicians with innovative companies, specifically
38 those working in the AI space. With that said, as noted, the PIN is undergoing a strategic review
39 and updates to maximize its impact to physicians in decreasing the burden of clinical technology.
40 As we continue to evaluate PIN, we will consider the significance of factors such as AI and other
41 evolving technologies to the practice of medicine and incorporate them into our approach to PIN.
42 At this time, the timing and approach are not aligned to create any specific workgroup linked to
43 PIN.

44
45 The costs associated with identifying, establishing and convening a formal advisory board to
46 facilitate relationships between physicians and the AI industry are significant. Additionally, the
47 existing engagement and collaboration the AMA has across initiatives from physicians, specialty
48 and state society and association stakeholders and industry allows AMA to obtain more diverse
49 perspectives and experiences than a formal advisory board. The AMA continues to ensure the
50 AMA is inclusive and equitable in its approach to research, advocacy and education.

1 RECOMMENDATIONS

2

3 The Board of Trustees recommends that Resolution 609-A-23 not be adopted and that this report be
4 filed.

Fiscal Note: Minimal

REFERENCES

1. Basu K, Sinha R, Ong A, Basu T. Artificial Intelligence: How is It Changing Medical Sciences and Its Future? *Indian J Dermatol.* 2020;65(5):365-370.
2. AiThORITY. Difference Between Augmented Intelligence and AI. AiThORITY. Published January 25, 2023. Accessed March 3, 2024. <https://aithority.com/technology/the-difference-between-augmented-intelligence-and-artificial-intelligence/>
3. CBInsights. Healthcare Remains The Hottest AI Category For Deals. CB Insights Research. Published April 12, 2017. Accessed March 3, 2024. <https://www.cbinsights.com/research/artificial-intelligence-healthcare-startups-investors/>
4. Lomis K, Jeffries P, Palatta A, et al. Artificial Intelligence for Health Professions Educators. *NAM Perspect.* Published online September 8, 2021. Accessed March 3, 2024. <https://nam.edu/artificial-intelligence-for-health-professions-educators/>
5. Mandal K. Role of Physician in the era of Artificial Intelligence Revolution. LinkedIn. Published August 11, 2023. Accessed March 4, 2024. <https://www.linkedin.com/pulse/role-physician-era-artificial-intelligence-revolution-kaushik-mandal-/>
6. American Medical Association. AMA Augmented Intelligence Research: Physician Sentiments Around the Use of AI in Health Care- Motivations, Opportunities, Risks, and Use Cases. Presented at: November 2023; American Medical Association. Accessed March 4, 2024. <https://www.ama-assn.org/system/files/physician-ai-sentiment-report.pdf>
7. Alsan M, Garrick O, Graziani GC. Does Diversity Matter for Health?: Experimental Evidence from Oakland. Published online June 2018. Accessed March 4, 2024. https://www.nber.org/system/files/working_papers/w24787/w24787.pdf
8. Snyder JE, Upton RD, Hassett TC, Lee H, Nouri Z, Dill M. Black Representation in the Primary Care Physician Workforce and Its Association With Population Life Expectancy and Mortality Rates in the US. *JAMA Netw Open.* 2023;6(4):e236687. <https://doi.org/10.1001/jamanetworkopen.2023.6687>
9. Howard J. Only 5.7% of US doctors are Black, and Experts Warn the Shortage Harms Public Health. National Medical Association. Published February 21, 2023. Accessed March 4, 2024. <https://www.nmanet.org/news/632592/Only-5.7-of-US-doctors-are-Black-and-experts-warn-the-shortage-harms-public-health.htm>
10. Crigger E, Reinbold K, Hanson C, Kao A, Blake K, Irons M. Trustworthy Augmented Intelligence in Health Care. *J Med Syst.* 2022;46(2):12. <https://doi.org/10.1007/s10916-021-01790-z>
11. American Medical Association. AMA Issues New Principles for AI Development, Deployment & Use. American Medical Association. Published November 28, 2023. Accessed March 4, 2024. <https://www.ama-assn.org/press-center/press-releases/ama-issues-new-principles-ai-development-deployment-use>

12. American Medical Association. Advancing Health Care AI Through Ethics, Evidence and Equity. American Medical Association. Published February 26, 2024. Accessed March 4, 2024. <https://www.ama-assn.org/practice-management/digital/advancing-health-care-ai-through-ethics-evidence-and-equity>

REPORT OF THE BOARD OF TRUSTEES

B of T Report 33-A-24

Subject: Employed Physicians

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

Referred to: Reference Committee F

1 BACKGROUND

2
3 At its November 2021 Special Meeting, the House of Delegates (HOD) referred Resolution 615,
4 which asked AMA to take a variety of actions to ensure that the voice of employed physicians is
5 heard within the organization.

6
7 BOT Report 9-I-22 subsequently argued that creation of an employed physician caucus, already in
8 the works at that time via efforts of the Organized Medical Staff Section (OMSS), would be the
9 most appropriate mechanism for giving voice to employed physicians in the HOD. The report
10 concluded that while it is beyond the scope of the Board to establish caucuses, the Board fully
11 supported the creation of an employed physician caucus in lieu of the asks of original Resolution
12 615.

13
14 As directed by BOT Report 9, this follow-up report provides an update on the caucus and
15 representation of employed physicians within our AMA.

16
17 DISCUSSION

18
19 The inaugural meeting of the OMSS-convened employed physician caucus was held at the 2022
20 Interim Meeting. Since then, the caucus has met in conjunction with each Annual and Interim
21 meeting, and between meetings as the need has arisen. Attendance at these meetings has ranged
22 from 15 to 20 participants per meeting, engaging not only OMSS members but also members from
23 most of the other AMA sections as well as members of the HOD who are not actively involved in
24 any section.

25
26 Facilitated by OMSS leadership, caucus meetings have focused on (1) discussion of resolutions and
27 reports under consideration by the HOD that are especially relevant to employed physicians, and
28 (2) general discussion of issues facing employed physicians and how AMA might address them,
29 whether through the policymaking process or otherwise. Through these actions, the group has
30 directly lent its expertise to the HOD, with one key example being the contributions of the caucus
31 to the development of OMSS-sponsored Resolution 017-A-23, which established AMA's definition
32 of "employed physician." Additionally, the group has served as a resource for AMA staff
33 addressing employment matters – for example, providing input on recent revisions to the *AMA*
34 *Physicians' Guide to Hospital Employment Contracts* and allowing for observation of the caucus
35 by AMA staff to garner ideas for a series of news articles on physician employment.

1 In 2024, the OMSS-convened employed physician caucus will focus on formalizing its structure
2 and processes, developing a charter that outlines caucus membership requirements, how caucus
3 leadership is selected, and the process by which the caucus determines positions it will voice on
4 items of business under consideration in the HOD. The caucus will next meet on Saturday, June 8,
5 from 9:30 to 10:30 a.m. at the Hyatt Regency Chicago (see Speakers' Letter for room location),
6 and all AMA members are invited to attend. The Board of Trustees looks forward to the continued
7 evolution of the caucus and its success in representing the interests of employed physicians within
8 our AMA.

9

10 RECOMMENDATION

11

12 The Board of Trustees recommends that the following be adopted and the remainder of the report
13 be filed:

14

- 15 1. That AMA policy D-405.969 be rescinded as having been accomplished by this report
16 (Rescind HOD Policy).

Fiscal Note: No significant fiscal impact.

JOINT REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS AND THE
COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CCB/CLRPD Report 1-A-24

Subject: Joint Council Sunset Review of 2014 House Policies

Presented by: Mark Bair, MD, Chair, Council on Constitution and Bylaws
Gary Thal, MD, Chair, Council on Long Range Planning and Development

Referred to: Reference Committee F

1 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of
2 American Medical Association (AMA) policies to ensure that our AMA’s policy database is
3 current, coherent, and relevant. Policy G-600.110 reads as follows, laying out the parameters for
4 review and specifying the procedures to follow:
5

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

11 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
12 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
13 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall
14 be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been
15 asked to review policies shall develop and submit a report to the House identifying policies
16 that are scheduled to sunset; (d) For each policy under review, the reviewing council can
17 recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain
18 part of the policy; or (iv) reconcile the policy with more recent and like policy (per Policy G-
19 600.111(4), The consolidation process permits editorial amendments for the sake of clarity, so
20 long as the proposed changes are transparent to the House and do not change the meaning); (e)
21 For each recommendation that it makes to retain a policy in any fashion, the reviewing council
22 shall provide a succinct, but cogent justification (f) The Speakers shall determine the best way
23 for the House of Delegates to handle the sunset reports.
24

25 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier
26 than its 10-year horizon if it is no longer relevant, has been superseded by a more current
27 policy, or has been accomplished.
28

29 4. The AMA councils and the House of Delegates should conform to the following guidelines for
30 sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has
31 been accomplished; or (c) when the policy or directive is part of an established AMA practice
32 that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA
33 House of Delegates Reference Manual: Procedures, Policies and Practices.
34

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

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

2

3 RECOMMENDATION

4

5 The Councils on Constitution and Bylaws and Long Range Planning and Development
6 recommend that the House policies that are listed in the appendix to this report be acted upon in
7 the manner indicated and the remainder of this report be filed.

APPENDIX – Recommended Actions

Policy Number	Title	Text	Recommendation
D-478.980	Anonymous Cyberspace Evaluations of Physicians	<p>Our AMA will: (1) work with appropriate entities to encourage the adoption of guidelines and standards consistent with AMA policy governing the public release and accurate use of physician data; (2) continue pursuing initiatives to identify and offer tools to physicians that allow them to manage their online profile and presence; (3) seek legislation that supports the creation of laws to better protect physicians from cyber-libel, cyber-slander, cyber-bullying and the dissemination of Internet misinformation and provides for civil remedies and criminal sanctions for the violation of such laws; and (4) work to secure legislation that would require that the Web sites purporting to offer evaluations of physicians state prominently on their Web sites whether or not they are officially endorsed, approved or sanctioned by any medical regulatory agency or authority or organized medical association including a state medical licensing agency, state Department of Health or Medical Board, and whether or not they are a for-profit independent business and have or have not substantiated the authenticity of individuals completing their surveys.</p>	<p>Consolidate D-445.997 and D-478.980 as editorially amended (by insertion and deletion) and Retain.</p> <p>D-445.997, Online Physician Reputation and Rating: Our AMA will: (1) encourages physicians to take an active role in managing their online reputation in ways that can help them improve practice efficiency and patient care; (2) encourages physician practices and health care organizations to establish policies and procedures to address negative online complaints directly with patients that do not run afoul of federal and state privacy laws; (3) will develop and publish educational material to help guide physicians and their practices in managing their online reputation, including recommendations for responding to negative patient reviews and clarification about how federal privacy laws apply to online reviews; and (4) will work with appropriate stakeholders to (a) consider an outlet for physicians to share their experiences and (b) potentially consider a mechanism for recourse for physicians whose practices have been affected by negative online reviews, consistent with federal and state privacy laws; D-478.980 Our AMA</p>

Policy Number	Title	Text	Recommendation
			<p>will: (1)(5) work with appropriate entities to encourage the adoption of guidelines and standards consistent with AMA policy governing the public release and accurate use of physician data; (2)(6) continue to pursuing initiatives to identify and offer tools to physicians that allow them to manage their online profile and presence; (3)(7) seek legislation that supports the creation of laws to better protect physicians from cyber-libel, cyber-slander, cyber-bullying and the dissemination of Internet misinformation and provides for civil remedies and criminal sanctions for the violation of such laws; and (4)(8) work to secure legislation that would require that the Web sites purporting to offer evaluations of physicians state prominently on their Web sites whether or not they are officially endorsed, approved or sanctioned by any medical regulatory agency or authority or organized medical association including a state medical licensing agency, state Department of Health or Medical Board, and whether or not they are a for-profit independent business and have or have not substantiated the authenticity of individuals completing their surveys.</p>
D-90.999	Interpreters For Physician Visits	Our AMA continues to monitor enforcement of those provisions of the ADA to assure that physician offices are not subjected to undue	Sunset; More recent and comprehensive policies exist.

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		<p>burdens in their efforts to assure effective communication with hearing disabled patients.</p>	<p>Policies include: H-385.929, Availability and Payment for Medical Interpreters Services in medical Practices; D-385.957, Certified Translation and Interpreter Services; H-385.928, Patient Interpreters; D-385.946, Physician Reimbursement for Interpreter Services; and D-385.978, Language Interpreters.</p>
<p>D-165.938</p>	<p>Redefining AMA's Position on ACA and Healthcare Reform</p>	<p>1. Our AMA will develop a policy statement clearly stating this organization's policies on the following aspects of the Affordable Care Act (ACA) and healthcare reform: A. Opposition to all P4P or VBP that fail to comply with the AMA's Principles and Guidelines; B. Repeal and appropriate replacement of the SGR; C. Repeal and replace the Independent Payment Advisory Board (IPAB) with a payment mechanism that complies with AMA principles and guidelines; D. Support for Medical Savings Accounts, Flexible Spending Accounts, and the Medicare Patient Empowerment Act ("private contracting"); E. Support steps that will likely produce reduced health care costs, lower health insurance premiums, provide for a sustainable expansion of healthcare coverage, and protect Medicare for future generations; F. Repeal the non-physician provider non-discrimination provisions of the ACA. 2. Our AMA will immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals. 3. There will be a report back at each meeting of the AMA HOD.</p>	<p>Sunset; No longer necessary.</p> <p><i>Authors' note: While AMA Councils currently collaborate where appropriate on technology-related projects, such AMA initiatives are often enterprise-wide, with the expertise of relevant Councils utilized during project development and implementation. More details about AMA's technology initiatives hcan be found online.</i></p>
<p>G-620.045</p>	<p>Medical Malpractice Discount Rates</p>	<p>Our AMA encourages member organizations of the Federation to offer access to discounted medical liability insurance premiums where legally permissible.</p>	<p>Retain; Still relevant.</p> <p>Nearly every state medical association or society actively endorses a medical liability product with most offering some sort of discount and AMA Insurance's Medical Liability Insurance Plan offers</p>

Policy Number	Title	Text	Recommendation
			<p>competitively priced medical liability insurance coverage (discounted rates for AMA members). However, a recent AMA study, Prevalence of Medical Liability Premium Increases Unseen Since 2000s Continues for Fourth Year in a Row, found that at least in some states medical liability premiums are increasing.</p>
G-635.015	Member Recognition	<p>Our AMA will study ways to provide recognition to member physicians in local communities, to give them and the community a greater personal sense of connection with our AMA.</p>	<p>Sunset; No longer necessary.</p> <p>AMA has a number of recognition and award programs: Women in Medicine Month (September); Senior Physicians Recognition Month (May) and IMG Recognition Week (October); AMA Award for Citizenship and Community Service; AMA Medal of Valor; the President’s Citation for Service to the Public; the Distinguished Service Award; and the AMA Physician's Recognition Award (PRA). The AMA Foundation offers multiple awards (including the AMA Foundation Award for Health Education, Excellence in Medicine Awards, and the Joan F. Giambalvo Fund for the Advancement of Women). Nominees for the AMA and AMA Foundation Awards are solicited from the House</p>

Policy Number	Title	Text	Recommendation
			of Delegates, AMA sections, and the Federation.
G-640.025	Encourage Physicians as Legislative Candidates	Our AMA continues to identify, encourage, and support physicians to run as state and national legislative candidates.	<p>Consolidate with G-640.015 as editorially amended (by insertion and deletion) and Retain.</p> <p>Our AMA <u>will</u> continue to identify, encourage, and support physicians to run as state and national legislative candidates. G-640.015. Our AMA will not use AMA corporate treasury funds to engage in partisan political activity.</p> <p><i>Authors' note: AAMPAC, AMA's bipartisan political action committee, strives to help more physicians get personally involved in politics, and holds workshops each year to educate physicians about the intricacies of politics and political campaigns. AMPAC also publishes political research on public perceptions of physicians as candidates, the latest being a 2022 Research Exploring Voters Perceptions about Physicians as Candidates Running for Elected Office.</i></p>
G-640.045	Helping to Better Inform Legislators on Medical Matters	Our AMA will inform members of Congress and their staff that AMA Morning Rounds is available through our website to the public without charge.	<p>Sunset; No longer necessary.</p> <p>AMA periodically sends faxes to the attention of health staff at Congressional offices encouraging them to subscribe to</p>

Policy Number	Title	Text	Recommendation
			<p>AMA Morning Rounds. Morning Rounds remains available to AMA members, nonmembers and the public.</p>
H-160.905	<p>Non-Physician Practitioners Certifying Medicare Patients' Need for Therapeutic Shoes and Inserts</p>	<p>Our AMA supports authorization of physician assistants, and nurse practitioners who practice in physician-led teams to certify Medicare beneficiaries' need for therapeutic shoes and/or inserts.</p>	<p>Consolidate with H-425.979 (as editorially amended by insertion and deletion) and Retain.</p> <p>H-160.905. (1) Our AMA supports authorization of physician assistants, and nurse practitioners who practice in physician-led teams to certify Medicare beneficiaries' need for therapeutic shoes and/or inserts.</p> <p>H.425.979(2) Our AMA: (4) recommends that public and private health insurance programs provide appropriate therapeutic shoes to patients with peripheral neuropathy who meet the eligibility criteria defined in the Medicare Benefit Policy Manual; and (2) strongly urges public and private health insurance programs to provide appropriate therapeutic shoes to patients with peripheral neuropathy who meeting the following criterion: they are currently being treated under a comprehensive treatment plan and have one of the following: (a) peripheral neuropathy with evidence of callus formation; (b) history of pre-ulcerative calluses; (c) history of previous</p>

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			ulceration; (d) foot deformity; (e) previous amputation of the foot or part of the foot; or (f) poor circulation.
H-180.973	The "Hassle Factor"	Our AMA will greatly intensify its efforts (including support of HR 2695) to reduce the burden of government and third-party regulation on medical practice and its intrusion into the physician-patient relationship and doctor-patient time.	Editorially amend (by deletion) and Retain. Our AMA will greatly intensify its efforts (including support of HR 2695) to reduce the burden of government and third-party regulation on medical practice and its intrusion into the physician-patient relationship and doctor-patient time.
H-185.934	Emergency Department Insurance Linking	Our AMA supports the establishment of insurance-linking programs in the emergency department in a manner that does not interfere with providing timely emergency medical services.	Sunset; superseded by more current and comprehensive Policy H-130.970 .
H-225.948	Hospital Policies on Interactions with Industry	<p>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:</p> <p>(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:</p> <p>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</p>	<p>Editorially Amend 1(b) (by deletion) and Retain.</p> <p>*** and 1(b) be consistent with applicable AMA policy and ethical opinions on the subject of medicine-industry interaction; including but not limited to:</p> <p>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</p>

Policy Number	Title	Text	Recommendation
		<p>H-460.981 University-Industry Cooperative Research Ventures.</p> <p>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.</p>	<p>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-9.015 Financial Relationships with Industry in Continuing Medical Education H-460.981 University-Industry Cooperative Research Ventures.</p> <p><i>Authors' note: When the AMA Code of Medical Ethics was modernized, many like policies were consolidated—see E-10.6, Industry Representatives in Clinical Settings]</i></p>
H-225.959	Medical Staff Testing	<p>Our AMA: (1) establish policy that, in the absence of statutory and/or regulatory requirements, hospital medical staffs should determine those tests and/or immunization that are required for medical staff members, and delineate under what circumstances such tests or immunizations should be administered; (2) encourages medical staffs to regularly review and update their bylaws and workplace policies to ensure that they reflect current laws, regulations, health care policy, and evidence-based medicine; and (3) encourages appropriate stakeholders to develop, promulgate, and adopt a uniform immunization form for medical students seeking to do rotations at hospitals away from their home institutions.</p>	Retain; Still relevant.
H-235.981	Qualifications, Selection, and Role of Medical Directors, Chief Medical Officers, Vice Presidents for Medical Affairs, and Others Employed by or Under Contract with Hospitals/Health Systems to Provide Medical	<p>1. Our AMA supports the following guidelines regarding the qualifications and selection of individuals employed by or under contract with a hospital/health system to provide medical management services, such as medical directors, chief medical officers, and vice presidents for medical affairs: a. The hospital governing body, management, and medical staff should jointly: (i) determine if there is a need to employ or contract with one or more individuals to provide medical management services; (ii) establish the purpose, duties, and responsibilities of these positions; (iii) establish the qualifications for these positions; and (iv) establish and sustain a mechanism for input</p>	<p>Editorially amend 1.c (by insertion and deletion) and Retain.</p> <p>Physicians providing medical management services at a single hospital should be licensed to practice medicine in the same state as the hospital for which they he or she provide such services. Additionally, he or she</p>

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	Management Services	<p>from and participation by elected leaders of the medical staff in the selection, evaluation, and termination of individuals holding these positions.</p> <p>b. An individual employed by or under contract with a hospital or health system to provide medical management services should be a physician (MD/DO). c. A physician providing medical management services at a single hospital should be licensed to practice medicine in the same state as the hospital for which he or she provides such services. Additionally, he or she should be a member in good standing of the organized medical staff of the hospital for which he or she provides medical management services. d. Where feasible, a physician providing medical management services at the system level for a multi-hospital health system should be licensed to practice medicine in each of the states in which the health system has a hospital that will be influenced by the physician's work. At a minimum, the physician should be licensed in at least one state in which the health system has a hospital over which the physician will exert influence, and in as many other states as may be required by state licensing law. e. Where feasible, a physician providing medical management services at the system level for a multi-hospital health system should be a member in good standing of the medical staff of each of the hospitals that will be influenced by the physician's work. At a minimum, the physician should: (i) be a member in good standing of at least one of the medical staffs of the hospitals that will be influenced by the physician's work; and (ii) work in collaboration with elected medical staff leaders throughout the system and with any individuals who provide medical management services at the hospital level.</p> <p>2. Our AMA supports the following guidelines regarding the role of the organized medical staff vis-a-vis individuals employed by or under contract with hospitals/health systems to provide medical management services: a. The purpose, duties, and responsibilities of individuals employed by or under contract with the hospital/health system to provide medical management services should be included in the medical staff bylaws and in the hospital/health system corporate bylaws. b. The organized medical staff should maintain overall responsibility for the quality of care provided to patients by the hospital, including the quality of the professional services provided by individuals with clinical privileges, and should have the responsibility of reporting to the governing body. c. The chief elected officer of the medical staff should represent the medical staff to the administration, governing body, and external</p>	<p><u>they</u> should be a member in good standing of the organized medical staff of the hospital for which he or she <u>they</u> provide medical management services.</p>

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		agencies. d. Government regulations that would mandate that any individual not elected or appointed by the medical staff would have authority over the medical staff should be opposed.	
H-315.980	Preservation of Medical Records	It is the policy of the AMA that medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes, chemotherapy records, and records documenting permanent structural alteration to the patients should always be part of the patient's chart.	Retain; Still relevant. <i>The Authors note that the AMA Code of Medical Ethics 3.3.1 provides extensive guidance related to medical records.</i>
H-35.967	Treatment of Persons with Hearing Disorders	<p>1. Our AMA believes that physicians should remain the primary entry point for care of patients with hearing impairment and continue to supervise and treat hearing, speech, and equilibratory disorders.</p> <p>2. Our AMA expressly opposes statements that the practice of audiology includes the diagnosis and treatment of hearing disorders; affirms that it is in the public interest that a medical assessment of any hearing or balance malfunction be made by a physician knowledgeable in diseases of the ear; reasserts that audiologists are individuals who perform non-medical testing, evaluating, counseling, instruction and rehabilitation of individuals whose communication disorders center in whole or in part in hearing function; and affirms its respect for the contribution which audiologists have made and continue to make to patient welfare and quality health care in their assistance in the treatment of hearing disorders.</p> <p>3. Should there be ambiguities in the statutory language of any state which defines audiology, state, and/or specialty medical societies should take steps to seek a legislative amendment to that statute to secure language that describes appropriately the practice of audiology. Misrepresentation by audiologists of their skills and/or the scope of their practice should be reported to appropriate state authorities.</p>	Retain; Still relevant.
H-365.999	Physician's Role in Returning Patients to Their Jobs	Our AMA encourages physicians everywhere to advise their patients to return to work at the earliest date compatible with health and safety and recognizes that physicians can, through their care, facilitate patients' return to work.	Consolidate with H-365.981 and H-365.976 (as editorially amended by insertion and deletion) and Retain. H-365.981, Workers' Compensation. Our AMA: (1) will promote the development of practice parameters, when appropriate, for use in the treatment of

Policy Number	Title	Text	Recommendation
			<p>injured workers and encourages those experienced in the care of injured workers to participate in such development.</p> <p>(2) will investigate support for appropriate utilization review guidelines for referrals, appropriate procedures and tests, and ancillary services as a method of containing costs and curbing overutilization and fraud in the workers' compensation system. Any such utilization review should be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession. Physicians with background appropriate to the care under review should have the ultimate responsibility for determining quality and necessity of care.</p> <p>(3) encourages the use of the Guides to the Evaluation of Permanent Impairment. The correct use of the Guides can facilitate prompt dispute resolution by providing a single, scientifically developed, uniform, and objective means of evaluating medical impairment.</p> <p>(4) encourages physicians to participate in the development of workplace health and safety programs.</p> <p>Physician input into</p>

Policy Number	Title	Text	Recommendation
			<p>healthy lifestyle programs (the risks associated with alcohol and drug use, nutrition information, the benefits of exercise, for example) could be particularly helpful and appropriate.</p> <p>(5) encourages the use of uniform claim forms (CMS 1500, UB04), electronic billing (with appropriate mechanisms to protect the confidentiality of patient information), and familiar diagnostic coding guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when appropriate, to facilitate prompt reporting and payment of workers' compensation claims.</p> <p>(6) will evaluate the concept of Independent Medical Examinations (IME) and make recommendations concerning IME's (i) effectiveness; (ii) process for identifying and credentialing independent medical examiners; and (iii) requirements for continuing medical education for examiners.</p> <p>(7) encourages state medical societies to support strong legislative efforts to prevent fraud in workers' compensation.</p> <p>(8) will continue to monitor and evaluate state and federal health system reform proposals which propose some</p>

Policy Number	Title	Text	Recommendation
			<p>form of 24-hour coverage.</p> <p>(9) will continue to evaluate these and other medical care aspects of workers' compensation and make timely recommendations as appropriate.</p> <p>(10) will continue activities to develop a unified body of policy addressing the medical care issues associated with workers' compensation, disseminate information developed to date to the Federation and provide updates to the Federation as additional relevant information on workers' compensation becomes available.</p> <p><u>(11) H 365.999, Physician's Role in Returning Patients to Their Jobs, Our AMA encourages physicians everywhere to advise their patients to return to work at the earliest date compatible with health and safety and recognizes that physicians can, through their care, facilitate patients' return to work.</u></p> <p><u>(12) H 365.976, Adopting the Use of the Most Recent and Updated Edition of the AMA Guides to the Evaluation of Permanent Impairment: Our AMA supports the adoption of the most current edition of the AMA Guides to the Evaluation of Permanent Impairment by all jurisdictions to</u></p>

Policy Number	Title	Text	Recommendation
			<u>provide fair and consistent impairment evaluations for patients and claimants including injured workers.</u>
H-85.954	Importance of Autopsies	<p>1. Our AMA supports seeking the cooperation of the National Advisory Council on Aging of the National Institutes of Health in recommending to physicians, hospitals, institutes of scientific learning, universities, and most importantly the American people the necessity of autopsy for pathological correlation of the results of the immeasurable scientific advancements which have occurred in recent years. Our AMA believes that the information garnered from such stringent scientific advancements and correlation, as well as coalitions, should be used in the most advantageous fashion; and that the conclusions obtained from such investigations should be widely shared with the medical and research community and should be interpreted by these groups with the utmost scrutiny and objectivity.</p> <p>2. Our AMA: (a) supports the efforts of the Institute of Medicine and other national organizations in formulating national policies to modernize and promote the use of autopsy to meet present and future needs of society; (b) promotes the use of updated autopsy protocols for medical research, particularly in the areas of cancer, cardiovascular, occupational, and infectious diseases; (c) promotes the revision of standards of accreditation for medical undergraduate and graduate education programs to more fully integrate autopsy into the curriculum and require postmortems as part of medical educational programs; (d) encourages the use of a national computerized autopsy data bank to validate technological methods of diagnosis for medical research and to validate death certificates for public health and the benefit of the nation; (e) requests The Joint Commission to consider amending the Accreditation Manual for Hospitals to require that the complete autopsy report be made part of the medical record within 30 days after the postmortem; (f) supports the formalization of methods of reimbursement for autopsy in order to identify postmortem examinations as medical prerogatives and necessary medical procedures; (g) promotes programs of education for physicians to inform them of the value of autopsy for medical legal purposes and claims processing, to learn the likelihood of effects of disease on other family members, to establish the cause of death when death is unexplained or poorly understood, to</p>	Retain; Still relevant.

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		<p>establish the protective action of necropsy in litigation, and to inform the bereaved families of the benefits of autopsy; and (h) promotes the incorporation of updated postmortem examinations into risk management and quality assurance programs in hospitals.</p> <p>3. Our AMA reaffirms the fundamental importance of the autopsy in any effective hospital quality assurance program and urges physicians and hospitals to increase the utilization of the autopsy so as to further advance the cause of medical education, research and quality assurance.</p> <p>4. Our AMA representatives to the Liaison Committee on Medical Education ask that autopsy rates and student participation in autopsies continue to be monitored periodically and that the reasons that schools do or do not require attendance be collected. Our AMA will continue to work with other interested groups to increase the rate of autopsy attendance.</p> <p>5. Our AMA requests that the National Committee on Quality Assurance (NCQA) and other accrediting bodies encourage the performance of autopsies to yield benchmark information for all managed care entities seeking accreditation.</p> <p>6. Our AMA calls upon all third-party payers, including CMS, to provide adequate payment directly for autopsies, and encourages adequate reimbursement by all third party payers for autopsies.</p> <p>7. It is the policy of our AMA: (a) that the performance of autopsies constitutes the practice of medicine; and (b) in conjunction with the pathology associations represented in the AMA House, to continue to implement all the recommendations regarding the effects of decreased utilization of autopsy on medical education and research, quality assurance programs, insurance claims processing, and cost containment.</p> <p>8. Our AMA affirms the importance of autopsies and opposes the use of any financial incentives for physicians who acquire autopsy clearance.</p>	

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-A-24

Subject: Establishment of a LGBTQ+ Section

Presented by: Gary Thal, MD, Chair

Referred to: Reference Committee F

1 In May 2023, the American Medical Association (AMA) Council on Long Range Planning and
2 Development (CLRPD) received a Letter of Application from the Advisory Committee (AC) on
3 Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) Issues requesting a change in status to
4 the LGBTQ+ Section. AMA bylaws on Sections (§7.00) define the mission of AMA sections and
5 identify each section as fixed or delineated. This report presents to the AMA House of Delegates
6 (HOD) CLRPD’s evaluation of the proposal for a LGBTQ+ Section using criteria identified by
7 Policy G-615.001, “[Establishment and Functions of Sections](#)” in consideration of requests for new
8 sections or changing the status of member component groups.
9

10 APPLICATION OF CRITERIA

11
12 Following an initial review and discussion of the AC’s proposal for section status, the CLRPD met
13 with the leadership of the AC to obtain clarification on some of the information presented in the
14 letter of application. This part of the report presents criterion followed by material excerpted from
15 the letter of application and the AC’s response to CLRPD’s request for additional information. The
16 assessment section conveys the Council’s evaluation of the proposal for delineated section status.
17

18 *1. Issue of Concern - Focus will relate to concerns that are distinctive to the subset within the*
19 *broader, general issues that face medicine. A demonstrated need exists to deal with these matters,*
20 *as they are not currently being addressed through an existing AMA group.*
21

22 Currently, the AC serves as the experts on LGBTQ+ issues. Transitioning the group to a section
23 would serve as an entry point to the HOD for most AMA resolutions seeking to advance LGBTQ+
24 physician and medical student needs and the practice of LGBTQ+ medicine. In this sense, the
25 LGBTQ+ Section would provide the opportunity for underrepresented members of the AMA to
26 introduce issues of concern and to participate in the AMA policymaking process.
27

28 The goals and objectives of the LGBTQ+ Section shall include, but not be limited, to:

- 29
- 30 • Provide a dedicated forum for involvement, mentoring, and networking for LGBTQ+
31 physicians and medical students.
- 32 • Increase the membership, participation, and representation of LGBTQ+ physicians and
33 students in the AMA.
- 34 • Advocate for practices at AMA meetings to be inclusive to the needs of LGBTQ+
35 physicians, residents, medical students, and guests in attendance (e.g., gender neutral
36 bathrooms, availability of gender pronouns ribbons for name badges).

- 1 • Enhance AMA policy, advocacy, and education on LGBTQ+ health and professional
2 issues.
- 3 • Advocate for best practices with AMA membership to foster camaraderie and safely
4 identify as LGBTQ+ physicians and trainees.
- 5 • Increase and foster further collaboration with Health Professionals Advancing LGBTQ
6 Equity (GLMA) and additional professional societies, associations, and across AMA
7 business units and sections on mutual interests and goals.
- 8 • Reduce inequities faced by LGBTQ+ students, physicians, and patients and build support
9 systems through representation in membership, LGBTQ+ focused programming, and
10 mentorship opportunities.

11

12 *2. Consistency - Objectives and activities of the group are consistent with those of the AMA.*
13 *Activities make good use of available resources and are not duplicative.*

14

15 Members of the LGBTQ+ Section would advocate for physicians and medical students by focusing
16 on strategies, programs, and policies to better serve AMA members, potential members, and
17 patients who identify as LGBTQ+. In 2022, the AC held an impromptu meeting with the Chair of
18 the AMA Board of Trustees (BOT) to discuss the AMA's messaging on Mpox, previously known
19 as Monkeypox or MPV. This meeting was to ensure that no groups affected by this public health
20 crises were further stigmatized, and to address the vaccine shortage so that distribution was
21 performed in an equitable and effective manner to prevent further spread.

22

23 The Committee holds a liaison position that serves on the AMA Foundation (AMAF) Fellowship
24 Commission on LGBTQ+ Health, which determines institutional grants to support the
25 advancement of LGBTQ+ Health and Equity initiatives. Additionally, the AC funds and selects
26 annual awardees for the AMAF LGBTQ+ Award for Excellence. These awards and grants are
27 establishing the pathway for physicians who identify as LGBTQ+ to become involved in the AMA,
28 gain peer recognition, and advance evidence-based practices of health equity standards for
29 LGBTQ+ patients. Given that the AC has been in existence since 2005, and that the strategic plan
30 and work of the Committee has demonstrated its continued need, the section would continue to be
31 essential, with neither change to staffing, nor duplicative efforts arising from the transition.

32

33 In November 2023, the AC sponsored a session with leading experts in the field of LGBTQ+ health
34 policy and legislation who discussed important and timely legislative efforts at the state and federal
35 levels impacting LGBTQ+ health care access and treatment, such as the current landscape of
36 legislation and bills that were passed recently affecting LGBTQ+ health care and access; current
37 court cases that resulted from enacted anti-LGBTQ+ legislation; newer bills, such as Shield laws,
38 that are being passed in an effort to protect access to LGBTQ+ health care services in some states,
39 and the sponsors and organizations backing anti-LGBTQ+ legislation and some of their strategies.

40

41 *3. Appropriateness - The structure of the group will be consistent with its objectives and activities.*

42

43 Due to its protected class nature and voluntary membership, the LGBTQ+ Section would not enroll
44 members based on sexual orientation, gender identity and expression (SOGIE) data. Instead,
45 members would need to opt in as members of the section. All AMA members may receive the
46 monthly LGBTQ+ newsletter, attend webinars, and AMA Interim and Annual meeting educational
47 programming.

48

49 The current AC leadership consists of a Chair, Vice Chair, GLMA Representative, Medical Student
50 Section (MSS) Representative, Young Physician Section (YPS) Representative, Resident Fellow
Section (RFS) Representative and two Members at-Large. As the LGBTQ+ Section, the governing

1 council (GC) would oversee the elections process for the delegate and alternate delegate positions
2 and allow any member of the section to apply for these positions. Section membership would then
3 vote to elect these positions. Terms of service for GC members will be addressed in the section's
4 internal operating procedure (IOP). The GC, including the delegates, would meet prior to the HOD
5 meetings and at other times throughout the year with elections taking place prior to the Annual
6 Meeting of the HOD. The Chair and Chair-elect positions would be elected positions from
7 members of the GC with the Chair-elect (now Vice Chair under current AC format) ascending to
8 Chair. Voting would be conducted in accordance with the section's IOP and call for a majority
9 consensus.

10
11 *4. Representation Threshold - Members of the formal group would be based on identifiable*
12 *segments of the physician population and AMA membership. A substantial number of members*
13 *would be represented by this formal group. At minimum, this group would be able to represent*
14 *1,000 AMA members. It is important to note this threshold will not be used to determine*
15 *representation, as each new section will be allocated only one delegate and one alternate delegate*
16 *in the AMA HOD.*

17
18 The percentage of U.S. adults who self-identify as gay, lesbian, bisexual, transgender, or something
19 other than heterosexual has increased to a new high of 7.2 percent, which is double the percentage
20 when Gallup first measured it a decade ago. Based on this estimate, there are approximately 23
21 million people who identify as transgender or non-binary, meaning those individuals whose gender
22 identity differs from cultural expectations based on the sex assigned at birth and/or falls outside
23 binary gender categories of “man” or “woman.”^{1 2}

24
25 The Association of American Medical Colleges Graduation Questionnaire notes that over one
26 percent of graduating medical students identify as a different gender than their sex assigned at
27 birth, and nearly 12 percent identify as gay, lesbian, bisexual, or another sexual identity besides
28 heterosexual.³ Of the 250,000 AMA members, nearly seven percent identify as LGBTQ+ based on
29 those who provided SOGIE information. The “prefer not to say” category in SOGIE data, is around
30 two percent, which is consistent with the 2022 Gallup census information. The AC has identified
31 another possible five percent of AMA membership as allies; so, as many as 12,500 active members
32 in the AMA would consider themselves allies to the LGBTQ+ Section.

33
34 With increased visibility as a section and additional opportunities for engagement and
35 collaboration, the section may be able to further reduce stigma within and outside the AMA.
36 Currently, the AC listserv engages a total of 1,703 individuals. Half of those are AMA members
37 (804) and the other half are not (899). As a section, it is anticipated that more LGBTQ+ members
38 will recruit friends and colleagues to be actively engaged members of the section. Groups where
39 the section may find opportunities to recruit new AMA members include GLMA, Medical Student
40 Pride Alliance (MSPA), LGBTQ+ members of specialty societies, and others.

¹ Gallup. US LGBT identification steady at 7.2%. Accessed August 6, 2023. <https://news.gallup.com/poll/470708/lgbt-identification-steady.aspx>.

² UCLA SCHOOL OF LAW WILLIAMS INSTITUTE. HOW MANY ADULTS AND YOUTH IDENTIFY AS TRANSGENDER IN THE UNITED STATES? ACCESSED MAY 19, 2023. <HTTPS://WILLIAMSINSTITUTE.LAW.UCLA.EDU/PUBLICATIONS/TRANS-ADULTS-UNITED-STATES/>.

³ AAMC. 2024 Medical School Graduation Questionnaire. Accessed May 19, 2004. <https://www.aamc.org/data-reports/students-residents/report/graduation-questionnaire-gq>.

1 *5. Stability - The group has a demonstrated history of continuity. This segment can demonstrate*
2 *an ongoing and viable group of physicians, who will be represented by this section. Both the*
3 *segment and the AMA will benefit from an increased voice within the policymaking body.*
4

5 The AC participates in several efforts aimed at growing AMA membership and engagement.
6 While attending outside organizations meetings and events, such as Howard Brown Health LGBTQ
7 Midwest Symposium, MSPA annual meeting, Building the Next Generation of Academic
8 Physicians (BNGAP) LGBT Workforce Conference, and GLMA's annual meeting, AC members
9 provide awareness and greater understanding of the benefits to working with and joining the AMA.
10 The current AC includes physicians from several stakeholder institutions such as Howard Brown
11 Health, MSPA and GLMA. AC members also collaborate and engage with students at the BNGAP
12 meeting and through the MSS representative for outreach to MSPA to engage interested students
13 with the AC and its work. As a section, the group plans on further educational outreach to MSS,
14 RFS and YPS within the AMA and LGBTQ+ groups outside the AMA.
15

16 The AC has convened meetings during Annual and Interim Meetings of the HOD. Attendance at
17 assembly meetings ranges between 80 to 150 members with 20-30 new members attending
18 meetings. The monthly newsletter listserv, which reaches approximately 1,700 individuals, remains
19 vital and connects AC membership between and during meetings. Committee members are very
20 well informed on the socio-economic facets of medicine and the group's leadership has remained
21 stable and consistent, with continuous growth in applicants for open positions. Engagement in the
22 Committee's newsletter continues to be among the highest open and click through rates across the
23 sections. For 2022, the monthly newsletter email was opened by 10,662 individuals with an open
24 percentage rate of 48.92.
25

26 Annually, the AC undergoes a strategic planning process where the top strategic initiatives are
27 identified and supporting tactics and measures are established. AC leadership performs quarterly
28 check-ins to assess how the Committee is progressing on these goals. The AC established its 2022-
29 2023 strategic priorities to:
30

- 31 • Facilitate member involvement, mentoring, leadership development, and networking for
32 LGBTQ+ physicians, medical students, and allies.
- 33 • Improve health equity for LGBTQ+ patients and communities and increase LGBTQ+
34 representation in the physician workforce.
- 35 • Engage internal and external stakeholders in amplifying AMA policy and enhancing
36 education and awareness efforts on LGBTQ+ health and well-being.
37

38 In addition to the strategic objectives, the Committee identified the following items as additional
39 priorities and areas of focus:
40

- 41 1. Promote physician safety from threats and violence, especially when providing medically
42 necessary, evidence-based care.
- 43 2. Mpox eradication including equitable vaccine and treatment distribution.
44

45 The AC has always been focused on establishing goals and priorities that support the mission and
46 continued growth and capacity to reach more LGBTQ+ physicians and medical students, and
47 understands the necessity to remain nimble and open to accommodating issues that inevitably arise
48 and require attention and support from the AC and AMA leadership, such as laws and regulations
49 that seek to deny access to health care, and penalize/criminalize the provision of medically
50 necessary and appropriate care.

1 For the June 2022 meeting, the LGBTQ+ Caucus had 146 registrants, which was nearly seven
2 percent of the total number of registered attendees for section caucus events. Compared to previous
3 caucus events, there has been consistent growth in registered attendees. In 2019, the AC had 83
4 registrants, and for 2021 there were 169 (no data for June 2020 as that meeting was cancelled).
5 Registration for the I-22 Meeting had 115 registered attendees, which is a marked increase from
6 November 2021, where 106 registrations were received for the virtual event and 40 attended in
7 person. This is also a marked increase from the virtual November 2020 meeting, when 30
8 participants attended the Caucus event. At the November 2019 Interim meeting there were 101
9 registered participants for the LGBTQ+ Caucus event.

10
11 In 2022, the AC hosted educational events with high attendance and registration rates and
12 supported the AMA's commitment to embedding health equity. The topics and speakers selected at
13 both the 2022 Annual and Interim meetings were non-profit providers who support marginalized
14 LGBTQ+ communities. At the June meeting, the AIDS Foundation of Chicago (AFC) presented,
15 "Policy, Housing, Health Equity." The session relayed AFC's impact on reducing HIV-related
16 health disparities among Black, Indigenous, and people of color and LGBTQ+ communities
17 through housing, case management, policy and advocacy, and community engagement. For the
18 November Interim education session, Hawaii Health and Harm Reduction Center presented
19 "Knowing Your Place." Attendees of this session gained an increased understanding of western
20 concepts of LGBTQ+ identities; increased knowledge about the culture, history, and role of native
21 Hawaiian Mahu and of the impacts of colonialism on the native Hawaiian Mahu community; and
22 gained increased confidence to provide culturally appropriate health services to Native Hawaiian
23 LGBTQ+ communities.

24
25 *6. Accessibility - Provides opportunity for members of the constituency, who are otherwise under-*
26 *represented, to introduce issues of concern and to be able to participate in the policymaking*
27 *process within the HOD.*
28

29 Since its formation, the AC has been well-organized and engaged in the AMA, has a collegial and
30 supportive relationship with the BOT and is recognized as the forum for physicians and medical
31 students who identify as LGBTQ+ within the AMA. The Committee conducts their meetings and
32 policy discussions in alignment with the HOD as do the sections, which the AC engages with, e.g.,
33 the Integrated Physician Practice Section, MSS, RFS, Minority Affairs Section, Women Physicians
34 Section and more on a regular and consistent basis. The AC has engaged with AMA staff to
35 support the AMA business efforts addressing the needs of physicians and health care of the
36 LGBTQ+ community. While many AC members are delegates or alternates who are familiar with
37 the activities and policymaking processes of the House, it is common that reference committee
38 members, section leaders, various delegations or BOT members may ask the unofficial opinion of
39 the AC on items of business at the HOD, despite the AC having no official standing at the House.
40 However, Committee members have not had a consistently visible identified voice in the HOD.
41 Members of the AC believe all of this has prepared the AC to transition quickly and efficiently to
42 become a highly functioning and effective section and that the time has come to transition to
43 section status with a delegate who can voice the official opinion of an LGBTQ+ Section.

44
45 The LGBTQ+ Section would serve as an entry point to the HOD for most AMA resolutions
46 seeking to support physicians, medical students, and patient health of the LGBTQ+ community.
47 This section can help ensure resolutions brought to the HOD provide opportunities for LGBTQ+
48 members to engage in the AMA policymaking process. Section members will be notified prior to
49 meetings of resolution submission guidelines and deadlines. Members would submit resolutions to
50 the GC for consideration that would then review the submission and assist the author(s) with
51 modifications, if needed. Section members could submit comments or testimony to revise the

1 original resolution. The GC would discuss resolutions and reports that are germane to the section
2 during their meetings. Section membership would vote to support, oppose, or recommend other
3 directives for the resolutions and reports, and would also solicit and discuss timely issues for future
4 policymaking activities. The LGBTQ+ Section could provide a friendly forum for under-
5 represented LGBTQ+ physicians and medical students who have often felt marginalized to
6 introduce issues of concern and to participate in the AMA policymaking process.

7
8 CLRPD ASSESSMENT

9
10 Within the AMA, there are no component groups solely devoted to advocacy and education related
11 to issues that are specific to LGBTQ+ individuals. Given the limited opportunity of the AC to
12 present issues of concern specific to this group, the CLRPD believes it would be appropriate to
13 afford LGBTQ+ physicians and medical students with an opportunity for a focused voice. The
14 proposed LGBTQ+ Section would be dedicated to advocacy on policy issues, provide leadership
15 development and educational opportunities for medical students and physicians, and monitor trends
16 and issues that affect physicians, medical students and patients who identify as LGBTQ+.

17
18 The LGBTQ+ Section would generate projects relevant to physicians and physicians in training
19 who have an interest in LGBTQ+ issues. Improving outreach and creating new opportunities for
20 participation among physicians and trainees may incentivize non-members of this demographic to
21 become AMA members. The structure of the proposed LGBTQ+ Section is conducive to sharing
22 key concerns and identifying meaningful opportunities for physicians, which supports the
23 objectives of this group. In accordance with the AMA bylaws, sections are required to have an
24 elected GC from the voting members of the section and establish a business meeting that would be
25 open to its members. The AC presently has an established online forum, which could create an
26 avenue for a voting body to elect GC members.

27
28 LGBTQ+ physicians and medical students remain a substantial market segment for our AMA and
29 this section would represent over 1,000 AMA members. Since its inception, the AC has taken steps
30 to align its structure with the activities of the AMA. AC leadership has built a solid foundation for
31 the group, which would benefit from a delegate's voice to address LGBTQ+ issues in the HOD.
32 The AMA's policymaking process could be strengthened by ensuring that the perspectives of these
33 physicians, medical students and patients are represented.

34
35 The CLRPD finds that the application meets all six criteria as defined in bylaws.

36
37 RECOMMENDATIONS

38
39 The Council on Long Range Planning and Development recommends that the following
40 recommendations be adopted and the remainder of the report be filed:

- 41
42 1. That our American Medical Association transition the Advisory Committee on Lesbian, Gay,
43 Bisexual, Transgender and Queer (LGBTQ+) Issues to the LGBTQ+ Section as a delineated
44 section. (Directive to Take Action)
45
46 2. That our AMA develop bylaw language to recognize the LGBTQ+ Section. (Directive to Take
47 Action)

Fiscal Note: The Advisory Committee on LGBTQ+ Issues submitted a detailed fiscal note that projected incremental expenditures of \$16,000 per annum for the proposed section.

REPORT OF THE HOUSE OF DELEGATES COMMITTEE
ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report, June 2024

Subject: REPORT OF THE HOUSE OF DELEGATES COMMITTEE ON THE
COMPENSATION OF THE OFFICERS

Presented by: Claudette Dalton, MD, Chair

Referred to: Reference Committee F

1 BACKGROUND

2
3 At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on
4 Trustee Compensation, currently named the Committee on Compensation of the Officers, (the
5 “Committee”). The Officers, defined in the American Medical Association’s (AMA) Constitution
6 and Bylaws, consist of all 21 members of the Board of Trustees, including the President, President-
7 Elect, Immediate Past President, Secretary, and Speaker and Vice Speaker of the HOD, and are
8 collectively referred to in this report as Officers. The composition, appointment, tenure, vacancy
9 process and reporting requirements for the Committee are covered under the AMA Bylaws. Bylaw
10 2.13.4.5 provides:

11
12 The committee shall present an annual report to the House of Delegates recommending the
13 level of total compensation for the Officers for the following year. The recommendations of
14 the report may be adopted, not adopted, or referred back to the committee, and may be
15 amended for clarification only with the concurrence of the committee.

16
17 At A-00, the Committee and the Board jointly adopted the American Compensation Association’s
18 definition of “Total Compensation” which was added to the Glossary of the AMA Constitution and
19 Bylaws. Total Compensation is defined as the complete reward/recognition package awarded to an
20 individual for work performance, including: (a) all forms of money or cash compensation; (b)
21 benefits; (c) perquisites; (d) services; and (e) in-kind payments.

22
23 Since the inception of this Committee, its reports have documented the process the Committee
24 follows to ensure that current or recommended Officer compensation is based on sound, fair, cost-
25 effective compensation practices as derived from research and use of independent external
26 consultants, expert in Board compensation. Reports beginning in December 2002 documented the
27 principles the Committee followed in creating its recommendations for Officer compensation.

28
29 METHODOLOGY

30
31 The Committee recently commissioned Willis Towers Watson (WTW), a major compensation
32 consulting firm with expertise in board compensation to review secretarial expense reimbursement
33 for not-for-profit board members. This review was requested so that we can ensure our AMA
34 board members have access to necessary secretarial services to assist them in representing the
35 AMA. The current \$750 secretarial allowance, in effect for at least the past 10 years, is a calendar

1 year annual maximum reimbursement, and it is included in the respective board member's taxable
2 income per IRS regulations.

3

4 FINDINGS

5

6 WTW reviewed external data on practices related to secretarial expense reimbursement of not-for-
7 profit boards. While the data showed that secretarial expense reimbursement was a minority
8 practice, it was noted that our board members have a significantly larger time commitment than
9 what is required by other not-for-profit boards. Given the work of the board members and the time
10 commitment, the secretarial needs of the board are different than a traditional not-for-profit that
11 supports providing board members with this benefit. The data also showed that when the
12 reimbursement was provided, practices are split between the reimbursement being capped or
13 uncapped with uncapped being slightly more common. Considering that trend, combined with the
14 fact that it has been 10 years since the reimbursement maximum was reviewed, this Committee
15 recommends increasing the maximum reimbursement to \$1,125 effective January 1, 2025.

16

17 RECOMMENDATIONS

18

19 The Committee on Compensation of the Officers recommends the following recommendations be
20 adopted and the remainder of this report be filed:

21

22 1. That the secretarial reimbursement be increased to \$1,125 effective January 1, 2025.

23

24 2. That there be no changes to Officers' compensation for the period beginning July 1, 2024
25 through June 30, 2025.

26

27 3. That the remainder of the report be filed.

28

29 Fiscal Note: \$4,500 if all non-leadership board members were reimbursed to the secretarial
30 reimbursement maximum.

1 APPENDIX

Definition of Governance Honorarium Effective July 1, 2017:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils, or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted up to eleven (11) Internal Representation days.

Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating, achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is \$1,400 per day.

Definition of Telephone Per Diem for External Representation effective July 1, 2017:

Officers, excluding the Board Chair and the President(s) who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for those meetings would require the approval of the Chair of the Board. The amount of the Telephonic Per Diem will be $\frac{1}{2}$ of the full Per Diem which is \$700.

REPORT OF THE SPEAKERS

Speakers' Report 01-A-24

Subject: Report of the Resolution Modernization Task Force Update

Presented by: Lisa Bohman Egbert, MD, Speaker, and John H. Armstrong, MD, Vice Speaker

Referred to: Reference Committee F

1 BACKGROUND

2
3 At the 2023 Annual Meeting, resolution 604 was adopted. Resolution 604 states:

4
5 RESOLVED, That our American Medical Association form a Speakers Task Force on the
6 Resolution Process to review the entire process of handling resolutions for our AMA
7 House of Delegates, including but not limited to definitions of on time resolutions,
8 emergency resolutions, and late resolutions, deadlines for submission of resolutions by all
9 sections, processing and review of reference committee reports, and use of virtual meetings
10 so that all on time resolutions can be submitted by the same deadline (Directive to Take
11 Action); and be it further

12
13 RESOLVED, That our AMA Speakers Task Force on the Resolution Process report back
14 to our AMA House of Delegates by the 2024 Annual Meeting with recommendations
15 regarding the resolution process. (Directive to Take Action)

16
17 Pursuant to this policy, the Resolution Modernization Task Force (RMTF) was appointed by the
18 Speaker with a broad representation in the House. The RMTF includes following nine members:

- 19
20
- 21 ● David Henkes, MD, Chair, Texas
 - 22 ● Sarah Candler, MD, American College of Physicians
 - 23 ● Ronnie Dowling, MD, Arizona Medical Association
 - 24 ● Rachel Ekaireb, MD, Resident/Fellow Section, California
 - 25 ● Michael Hanak, MD, American Academy of Family Physicians
 - 26 ● Susan Hubbell, MD, American Academy of Physical Medicine and Rehabilitation
 - 27 ● Gary Pushkin, MD, The Maryland State Medical Society
 - 28 ● Kaylee Scarnati, Medical Student Section, Ohio
 - 29 ● Rachel Kylo, MD, American Society for Dermatologic Surgery
 - 30 ● Lisa Bohman Egbert, MD, Speaker, Ohio
 - 31 ● John H. Armstrong, MD, Vice Speaker, American College of Surgeons

32 The RMTF held their initial meeting on August 27, 2023, and developed an informational report,
33 Speakers' Report 01-I-23, which delineated issues with the resolutions process. This report was
34 used to guide the RMTF Open Forum which was held at the 2023 Interim Meeting to solicit input
35 from House of Delegates (HOD) and other AMA members attending the meeting. In addition, an
36 RMTF email box was established and announced during the open forum to enable members to
37 continue to submit comments after I-23 adjourned. There was robust discussion during the open

1 forum and many comments were received into the RMTF email box. The discussion topics at the
2 open forum included:

- 3
- 4 ● Unequal time for delegates to evaluate items for HOD business
- 5 ● Avoiding Redundancy with Existing Policy
- 6 ● Reference Committee Process
- 7 ● Reference Committee Hearings
- 8

9 The RMTF met again in early January 2024 to review comments received. As was stated at their
10 initial meeting, the task force, "...seeks to develop efficient processes that allow for all business
11 before the House to be equally reviewed by all delegates with the ultimate goal of the best policy
12 being developed for our AMA," and that remained their guiding principle in developing this report
13 and its recommendations.

14 15 DISCUSSION

16
17 Based on comments heard at the open forum, there was general consensus that the resolution
18 process is outdated, inefficient and requires modernization. The task force notes that the resolution
19 submission process and policies have not been changed since 2012; however, the HOD office has
20 begun significant technical improvements to PolicyFinder and to the procedures for submission and
21 processing of resolutions. Because these technical improvements are ongoing, the RMTF focused
22 on changes that would allow the consideration of HOD business to be more efficient, more
23 inclusive to members, and more equitable so that all items of business receive adequate and
24 equivalent consideration by the House. Therefore, the proposed recommendations address
25 resolution deadlines, the online forum, reference committee reports, and reaffirmation.

26 27 *Resolution Deadlines*

28
29 The resolution submission deadlines as stated in AMA Bylaws are as follows:

30
31 2.11.3.1 Resolutions. To be considered as regular business, each resolution must be
32 introduced by a delegate or organization represented in the House of Delegates and must
33 have been submitted to the AMA not later than 30 days prior to the commencement of the
34 meeting at which it is to be considered, with the following exceptions.

35
36 2.11.3.1.1 Exempted Resolutions. If any member organization's house of delegates
37 or primary policy making body, as defined by the organization, adjourns during the
38 5-week period preceding commencement of an AMA House of Delegates meeting,
39 the organization is allowed 7 days after the close of its meeting to submit
40 resolutions to the AMA. All such resolutions must be received by noon of the day
41 before the commencement of the AMA House of Delegates meeting. The presiding
42 officer of the organization shall certify that the resolution was adopted at its just
43 concluded meeting and that the body directed that the resolution be submitted to
44 the AMA House of Delegates.

45
46 2.11.3.1.2 AMA Sections. Resolutions presented from the business meetings of the
47 AMA Sections may be presented for consideration by the House of Delegates no
48 later than the recess of the House of Delegates opening session to be accepted as
49 regular business. Resolutions presented after the recess of the opening session of
50 the House of Delegates will be accepted in accordance with Bylaw 2.11.3.1.4.

1 2.11.3.1.3 Late Resolutions. Late resolutions may be presented by a delegate prior
2 to the recess of the opening session of the House of Delegates, and will be
3 accepted as business of the House of Delegates only upon two-thirds vote of
4 delegates present and voting.

5
6 2.11.3.1.4 Emergency Resolutions. Resolutions of an emergency nature may be
7 presented by a delegate any time after the opening session of the House of
8 Delegates is recessed. Emergency resolutions will be accepted as business only
9 upon a three-fourths vote of delegates present and voting, and if accepted shall be
10 presented to the House of Delegates without consideration by a reference
11 committee. A simple majority vote of the delegates present and voting shall be
12 required for adoption.

13
14 Currently, it is difficult for staff, delegations and members to review and fully vet all items of
15 business before the House due to the multiple exceptions to the "on-time" deadline as defined
16 above. These multiple exceptions mean that business is being processed in an ongoing fashion and
17 results in a fairly significant amount of "on-time" business being submitted after the 30-day
18 deadline through the closing of the HOD Opening Session. Although exempted resolutions are
19 posted on the website as soon as they are processed, they are not able to be included in the HOD
20 Delegate Handbook or the Online Member Forums (forums) and are often not seen by delegations
21 until the release of the "meeting tote" prior to the HOD Second Opening Session. These items of
22 business are not available to undergo the same consideration as those submitted before the 30-day
23 deadline. The inability to adequately review these late arriving "on-time" resolutions has been
24 identified as a major frustration by delegations. The short timeframe for review also limits
25 opportunities for collaboration and consensus building among delegations. Many suggestions to
26 rectify this problem were offered at the open forum and by email. The majority favored having one
27 set "on-time" deadline. Some delegates voiced concern for the Sections who meet and pass
28 resolutions just prior to the meeting. However, representatives from the MSS and RFS stated that
29 they have a very robust process for vetting their resolutions; by default, resolutions are deferred to
30 the following HOD meeting, and only those of an urgent nature are immediately forwarded. Given
31 that late resolutions are specifically reviewed for their timeliness and urgency, these resolutions
32 would be well positioned to be recommended for consideration if submitted as such.

33
34 Therefore, the RMTF recommends that the "on-time" deadline for resolutions be set at 45 days
35 prior to the commencement of the meeting at which it is to be considered. This recommendation
36 discontinues the exemptions for late society meetings and AMA Sections. Resolutions will be
37 considered "late" when received after the 45-day deadline and prior to the beginning of the HOD
38 Opening Session. Late resolutions will continue to be under the purview of the Rules and
39 Credentials Committee and the criteria for which late resolutions would be recommended for
40 consideration will continue to include the resolution's timeliness and the urgency of the topic.
41 Recommendations for consideration of late resolutions will continue to be included as a consent
42 calendar on the Rules and Credentials Report presented at the Second Opening Session and require
43 a two-thirds vote for consideration. The emergency resolution process would remain unchanged;
44 however, any resolution submitted after the HOD Opening Session begins will be treated as an
45 emergency resolution.

46
47 In summary, resolutions will fall into one of three categories: on time (45 days prior to the
48 meeting), late (after the on-time deadline and before the Opening Session begins), or emergency
49 (after the Opening Session begins). The Sections and organizations that hold their policy-making
50 meetings after the on-time deadline would be encouraged to review their resolutions for timeliness
51 and urgency and hold those not meeting this criteria for the next coming AMA meeting. Those

1 resolutions deemed timely and urgent could be submitted as late resolutions which will require a
2 two-thirds vote for consideration. These adjusted deadlines would allow staff to more easily
3 process items of business, prepare and post the HOD Delegate Handbook in its entirety, and post
4 the entire handbook on the Online Member Forums. In turn, this should allow delegations more
5 time to consider items of business without the scramble and frustration that the current process
6 produces. Overall, these changes will level the playing field so that all resolutions will be able to be
7 reviewed equally.

8
9 *Reference Committees Hearings and Reports*

10
11 The Online Member Forums were identified as an area ripe for improvement. Many commenters
12 noted experience from their own organizations in which a more robust virtual preliminary reference
13 committee process led to a more efficient in-person process and ultimately to policy that has been
14 more thoughtfully crafted and more thoroughly vetted. Additionally, Res. 606-I-21, established
15 policy D-600.956 which called for a two-year trial requiring that reference committees, prior to the
16 in-person reference committee hearing, produce a preliminary reference committee document
17 based on the written online testimony. An evaluation to determine if this procedure should be
18 continued is a directive of this policy. The RMTF was asked to conduct this evaluation as part of
19 their overall review to modernize the HOD.

20
21 Assessing the success of the trial of the Online Member Forums is difficult. As noted above, the
22 vast majority of the comments submitted to the RMTF suggested that these online forums should
23 be utilized in a much more robust and productive way to move the business of the HOD forward.
24 Polling of HOD delegates over a course of three meetings (A-22, I-22 and A-23), found that
25 consistently around 70% of delegates had viewed at least a few items on the forums. The
26 preliminary documents were found to be at least "somewhat helpful" by around 65% of those
27 responding. This would suggest that, although delegates find the forums to be a useful tool to
28 review items of business, they are currently being underutilized.

29
30 In their current state, the comments received on the forums are viewed by many to not carry the
31 same importance as in person testimony which is multifactorial in origin. A significant factor, as
32 discussed above, is that many "on-time" resolutions are not even posted on the forums. In addition,
33 the current process for developing a preliminary document, as defined in policy D-600.956, gives
34 very little insight into the direction of the reference committee's actions. By explicitly treating this
35 as an official reference committee hearing with a report, the RMTF believes this will drive greater
36 utilization of this valuable tool by elevating the importance of contributing to the online discussion.
37 This change would thus give equal weight to the testimony gathered online. In addition, there are
38 multiple advantages to online testimony which include:

- 39
40
- 41 ● The ability to submit amendments and/or supporting documentation with unlimited text
42 which allows for consideration and comment by other delegations.
 - 43 ● More time and opportunity for delegates and delegations to collaborate to improve
44 proposed resolutions.
 - 45 ● The opportunity for the entire AMA membership to submit comments, offering a wider
46 voice in the development of AMA policy.
 - 47 ● Increased inclusivity by allowing those unable or who prefer not to travel to meetings the
48 opportunity to participate.
 - 49 ● The opportunity for small delegations to provide input on all items of business by avoiding
the inherent difficulty of presenting at concurrent in-person reference committee hearings.

1 Therefore, the RMTF recommends that the Online Member Forums be renamed the Online
2 Reference Committee Hearings. These online ref coms will open 10 days following the 45-day
3 resolution submission deadline and be open for 21 days. As noted above, this 10-day window will
4 allow adequate time for staff processing of resolutions, the development of the HOD Handbook,
5 the review of the Resolution Committee for Interim, and the posting of resolutions on the Online
6 Reference Committees which currently is a lengthy process. This also extends the online ref coms
7 by one week beyond the current two-week window. For these reasons, the RMTF chose 45 days for
8 the "on-time" deadline. All items of business received by the resolution deadline will be included
9 in the Online Reference Committee Hearings.

10
11 The RMTF recommends that reference committees convene virtually after the online ref com 21-
12 day window closes, to develop a Preliminary Reference Committee Report. The task force further
13 recommends that the bylaws be amended so that the term for all committees of the House shall
14 commence upon their formation and shall continue throughout the meeting for which they were
15 appointed unless otherwise directed by the HOD, such as Reference Committee F.

16
17 The Preliminary Reference Committee Report will follow the same format as the reference
18 committee reports which are produced following the in-person hearings with the exception that
19 they shall not be consent calendars. The reports would include recommended actions by the
20 reference committee with items grouped by action, a summary of testimony to date, and a rationale
21 for the action recommended. The reports would be posted to the HOD website at least four days
22 prior to the opening of the HOD meeting for which they were submitted.

23
24 The in-person reference committee hearings will continue to hear testimony on each item before
25 the reference committee with the exception that the order of business would follow the order listed
26 on the Preliminary Reference Committee Report. Therefore, those items recommended for
27 adoption would go first followed by those recommended for adoption as amended and so forth,
28 with items for reaffirmation in lieu of being heard last. Although the preliminary reports will offer
29 recommendations for action for each item, this does not preclude discussion of the original item
30 and/or alternate actions or the submission of supporting documentation for the reference committee
31 to consider. Following the in-person hearing, the reference committees will convene to review the
32 in-person testimony and make necessary adjustments to their reports taking both online ref com
33 and in-person testimony into consideration. The final reference committee report to be considered
34 at the HOD will then be posted in the usual fashion.

35
36 In prior discussions of preliminary reports, concerns included that recommendations contained in
37 the report would be based on insufficient input or include recommendations that bias the outcome
38 of an item of business. However, those with experience with such a preliminary report with
39 recommendations noted that the inclusion of recommendations actually led to more robust online
40 discussions and thus more accurate initial recommendations. Additionally, as previously stated, the
41 recommendations included in the preliminary report are based on initial testimony only and would
42 be updated to reflect the totality of testimony from both the online and in-person testimony and that
43 stating a preliminary action does not preclude discussion of the original item or alternative actions
44 at the in-person hearing. Reference committee members should be trusted to incorporate in-person
45 testimony and change recommendations as warranted.

46
47 The task force believes this iterative process affords delegates and delegations the time to
48 collaborate on language and to fully review topics that are more complicated in nature and provides
49 the opportunity to perfect reference committee recommendations for their final report. Ultimately,
50 reference committee reports are not definitive until the House acts, and this process provides ample

1 opportunity to discuss each item of business to achieve the goal of developing the best possible
2 policy of our AMA.

3
4 *Reaffirmation*

5
6 The reaffirmation process was universally identified as a significant problem to be addressed and
7 was generally described as “broken.” This was highlighted at I-23 when all of the items placed on
8 the consent calendar were subsequently removed from it. In their discussions, the task force
9 identified some of the sources of items recommended for reaffirmation which include:

- 10
11 ● Policy exists but the authors are either not aware of the policy or current AMA activity to
12 achieve the goals of the existing policy.
13 ● Some delegations have a directive to their delegation from their parent organization to
14 submit all resolutions earmarked to go to the AMA for consideration, even when they are
15 aware that there is current existing policy.
16 ● There is current AMA policy on the subject, but authors are not satisfied with AMA
17 activity as a result of the existing policy.

18
19 The task force noted that many members consider reaffirmation a “defeat” of their resolution. On
20 the contrary the task force believes that reaffirmation should be seen as a “win” as it resets the
21 sunset clock and brings the issue back to the attention of our leadership and management team.

22
23 The RMTF spent significant time discussing the current process and potential improvements for it.
24 Ultimately, the task force decided that the current process of having resolutions placed on a
25 reaffirmation calendar should be discontinued and that the recommended firm on-time deadline
26 along with the implementation of the online ref coms with subsequent preliminary reports, would
27 be the best method to handle the identification of items for reaffirmation. As envisioned, the
28 process would be as follows: AMA content experts would continue to review submitted
29 resolutions and identify relevant current policy which is included as background information.
30 These policies would also be posted on the online reference committee hearing and, when
31 appropriate, a notation would be added that an identified policy may be reaffirmed in lieu of the
32 resolution. Online comments regarding these so identified items could then proceed regarding the
33 merits of reaffirmation along with the merits of the item itself. The reference committee will then
34 have the option to recommend “reaffirmation in lieu of” for these or any other item it deems
35 appropriate on its preliminary reference committee report. Further discussion of the handling of
36 these items will then be entertained at the in-person hearing.

37
38 **CONCLUSION:**

39
40 The RMTF recommends the establishment of a firm deadline of 45 days prior to the start of a
41 meeting for on-time resolutions with all resolutions received after this deadline and prior to the
42 start of the meeting considered late. This strict deadline will allow for all on-time resolutions to be
43 included in the Online Reference Committee Hearings (renamed from the Online Member Forums)
44 and for these online ref coms to remain open for 21 days rather than the current 14. The online ref
45 coms will produce Preliminary Reference Committee Reports which will include preliminary
46 recommendations. Recommendations regarding reaffirmation in lieu of a resolution will be
47 included in the Preliminary Reference Committee Report rather than a reaffirmation calendar so
48 that comments regarding reaffirmation can be made in the online ref coms and discussed further at
49 the in-person hearings. Delegations and Sections that meet after the 45 day on-time deadline will
50 have the opportunity to present late resolutions which they deem timely and urgent to the Rules and
51 Credentials Committee which will in turn recommend for or against consideration based on these

1 criteria. These changes will allow for equal consideration of all on-time resolutions as well as equal
2 application of the timeliness and urgency considerations for all late resolutions. It will eliminate the
3 current "broken" reaffirmation process and allow for open discussion of the merits of reaffirmation
4 on any given item.

5
6 The objective of the task force was to increase the efficiency of the resolution process but also
7 paramount was to maintain member input and the voice of the minority. The task force tried to
8 individually look at each of the issues identified at the town hall meeting and the email box but
9 found that the issues and solutions were integrated. Your task force believes that all of the proposed
10 recommendations work together to provide the fairest, most effective, and efficient manner to
11 develop the best policy for our AMA. The RMTF expresses the need for caution in that changes in
12 one recommendation may reduce the effectiveness of others and urges the House to accept the
13 proposed recommendations in aggregate to achieve these goals.

14
15 RECOMMENDATIONS:

16
17 The Resolution Modification Task Force recommends that the following be adopted to be
18 implemented for Interim 2024 and the remainder of the report be filed:

- 19
20 1. The bylaws be amended so that the resolution submission deadline be 45 days prior to the
21 opening session of the House of Delegates. (Directive to take Action)
22
- 23 2. The bylaws be amended so that the definition of a late resolution shall be all resolutions
24 submitted after the resolution submission deadline and prior to the beginning of the
25 Opening Session of the House of Delegates. (Directive to take Action)
26
- 27 3. The bylaws be amended so that the definition of an emergency resolution shall be all
28 resolutions submitted after the beginning of the Opening Session of the House of
29 Delegates. (Directive to take Action)
30
- 31 4. The bylaws be amended so that the term of committees of the House of Delegates shall
32 commence upon their formation and shall conclude at the end of the meeting for which
33 they were appointed, unless otherwise directed by the House of Delegates. (Directive to
34 take Action)
35
- 36 5. That our AMA will convene Online Reference Committee Hearings prior to each House of
37 Delegates meeting. These hearings shall open 10 days following the resolution submission
38 deadline and remain open for 21 days. This shall be accomplished in lieu of Policy G-
39 600.045. (New HOD Policy)
40
- 41 6. Prior to House of Delegates meetings, reference committees will convene after the close of
42 the Online Reference Committee Hearings to develop a Preliminary Reference Committee
43 Report. These reports shall include preliminary recommendations and will serve as the
44 agenda for the in-person reference committee hearing. This shall be accomplished in lieu of
45 Policy G-600.060(8). (New HOD Policy)
46
- 47 7. That Policy D-600.956 be rescinded. (Rescind HOD Policy)

1 **Relevant AMA Policy:**

2
3 **Increasing the Effectiveness of Online Reference Committee Testimony Policy D-600.956**

- 4 1. Our AMA will conduct a trial of two-years during which all reference committees, prior to the
5 in-person reference committee hearing, produce a preliminary reference committee document
6 based on the written online testimony.
7 2. The preliminary reference committee document will be used to inform the discussion at the in-
8 person reference committee.
9 3. There be an evaluation to determine if this procedure should continue.
10 4. The period for online testimony will be no longer than 14 days.
11 5. The trial established by Policy D-600.956 be continued through Annual 2024.
12

13 **Online Member Forums in the House of Delegates G-600.045**

- 14 1. Online member forums should be incorporated into every House of Delegates policymaking
15 meeting, using the following parameters: a. Each reference committee should participate in the
16 online member forum process; b. Each online member forum should cover as many items of
17 business as possible, including, at minimum, those items that appear in the initial compilation of
18 the Delegate Handbook; c. Comments submitted to an online member forum should be used to
19 prepare a summary report that reflects the comments received up to that point; d. Full, free and
20 complete testimony should be allowed in the onsite hearings; and e. The Speakers should
21 experiment with alternative procedures to enhance and improve the overall online member forum
22 process.
23 2. Our American Medical Association will form a Speakers Task Force on the Resolution Process
24 to review the entire process of handling resolutions for our AMA House of Delegates, including
25 but not limited to definitions of on time resolutions, emergency resolutions, and late resolutions,
26 deadlines for submission of resolutions by all sections, processing and review of reference
27 committee reports, and use of virtual meetings so that all on time resolutions can be submitted by
28 the same deadline.
29 3. Our AMA Speakers Task Force on the Resolution Process will report back to our AMA House
30 of Delegates by the 2024 Annual Meeting with recommendations regarding the resolution process.
31

32 **Introducing Business to the AMA House G-600.060**

33 AMA policy on introducing business to our AMA House includes the following:

- 34 1. Delegates submitting resolutions have a responsibility to review the Resolution checklist and
35 verify that the resolution is in compliance. The Resolution checklist shall be distributed to all
36 delegates and organizations in the HOD prior to each meeting, as well as be posted on the HOD
37 website.
38 2. An Information Statement can be used to bring an issue to the awareness of the HOD or the
39 public, draw attention to existing policy for purposes of emphasis, or simply make a statement.
40 Such items will be included in the section of the HOD Handbook for informational items and
41 include appropriate attribution but will not go through the reference committee process, be voted
42 on in the HOD or be incorporated into the Proceedings. If an information statement is extracted,
43 however, it will be managed by the Speaker in an appropriate manner, which may include a simple
44 editorial correction up to and including withdrawal of the information statement.
45 3. Required information on the budget will be provided to the HOD at a time and format more
46 relevant to the AMA budget process.
47 4. At the time the resolution is submitted, delegates introducing an item of business for
48 consideration of the House of Delegates must declare any commercial or financial conflict of
49 interest they have as individuals and any such conflict of interest must be noted on the resolution at
50 the time of its distribution.

- 1 5. The submission of resolutions calling for similar action to what is already existing AMA policy
2 is discouraged. Organizations represented in the House of Delegates are responsible to search for
3 alternative ways to obtain AMA action on established AMA policy, especially by communicating
4 with the Executive Vice President. The EVP will submit a report to the House detailing the items
5 of business received from organizations represented in the House which he or she considers
6 significant or when requested to do so by the organization, and the actions taken in response to
7 such contacts.
- 8 6. Our AMA will continue to safeguard the democratic process in our AMA House of Delegates
9 and ensure that individual delegates are not barred from submitting a resolution directly to the
10 House of Delegates.
- 11 7. Our AMA encourages organizations and Sections of the House of Delegates to exercise restraint
12 in submitting items on the day preceding the opening of the House.
- 13 8. Resolutions will be placed on the Reaffirmation Consent Calendar when they are identical or
14 substantially identical to existing AMA policy. For resolutions placed on the Reaffirmation
15 Consent Calendar, the pertinent existing policy will be clearly identified by reference to the Policy
16 Database identification number. When practical, the Reaffirmation Consent Calendar should also
17 include a listing of the actions that have been taken on the current AMA policies that are equivalent
18 to the resolutions listed. For resolutions on the Reaffirmation Consent Calendar which are not
19 extracted, the existing, pertinent AMA policy will be deemed to be reaffirmed in lieu of the
20 submitted resolution which resets the sunset clock for ten years.
- 21 9. Updates on referred resolutions are included in the chart entitled "Implementation of
22 Resolutions," which is made available to the House.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(A-24)

Introduced by: Medical Student Section

Subject: Annual Holocaust Remembrance Event

Referred to: Reference Committee F

1 Whereas, physicians played leading roles in the Holocaust and were a driving force behind
2 some of the worst atrocities perpetrated on Jewish and other marginalized communities,
3 demonstrating the negative impact physicians can have during political turmoil^{1,2,3}; and
4

5 Whereas, heinous medical experimentation took place during the Holocaust despite Germany's
6 pre-existing Guidelines for Human Experimentation, which at the time was one of the only codes
7 for ethical human experimentation in the world and which called for unambiguous informed
8 consent, demonstrating the potential for codes of ethics to be ignored or subverted if they are
9 not protected and supported⁴; and
10

11 Whereas, even with a code of ethics, Nazi physicians believed they were operating under
12 scientifically and ethically sound beliefs due to their prioritization of the national effort and
13 government agenda^{2,3}; and
14

15 Whereas, medical involvement in the Holocaust has profoundly influenced contemporary
16 medical ethics, and current thinking on medical ethical issues can be understood better by
17 learning about and reflecting on the legacy of medical involvement in the Holocaust^{2,3}; and
18

19 Whereas, in addition to the well-known Nazi medical experiments, German physicians created
20 and led Nazi programs such as forced sterilizations, child "euthanasia," and the T4 program to
21 murder institutionalized adults, which are critical aspects of medical history (and some of which
22 were directly influenced by American medical and racial policies), but these are much less
23 widely studied by students in medical school^{3,4}; and
24

25 Whereas, learning about and reflecting on the implications of physician involvement in the
26 Holocaust can not only help students understand contemporary medical ethics, but can also
27 help protect against future human rights abuses by physicians^{2,3,5}; and
28

29 Whereas, per the Liaison Committee for Medical Education (LCME) annual survey, only 16% of
30 US and Canadian medical schools devote any required curricular time to learning about the
31 roles of physicians in the Holocaust and contemporary implications^{5,6}; and
32

33 Whereas, abundant curricular resources on Holocaust education are available, relieving the
34 burden of medical schools having to create novel educational materials to support medical
35 student learning and reflection on this history and its contemporary relevance^{5,7}; and
36

37 Whereas, the AMA Code of Medical Ethics only mentions physicians' role in the Holocaust once
38 as an example of information obtained from unethical experiments (E-7.2.2); and

1 Whereas, the legacy of medical involvement in the Holocaust is increasingly recognized as
2 critical to understanding contemporary concerns around health equity and justice and the roles
3 of health professionals in either perpetuating or alleviating injustice^{5,8}; and
4

5 Whereas, experts in medical ethics education and professional identity formation are
6 increasingly calling for inclusion of these issues as part of the medical curriculum, including in
7 the *Lancet*, the *AMA Journal of Ethics*, and in a presentation held by the AAMC^{3,5,9}; and
8

9 Whereas, a single event on an annual basis, held on an internationally-recognized day of
10 remembrance, could present a valuable opportunity for student and faculty learning and
11 reflection about the legacy of health professional involvement in the Holocaust¹⁰, therefore be it
12

13 **RESOLVED**, that our American Medical Association host an annual event in support of
14 International Holocaust Remembrance Day (January 27) to provide education to medical
15 trainees about the role of physicians in the Holocaust. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 4/19/2024

REFERENCES

1. Anderlini D. Cultivating awareness of the holocaust in medicine. *The Lancet*. 2020;395(10221):334-335. doi:10.1016/s0140-6736(19)32609-1
2. Baker R. How should students learn about contemporary implications of health professionals' roles in the Holocaust? *AMA Journal of Ethics*. 2021;23(1).doi:10.1001/amajethics.2021.31
3. Chelouche T, Wynia MK, Why does medical participation in the Holocaust still matter? *AMA Journal of Ethics*. 2021;23(1). doi:10.1001/amajethics.2021.3
4. Chelouche T. Teaching hard truths about medicine and the Holocaust. *AMA Journal of Ethics*. 2021;23(1). doi:10.1001/amajethics.2021.59
5. Silvers WS, Wynia MK, Levine MA, Himer M. Teaching health professions students about the Holocaust. *AMA Journal of Ethics*. 2021;23(1). doi:10.1001/amajethics.2021.26
6. Wynia MK, Silvers WS, Lazarus JA. How do U.S and Canadian Medical Schools Teach About the Role of Physicians in the Holocaust? *Academic Medicine*. 2015;90(6):699-700. doi:10.1097/acm.0000000000000724
7. Reis SP, Wald HS, Weindling P. The Holocaust, medicine and becoming a physician: The crucial role of Education. *Israel Journal of Health Policy Research*. 2019;8(1). doi:10.1186/s13584-019-0327-3
8. Roelcke V, Hildebrandt S, Reis S. Announcing The Lancet Commission on medicine and the holocaust: Historical evidence, implications for today, teaching for Tomorrow. *The Lancet*. 2021;397(10277):862-864. doi:10.1016/s0140-6736(21)00157-4
9. Horton R. Offline: Holocaust education—A medical imperative. *The Lancet*. 2020;396(10263):1619. doi:10.1016/s0140-6736(20)32468-5
10. Wynia MK, Silvers WS. A call to commemorate International Holocaust Remembrance Day, January 27, in all Health Science Schools. *AMA Journal of Ethics*. 2021;23(1). doi:10.1001/amajethics.2021.75

RELEVANT AMA Policy

H-295.961 Medicolegal, Political, Ethical and Economic Medical School Course

1. The AMA urge every medical school and residency program to teach the legal, political, ethical and economic issues which will affect physicians.
2. The AMA will work with state and county medical societies to identify and provide speakers, information sources, etc., to assist with the courses.
3. An assessment of professional and ethical behavior, such as exemplified in the AMA Principles of Medical Ethics, should be included in internal evaluations during medical school and residency training, and also in evaluations utilized for licensure and certification.
4. The Speaker of the HOD shall determine the most appropriate way for assembled physicians at the opening sessions of the AMA House of Delegates Annual and Interim Meetings to renew their commitment to the standards of conduct which define the essentials of honorable behavior for the physician, by reaffirming or reciting the seven Principles of Medical Ethics which constitute current AMA policy.
5. There should be attention to subject matter related to ethics and to the doctor-patient relationship at all levels of medical education: undergraduate, graduate, and continuing. Role modeling should be a key

element in helping medical students and resident physicians to develop and maintain professionalism and high ethical standards.

6. There should be exploration of the feasibility of improving an assessment of ethical qualities in the admissions process to medical school.

7. Our AMA pledges support to the concept that professional attitudes, values, and behaviors should form an integral part of medical education across the continuum of undergraduate, graduate, and continuing medical education. [Res. 189, A-90; Modified by CME Rep. 1, I-95; Appended: Res. 318, I-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed in lieu of Res. 902, I-13; Reaffirmation I-15]

E-7.2.2 Release of Data from Unethical Experiments

Research that violates the fundamental principle of respect for persons and basic standards of human dignity, such as Nazi experiments during World War II or from the US Public Health Service Tuskegee Syphilis Study, is unethical and of questionable scientific value. Data obtained from such cruel and inhumane experiments should virtually never be published. If data from unethical experiments can be replaced by data from ethically sound research and achieve the same ends, then such must be done. In the rare instances when ethically tainted data have been validated by rigorous scientific analysis, are the only data of such nature available, and human lives would certainly be lost without the knowledge obtained from the data, it may be permissible to use or publish findings from unethical experiments. Physicians who engage with data from unethical experiments as authors, peer reviewers, or editors of medical publications should:

(a) Disclose that the data derive from studies that do not meet contemporary standards for the ethical conduct of research.

(b) Clearly describe and acknowledge the unethical nature of the experiment(s) from which the data are derived.

(c) Provide ethically compelling reasons for which the data are being released or cited, such as the need to save human lives when no other relevant data are available.

(d) Pay respect to those who were the victims of the unethical experimentation. [Issued: 2016]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(A-24)

Introduced by: Young Physicians Section

Subject: Ranked Choice Voting

Referred to: Reference Committee F

1 Whereas, American Medical Association elections require run-off elections to elect candidates
2 by majority; and
3

4 Whereas, ranked-choice voting elections can be run more efficiently without the need for runoff
5 elections, while still ensuring the outcome preferred by a majority of voters; therefore be it
6

7 RESOLVED, that our American Medical Association study ranked-choice voting for all elections
8 within the House of Delegates. (Directive to Take Action)
9

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

Received: 4/8/2024

RELEVANT AMA POLICY

Elections. B-3.4

3.4.1 Time of Election. Officers of the AMA, except the Secretary, the medical student trustee, and the public trustee, shall be elected by the House of Delegates at the Annual Meeting, except as provided in Bylaws 3.6 and 3.7. The public trustee may be elected at any meeting of the House of Delegates at which the Selection Committee for the Public Trustee submits a nomination for approval by the House of Delegates. On recommendation of the Committee on Rules and Credentials, the House of Delegates shall set the day and hour of such election. The Medical Student Section shall elect the medical student trustee in accordance with Bylaw 3.5.6.

3.4.2 Method of Election. Where there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.

3.4.2.1 At-Large Trustees.

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

3.4.2.1.2 Runoff Ballot. A runoff election shall be held to fill any vacancy not filled because of a tie vote.

3.4.2.1.3 Subsequent Ballots. If all vacancies for Trustees are not filled on the first ballot and 3 or more Trustees are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and

eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. When 2 or fewer Trustees are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are Trustees yet to be elected, and must cast each vote for different nominees. This procedure shall be repeated until all vacancies have been filled.

3.4.2.2 All Other Officers, except the Medical Student Trustee and the Public Trustee. All other officers, except the medical student trustee and the public trustee, shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

3.4.2.3 Medical Student Trustee. The medical student trustee is elected by the Medical Student Section in accordance with Bylaw 3.5.6.

3.4.2.4 Public Trustee. The public trustee shall be elected separately. The nomination for the public trustee shall be submitted to the House of Delegates by the Selection Committee for the Public Trustee. Nominations from the floor shall not be accepted. A majority vote of delegates present and voting shall be necessary to elect.

Election - Council on Constitution and Bylaws, Council on Medical Education, Council on Medical Service, and Council on Science and Public Health. B-6.8

6.8.1 Nomination and Election. Members of these Councils, except the medical student member, shall be elected by the House of Delegates. Nominations shall be made by the Board of Trustees and may also be made from the floor by a member of the House of Delegates.

6.8.1.1 Separate Election. The resident/fellow physician member of these Councils shall be elected separately. A majority of the legal votes cast shall be necessary to elect. In case a nominee fails to receive a majority of the legal votes cast, the nominees on subsequent ballots shall be determined by retaining the 2 nominees who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest votes on the preceding ballot, except where there is a tie. This procedure shall be continued until one of the nominees receives a majority of the legal votes cast.

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

6.8.1.3 Run-Off Ballot. A run-off election shall be held to fill any vacancy that cannot be filled because of a tie vote.

6.8.1.4 Subsequent Ballots. If all vacancies are not filled on the first ballot and 3 or more members of the Council are still to be elected, the number of nominees on subsequent ballots shall be reduced to no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating the nominee(s) who received the fewest number of votes on the preceding ballot, except where there is a tie. When 2 or fewer members of the Council are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies, with the nominees determined as indicated in the preceding sentence. In any subsequent ballot the electors shall cast as many votes as there are members of the Council yet to be elected, and must cast each vote for a

different nominee. This procedure shall be repeated until all vacancies have been filled.

6.8.2 Medical Student Member. Medical student members of these Councils shall be appointed by the Governing Council of the Medical Student Section with the concurrence of the Board of Trustees.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(A-24)

Introduced by: Resident and Fellow Section, Medical Student Section, Minority Affairs
Section

Subject: End Attacks on Health and Human Rights in Israel and Palestine

Referred to: Reference Committee F

- 1 Whereas, the attack on October 7th resulted in the death of over 1,100 Israelis, including
2 around 700 civilians, and the displacement of over 200,000 individuals^{1,2}; and
3
4 Whereas, the resultant escalating crisis in the Gaza Strip, home to over 2.3 million individuals
5 with half being children, has led to the loss of civilian life surpassing that of any conflict in this
6 region in the past 17 years and the displacement of 1.7 million civilians to already severely
7 overcrowded refugee camps^{1,3,4}; and
8
9 Whereas, attacks have resulted in the death of over 33,000 civilians across Gaza, the West
10 Bank, and Jerusalem, including over 13,000 children, with a further 75,000 wounded and at
11 least 10,000 people missing and believed to be buried under rubble, with an estimated 17,000
12 children unaccompanied or separated; further, the conflict has spilled over into neighboring
13 nations resulting in deaths of over 300 people in Lebanon and over 200 people in Syria^{1,4-12}; and
14
15 Whereas, the Geneva Conventions protect journalists, refugees, children, pregnant women and
16 mothers with infants, civilians, patients, physicians, and other medical personnel during times of
17 conflict¹³; and
18
19 Whereas, United Nations (UN) officials proclaim there is “no safe place in Gaza,” as shelters,
20 refugee camps, hospitals, ambulances, homes, bakeries, places of worship, toy stores, and UN-
21 funded schools, clinics and shelters have faced airstrikes, shootings, and have been flooded
22 with poisonous white phosphorous gasses¹⁴⁻¹⁶; and
23
24 Whereas, Attacks on over 99 health facilities, including 30 of the 36 hospitals in the Gaza Strip,
25 have resulted in the deaths of over 685 healthcare personnel, injured another 900, and
26 damaged 54 ambulances, 99 health facilities, including 30 hospitals^{1,5,17}; and
27
28 Whereas, physicians and other medical personnel have been forced to perform surgeries in
29 corridors and waiting rooms, conserve supplies due to a lack of basic medical supplies,
30 anesthetics, or painkillers, and utilize vinegar in place of antibiotics on open wounds¹⁸⁻²¹; and
31
32 Whereas, restrictions on the passage of fuel supplies and clean water have led to shutdowns of
33 medical equipment across hospitals, leaving critically ill patients at especially high risk and
34 increasing infectious disease outbreaks^{13,22}; and
35
36 Whereas, the destruction of homes and vital infrastructure, targeting of hospitals and refugee
37 camps, and depletion of medical resources in the setting of a complete blockade have led to a
38 critical humanitarian crisis and collapse of the Gazan healthcare system, leading the World
39 Health Organization (WHO) to proclaim on April 5 that “the systematic dismantling of healthcare
40 must end” as access to healthcare “has now become totally inadequate” in Gaza^{17,23}; and

1 Whereas, in April 2024, famine was confirmed in parts of Gaza, and the WHO Integrated Food
2 Security Phase Classification partnership has raised the alarm that “over a million people are
3 expected to face catastrophic hunger” unless the situation is addressed^{24,25}; and
4

5 Whereas, between 12.4–16.5% of children aged 5 years or younger in Gaza are already
6 suffering from severe malnutrition^{24,26}; and
7

8 Whereas, if a ceasefire is not achieved, the war in Gaza is projected to cause a further 58,260
9 to 66,720 excess deaths by August 2024²⁷; and
10

11 Whereas, the UN General Assembly, in a 153-10 vote, called for an immediate ceasefire in
12 December 2023, while the UN Security Council called for an immediate ceasefire for the month
13 of Ramadan, leading to a lasting ceasefire in March 2024^{28,29}; and
14

15 Whereas, a ceasefire is defined as a long-term suspension of fighting in the entire geographic
16 area that is agreed upon by all involved parties and would allow for the continuous flow of
17 humanitarian aid^{30,31}; and
18

19 Whereas, numerous leading healthcare advocacy and humanitarian organizations, including
20 Doctors Without Borders, Amnesty International, Human Rights Watch, the World Health
21 Organization, the UN Security Council, and the UN High Commissioner on Human Rights, have
22 called for an immediate ceasefire, safe transit of aid and Gaza's civilian population, and
23 protection of civilian infrastructure^{2,8,28,32-38}; and
24

25 Whereas, many organizations are diligently recruiting volunteers to aid the civilian population in
26 Gaza but they are often unable to enter due to the increasingly unsafe conditions³⁸⁻⁴³; and
27

28 Whereas, healthcare professionals and organizations are responsible for upholding medical
29 neutrality and condemning violence against healthcare infrastructure, hospitals, first responders,
30 patients, children, refugees, and the blockade of essential health supplies, water, and fuel,
31 including in times of war and siege^{2,14,30,44-47}; and
32

33 Whereas, our AMA President issued a statement condemning the October 7th attack on Israel,
34 and the AMA has previously released statements vocalizing solidarity with Ukraine, passed a
35 policy calling for continuous support of organizations providing humanitarian missions to
36 Ukrainian refugees, and contributed \$100,000 in humanitarian aid through the AMA Foundation
37 to Ukraine^{48,49}; and
38

39 Whereas, on November 9, 2023, our AMA Board of Trustees released a statement on the
40 humanitarian crisis in Israel and Palestine but did not address the pivotal and life-saving issue of
41 ceasefire⁵⁰; therefore be it
42

43 RESOLVED, that our American Medical Association supports a ceasefire in Israel and Palestine
44 in order to protect civilian lives and healthcare personnel. (New HOD Policy)

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

Received: 4/24/2024

REFERENCES:

1. Frankel J. Half a year into the war in Gaza, here's a look at the conflict by the numbers. Associated Press. April 6, 2024. Accessed April 22, 2024. <https://apnews.com/article/israel-hamas-gaza-war-statistics-95a6407fac94e9d589be234708cd5005>
2. These numbers show the staggering toll of the Israel-Hamas war. November 5, 2023. Accessed November 6, 2023. <https://apnews.com/article/israel-hamas-war-death-toll-numbers-injured-5c9dc40bec95a8408c83f3c2fb759da0>.
3. Occupied Palestinian Territory. UNFPA. April 2, 2024. Accessed April 6, 2024. <https://www.unfpa.org/occupied-palestinian-territory>
4. Leila Molana-Allen. Israeli airstrikes hit Gaza, the West Bank, Lebanon and Syria amid fears of widening war. October 22, 2023. Accessed November 7, 2023. <https://www.pbs.org/newshour/show/israeli-airstrikes-hit-gaza-the-west-bank-lebanon-and-syria>
5. Batrawy, Aya. Gaza's death toll now exceeds 30,000. Here's why it's an incomplete count. February 29, 2024. Accessed April 7, 2024. <https://www.npr.org/2024/02/29/1234159514/gaza-death-toll-30000-palestinians-israel-hamas-war>
6. Palestinian children killed in Israeli attacks in Gaza | Al Jazeera Newsfeed. Al Jazeera English. February 2, 2024. Accessed April 7, 2024. https://www.youtube.com/watch?v=NICzT9_YE9Y
7. The Latest | Gaza death toll tops 30,000 as over 100 killed in aid convoy violence. AP. February 29, 2024. Accessed April 7, 2024. <https://apnews.com/article/israel-hamas-war-latest-02-29-2024-ae3d114b28cafd3b1a806bfaa9f83cab>
8. STATEMENT OF THE COMMISSIONER-GENERAL OF UNRWA TO THE GENERAL ASSEMBLY. UNRWA. March 4, 2024. Accessed April 7, 2024. <https://www.unrwa.org/newsroom/official-statements/statement-commissioner-general-unrwa-general-assembly>
9. Israeli attacks wipe out entire families in Gaza. Amnesty International. October 23, 2023. Accessed November 5, 2023. <https://www.amnesty.org/en/latest/news/2023/10/damning-evidence-of-war-crimes-as-israeli-attacks-wipe-out-entire-families-in-gaza/>.
10. Israeli forces cut off north Gaza to isolate Hamas as an advance on the urban center looms. November 6, 2023. Accessed November 7, 2023. <https://apnews.com/article/israel-hamas-war-news-11-6-2023-51286d15d4dd77ae0dd7ea76ee52bc71>.
11. People from 35 countries killed, missing in Israel-Gaza war: What to know. October 11, 2023. Accessed November 7, 2023. <https://www.washingtonpost.com/world/2023/10/11/israel-hamas-war-foreign-nationals/>
12. Bassam Hatoum. Lebanese woman and her 3 granddaughters killed in Israeli strike laid to rest. November 7, 2023. Accessed November 7, 2023. <https://abcnews.go.com/International/wireStory/lebanese-woman-3-granddaughters-killed-israeli-strike-laid-104683802>
13. Convention (IV) relative to the Protection of Civilian Persons in Time of War. Geneva, 12 August 1949. IHL. Accessed November 5, 2023. <https://ihl-databases.icrc.org/en/ihl-treaties/gciv-1949>.
14. oPt EMERGENCY SITUATION REPORT - Issue 10. WHO Regional Office for the Eastern Mediterranean. November 1, 2023. Accessed November 6, 2023. https://www.emro.who.int/images/stories/palestine/WHO_oPt_Sitrep_10.pdf.
15. Ferguson S. No Place is Safe for Children in Gaza. UNICEF USA. October 24, 2023. Accessed November 5, 2023. <https://www.unicefusa.org/stories/no-place-safe-children-gaza>.
16. Israel: White phosphorus used in Gaza, Lebanon. Human Rights Watch. October 13, 2023. Accessed November 5, 2023. <https://www.hrw.org/news/2023/10/12/israel-white-phosphorus-used-gaza-lebanon>.
17. Mhawish MR. "We have nothing": Families seek safety from bombs inside Gaza hospitals. Al Jazeera. November 4, 2023. Accessed November 5, 2023. <https://www.aljazeera.com/news/2023/11/4/we-have-nothing-families-seek-safety-from-bombs-inside-gaza-hospitals>.
18. Al-Mughrabi N. Bodies Line Gaza Hospital Wall and surgeons operate in corridors. Reuters. October 31, 2023. Accessed November 5, 2023. <http://www.reuters.com/world/middle-east/gaza-surgeons-operate-corridors-israeli-bombs-fill-hospitals-2023-10-31/>.
19. Yazbek H, Zraick K. A doctor in Gaza describes "horrific scenes" after Israeli airstrikes. The New York Times. November 2, 2023. Accessed November 5, 2023. <https://www.nytimes.com/2023/11/02/world/middleeast/voices-airstrikes-jabaliya-hospital.html>.
20. Shurafa W, Magdy S, Kullab S. Dwindling fuel supplies for Gaza's hospital generators put premature babies in incubators at risk. AP News. October 23, 2023. Accessed November 5, 2023. <https://apnews.com/article/israel-gaza-hamas-babies-crisis-9ec2e404e16a132821dac644af110ef6>.
21. Shurafa W, Magdy S, Kullab S. Dozens of premature babies at risk of death as fuel supplies dwindle in Gaza, doctors say. PBS. October 23, 2023. Accessed November 6, 2023. <http://www.pbs.org/newshour/world/dozens-of-premature-babies-at-risk-of-death-as-fuel-supplies-dwindle-in-gaza-doctors-say>.
22. Lederer EM. Un agency in Gaza says urgent cease-fire is a matter of life and death for millions of Palestinians. AP News. October 31, 2023. Accessed November 6, 2023. <https://apnews.com/article/un-palestinian-israel-humanitarian-ceasefire-catastrophe-unrwa-a26629bbda0c6b2e2bc46a6896c944fe>.
23. Gaza: 'Systematic dismantling of healthcare must end' says WHO. UN News. April 6, 2024. Accessed April 22, 2024. <https://news.un.org/en/story/2024/04/1148316>
24. McKernan B. 'It's death there': babies and children hit hardest as famine tightens hold on Gaza. The Guardian. April 15, 2024. Accessed April 22, 2024. <https://www.theguardian.com/world/2024/apr/15/babies-children-gaza-famine>
25. Famine in Gaza is imminent, with immediate and long-term health consequences. World Health Organization. March 18, 2024. Accessed April 7, 2024. <https://www.who.int/news/item/18-03-2024-famine-in-gaza-is-imminent--with-immediate-and-long-term-health-consequences>
26. Gaza: Israel's Imposed Starvation Deadly for Children. Human Rights Watch. April 9, 2024. Accessed April 22, 2024. <https://www.hrw.org/news/2024/04/09/gaza-israels-imposed-starvation-deadly-children>
27. Lambert J. Even if there's a ceasefire, thousands of deaths projected in Gaza over next 6 months. NPR. March 1, 2024. Accessed April 22, 2024. <https://www.npr.org/sections/goatsandsoda/2024/03/01/1234993226/deaths-gaza-hamas-israel-war-projection>
28. Security Council Demands Immediate Ceasefire in Gaza for Month of Ramadan, Adopting Resolution 2728 (2024) with 14 Members Voting in Favour, United States Abstaining. United Nations Meetings Coverage and Press Releases. March 25, 2024. Accessed April 7, 2024. <https://press.un.org/en/2024/sc15641.doc.htm>
29. UN General Assembly votes by large majority for immediate humanitarian ceasefire during emergency session. UN News. December 12, 2023. Accessed April 22, 2024. <https://news.un.org/en/story/2023/12/1144717>

30. Glossary of humanitarian terms on pauses during conflict in Ukraine. United Nations. MRCH 14, 2022. Accessed November 6, 2023. <https://ukraine.un.org/en/174777-glossary-humanitarian-terms-pauses-during-conflict>.
31. IRC statement: What a “humanitarian ceasefire” means, and why it is necessary. The IRC. November 5, 2023. Accessed November 6, 2023. <https://www.rescue.org/press-release/irc-statement-what-humanitarian-ceasefire-means-and-why-it-is-necessary#:~:text=A%20halt%20to%20the%20fighting,make%20possible%20effective%20aid%20delivery>.
32. Statement by the members of the Governing Board of the International Federation of Red Cross and Red Crescent Societies: IFRC. IFRC. February 11, 2023. Accessed November 6, 2023. <https://www.ifrc.org/article/statement-members-governing-board-international-federation-red-cross-and-red-crescent>.
33. UN Security Council emergency briefing on “The situation in the Middle East, Including the Palestinian Question.” UNRWA Newsroom. October 30, 2023. Accessed November 6, 2023. <https://www.unrwa.org/newsroom/official-statements/un-security-council-emergency-briefing-situation-middle-east>.
34. International Committee of the Red Cross. Israel and the Occupied Territories: Deescalate now to prevent further human suffering. International Committee of the Red Cross. November 2, 2023. Accessed November 6, 2023. <https://www.icrc.org/en/document/israel-and-occupied-territories-deescalate-now-prevent-further-human-suffering>.
35. Doctors without Borders calls for immediate ceasefire in Gaza. Doctors Without Borders - USA. October 26, 2023. Accessed November 6, 2023. <http://www.doctorswithoutborders.org/latest/doctors-without-borders-calls-immediate-ceasefire-gaza>.
36. Oxfam. Lack of food and water a major threat to people in Gaza. Oxfam. October 30, 2023. Accessed November 6, 2023. <http://www.oxfamamerica.org/explore/stories/lack-of-food-and-water-a-major-threat-to-people-in-gaza>.
37. Stroehlein A. Gaza needs water, food, electricity – and Justice. Human Rights Watch Daily Brief. October 30, 2023. Accessed November 6, 2023. <http://www.hrw.org/the-day-in-human-rights/2023/10/30>.
38. Gaza: 3,195 children killed in three weeks surpasses annual number of children killed in conflict zones since 2019. Save the Children. October 29, 2023. Accessed November 6, 2023. <http://www.savethechildren.org/us/about-us/media-and-news/2023-press-releases/gaza--3-195-children-killed-in-three-weeks>.
39. Gaza. International Medical Corps. October 24, 2023. Accessed November 6, 2023. <https://internationalmedicalcorps.org/country/gaza/>.
40. Gaza: Update on the movement of staff via Rafah Crossing. Doctors Without Borders - USA. November 1, 2023. Accessed November 6, 2023. <http://www.doctorswithoutborders.org/latest/gaza-update-movement-staff-rafah-crossing>.
41. SCCM: SCCM calls for volunteers. Society of Critical Care Medicine (SCCM). Accessed November 6, 2023. <https://www.sccm.org/Clinical-Resources/globalhealth/Crisis-Response/Calls-for-Volunteers>.
42. Palestine. Doctors of the World. Accessed November 6, 2023. <https://www.doctorsoftheworld.org.uk/our-work/uncategorised/palestine/>.
43. PAMA. Volunteer with PAMA. PAMA. Accessed November 6, 2023. <https://palestinian-ama.org/volunteer/create>.
44. Volunteer Medical Missions. PCRF. Accessed November 6, 2023. <https://www.pcrf.net/volunteer-medical-missions>.
45. WMA - The World Medical Association-The World Medical Association stands firmly for the principles of medical neutrality as defined by the Geneva Convention, and calls on all parties to respect international law and the integrity of unrelated civilian populations. WMA The World Medical Association. October 15, 2023. Accessed November 6, 2023. <http://www.wma.net/news-post/the-world-medical-association-stands-firmly-for-the-principles-of-medical-neutrality-as-defined-by-the-geneva-convention-and-calls-on-all-parties-to-respect-international-law-and-the-integrity-of-unr>.
46. Galea S. Physicians and the Health Consequences of War. *JAMA Health Forum*. 2022;3(3). doi:10.1001/jamahealthforum.2022.0845
47. Mansoor S. The harrowing work facing Gaza doctors in wartime. *Time*. October 25, 2023. Accessed November 6, 2023. <https://time.com/6328314/gaza-doctors-hospital-electricity-fuel/>.
48. Final 2022 impact report - amafoundation.org. Annual Report 2022. Accessed November 6, 2023. https://amafoundation.org/wp-content/uploads/2023/06/FINAL-2022-Impact-Report_62223.pdf.
49. Ehrenfeld, Jesse (@DoctorJesseMD). “The @AmerMedicalAssn joins the @medwma in condemning the attacks on #Israel. <http://spr.ly/6018uV6cs>”. October 14, 2023. <https://x.com/DoctorJesseMD/status/1713201779792556252?s=20>
50. Statement from the AMA Board of Trustees. Released November 9, 2023. <https://www.ama-assn.org/press-center/press-releases/statement-ama-board-trustees#:~:text=The%20conflict%20unfolding%20in%20Israel,afflicting%20Israelis%2C%20Palestinians%20and%20others>

RELEVANT AMA POLICY

War Crimes as a Threat to Physicians' Humanitarian Responsibilities D-65.993

Our AMA will (1) implore all parties at all times to understand and minimize the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular, (2) support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime, episodes of civil strife, or sanctions and condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, by any party, wherever and whenever it occurs, and (3) advocate for the protection of physicians' rights to provide ethical care without fear of persecution. [BOT Action in response to referred for decision Res. 620, A-09 Modified: BOT Rep. 09, A-19 Modified: Res. 002, I-22]

Medical Neutrality H-520.998

Our AMA supports medical neutrality, under the principles of the Geneva Convention, for all health care workers and the sick and wounded in all countries. [Sub. Res. 72, I-81 Reaffirmed: CLRPD Rep. F, I-91 Reaffirmed: Sunset Report, I-01 Reaffirmed: CEJA Rep. 8, A-11 Reaffirmed in lieu of Res. 601, I-13 Reaffirmed: CEJA Rep. 05, A-23]

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]

Protecting Physicians and Other Healthcare Workers in Society H-515.950

Our AMA: (1) acknowledges and will act to reduce the incidence of antagonistic actions against physicians as well as other health care workers including first responders and public health officials, outside as well as within the workplace, including physical violence, intimidating actions of word or deed, and cyber-attacks, particularly those which appear motivated simply by their identification as health care workers; (2) will educate the general public on the prevalence of violence and personal harassment against physicians as well as other health care workers including first responders, and public health officials, outside as well as within the workplace; and (3) will work with all interested stakeholders to improve safety of health care workers including first responders and public health officials and prevent violence to health care professionals. [Res. 413, I-20]

A Declaration of Professional Responsibility H-140.900

Our AMA adopts the Declaration of Professional Responsibility

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

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all. As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to: (1) Respect human life and the dignity of every individual.

(2) Refrain from supporting or committing crimes against humanity and condemn any such acts.

(3) Treat the sick and injured with competence and compassion and without prejudice.

(4) Apply our knowledge and skills when needed, though doing so may put us at risk.

(5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.

(6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.

(7) Educate the public and polity about present and future threats to the health of humanity.

(8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.

(9) Teach and mentor those who follow us for they are the future of our caring profession.

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

[CEJA Rep. 5, I-01 Reaffirmation A-07 Reaffirmed: CEJA Rep. 04, A-17 Reaffirmed: Res. 215, A-23]

Condemning the Use of Children as Instruments of War H-520.987

Our AMA: (1) condemns the use of children as instruments of war; and (2) encourages evaluation, treatment, and follow-up for children who have been used as instruments of war. [Res. 411, I-01 Reaffirmed: CEJA Rep. 8, A-11 Reaffirmed: CEJA Rep. 1, A-21]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(A-24)

Introduced by: Senior Physicians Section

Subject: Confronting Ageism in Medicine

Referred to: Reference Committee F

1 Whereas, research has shown a strong link between ageism, in the form of negative
2 stereotypes, prejudice and discrimination, and risks for one's physical and mental health¹; and
3

4 Whereas, ageism refers to the stereotypes (how we think), prejudice (how we feel) and
5 discrimination (how we act) towards others or ourselves based on age. Structural ageism is the
6 way in which society and its institutions sustain ageist attitudes, actions or language in laws,
7 policies, practices or culture per the World Health Organization (WHO) and AGE Platform
8 Europe²; and
9

10 Whereas, ageism affects everyone by stereotyping and/or discriminating against, at both the
11 structural level (in which societal institutions reinforce systematic bias against older persons)
12 and individual level (in which older persons take in the negative views of aging of their culture)
13 especially when it exists in an environment of disproportionate power and privilege³; and
14

15 Whereas, ageism can be internalized by elders putting them at risk for diminished access to
16 physical and mental health care and/or suboptimal care; and
17

18 Whereas, ageism thereby negatively impacts health, longevity and well-being of elders while
19 having far-reaching economic consequences⁴; and
20

21 Whereas, the percentage of people worldwide aged 65 and over is projected to increase to
22 nearly 17 percent of the world's population by 2050⁵; and
23

24 Whereas, research has paid little attention to the intersectionality of aging and gender
25 influences whereby socio-economic inequalities can be vastly different for men versus women
26 over time⁶; and
27

28 Whereas, advocacy, beginning with education about and prevention of ageism by the AMA, can
29 help to prevent negative subconscious attitudes, i.e. stigmas, from developing or continuing;
30 therefore be it
31

32 RESOLVED, that our American Medical Association adopt the following definition of ageism
33 based on the World Health Organization (WHO) and AGE Platform Europe: "Ageism refers to
34 the stereotypes (how we think), prejudice (how we feel) and discrimination (how we act) towards
35 others or oneself based on age; structural ageism is the way in which society and its institutions
36 sustain ageist attitudes, actions or language in laws, policies, practices or culture" (New HOD
37 Policy); and be it further
38

39 RESOLVED, that our AMA establish a definition of "age equity," and consider adoption of the
40 AGE Platform Europe vision: "Age equity is an inclusive society, based on well-being for all,

1 solidarity between generations and full entitlement to enjoy life, participate in and contribute to
2 society. At the same time, each person's rights and responsibilities throughout their life course
3 have to be fully respected" (Directive to Take Action); and be it further
4

5 RESOLVED, that our AMA review all existing policy regarding discrimination, bias and
6 microaggressions, and add age or ageism if not already mentioned (Directive to Take Action);
7 and be it further
8

9 RESOLVED, that our AMA routinely incorporate intersectional approaches to ageism (Directive
10 to Take Action); and be it further
11

12 RESOLVED, that our AMA conduct ongoing (1) advocacy for hospital and regulatory policy
13 changes focused on individual physicians' care quality data rather than their age; and (2)
14 educational outreach to AMA members (i.e. starting with a Prioritizing Equity episode panel
15 discussion to be posted on Ed Hub™ for CME, as a video and podcast, and promoted through
16 the UCEP/GCEP channels) (Directive to Take Action); and be it further
17

18 RESOLVED, that our AMA work with the World Medical Association (WMA) and other interested
19 stakeholders to have AMA's work significantly inform the global health organization's work on
20 ageism. (Directive to Take Action)
21

Fiscal Note: \$47,934: Initial cost to review and report back on existing policy and develop
educational session for CME, plus annual costs for continued advocacy and education.

Received: 5/2/2024

REFERENCES

1. Burnes, D., Sheppard, C., Henderson Jr. C.R., Wassel, M., Cope, R., Barber, C., & Pillemer, K. (2019). Interventions to Reduce Ageism Against Older Adults: A Systematic Review and Meta-Analysis. *American Journal of Public Health*, 109 (8), E1-E9.
2. Europe, A. P. Age Platform Europe Position on Structural Ageism.(2016). (AGE_IntergenerationalSolidarity_Position_on_Structural_Ageism2016.pdf (age-platform.eu)
3. Europe, A. P. Age Platform Europe Position on Structural Ageism.(2016). (AGE_IntergenerationalSolidarity_Position_on_Structural_Ageism2016.pdf (age-platform.eu)
4. Levy, S. R., Lytle, A., & Macdonald, J. (2022). The worldwide ageism crisis. *Journal of Social Issues*, 78(4), 743-768.
5. NIH (2016, March 28) World's Older Population Grows Dramatically?National Institutes of Health (NIH) [Press Release]
6. Holman, D., Walker, A. Understanding unequal ageing: towards a synthesis of intersectionality and life course analyses. *Eur J Ageing* 18, 239–255 (2021). <https://doi.org/10.1007/s10433-020-00582-7>

RELEVANT AMA POLICY

H-65.951 Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions

Our AMA adopted the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine.

GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that

actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.

- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Create anti-discrimination policies that:
 - Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
 - Define expected and prohibited behavior.
 - Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias and microaggressions.
 - Ensure privacy and confidentiality to the reporter.
 - Provide a confidential method for documenting and reporting incidents.
 - Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.
- These policies should include:
 - Taking every complaint seriously.
 - Acting upon every complaint immediately.
 - Developing appropriate resources to resolve complaints.
 - Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
 - Communicating decisions and actions taken by the organization following a complaint to all affected parties.
 - Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:

- Surveying staff, trainees and medical students, anonymously and confidentially to assess:
 - Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias and microaggressions.
 - Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias or microaggressions.
- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.
- Providing designated support person to confidentially accompany the person reporting an event through the process.

[Res. 003, A-21]

H-65.946 Towards Diversity and Inclusion: A Global Nondiscrimination Policy Statement and Benchmark for our AMA

Our AMA reaffirms its commitment to complying with all applicable laws, rules or regulations against discrimination on the basis of protected characteristics, including Title VII of the Civil Rights Act, The Age Discrimination in Employment Act, and the Americans with Disabilities Act, among other federal, state and local laws, and will provide updates on its comprehensive diversity and inclusion strategy as part of the annual Board report to the AMA House of Delegates on health equity.

[BOT Rep. 5, I-22]

H-65.965 Support of Human Rights and Freedom

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.

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

H-25.996 Retirement and Hiring Practices

It is urged that physicians, individually and through their constituent, component, and specialty medical societies, continue to stress the need to reappraise policies calling for compulsory retirement and age discrimination in hiring from the standpoint of health among older people, and that they participate actively and lend medical weight in the efforts of other groups to create a new climate of opportunity for the older worker.

[Committee on Aging Report, I-62; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed CSAPH Rep. 2, A-08; Modified CCB Rep. 01, A-18]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(A-24)

Introduced by: Senior Physicians Section
Subject: Walking the Walk of Climate Change
Referred to: Reference Committee F

- 1
2 Whereas, our American Medical Association has declared that climate change is an “urgent”
3 public health crisis per AMA Policy H-135.938, “Global Climate Change and Human Health”;
4 and
5
6 Whereas, our AMA “will protect patients by advocating for policies” that promote carbon
7 neutrality by the middle of this century in AMA Policy D-135.966, “Declaring Climate Change a
8 Public Health Crisis”; and
9
10 Whereas, our AMA has pledged to “incorporate principles of environmental sustainability within
11 its business operations” in AMA Policy, H-135.923, “AMA Advocacy for Environmental
12 Sustainability and Climate”; and
13
14 Whereas, there is considerable evidence that plant-based diets are more carbon friendly than
15 omnivorous or meat-heavy diets^{1,2}; and
16
17 Whereas, emissions from agriculture, made up largely of ruminant meat and dairy farming, will
18 still push the world past safe climate change targets even if fossil fuel emissions were
19 eliminated immediately, thereby creating a dietary pattern that reduces the risk of diet-related
20 disease is the same diet that mitigates climate change; and
21
22 Whereas, our AMA through its flagship journal, JAMA, has recently launched a series on
23 “Climate Change and Health” urging a commitment to actions that decrease greenhouse
24 emissions³; and
25
26 Whereas, BOT Report 17-A-23 discussed our AMA’s plan to address and mitigate the health
27 effects of climate change as well as its participation in the National Academy Action
28 Collaborative on Decarbonizing the U.S. Health Sector, it was silent on addressing these same
29 issues within the AMA itself; therefore be it
30
31 RESOLVED, that our American Medical Association Board of Trustees present to the House of
32 Delegates at Interim 2024 a detailed timeline as to when and how to achieve our organizational
33 carbon neutrality (Directive to Take Action); and be it further
34
35 RESOLVED, that our AMA staff study AMA-related corporate travel with respect to minimizing
36 carbon emissions and/or mitigating or off-setting such emissions (Directive to Take Action); and
37 be it further
38
39 RESOLVED, that our AMA adopt a policy for plant-based menus as the default option when
40 planning meeting venues with an opt-out alternative as appropriate. (Directive to Take Action)
41

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 5/2/2024

REFERENCES

1. Rosi, A., Mena, P., Pellegrini, N., Turrone, S., Neviani, E., Ferrocino, I., ... & Scazzina, F. (2017). Environmental impact of omnivorous, ovo-lacto-vegetarian, and vegan diet. *Scientific reports*, 7(1), 6105.
2. Scarborough, P., Clark, M., Cobiac, L., Papier, K., Knuppel, A., Lynch, J., ... & Springmann, M. (2023). Vegans, vegetarians, fish-eaters and meat-eaters in the UK show discrepant environmental impacts. *Nature Food*, 4(7), 565-574.
3. Ebi, K. L., & Hess, J. J. Introduction to JAMA Climate Change and Health Series. *JAMA*. 2024;331(5):436–437. doi:10.1001/jama.2023.25878

RELEVANT AMA POLICY

H-135.923 AMA Advocacy for Environmental Sustainability and Climate

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities. [Citation: Res. 924, I-16; Reaffirmation:1-19]

H-135.938 Global Climate Change and Human Health

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

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

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

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

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

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

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

[CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed CSAPH Rep.04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22; Modified: CSAPH Rep. 2, I-22]

D-135.966 Declaring Climate Change a Public Health Crisis

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. [Res. 420, A-22; Appended: CSAPH Rep.02, I-22]

D-440.912 AMA Public Health Strategy

Our AMA will distribute evidence-based information on the relationship between climate change and human health through existing platforms and

communications channels, identify advocacy and leadership opportunities to elevate the voices of physicians on the public health crisis of climate change, and centralize our AMA's efforts towards environmental justice and an equitable transition to a net-zero carbon society by 2050.

2. Our AMA Board of Trustees will provide an update on loss of coverage and uninsurance rates following the return to regular Medicaid redeterminations and the end of the COVID-19 Public Health Emergency, the ensuing financial and administrative challenges experienced by physicians, physician practices, hospitals, and the healthcare system; and a report of actions taken by the AMA and recommendation for further action to address these issues at I-2023.

3. Our AMA Board of Trustees will provide a strategic plan or outline for the AMA's plan to address and combat the health effects of climate change at I-2023.

4. Our AMA Board of Trustees will provide an update on the efforts and initiatives of the AMA's gun violence task force at I-2023.

5. Our AMA will continue to support increased funding for public health infrastructure and workforce, which should include funding for preventative medicine related residency programs, to increase public health leadership in this country

[BOT Rep. 17, A-23; Modified: BOT Rep. 05, I-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(A-24)

Introduced by: New England

Subject: Creation of an AMA Council with a Focus on Digital Health Technologies and AI

Referred to: Reference Committee F

1 Whereas, there is an unparalleled effort to apply emerging digital technologies to healthcare,
2 including but not limited to augmented/artificial intelligence (AI) systems¹⁻⁴, simulation and
3 virtual/augmented reality (VR/AR)^{5,6}, telehealth^{7,8}, and even quantum computing⁹; and
4

5 Whereas, emerging digital technologies including AI are being theorized (and even promoted)
6 as a disruptive threat to the practice, business, and teaching of medicine;¹⁰⁻¹³ and
7

8 Whereas, during the last major wave of digital health and informatics innovation, the AMA
9 lacked a policy-making body and expertise dedicated to such technology to help predict and
10 prevent the disruptions related to meaningful use, electronic medical record interoperability,
11 telehealth, etc.; and
12

13 Whereas, at the 2023 AMA Annual meeting, in addition to the resolutions in the Reference
14 Committee on Science & Technology (E), there were 8 resolutions involving innovative
15 technologies spread across various reference committees, with reports subsequently distributed
16 across multiple councils; and
17

18 Whereas, the rapid evolution of AI and digital technology within healthcare, as well as the
19 increasing volume of related House of Delegates (HOD) resolutions, reports, and advocacy
20 necessitates better coordination of HOD expertise and policymaking for the benefit of physicians
21 and patients alike; and
22

23 Whereas, our AMA has developed a variety of staff-driven responses to the proliferation of new
24 health technologies, such as the Office of Digital Health Innovation and Health2047, but there is
25 no dedicated body of the HOD focusing on this critical policy area; and
26

27 Whereas, policy regarding digital health technologies and AI requires relevant expertise in
28 multiple domains (practice, payment, liability, ethics, EHR integration, education, etc.)¹²⁻¹⁹ not
29 currently served by a single council, causing an inefficient distribution of these topics across
30 councils and severely limiting potential impact; and
31

32 Whereas, a new AMA council focused on digital health technologies, informatics, and AI would
33 benefit the HOD, Board of Trustees, and other Councils by organizing and cultivating precisely
34 this type of HOD staff expertise and physician leadership; therefore be it
35

36 RESOLVED, that our American Medical Association define and propose a new AMA council
37 focused on digital health, technology, informatics, and augmented/artificial intelligence, whose
38 members shall be elected by the House of Delegates, for presentation and constitution at the
39 2025 Annual Meeting. (Directive to Take Action)

Fiscal Note: To Be Determined

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REFERENCES

1. Haupt CE, Marks M. AI-Generated Medical Advice-GPT and Beyond. *JAMA*. 2023;329(16):1349-1350. DOI: 10.1001/jama.2023.5321. PMID: 36972070.
2. Kanjee Z, Crowe B, Rodman A. Accuracy of a Generative Artificial Intelligence Model in a Complex Diagnostic Challenge. *JAMA*. 2023;330(1):78-80. DOI: 10.1001/jama.2023.8288. PMID: 37318797.
3. Kulkarni PA, Singh H. Artificial Intelligence in Clinical Diagnosis Opportunities, Challenges, and Hype. *JAMA*. 2023;330(4):317-318. DOI: 10.1001/jama.2023.11440. PMID: 37410477.
4. "DAX Copilot: AI-automated clinical notes in seconds". Microsoft and Nuance Communications, Inc. Accessed: 4/16/2024 at <https://www.nuance.com/healthcare/campaign/ppc/dax-copilot.html>.
5. Azad TD, Warman A, Tracz JA, Hughes LP, Judy BF, Witham TF. Augmented reality in spine surgery – past, present, and future. *Spine J*. 2024;24(1):1-13. DOI: 10.1016/j.spinee.2023.08.015. PMID: 37660893.
6. Bhugaonkar K, Bhugaonkar R, Masne N. The Trend of Metaverse and Augmented & Virtual Reality Extending to the Healthcare System. *Cureus*. 2022;14(9):e29071. DOI: 10.7759/cureus.29071. PMID: 36258985.
7. Pool J, Indulska M, Sadiq S. Large language models and generative AI in telehealth: a responsible use lens. *J Am Med Inform Assoc*. Epub ahead of print: 2024 Mar 4. DOI: 10.1093/jamia/ocae035. PMID: 38441296.
8. Reed M, Huang J, Somers M, Hsueh L, Graetz I, Muelly E, Gopalan A. Telemedicine Versus In-Person Primary Care: Treatment and Follow-up Visits. *Ann Intern Med*. 2023;176(10):1349-1357. DOI: 10.7326/M23-1335. PMID: 37844311.
9. Shams M, Choudhari J, Reyes K, Prentzas S, Gapizov A, Shehryar A, Affaf M, Grezenko H, Gasim R, Naveed Mohsin S, Rehman A, Rehman S. The Quantum-Medical Nexus: Understanding the Impact of Quantum Technologies on Healthcare. *Cureus*. 2023;15(10):e48077. DOI: 10.7759/cureus.48077. PMID: 38046499.
10. Suran M, Hswen Y. How to Navigate the Pitfalls of AI Hype in Health Care. *JAMA*. 2024;331(4):273-276. DOI: 10.1001/jama.2023.23330. PMID: 38170492.
11. Elmahdy M, Sebros R. A snapshot of artificial intelligence research 2019-2021: is it replacing assisting physicians? *J Am Med Inform Assoc*. 2023;30(9):1552-1557. DOI: 10.1093/jamia/ocad094. PMID: 37279884.
12. Kung TH, Cheatham M, Medenilla A, Sillos C, De Leon L, Elepano C, Madriaga M, Aggabao R, Diaz-Dandido G, Maningo J, Tseng V. Performance of ChatGPT on USMLE: Potential for AI-assisted medical education using large language models. *PLOS Digital Health*. 2023;2(2):e0000198. DOI: 10.1371/journal.pdig.0000198. PMID: 36812645.
13. Kumah-Crystal Y, Mankowitz S, Embi P, Lehmann C. ChatGPT and the clinical informatics board examination: the end of unproctored maintenance of certification? *J Am Med Inform Assoc*. 2023;30(9):1558-1560.
14. Jindal JA, Lungren MP, Shah NH. Ensuring useful adoption of generative artificial intelligence in healthcare. *J Am Med Inform Assoc*. Epub ahead of print: 2024 Mar 7. DOI: 10.1093/jamia/ocae043. PMID: 38452298.
15. Evans RP, Bryant LD, Russell G, Absolom K. Trust and acceptability of data-driven clinical recommendations in everyday practice: A scoping review. *Int J Med Inform*. 2024;183:105342. DOI: 10.1016/j.ijmedinf.2024.105342. PMID: 38266426.
16. Reddy S, Allan S, Coghlan S, Cooper P. A governance model for the application of health care. *J Am Med Inform Assoc*. 2020;27(3):491-497.
17. Maurud S, Henni SH, Moen A. Health Equity in Clinical Research Informatics. *Yearb Med Inform*. 2023;31(1):138-145. DOI: 10.1055/s-0043-1768720. PMID: 37414033.
18. Chen F, Wang L, Hong J, Jiang J, Zhou L. Unmasking bias in artificial intelligence: a systematic review of bias detection and mitigation strategies in electronic health record-based models. *J Am Med Inform Assoc*. Epub ahead of print: 2024 Mar 23. DOI: 10.1093/jamia/ocae060. PMID: 38520723.
19. Economou-Zaclanos NJ, Bessias S, Cary MP Jr, et al. Translating ethical and quality principles for the effective, safe and fair development, deployment and use of artificial intelligence technologies in healthcare. *J Am Med Inform Assoc*. 2024;31(3):705-713. DOI: 10.1093/jamia/ocad221. PMID: 38031481.

RELEVANT AMA POLICY**Responsibilities. B-6.0.1**

6.0.1.1 Information and Recommendations. All Councils have a continuing duty to provide information and to submit recommendations to the House of Delegates, through the Board of Trustees, on matters relating to the areas of responsibility assigned to them under the provisions of these Bylaws.

6.0.1.1.1 Method of Reporting. Councils, except the Council on Ethical and Judicial Affairs and the Council on Legislation shall submit their reports to the House of Delegates through the Board of Trustees. The Board of Trustees may make such non-binding recommendations regarding the reports to the Councils as it deems appropriate, prior to transmitting the reports to the House of Delegates without delay or modification by the Board. The Board may also submit written recommendations regarding the reports to the House of Delegates.

6.0.1.1.2 Method of Referral. Referrals from the House of Delegates to a Council shall be made through the Board of Trustees. The Board may, in addition, refer the matter to such other councils as it deems appropriate.

6.0.1.2 Strategic Planning. All Councils have a responsibility to participate in the strategic planning process with the Board of Trustees, other Councils, and other organizational units as may be appropriate.

6.0.1.3 Communications and Working Relationships. All Councils have a responsibility to communicate

and develop working relationships with the Board of Trustees, other Councils, the Sections, organizations represented within the House of Delegates and other organizational units as may be appropriate.

Medical Innovations H-480.978

It is the policy of the AMA to continue to publicly support adequate funding for the development and implementation of medical innovations, and that the reasoning behind this position be communicated to physicians, the public, and appropriate policymakers.

Sub. Res. 508, I-92 Reaffirmed: CSA Rep. 8, A-03 Modified: CSAPH Rep. 1, A-13 Reaffirmed: CSAPH Rep. 08, A-23

Evolving Impact of Telemedicine H-480.974

Our AMA:

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

CMS/CME Rep., A-94 Reaffirmation A-01 Reaffirmation A-11 Reaffirmed: CMS Rep. 7, A-11 Reaffirmed in lieu of Res. 805, I-12 Appended: BOT Rep. 26, A-13 Modified: BOT Rep. 22, A-13 Reaffirmed: CMS Rep. 7, A-14 Reaffirmed: CME Rep. 06, A-16 Reaffirmation: A-18

Augmented Intelligence in Health Care H-480.940

As a leader in American medicine, our American Medical Association 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.
- BOT Rep. 41, A-18

Technology and the Practice of Medicine G-615.035

Our AMA encourages the collaboration of existing AMA Councils and working groups on matters of new and developing technology, particularly electronic medical records (EMR) and telemedicine.
Res. 606, A-14

Health Information Technology Principles H-478.981

Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:

1. Enhance physicians' ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.

Our AMA will utilize HIT principles to:

1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of "Information Blocking."

Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.

BOT Rep. 19, A-18 Reaffirmation: A-19

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

National Agency for Technology Evaluations H-480.954

Our AMA advocates for active AMA input into any national agency whose role would be to evaluate technology for its value, to assist Medicare and other payors in making appropriate coverage decisions.
Res. 221, I-08Reaffirmed: CMS Rep. 01, A-18

Augmented Intelligence in Medical Education H-295.857

Our AMA encourages:

(1) accrediting and licensing bodies to study how AI should be most appropriately addressed in accrediting and licensing standards;

(2) medical specialty societies and boards to consider production of specialty-specific educational modules related to AI;

(3) research regarding the effectiveness of AI instruction in medical education on learning and clinical outcomes;

(4) institutions and programs to be deliberative in the determination of when AI-assisted technologies should be taught, including consideration of established evidence-based treatments, and including consideration regarding what other curricula may need to be eliminated in order to accommodate new training modules;

(5) stakeholders to provide educational materials to help learners guard against inadvertent dissemination of bias that may be inherent in AI systems;

(6) the study of how differences in institutional access to AI may impact disparities in education for students at schools with fewer resources and less access to AI technologies;

(7) enhanced training across the continuum of medical education regarding assessment, understanding, and application of data in the care of patients;

(8) the study of how disparities in AI educational resources may impact health care disparities for patients in communities with fewer resources and less access to AI technologies;

(9) institutional leaders and academic deans to proactively accelerate the inclusion of nonclinicians, such as data scientists and engineers, onto their faculty rosters in order to assist learners in their understanding and use of AI; and

(10) close collaboration with and oversight by practicing physicians in the development of AI applications.
CME Rep. 04, A-19

Update on the Uses of Simulation in Medical Education D-295.330

Our AMA will:

1. continue to advocate for additional funding for research in curriculum development, pedagogy, and outcomes to further assess the effectiveness of simulation and to implement effective approaches to the use of simulation in both teaching and assessment;

2. continue to work with and review, at five-year intervals, the accreditation requirements of the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the Accreditation Council for Continuing Medical Education (ACCME) to assure that program requirements reflect appropriate use and assessment of simulation in education programs;

3. encourage medical education institutions that do not have accessible resources for simulation-based teaching to use the resources available at off-site simulation centers, such as online simulated assessment tools and simulated program development assistance;

4. monitor the use of simulation in high-stakes examinations administered for licensure and certification as the use of new simulation technology expands;

5. further evaluate the appropriate use of simulation in interprofessional education and clinical team building; and

6. work with the LCME, the ACGME, and other stakeholder organizations and institutions to further identify appropriate uses for simulation resources in the medical curriculum.

CME Rep. 8, A-09Reaffirmed: CME Rep. 01, A-19

Redefine "Meaningful Use" of Electronic Health Records D-478.982

1. Our AMA will work with the federal government and the Department of Health and Human Services to: (A) set realistic targets for meaningful use of electronic health records such as percentage of computerized order entry, electronic prescribing, and percentage of inclusion of laboratory values; and (B) improve the electronic health records incentive program requirements to maximize physician participation.

2. Our AMA will continue to advocate that, within existing AMA policies, the Centers for Medicare & Medicaid Services suspend penalties to physicians and health care facilities for failure to meet Meaningful Use criteria.

Res. 222, A-10Reaffirmation I-10Reaffirmation A-14Appended: Res. 210, I-14Reaffirmed in lieu of Res. 203, I-15Reaffirmed in lieu of Res. 216, I-15Reaffirmed: Res. 211, I-16

Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians D-478.976

1) Our AMA will: (A) advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace; (B) continue to advocate for research and physician education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-source status; and (C) through its partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and support more informed decision making in the selection of EHRs.

2) Our AMA will, through partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and formulate more formal decision making in the selection of EHRs.

3) Our AMA will work with AmericanEHR Partners to modify the current survey to better address the economics of EHR use by physicians including the impact of scribes.

4) Our AMA will make available the findings of the AmericanEHR Partners' survey and report back to the House of Delegates.

BOT Rep. 23, A-13BOT Rep. 24, A-13Reaffirmed: BOT Rep. 17, A-15Appended: Res. 603, I-16Modified: BOT Rep. 20, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607
(A-24)

Introduced by: New Jersey

Subject: Appealing to our AMA to add clarity to its mission statement to better meet the need of physicians, the practice of medicine and the public health.

Referred to: Reference Committee F

1 Whereas, most leading national health organizations focus their mission statement on
2 empowering members to carry out the organizational mission; and

3
4 Whereas, physicians, while seeking to promote our AMA's mission, face significant challenges
5 such as loss of autonomy, scope creep or prior authorization that have contributed to poor
6 morale, high burn out rate, and an above average suicide rate among other professions; and

7
8 Whereas, despite our AMA's work to support physicians, most physicians fail to appreciate the
9 value of the AMA and less than 20 % of physicians are members of the AMA; and

10
11 Whereas, physicians are the primary stewards to carry out our AMA's mission statement; and,
12 the importance of a mission statement is to communicate an organization's values, priorities,
13 goals and serve as a moral compass that guides institutional decision making;
14 therefore be it

15
16 RESOLVED, that our American Medical Association amends its mission's statement from "to
17 promote the art and science of medicine and the betterment of public health" to "to empower
18 physicians to better care for their patients, advance the art and science of medicine, and
19 promote the betterment of physicians and the public health". (Directive to Take Action)

20
Fiscal Note: Minimal - less than \$1,000

Received: 5/7/2024

REFERENCE

1. About Ana: Ana enterprise. ANA. (2017, October 14). <https://www.nursingworld.org/ana/aboutana/#:~:text=Fostering%20high%20standards%20of%20nursing,affect%20nurses%20and%20the%20public>
2. About the American Association of Nurse Practitioners® (AANP). American Association of Nurse Practitioners. (n.d.). <https://www.aanp.org/about/about-the-american-association-of-nurse-practitioners#aanp#:~:text=AANP%27s%20Mission,%2C%20advocacy%2C%20research%20and%20leadership>
3. About. Home. (n.d.). <https://www.pharmacist.com/who-we-are#:~:text=APhA%20Mission,based%2C%20patient%2Dcentered%20care>
4. Learn more about the American Academy of PAs - AAPA. AAPA. Published 2016. <https://www.aapa.org/about/>
5. Pompili M, Innamorati M, Narciso V, et al. Burnout, hopelessness and suicide risk in medical doctors. *La Clinica Terapeutica*. 2010;161(6):511-514. <https://pubmed.ncbi.nlm.nih.gov/21181078/>
6. Dutheil F, Aubert C, Pereira B, et al. Suicide among physicians and health-care workers: A systematic review and meta-analysis. *PLOS ONE*. Accessed January 4, 2024. <https://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0226361#sec028>.
7. Physician Stewardship of Health Care Resources. AMA. Accessed January 4, 2024. <https://code-medical-ethics.ama-assn.org/ethics-opinions/physician-stewardshiphealth-care-resources>
8. Meacham J. What is the use of a mission statement? *Academe*. 2008;94(1):21-24
9. Pearson SD, Sabin J, Emanuel EJ. *No Margin, No Mission: Health Care Organizations and the Quest for Ethical Excellence*. New York, NY: Oxford University Press; 2003.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608
(A-24)

Introduced by: Minority Affairs Section

Subject: The American Medical Association Diversity Mentorship Program

Referred to: Reference Committee F

1 Whereas, members of our American Medical Association have expressed interest in serving as
2 volunteer mentors to medical students, residents, and fellows; and
3
4 Whereas, volunteer mentorship programs have proven to be successful and cost-effective
5 platforms for addressing physician diversity gaps;¹ and
6
7 Whereas, our AMA has recognized the importance of supporting racial and ethnic populations
8 that are underrepresented in the medical profession relative to their numbers in the general
9 population; and
10
11 Whereas, alarming representation gaps still exist in medicine for American Indian & Alaska
12 Native, Hispanic, and Black Americans;² and
13
14 Whereas, our AMA carries the membership strength of over 270,000 dues-paying members;
15 and
16
17 Whereas, volunteer mentorship programs can help recruit and retain members through active
18 and rewarding engagement; and
19
20 Whereas, our AMA has outwardly emphasized the importance of mentorship via both accepted
21 policy and advocacy efforts, but has not enacted a successful internal platform; and
22
23 Whereas, our AMA is uniquely positioned to construct a first-in-class national mentorship
24 program through our strategic partners and extensive network of over 120 national medical
25 specialties and other societies;³ and
26
27 Whereas, mentorship has the powerful capacity to bring people together, share perspectives,
28 and promote a culture of togetherness; therefore be it
29
30 RESOLVED, that our American Medical Association establish a diversity mentorship program to
31 connect volunteer mentors with residents, fellows, and medical student mentees who are
32 underrepresented in medicine. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 5/8/2024

REFERENCES

1. Yehia, B.R., Cronholm, P.F., Wilson, N. *et al.* Mentorship and pursuit of academic medicine careers: a mixed methods study of residents from diverse backgrounds. *BMC Med Educ* **14**, 26 (2014). <https://doi.org/10.1186/1472-6920-14-26>
2. 2022 Physician Specialty Data Report. Association of American Medical Colleges. <https://www.aamc.org/data-reports/data/2022-physician-specialty-data-report-executive-summary>
3. Member Organizations of the AMA House of Delegates. American Medical Association. Accessed May 1, 2024. <https://www.ama-assn.org/house-delegates/hod-organization/member-organizations-ama-house-delegates>

RELEVANT AMA Policy

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations. [CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21]

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 unequivocally opposes legislation that would dissolve affirmative action or punish institutions for properly employing race-conscious admissions as a measure of affirmative action in order to promote a diverse student population.

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-10Reaffirmation 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; Modified: Res. 320, A-23]

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its 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; (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; (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; (7) investigate the impacts of state legislation regarding DEI-related efforts on the education and careers of students, trainees, and faculty; (8) recognize the disproportionate efforts by and additional responsibilities placed on minoritized individuals to engage in diversity, equity, and inclusion efforts; and (9) collaborate with the Association of American Medical Colleges, the Liaison Committee on Medical Education, and relevant stakeholders to encourage academic institutions to utilize Diversity, Equity, and Inclusion activities and community engagement as criteria for faculty and staff promotion and tenure. [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; Appended: Res. 319, A-22; Modified: Res. 319, A-23]

Diversity of AMA Delegations G-600.030

1. Our AMA encourages: (a) medical societies to develop methods for selecting AMA delegates that provide an exclusive role for AMA members; (b) state medical societies to collaborate more closely with state chapters of medical specialty societies, and to include representatives of these organizations in their AMA delegations whenever feasible; (c) state and specialty medical societies to adopt election procedures through which only AMA members may cast ballots for the state/specialty society's delegates to our AMA; (d) state medical associations and national medical specialty societies to review the composition of their AMA delegations with regard to enhancing diversity; (e) specialty and state societies to develop training and/or mentorship programs for their student, resident and fellow and young physician section representatives, and current HOD delegates for their future activities and representation of the delegation; (f) specialty and state societies to include in their delegations physicians who meet the criteria for membership in the Young Physicians Section; and (g) delegates and alternates who may be entitled to a dues exemption, because of age and retirement status, to demonstrate their full commitment to our AMA through payment of dues.

2. It is also suggested that each delegation have at least one member involved in the governance of the sponsoring organization. [CCB/CLRPD Rep. 3, A-12; Modified: CCB/CLRPD Rep. 1, A-22]

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]

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979

Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.

(2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.

(3) Urging medical school and undergraduate admissions committees to proactively implement policies and procedures that operationalize race-conscious admission practices in admissions decisions, among other factors.

(4) Increasing the supply of minority health professionals.

(5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.

(6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.

(7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.

(8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.

(9) Recognizing the consideration of race in admissions is a necessary safeguard in creating a pipeline to an environment within medical education that will propagate the advancement of health equity through diversification of the physician workforce. [CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18; Modified: Res. 320, A-23; Appended: Res. 320, A-23]

Reference Committee G

Report(s) of the Board of Trustees

- 29 Transparency and Accountability of Hospitals and Hospital Systems
- 30 Proper Use of Overseas Virtual Assistants in Medical Practice

Report(s) of the Council on Medical Service

- 01 Council on Medical Service Sunset Review of 2014 House Policies
- 05 Patient Medical Debt
- 06 Economics of Prescription Medication Prior Authorization

Resolutions

- 701 Opposition to the Hospital Readmissions Reduction Program
- 702 The Corporate Practice of Medicine, Revisited
- 703 Upholding Physician Autonomy in Evidence-Based Off-Label Prescribing and Condemning Pharmaceutical Price Manipulation
- 704 Pediatric Readiness in Emergency Departments
- 705 20 Minute Primary Care Visits
- 706 Automatic Pharmacy-Generated Prescription Requests
- 707 Alternative Funding Programs
- 708 Medicolegal Death Investigations
- 709 Improvements to Patient Flow in the U.S. Healthcare System
- 710 The Regulation of Private Equity in the Healthcare Sector
- 711 Insurer Accountability When Prior Authorization Harms Patients
- 712 Full transparency - Explanation of Benefits
- 713 Transparency – non-payment for services to patients with ACA exchange plans with unpaid premiums

EXECUTIVE SUMMARY

At the 2023 Annual Meeting of the House of Delegates, Policy D-200.971, “Transparency and Accountability of Hospitals and Hospital Systems” was adopted. This policy directed the American Medical Association (AMA) to (1) identify options for developing and implementing processes – including increased transparency of physicians complaints made to the Equal Employment Opportunity Commission (EEOC) and The Joint Commission – for tracking and monitoring physicians complaints against hospitals and hospital systems and (2) report back with recommendations for implementing such processes, including potential revisions to the Health Care Quality Improvement Act (HCQIA) of 1986 to include monetary penalties for institutions performing bad-faith peer reviews (Directive to Take Action).

This report provides detailed information about multiple systems in place for physicians to report concerns about their health system or hospital employer. Barriers persist that prevent physicians from reporting patient care concerns or seeking recourse if a bad-faith peer review process has been initiated against them based on what they believe are unfounded, unfair allegations.

To our knowledge, no systems are in place to track and publicly report malpractice information or complaints against hospitals or health systems. It is the AMA’s position that malpractice payment information should not be made public. AMA policy requires state medical boards report disciplinary action to the AMA and Federation of State Medical Boards, but does not endorse the public reporting of such information. The AMA does not support efforts to require the AMA, FSMB, The Joint Commission or any state or federal entity to dedicate resources to providing this information to the public; however, the AMA does support transparency of physician complaints against hospitals and hospital systems through publicly accessible channels, such as the Joint Commission Quality Check reports.

Considering (1) that organizations found to have conducted bad-faith peer reviews are not granted immunity by the HCQIA, (2) the AMA has historically opposed attempts to amend the HCQIA and (3) monetary penalties at the state level have not resulted in increased reporting or reduced incident rates, the AMA does not recommend new attempts to amend the HCQIA for the purposes of adding such penalties for organizations involved in bad-faith peer reviews.

Finally, the AMA, despite having an abundance of policy on the matter, has not published many resources to help physicians navigate the tumultuous processes of reporting concerns or being the subject of a peer review. This report makes a recommendation for the AMA to enhance content offerings on this topic.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 29-A-24

Subject: Transparency and Accountability of Hospitals and Hospital Systems

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee G

1 INTRODUCTION

2
3 At the 2023 Annual Meeting, the House of Delegates (HOD) adopted Policy D-200.971,
4 “Transparency and Accountability of Hospitals and Hospital Systems.” This resolution asked that
5 our American Medical Association (AMA) (1) identify options for developing and implementing
6 processes – including increased transparency of physicians complaints made to the Equal
7 Employment Opportunity Commission (EEOC) and The Joint Commission – for tracking and
8 monitoring physician complaints against hospitals and hospital systems and (2) report back with
9 recommendations for implementing such processes, including potential revisions to the Health
10 Care Quality Improvement Act (HCQIA) of 1986 to include monetary penalties for institutions
11 performing bad-faith peer reviews.

12
13 BACKGROUND

14
15 Key issues raised by the resolution that resulted in Policy D-200.971 were (1) the perceived
16 limitations for physicians to safely, and without fear of retaliation, report patient care concerns due
17 to the large influence and market dominance many health systems have; (2) mistreatment of or
18 retaliation against physicians who report concerns, including through the conduct of bad-faith peer
19 reviews; (3) the lack of publicly available information about complaints against hospitals and
20 health systems; and (4) the potential amendment of the HCQIA to add monetary penalties for
21 entities found to have conducted bad-faith peer reviews. Testimony in the Reference Committee
22 hearing on this resolution also indicated that access to information about complaints filed on health
23 systems would be valuable to physicians considering new employment. This report will address
24 these items, in addition to brief background on peer reviews and the HCQIA, and make
25 recommendations for further HOD action.

26
27 DISCUSSION

28
29 *Whistleblower reports*

30
31 Physicians or other medical professionals may have the unfortunate experience of witnessing
32 unethical behavior, an incident where a patient was harmed or a colleague committing some type of
33 wrongdoing. Upholding the ethical standards of the profession is among the duties of all health
34 care professionals, and part of fulfilling that duty includes reporting concerns and issues when they
35 happen. Hospitals and health systems, who depend on high quality ratings and safety scores, as
36 well as low numbers of safety violations, do not always receive these reports well. Although

1 unlawful, since whistleblowers are protected by dozens of laws, people who report complaints or
2 concerns, or “whistleblowers,” may be ostracized, pressured to withdraw their report or threatened
3 with counter allegations. Worse, a hospital may turn against the complainant and punish them
4 through other means of retaliation such as a false or fabricated peer review. Given the potential
5 negative consequences, many health care workers may avoid reporting ethical or patient safety
6 concerns out of fear for their own livelihood, safety or reputation.¹

7
8 *Peer review*

9
10 When a patient-safety or ethical violation is investigated, peer reviews are often the mechanism for
11 evaluating the circumstances, conduct and outcomes of the incident. Peer review processes are
12 long-established within organized medicine, intended to ensure patient safety but also to scrutinize
13 professional conduct and protect hospitals from liability.² The responsibility to ensure quality care
14 through physician monitoring has been delegated to committees composed mainly of medical staff
15 that review physician credentials and applications for admission to the medical staff, as well as
16 determine the privileges physicians have at a hospital.³ Peer review is recognized and accepted as a
17 means of promoting professionalism and maintaining trust. The peer review process is intended to
18 balance physicians’ right to exercise medical judgment freely with the obligation to do so wisely
19 and temperately.²

20
21 The AMA defines peer review, in part, as: “... the task of self-monitoring and maintaining the
22 administration of patient safety and quality of care, consistent with optimal standards of
23 practice...” Peer review goes beyond individual review of instances or events; it is a mechanism
24 for assuring the quality, safety and appropriateness of hospital services. The duties of peer review
25 are addressing the standard of care, preventing patient harm, evaluating patient safety and quality
26 of care and ensuring that the design of systems or settings of care support safety and high quality
27 care ([Policy H-375.962, “Legal Protections for Peer Review”](#)).⁴

28
29 This policy continues to discuss a “good faith peer review”: a “peer review conducted with honest
30 intentions that assess appropriateness and medical necessity to assure safe, high-quality medical
31 care is good faith peer review. Misfeasance (i.e., abuse of authority during the peer review process
32 to achieve a desired result other than improved patient care), or misuse of the peer review process,
33 or peer review that is politically motivated, manipulated to achieve economic gains or due to
34 personal vendetta is not considered a good faith peer review”.⁴

35
36 *Health Care Quality Improvement Act of 1986*

37
38 The HCQIA of 1986 was introduced to provide protection from liability under federal and state
39 laws for members of a professional review body and their staffs, and establish a national repository
40 for reported information regarding medical malpractice payments and adverse actions involving
41 physicians.⁵ Since then, each state (and the District of Columbia) have passed their own laws
42 requiring the peer review process to improve health care quality.³

43
44 In addition to establishing the National Practitioner Data Bank (NPDB) to monitor hospital- and
45 state-level credentialing of physicians, the HCQIA also granted federal immunity protections to
46 physicians that participate in good faith evaluation of their peers. To qualify for immunity
47 protections under the Act, it is presumed that the actions of peer review committees meet four
48 standards, unless their actions are rebutted by a “preponderance of the evidence”, wherein the
49 burden of proof is on the physician undergoing review.^{3,6} First, there must be a reasonable belief
50 that peer review action was taken to ensure quality care. Second, peer review action should only be
51 taken after a reasonable effort to obtain the facts surrounding the case. Third, the physician

1 undergoing peer review must be afforded sufficient notice and hearing procedures or other fair
2 protocols relevant to the circumstances of the case. Last, after reasonable efforts to obtain the facts
3 of the case have been made, reasonable belief that peer review action was warranted by these facts
4 is then also required.³

5 6 *Bad-faith peer review*

7
8 Because peer review committees are typically not independent, and often comprise hospital-
9 employed physicians who have agreed to make decisions on behalf of the organization, judgments
10 made by these committees have the potential to be biased. A bad-faith, or “sham” peer review, may
11 be politically motivated, manipulated to achieve economic gains or to avoid financial risks,
12 conducted in a way that helps the organization avoid reputational damage or is facilitated to fulfill
13 a personal vendetta against an individual. The peer review process may also be exploited to deem
14 the whistleblower incompetent or disruptive, undermining the merits of their report. Such
15 inappropriate peer reviews were the subject of AMA Board of Trustees Report 24-A-08, titled
16 “Inappropriate Peer Reviews,” which described several cases of improperly motivated peer review,
17 including *Patrick v Burget* (1998), *Rosenblit v Superior Court* (1991), *Clark v Columbia/HCA*
18 *Information Services* (2001), and *Poliner vs Presbyterian Hospital of Dallas* (2006).⁷

19
20 Victims of bad-faith peer reviews often share similar characteristics that cause them to be
21 perceived as “easy targets.” Such characteristics include independent physicians that lack the social
22 and political support and other resources frequently enjoyed by physicians who are part of large
23 health systems, physicians who are new on staff and haven’t yet had the opportunity to develop
24 strong connections and physicians that perform “new” or “different” procedures.³

25 26 *Racial inequities in adverse action reports*

27
28 Anecdotal evidence from the media and health law bar have reported a rise in racial inequities in
29 adverse medical staff actions. This increase is believed to be due to racially motivated actions and
30 more physicians of color challenging such actions. One example of this involved a Black physician
31 who, over the course of 25 years, resided in a rural community, established a practice, and
32 maintained an honorable career in her specialty. After identifying an unmet need of a patient
33 population in her rural community that went unaddressed by local health systems, she established
34 an outpatient facility that thrived. After she brought forward quality of care concerns regarding the
35 danger to high-risk patients created by a gap in specialty coverage and quality nursing care at the
36 hospital, a medical staff investigation was initiated against her by the hospital’s peer review
37 committee in response to retaliatory nursing staff claims. To avoid a potentially career-ending
38 report to the NPDB, the physician was forced to invest time, money and energy toward
39 participation in the demoralizing, retaliatory medical staff investigation.⁶

40
41 Adverse medical staff actions that cite subjective reasons such as “disruptive” behavior,
42 competency concerns and/or unprofessional conduct have served to justify racism against Black
43 physicians and other minoritized physicians. Racially motivated bad-faith peer reviews threaten the
44 economic and mental well-being of physicians of color in addition to the health outcomes of the
45 diverse patient populations they care for.⁶

46
47 Some hospital- and health system-level recommendations that have been proposed to prevent racial
48 discrimination in the peer review process include hiring racially diverse leadership, as well as
49 representation on peer review committees and reviewing and revising peer review protocols
50 through an equity lens.⁶

1 *Perceived barriers to reporting patient care concerns*

2
3 The authors of AMA [Policy D-200.971](#) raised concerns about perceived barriers for physicians to
4 report patient care or other concerns without fear of retaliation due to the large influence and
5 market dominance many health systems have. AMA [Board of Trustees Report 5-I-17, “Effective
6 Peer Review”](#), discussed this issue, addressing physicians’ concerns with the waning influence or
7 control they have over their employment or patient care, as they are increasingly becoming
8 employed by or affiliated with large hospital systems or health care organizations.⁸ Despite BOT
9 Report 5-I-17 having been published more than six years ago, the issues addressed within it remain
10 relevant and thus appropriate to cite within this current report.

11
12 “In a large health system or hospital, peer review systems are integral to safeguarding patient safety
13 and care. Because peer review can involve close scrutiny of all aspects of patient care and safety,
14 both with respect to organization-wide patient care and safety issues and issues concerning
15 individual physicians and health care practitioners, the peer review process may bring to light
16 serious patient care and safety issues that are systemic to a hospital or other lay organization.
17 Exposure of such issues could damage the hospital’s or organization’s reputation in its community
18 or its other business interests. Consequently, a physician may be reluctant to participate in a peer
19 review proceeding for fear of retaliation if the physician believes that the hospital or lay
20 organization will take issue with the result of, or the physician’s role in, that proceeding. This fear
21 is exacerbated if the hospital or lay organization dominates the physician’s community. Thus, to
22 ensure effective peer review, physician peer review participants must be protected from the
23 possibility of retaliation”.⁸

24
25 Physician concerns about retaliation against physician peer review participants have grown as
26 hospitals employ more physicians and hospital markets become more concentrated. Many
27 communities in the United States are dominated by only a few hospitals, or even by a single
28 hospital. As more physicians have become employed by, or affiliated with, dominant hospitals or
29 other powerful lay organizations, some physicians increasingly fear retaliation for expressing
30 patient safety or care concerns during a peer review proceeding, or otherwise participating in a peer
31 review process, that the hospital or organization perceives as being contrary to its financial
32 interests.⁸

33
34 *Existing mechanisms for reporting complaints or concerns*

35
36 To understand the issue of the perceived limitations for physicians to safely report patient care
37 concerns due to the large influence and dominance of their health systems and/or seek recourse if
38 they believe a peer review process has been initiated against them based on unfounded, unfair
39 allegations, we evaluated the landscape of reporting mechanisms currently in place. Numerous
40 systems exist for physicians to report complaints about a peer, patient safety concerns within their
41 health system or other unethical or egregious practices they experience or observe within their
42 place of practice. These systems are in place at multiple levels to promote patient safety and
43 typically great efforts are made to ensure reports are confidential, so individuals feel safe and
44 confident in reporting concerns without fear of retaliation.

45
46 The most appropriate organization for a physician to file a complaint against a health care system
47 or hospital is their state medical board. Each state has at least one medical board that licenses
48 allopathic or osteopathic doctors, investigates complaints, disciplines physicians, and refers
49 physicians for evaluation and rehabilitation when appropriate.

1 Health care organizations should have in place reporting mechanisms through which physicians or
2 other professionals can confidentially submit concerns or complaints without fear of recourse or
3 retaliation. While this may be reasonable for expressing concerns about one's peer or colleague,
4 due to concerns about privacy or fear of consequences many physicians may not feel comfortable
5 bringing organization or system-level issues to their organization's leadership.

6
7 If physicians do not feel comfortable reporting concerns directly to their leadership or organization,
8 they may report concerns or complaints about their health system or hospital to The Joint
9 Commission if the organization is accredited or certified by The Joint Commission.⁹ The Joint
10 Commission's standards require leaders to provide and encourage the use of systems for blame-free
11 reporting of a system or process failure. The Joint Commission encourages practices to engage
12 frontline staff in internal reporting in a number of ways including (1) creating a nonpunitive
13 approach to patient safety event reporting, (2) educating staff on and encouraging them to identify
14 patient safety events that should be reported and (3) providing timely feedback regarding actions
15 taken on reported patient safety events.¹⁰

16
17 The U.S. Department of Health & Human Services (HHS) provides a mechanism for physicians
18 employed by HHS or one of its agencies, or whose employer receives HHS contract or grant
19 funding, to have their whistleblower retaliation complaints processed by HHS-Office of the
20 Inspector General. The actions of these physicians to expose unlawful activities such as abuse and
21 mismanagement within an HHS agency, (sub)contractor or (sub)grantee organization are protected
22 by HHS.¹¹ Individuals that submit a complaint can choose whether to provide identifying
23 information or remain anonymous.¹²

24
25 Also at the federal level, if a physician has been unfairly subjected to a peer review due to
26 underlying racial discrimination or denied compensation or benefits following a bad-faith peer
27 review, for example, they can report such violations to the U.S. Department of Labor (DOL). The
28 agency within the DOL that handles whistleblower retaliation allegations is the Occupational
29 Safety and Health Administration (OSHA). OSHA enforces the retaliation protections of more than
30 20 federal laws.¹³

31
32 If a physician believes they have been subjected to a bad-faith peer review in retaliation for making
33 complaints about discriminatory behavior, disclosing violations of the law, fraud, or abuse,
34 refusing to obey an order believed to be discriminatory or participating in discrimination or
35 whistleblower proceedings, one resource available to them for recourse is the EEOC.^{14,15} A
36 physician in this circumstance must provide evidence that (1) they participated in a protected
37 activity, (2) their employer took materially adverse action and (3) retaliation was the driving force
38 behind the employer's adverse action. Employer retaliatory action is any action that might deter a
39 reasonable person from engaging in protected activity.¹⁴

40
41 Two additional resources that may be beneficial to physicians harmed by a bad-faith peer review
42 are the Association of American Physicians and Surgeons (AAPS) Sham Peer Review Hotline and
43 the Center for Peer Review Justice. Physicians can call or email the AAPS hotline for an attorney
44 referral – a free resource for AAPS members.¹⁶ The Center for Peer Review Justice offers
45 complimentary second opinions, legal services, lectures and consultations regarding the NPDB.¹⁷

46
47 *Lack of publicly available information about complaints against hospitals and health systems*

48
49 There are no publicly available universal repositories that house information about U.S. physician
50 or hospital misconduct, sanctions, malpractice incidents or other complaints. Some entities collect
51 and track these elements, but none provide large-scale searchable tools for the public or for

1 physicians seeking information about health systems or hospitals. Most, if not all, states protect the
2 confidentiality of peer review information, meaning that peer review information, documents and
3 records cannot lawfully be disclosed to anyone except those conducting the peer review and any
4 other specific individuals or entities identified in the peer review statute.⁸ Here we describe the
5 available resources and their respective access levels.

6
7 The Joint Commission does not publish information about complaints, but its publicly available
8 Quality Check reports provide an indication of accreditation and quality performance. These
9 reports could be accessed by a physician looking to verify an organization's accreditation status
10 and quality reports before considering employment. The Quality Check reports published by The
11 Joint Commission could serve as a publicly accessible channel in which to publish final
12 determinations of physician complaints against hospitals and hospital systems.

13
14 Complaints to the EEOC are confidential and maintained for record-keeping purposes, as well as to
15 determine if the situation is covered by the EEOC, unless and until an individual files a
16 discrimination charge. After a charge is filed, the individual's name and basic information
17 surrounding the allegations are released to their employer. However, by law, this information is not
18 available to the public. Different protocols apply to federal employees.¹⁸

19
20 Individuals seeking information about a hospital or health system's involvement in malpractice
21 cases have the right to access public records through the federal, state or county court systems.
22 Typically, the public-facing systems provide basic information about cases, and do not disclose
23 information about proceedings or outcomes. More detailed court records may be accessible by the
24 public for a fee. These systems only demonstrate legal actions involving individuals or businesses,
25 however, and are not necessarily an indication of a hospital's quality or a physician's medical
26 competence. It is not recommended public court records be used as a basis for making employment
27 decisions.

28
29 State licensure and hospital credentialing entities require reporting of disciplinary investigations
30 and related actions on applications and renewal forms, which may include peer review committee
31 investigations. The NPDB collects and maintains information reported by the states and hospitals
32 including adverse licensure, professional review actions, clinical privileges actions, and medical
33 malpractice actions. It is the only federal database containing information about physician
34 malpractice, but the lack of contextual information about individual cases makes it an incomplete
35 and potentially misleading resource. The NPDB does not track and publish individual complaints
36 about health care organizations, health systems or other health care employers. The NPDB provides
37 access about individual practitioners only to authorized users, such as hospitals and medical boards,
38 but not the general public.¹⁹ Since its inception, there have been multiple attempts from members
39 of Congress and other stakeholders to make the NPDB public.²⁰⁻²²

40
41 Of note, the AMA has historically maintained opposition of attempts to make the NPDB available
42 to the public, instead supporting state-level efforts and the Federation of State Medical Boards
43 (FSMB) Physician Data Center ([Policy H-355.975, "Opposition to the National Practitioner Data
44 Bank"](#)).²³

45
46 The FSMB Physician Data Center collects information reported from state medical boards,
47 government regulatory entities, and international licensing authorities. Hospitals and health care
48 organizations, not the public, can search licensure history and past regulatory actions, including
49 revocations, suspensions, loss of license, probation restrictions and licensure denials, for actively
50 licensed physicians.²⁴

1 State medical boards provide the public with access to information about physician licensure status.
2 Many, if not most, also include general information about whether a physician has had disciplinary
3 action against them. These systems do not publish information about health care organizations.

4 *Amending the HCQIA to mandate monetary penalties for bad-faith peer reviews*

5
6 Policy H-200.971 recommends amendments to the HCQIA to impose monetary penalties for
7 institutions performing bad-faith peer reviews. Similarly, proposals for the imposition of monetary
8 penalties against hospitals that fail to report adverse actions to the NPDB have been attempted but
9 not adopted.²⁵ Some states impose financial penalties on hospitals for failure to report physician
10 misconduct, but they are reportedly difficult to enforce due to lack of resources for investigations
11 and a tendency for the state medical board to investigate the individual physician rather than the
12 entity that failed to report the incident.^{25,26}

13
14 Sham peer reviews are difficult to identify, prove, and track. The burden of proof lies with the
15 complainant, and it is challenging to acquire tangible proof that a hospital acted maliciously in
16 conducting a peer review. If an organization is found to have participated in or conducted a bad-
17 faith peer review, it is no longer protected by the immunity the HCQIA otherwise offers these
18 entities. It is thus subject to exposure to lawsuits, claims for damages and the risk of very costly
19 rulings.

20
21 Your Board of Trustees does not at this time recommend pursuing a HCQIA amendment strategy
22 because doing so could result in significant, negative unintended consequences, especially with
23 respect to the NPDB. Opening the law for amendment to mandate monetary penalties for health
24 care organizations could present opportunities for parties, whose interests are not aligned with
25 those of organized medicine, to reintroduce changes that have in the past been attempted. For
26 example, stakeholders outside organized medicine have strongly urged Congress to amend the
27 HCQIA so that the information in the NPDB would be publicly available. AMA opposes such
28 efforts. For example, AMA [Policy H-355.976, "National Practitioner Data Bank"](#) states in part:
29 "Our AMA: (a) opposes all efforts to open the National Practitioner Data Bank to public access; (b)
30 strongly opposes public access to medical malpractice payment information in the National
31 Practitioner Data Bank; and (c) opposes the implementation by the National Practitioner Data Bank
32 of a self-query user fee." The AMA has taken this position because information in the NPDB is
33 often incomplete and inaccurate, not organized in a way that patients will understand and is thus
34 highly likely to be misunderstood or misinterpreted by patients. For these reasons and those
35 previously mentioned, the Board does not recommend attempting to amend HCQIA.

36
37 **AMA POLICY**

38
39 The AMA has numerous policies affirming its position supporting retaliation protections, including
40 specifically in the context of peer review participation.

41
42 Our AMA: (1) opposes mandates from employers to supervise non-physician providers as a
43 condition for physician employment and in physician employment contracts; and (2) supports
44 whistleblower protections for physicians who report unsafe care provided by non-physicians to the
45 appropriate regulatory board ([Policy H-405.950, "Preserving the Practice of Medicine"](#)).

46
47 AMA policy states that physicians should be free to exercise their personal and professional
48 judgment in advocating on any matter regarding patient care interests and that employed physicians
49 should not be deemed in breach of their employment agreements, nor be retaliated against by their
50 employers for asserting these interests ([Policy H-225.950, "Principles for Physician Employment"](#));

1 [Policy H-225.952, “The Physician’s Right to Exercise Independent Judgement in All Organized](#)
2 [Medical Staff Affairs”](#)).
3

4 Further, the AMA condemns any action taken by administrators or governing bodies of hospitals or
5 other health care delivery systems who act in an administrative capacity to reduce or withdraw or
6 otherwise prevent a physician from exercising professional privileges because of medical staff
7 advocacy activities unrelated to professional competence, conduct or ethics ([Policy H-230.965,](#)
8 [“Immunity from Retaliation Against Medical Staff Representatives by Hospital Administrators”](#)).
9

10 Our AMA (1) supports whistleblower protections for health care professionals and parties who
11 raise questions that include, but are not limited to, issues of quality, safety and efficacy of health
12 care and are adversely treated by any health care organization or entity and (2) will advocate for
13 protection in medical staff bylaws to minimize negative repercussions for physicians who report
14 problems within their workplace ([Policy H-435.942, “Fair Process for Employed Physicians”](#)).
15

16 AMA policy also states that entities and participants engaged in good faith peer review activities
17 should be immune from civil damages, injunctive or equitable relief and criminal liability, and
18 should be afforded all available protections from any retaliatory actions that might be taken against
19 such entities or participants because of their involvement in peer review activities. This policy also
20 defines a “good faith peer review”, supports the confidentiality of peer review committee
21 proceedings and opposes efforts to make these proceedings or any resulting decisions public or
22 available via self-query ([Policy H-375.962, “Legal Protections for Peer Review”](#)).
23

24 Moreover, the AMA monitors legal and regulatory challenges to peer review immunity and non
25 discoverability of peer review records/proceedings and continues to advocate for adherence to
26 AMA policy, reporting challenges to peer review protections to the HOD ([Policy D-375.997, “Peer](#)
27 [Reviewer Immunity”](#)).
28

29 Additional AMA policies call for fair and unbiased peer review procedures that enable due process
30 for all participants.
31

32 In 2016, the AMA adopted policy directing it to study the current environment for effective peer
33 review in order to update current policy to include strategies for promoting effective peer review by
34 physicians and to consider a national strategy for protecting all physicians from retaliation as a
35 result from participating in effective peer review ([Policy D-375.987, “Effective Peer Review”](#)).
36

37 Additionally, the AMA published policy outlining appropriate peer review procedures that urge
38 state medical associations to determine if additional state agency supervision of peer review is
39 needed to meet the active state supervision requirement set forth by the Supreme Court, and that
40 peer review procedures should, at a minimum, meet the HCQIA standards for federal immunity
41 ([Policy H-375.983, “Appropriate Peer Review Procedures”](#)).
42

43 The AMA also adopted guidelines for obtaining outside reviewers when a fair review cannot be
44 conducted by hospital medical staff ([Policy H-375.960, “Protection Against External Peer Review](#)
45 [Abuses”](#)).
46

47 AMA policy encourages the use of physician data to benefit both patients and physicians and to
48 improve the quality of patient care and the efficient use of resources in the delivery of health care
49 services. The AMA supports this use of physician data when it is used in conjunction with
50 program(s) designed to improve or maintain the quality of, and access to, medical care for all

1 patients and is used to provide accurate physician performance assessments ([Policy H-406.991](#),
2 [“Work of the Task Force on the Release of Physician Data”](#)).

3 However, the AMA opposes the requirement that peer review organizations and private
4 accreditation entities report any negative action or finding to the NPDB ([Policy H-355.975](#),
5 [“Opposition to the National Practitioner Data Bank”](#)), advocates for amendments to the Freedom of
6 Information Act to exempt confidential peer review information from disclosure under the Act, and
7 supports appropriate efforts to prohibit discovery of information obtained in the course of peer
8 review proceedings ([Policy D-375.999](#), [“Confidentiality of Physician Peer Review”](#)).

9
10 Finally, the AMA Code of Medical Ethics includes opinions related to physicians’ right to report
11 concerns about their peers or organizations, the peer review process, and protections against
12 retaliation.

13
14 The AMA believes that physicians have mutual obligations to hold one another to the ethical
15 standards of their profession. Peer review, by the ethics committees of medical societies, hospital
16 credentials and utilization committees, or other bodies, has long been established by organized
17 medicine to scrutinize professional conduct. Peer review is recognized and accepted as a means of
18 promoting professionalism and maintaining trust. The peer review process is intended to balance
19 physicians’ right to exercise medical judgment freely with the obligation to do so wisely and
20 temperately ([Opinion 9.4.1 Peer Review & Due Process](#)).

21
22 The AMA also believes that physicians who become aware of or strongly suspect that conduct
23 threatens patient welfare or otherwise appears to violate ethical or legal standards should:

- 24
- 25 a) Report the conduct to appropriate clinical authorities in the first instance so that the
26 possible impact on patient welfare can be assessed and remedial action taken;
 - 27 b) Report directly to the state licensing board when the conduct in question poses an
28 immediate threat to the health and safety of patients or violates state licensing provisions.
 - 29 (c) Report to a higher authority if the conduct continues unchanged despite initial reporting.
 - 30 (d) Protect the privacy of any patients who may be involved to the greatest extent possible,
31 consistent with due process.
 - 32 (e) Report the suspected violation to appropriate authorities ([Opinion 9.4.2 Reporting](#)
33 [Incompetent or Unethical Behavior by Colleagues](#)).
- 34

35 AMA RESOURCES

36
37 The AMA, despite having an abundance of policy on the matter, has not published a significant
38 number of resources to help physicians navigate the tumultuous processes of reporting concerns or
39 being the subject of a peer review. Existing resources include the following.

40
41 The AMA’s [Principles for Physician Employment](#) include principles for peer review and
42 performance evaluations and state that employed physicians should be accorded due-process
43 protections, including a fair and objective hearing, in all peer review proceedings.
44 For medical staff leadership, the AMA Credentialing Services offers a webinar entitled, [“Medical](#)
45 [Group Peer Review: Legal Issues and Possible Protections”](#), that provides information about the
46 importance of ensuring fair peer review proceedings to mitigate liability.

47
48 Finally, physicians can submit concerns or complaints about another physician or health
49 professional to the AMA, although the AMA Code of Medical Ethics states that grievances against
50 a medical professional who is believed to be acting unethically or not providing a certain standard

1 of care should be directed to the state medical licensing board. The AMA will not investigate any
2 complaints of misconduct or unethical behavior by physicians or health care organizations, nor
3 does the AMA have legal authority or the proper resources to investigate individual cases.

4
5 CONCLUSION

6
7 The key issues underpinning Policy H-200.971 are the (1) perceived limitations for physicians to
8 safely, and without fear of retaliation, report patient care concerns due to the large influence and
9 market dominance many health systems have; (2) the conduct of bad-faith peer reviews or other
10 mistreatment or retaliation against physicians that have reported concerns; (3) lack of publicly
11 available information about complaints against hospitals and health systems; and (4) the potential
12 amendment of the HCQIA to add monetary penalties for entities found to have conducted bad-faith
13 peer reviews.

14
15 This report provides detailed information about multiple systems in place for physicians to report
16 concerns about their health system or hospital employer. Despite the attempts to make these
17 systems safe and confidential, and the fact that employed physicians are protected from retaliation
18 by state and federal laws, there are often still barriers that prevent physicians from reporting
19 concerns without fear of retaliation in some form and/or seeking adequate recourse if a bad-faith
20 peer review process is initiated against them.

21
22 Peer reviews in medicine will continue to be a mainstay in ensuring safe and ethical patient care is
23 provided by competent physicians. When conducted appropriately and according to acceptable
24 standards, peer reviews are a valuable tool for the health care system. The conduct of bad-faith peer
25 reviews, however, is morally, ethically and professionally abhorrent, and runs counter to
26 everything that physicians and the practice of medicine stand for.

27 Also highlighted in this report are several entities that collect and publish data on physician
28 licensure, malpractice payments, and disciplinary actions. None of the systems that house this data
29 make it available to the public. To our knowledge, no systems are in place to track and publicly
30 report malpractice information or complaints against hospitals or health systems. It has long been
31 the position of the AMA that malpractice payment information should not be made public. And
32 while AMA policy requires state medical boards report disciplinary action to the AMA and FSMB,
33 it does not call for or endorse the public reporting of such information. Physicians have numerous
34 other options for locating organization-related information when seeking new employment, and the
35 AMA does not support efforts to require the AMA, FSMB, The Joint Commission or any state or
36 federal entity to dedicate resources to providing this information to the public for the purposes of
37 aiding job seekers in their employment decisions. It is also the AMA's position that providing the
38 public with access to incomplete information devoid of context would invite more issues than it
39 would resolve. The AMA does, however, support transparent reporting of final determinations of
40 physician complaints against hospitals and health systems through publicly accessible channels
41 such as The Joint Commission Quality Check reports.

42
43 Finally, we address the request for the AMA to recommend amendments to the HCQIA to impose
44 monetary penalties on perpetrators of bad-faith peer reviews. The HCQIA provides protection for
45 hospitals and peer review committees, so long as their peer reviews are conducted in a manner
46 consistent with the law. They are no longer entitled to such immunity if it is found they participated
47 in or led a bad-faith peer review. In the U.S., the justice system is in the position to facilitate the
48 appropriate penalization of organizations faced with lawsuits and damages brought on by their
49 participation in bad-faith peer reviews. Considering (1) that protection under the HCQIA is not

1 provided to organizations failing to meet the HCQIA’s four standards of professional review; (2)
2 the AMA has historically opposed attempts to amend the HCQIA; and (3) monetary penalties at the
3 state level have not resulted in increased reporting or reduced incident rates, the AMA does not
4 recommend new attempts to amend the HCQIA for the purposes of adding such penalties for
5 organizations involved in bad-faith peer reviews.^{25,27,28}

6 RECOMMENDATIONS

7

8 The Board of Trustees recommends:

9

- 10 1. The following policies be reaffirmed:
- 11 a. Policy H-405.950, “Preserving the Practice of Medicine”
 - 12 b. Policy H-225.950, “Principles for Physician Employment”
 - 13 c. Policy H-225.952, “The Physician’s Right to Exercise Independent Judgement in
 - 14 All Organized Medical Staff Affairs”
 - 15 d. Policy H-230.965, “Immunity from Retaliation Against Medical Staff
 - 16 Representatives by Hospital Administrators”
 - 17 e. Policy H-435.942, “Fair Process for Employed Physicians”
 - 18 f. Policy H-375.962, “Legal Protections for Peer Review
 - 19 g. Policy D-375.987, “Effective Peer Review”
 - 20 h. Policy H-375.960, “Protection Against External Peer Review Abuses” (Reaffirm
 - 21 HOD policy); and
 - 22
- 23 2. That the following policy statement be adopted to supersede Policy H-200.971,
- 24 “Transparency and Accountability of Hospitals and Hospital Systems,”:
- 25 a. The AMA supports transparent reporting of final determinations of physician
 - 26 complaints against hospitals and health systems through publicly accessible
 - 27 channels such as the Joint Commission Quality Check reports (New HOD Policy).
 - 28 b. The AMA will develop educational materials on the peer review process, including
 - 29 information about what constitutes a bad-faith peer review and what options
 - 30 physicians may have in navigating the peer review process (Directive to Take
 - 31 Action).
 - 32
- 33 3. That the title of Policy H-200.971, “Transparency and Accountability of Hospitals and
- 34 Hospital Systems,” be changed to:
- 35 a. “Transparent Reporting of Physician Complaints Against Hospitals and Health
 - 36 Systems”
 - 37
- 38 4. That the remainder of this report be filed.

Fiscal note: Minimal

REFERENCES

1. Gharagozloo F, Poston R, Gruessner RW. Consequences for Whistleblowing: Retaliation, Sham Peer Review and Hospital Immunity. *J Biomed Res Environ Sci.* 2023;4(2):235-238.
2. American Medical Association. Chapter 9.4.1: Peer Review & Due Process. *AMA Code of Medical Ethics.* American Medical Association; 2022. Accessed February 26, 2024. <https://code-medical-ethics.ama-assn.org/ethics-opinions/peer-review-due-process>
3. van Geertruyden YHH. The Fox Guarding the Henhouse: How the Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review in the Medical Community Comment. *J Contemp Health Law Policy.* 2001;18(1):239-272. <https://heinonline.org/HOL/P?h=hein.journals/jchlp18&i=249>
4. American Medical Association. *Legal Protections for Peer Review.* H-375.962.; 2017. Accessed February 27, 2024. <https://policysearch.ama-assn.org/policyfinder/detail/Legal%20Protections%20for%20Peer%20Review?uri=%2FAMADoc%2FHOD.xml-0-3167.xml>
5. Wyden R. *Health Care Quality Improvement Act of 1986.*; 1986. Accessed February 27, 2024. <https://www.congress.gov/bill/99th-congress/house-bill/5540>
6. Welch SS, Hoffler T “CK.” An Epidemic of Racism in Peer Review: Killing Access to Black and Brown Physicians. *Race, Racism and the Law.* Published June 12, 2022. Accessed February 23, 2024. <https://racism.org/articles/basic-needs/54-health-and-health-care/230-health-care-generally/191-barrierstoaccess/10414-an-epidemic>
7. American Medical Association. Inappropriate Peer Review. *Proceedings of the American Medical Association House of Delegates 157th Annual Meeting.*; 2008. Accessed February 26, 2024. http://ama.nmtvault.com/jsp/PsImageViewer.jsp?doc_id
8. American Medical Association. Effective Peer Review. *2017 Interim Meeting of the AMA House of Delegates Reference Committee on Amendments to Constitution and Bylaws.*; 2017. Accessed February 27, 2024. <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/hod/i17-refcomm-conby.pdf>
9. The Joint Commission. Report a Patient Safety Concern or File a Complaint. The Joint Commission. Published 2024. Accessed February 27, 2024. <https://www.jointcommission.org/resources/patient-safety-topics/report-a-patient-safety-concern-or-complaint/>
10. The Joint Commission. Patient Safety Systems (PS). The Joint Commission. Published January 2024. Accessed February 27, 2024. https://www.jointcommission.org/-/media/tjc/documents/standards/ps-chapters/2023/camobs_ps_20230905_115451.pdf
11. Office of the Inspector General. Report Whistleblower Retaliation: Eligibility. OIG-HHS. Published 2024. Accessed February 24, 2024. <https://tips.oig.hhs.gov/report-whistleblower-retaliation/eligibility>
12. Office of the Inspector General. Report Whistleblower Retaliation: Your Identity. OIG-HHS. Published 2024. Accessed February 24, 2024. <https://tips.oig.hhs.gov/report-whistleblower-retaliation/identity>
13. Meyers C. How to Report an Employer to the Department of Labor. Findlaw. Published November 19, 2021. Accessed February 24, 2024. <https://www.findlaw.com/employment/whistleblowers/how-to-report-an-employer-to-the-department-of-labor.html>
14. U.S. Equal Employment Opportunity Commission. Questions and Answers: Enforcement Guidance on Retaliation and Related Issues. US EEOC. Published August 26, 2016. Accessed February 23, 2024. <https://www.eeoc.gov/laws/guidance/questions-and-answers-enforcement-guidance-retaliation-and-related-issues>

15. U.S. Department of the Interior. What are Discrimination, Harassment, Harassing Conduct, and Retaliation? DOI. Published December 14, 2017. Accessed February 23, 2024. <https://www.doi.gov/employees/anti-harassment/definitions>
16. Association of American Physicians and Surgeons. Sham Peer Review: Resources for Physicians. AAPS. Published November 17, 2023. Accessed February 24, 2024. <https://aapsonline.org/sham-peer-review-resources-for-physicians/>
17. Center for Peer Review Justice. Center for Peer Review Justice. Center for Peer Review Justice. Published 2018. Accessed February 24, 2024. <https://peerreviewjustice.org/>
18. U.S. Equal Employment Opportunity Commission. Confidentiality. US EEOC. Published 2024. Accessed February 23, 2024. <https://www.eeoc.gov/confidentiality>
19. National Practitioner Data Bank. How to Get Started for Practitioners. NPDB. Published 2024. Accessed February 27, 2024. <https://www.npdb.hrsa.gov/pract/howToGetStarted.jsp>
20. Bliley T. *Patient Protection Act of 2000.*; 2000. Accessed February 27, 2024. <https://www.govinfo.gov/app/details/BILLS-106hr5122ih>
21. Barker Pape J. Physician Date Banks: The Public's Right to Know Versus the Physician Date Banks: The Public's Right to Know Versus the Physician's Right to Privacy. *Fordham Law Rev.* 1997;66(3). Accessed February 27, 2024. <https://ir.lawnet.fordham.edu/cgi/viewcontent.cgi?article=3417&context=flr>
22. Wolfe SM. Congress Should Open the National Practitioner Data Bank to All. *Public Health Rep.* 1995;110(4):378-379. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1382144/>
23. American Medical Association. *Opposition to the National Practitioner Data Bank.* Vol H-355.975.; 2014. Accessed February 27, 2024. <https://policysearch.ama-assn.org/policyfinder/detail/Opposition%20to%20the%20National%20Practitioner%20Data%20Bank?uri=%2FAMADoc%2FHOD.xml-0-3050.xml>
24. FSMB. PDC Query. FSMB. Published 2024. Accessed February 27, 2024. <https://www.fsmb.org/PDC/pdc-query/>
25. Sawicki NN. State Peer Review Laws as a Tool to Incentivize Reporting to State Peer Review Laws as a Tool to Incentivize Reporting to Medical Boards Medical Boards. *Loyola Univ Chic Law ECommons.* Published online 2021. Accessed February 27, 2024. <https://lawecommons.luc.edu/cgi/viewcontent.cgi?article=1727&context=facpubs>
26. Pendo E, McIntosh T, Walsh H, Baldwin K, Dubois JM. Protecting Patients from Physicians Who Inflict Harm: New Legal Resources for State Medical Boards. *J Health Law Policy.* 2022;15(1). Accessed February 27, 2024. <https://papers.ssrn.com/abstract=4078215>
27. U.S. Government Publishing Office. Chapter 117, §11112- Standards for Professional Review Actions. *Title 42, Chapter 117- Encouraging Good Faith Professional Review Activities.* 2011th ed. United States Code; 2011. Accessed March 5, 2024. <https://www.govinfo.gov/content/pkg/USCODE-2011-title42/html/USCODE-2011-title42-chap117.htm>
28. Rodgers AW. Procedural Protections During Medical Peer Review: A Reinterpretation of the Health Care Quality Improvement Act of Reinterpretation of the Health Care Quality Improvement Act of 1986. *Dickinson Law Rev.* 2007;111(2006-2007). Accessed March 5, 2024. <https://ideas.dickinsonlaw.psu.edu/cgi/viewcontent.cgi?article=3838&context=dlra>

REPORT OF THE BOARD OF TRUSTEES

B of T Report 30-A-24

Subject: Proper Use of Overseas Virtual Assistants in Medical Practice

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee G

1 At the 2023 Annual Meeting of the House of Delegates (HOD), Policy H-200.947, “Proper Use of
2 Virtual Assistants in Medical Practice”, was adopted. This policy directed the American Medical
3 Association (AMA) to (1) support the concept that properly trained overseas virtual assistants are
4 an acceptable way to staff administrative roles in medical practice (New HOD Policy), and (2)
5 study and offer formal guidance for physicians on how best to utilize overseas virtual assistants in
6 such a way as to ensure protections for physicians, practices, patient outcomes, and overseas
7 medical staff (Directive to Take Action).

8
9 This report details guidance, considerations (e.g., equity, diversity and inclusion, business and
10 compliance), opportunities and challenges regarding the appropriate use of overseas virtual
11 assistants by medical practices. Additionally, relevant AMA policy is discussed. Based on this
12 information, AMA identified the need for the creation and publication of educational materials for
13 medical practices that provide guidance on how best to utilize overseas virtual assistants in a
14 manner that protects physicians, practices, patients, and overseas medical staff.

15
16 **BACKGROUND**

17
18 Over the last two decades, health care organizations have increasingly outsourced administrative
19 and certain clinical work – such as revenue cycle management, coding and billing, IT support and
20 prior authorization tasks – to entities or individuals that reside in different time zones. Outsourcing,
21 a business agreement in which an organization contracts out the procurement of products or
22 services to an external firm, became widely used in health care during the early 2000s.

23 Organizations pursue these arrangements with the goals of lowering administrative costs, raising
24 productivity, and addressing workforce shortages. In 2017 alone, health care industry outsourcing
25 grew by 36%.¹

26
27 In addition to outsourcing, health care organizations also began using remote employees for
28 administrative positions. Remote work is the practice of working from one’s home or another space
29 separate from the office. Medical practices adopted remote work for employees for several reasons,
30 including office closures during the COVID-19 pandemic, limited working space within the
31 medical practice, employee retention and satisfaction and decreased practice overhead costs.¹

32
33 In recent years, there has been an evolution from remote employees to virtual assistants. While
34 remote employees are employed by the practice directly, a virtual assistant is an independent
35 contractor who provides administrative services to clients while operating outside of the client’s
36 office. As such, the individual can be located anywhere in the world, broadening the candidate
37 options for companies. Virtual assistants can also include artificial intelligence in software used by

1 medical practices. As this resolution is specific to human virtual assistants, this report does not
2 consider artificial intelligence virtual assistants.¹

3
4 The primary benefit of using virtual assistants in medical practice is to offload administrative
5 duties to decrease physician workload and allow more time for patient care. Properly informed
6 medical practices can successfully utilize overseas or domestic virtual assistants for nonclinical,
7 administrative tasks, including but not limited to appointment scheduling and reminders, sending
8 and receiving patient medical records, visit note dictation, prior authorization requests, charge
9 entry, claim submission, claim control, and follow-up. Additionally, the use of overseas virtual
10 assistants can have economic benefits for medical practices. For instance, virtual assistants can be
11 hired for a set number of hours or tasks each week instead of hiring a full-time employee, lowering
12 staffing costs for the practice. They also typically have a lower hourly rate than those in the U.S.
13 largely due to a lower cost of living in the countries they live.²

14
15 Medical practices seeking virtual assistants outside of the U.S. can utilize online job boards
16 specific to the geographical area they would like to search. One example is [OnlineJobs.ph](https://www.onlinejobs.ph), a job
17 board that connects companies to virtual assistants located in the Philippines.³ These online job
18 boards facilitate the initial communication and interview process and provide employers with best
19 practices for training virtual assistants located within the U.S. or overseas.

20 21 *Business and Compliance Considerations*

22
23 There are several business and compliance considerations that medical practices should review
24 before hiring a virtual assistant, including employee classification, global labor protections, and
25 HIPAA compliance standards. Virtual assistants classified as independent contractors are required
26 to report their income for taxes and social contributions within their country on their own. In
27 contrast, remote direct hires are employed by the practice and may require additional tax liabilities,
28 withholdings and employee benefits depending on local labor laws where the individual lives.
29 Medical practices should consult an accountant for any reporting requirements the practice has for
30 virtual assistants classified as independent contractors.⁴

31
32 Securing private and confidential data is of the utmost importance, especially when working
33 remotely. To protect sensitive data, health care organizations and medical practices that utilize
34 virtual assistants should establish data protection protocols and obtain the appropriate consents
35 from users.⁵ The AMA has created several resources to guide medical practices through the process
36 of securing patient health information, including guidance on [Implementing a Work-From-Home
37 Program](#), a tip sheet for [Working from home during COVID-19 pandemic](#), a checklist for
38 [protecting office computers in medical practices against cyberattacks](#) and [technology
39 considerations for working remotely](#). However, medical practices employing virtual assistants
40 should still consult with their IT vendor to ensure the security of patient health information.

41 42 *Equity, Diversity, and Inclusion Considerations*

43
44 When considering using overseas virtual assistants, medical practices and health care organizations
45 should prioritize equity, diversity, and inclusion. For example, it is important that practices and
46 organizations verify the U.S. Dollar conversion to the currency used by the virtual assistant or
47 employee to ensure fair and reasonable compensation.

48
49 Other considerations include the virtual assistant work schedule if there is a large time difference
50 between in-office staff within the country the organization operates in and the country in which
51 overseas virtual assistants live. This is essential to promote a healthy work environment.¹ For

1 example, some medical practices and health care organizations outsource the entirety of their
2 customer service operations overseas and also supply these services for 24-hours. Time zone
3 compatibility between the medical practice and virtual assistant can impact employee health and
4 quality of life. Night shift workers experience an incompatibility with family leisure time and the
5 unavailability of services during nighttime hours.⁶ These workers are prevented from recovering
6 from a long day of work in the way that day shift workers can. Rather, when their shift ends, they
7 must still function in a world operating on a completely different schedule. Studies have examined
8 the social ramifications to this work. For instance, night shift workers have been demonstrated to
9 experience divorce rates as high as 30 percent.⁷ Health risks among night shift workers have also
10 been analyzed. In a study of night shift employees working at international call centers in the
11 National Capital Region (NCR) of Delhi, 77.6 percent of participants had some suspicion of
12 insomnia or suspected insomnia. In addition to sleep quality issues, 44.3 percent of participants
13 were cigarette smokers and 37 percent reported physical ailments.⁸ Further, a Circadian
14 Technologies study reported that night shift workers were 20 percent more likely to experience
15 severe accidents.⁷ Additionally, research shows that these workers may be at greater risk of
16 cardiovascular disease, gastrointestinal disease, psychological disorders, cancers, diabetes, obesity
17 and adverse reproductive outcomes.^{7,9}

18
19 However, instances also exist where time zone differences can benefit both U.S. and overseas staff.
20 For example, some organizations and practices outsource their operations overseas part-time so that
21 work is performed by overseas staff during their local day-time hours after which their workday
22 concludes and the work they performed is available to U.S. staff who then begin working their day-
23 time schedule.

24 25 *Training for Overseas Virtual Assistants in Medical Practice*

26
27 Medical practices would benefit from the adoption of in-house training programs for virtual
28 assistants that includes general knowledge of health care administration and compliance, as well as
29 processes and procedures specific to the practice. Training on the general knowledge of health care
30 administration is available for little or no cost from professional organizations, such as the AMA's
31 [Navigating Practice Series](#) and [AMA STEPS Forward® Private Practice playbook](#). Several
32 resources also exist from the Medical Group Management Association. Before implementing any
33 virtual assistant or employee, the medical practice or health care organization would benefit from a
34 clear strategic plan that outlines and addresses the risks previously mentioned.

35 36 AMA POLICY

37
38 The AMA has several policies related to the appropriate use of overseas virtual assistants for
39 administrative functions within medical practices.

40
41 The AMA will work towards its goal of health equity, defined as optimal health for all, by
42 advocating for health care access, research, and data collection; promoting equity in care;
43 increasing health workforce diversity; influencing determinants of health; and voicing and
44 modeling commitment to health equity ([Policy H-180.944, "Plan for Continued Progress Toward
45 Health Equity"](#)).

46
47 The AMA will also explore emerging technologies to automate the prior authorization process for
48 medical services and evaluate their efficiency and scalability, while advocating for reduction in the
49 overall volume of prior authorization requirements to ensure timely access to medically necessary
50 care for patients and reduce practice administrative burdens ([Policy D-320.982, "Prior
51 Authorization Reform"](#)).

1 Additionally, the AMA:

- 2
- 3 a. Supports the need for developing and implementing technologies to reduce glare from
4 vehicle headlamps and roadway lighting schemes, and developing lighting technologies at
5 home and at work that minimize circadian disruption, while maintaining visual efficiency.
- 6 b. Recognizes that exposure to excessive light at night, including extended use of various
7 electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and
8 adolescents. This effect can be minimized by using dim red lighting in the nighttime
9 bedroom environment.
- 10
- 11 c. Supports the need for further multidisciplinary research on the risks and benefits of
12 occupational and environmental exposure to light-at-night.
- 13
- 14 d. Encourages work environments that operate in a 24/7 hour fashion to have an employee
15 fatigue risk management plan in place ([Policy H-135.932, "Light Pollution: Adverse
16 Health Effects of Nighttime Lighting"](#)).
- 17

18 DISCUSSION

19 *Opportunities for Overseas Virtual Assistants in Medical Practice*

20 U.S. companies have struggled with staffing shortages since 2021, known as “The Great
21 Resignation”.¹⁰ Health care is no exception, and the industry has arguably struggled more with
22 staffing shortages due to higher levels of burnout post-COVID-19 pandemic, higher levels of
23 administrative burden, diminished reimbursement and a decline in overall annual revenue.¹¹⁻¹⁴

24 The ability to quickly find and hire experienced individuals is crucial for the success of medical
25 practices. When practices are short-staffed, physicians take on the extra workload, decreasing time
26 spent with patients and contributing to burnout. Overseas virtual assistants, when successfully
27 integrated into practice operations, can enable medical practices to expand their talent search
28 beyond U.S. borders to choose among an expansive talent pool to quickly hire an experienced
29 workforce at a much lower cost than those based in the U.S. Additionally, virtual assistants do not
30 require physical space to work in the office, thus lowering the physical infrastructure cost for
31 medical practices.

32 *Risks Associated with Utilizing Overseas Virtual Assistants in Medical Practice*

33 Despite expectations, studies show that outsourcing any health care role contains risks such as the
34 loss of control over work quality, exposure of patient health information and other secure data, the
35 lack of provision of anticipated financial benefits and jeopardization of the organization’s culture
36 and reputation.¹

37 CONCLUSION

38 Medical practices struggling to fill vacant positions may turn to virtual assistants within the U.S. or
39 overseas. While virtual assistants can offer cost-saving and efficiency benefits to medical practices,
40 it is imperative that practices have a clear strategic plan before hiring a virtual assistant. This plan
41 should include the security of patient information, in-house training/onboarding for the employee,
42 fair pay and working hours, and management of the virtual employee's work quality and
43 engagement with the rest of the practice. The creation of a strategic plan will allow the medical
44 practice to consider all variables and determine how best to utilize a virtual assistant within their

1 practice. With an informed approach, the use of properly trained overseas virtual assistants is an
2 option for medical practices.

3

4 RECOMMENDATIONS

5

6 The Board of Trustees recommends that the following be adopted, and the remainder of the report
7 be filed:

8

9 1. That our American Medical Association (AMA) reaffirm the following policies:

10

a. H-385.951- Remuneration for Physician Services

11

b. H-180.944 - Plan for Continued Progress Toward Health Equity

12

c. H-135.932 - Light Pollution: Adverse Health Effects of Nighttime Lighting;

13

(Reaffirm HOD Policy) and

14

15 2. That Policy H-200.947 be amended to read as follows: “Our AMA: (1) supports the
16 concept that properly trained ~~overseas~~ virtual assistants, in the U.S. or overseas, are an
17 acceptable way to staff administrative roles in medical practices; and (2) will ~~study and~~
18 ~~offer formal guidance for physicians on how best to utilize overseas virtual assistants to~~
19 ~~ensure protection of patients, physicians, practices, and equitable employment in~~
20 ~~communities served, in a manner consistent with appropriate compliance standards~~ create
21 and publish educational materials for medical practices that offer formal guidance on how
22 best to utilize virtual assistants to ensure protection of patients, physicians, virtual
23 assistants and practices.” (Modify Current HOD Policy).

Fiscal Note: Moderate

REFERENCES

1. Berry LL, Letchuman S, Ramani N, Barach P. The High Stakes of Outsourcing in Health Care. *Mayo Clin Proc*. Published 2021;96(11):2879-2890. Accessed February 2024. <https://pubmed.ncbi.nlm.nih.gov/34412855/>
2. Chappell N. Offshore vs Local Outsourcing to Virtual Assistants. *Positively Sorted*. Published October 3, 2019. Accessed March 14, 2024. <https://www.positivelysorted.com.au/blog/offshore-vs-local-virtual-assistants>
3. OnlineJobs.ph. The Job Board for Virtual Workers in the Philippines. *OnlineJobs.ph*. Published 2024. Accessed February 9, 2024. <https://www.onlinejobs.ph/>
4. We Work Remotely. Hiring Overseas Employees: A Complete Guide. *We Work Remotely*. Published 2024. Accessed February 1, 2024. <https://weworkremotely.com/hiring-overseas-employees-a-complete-guide>
5. San Jose P. Legal Issues Having a Virtual Assistant. *LinkedIn*. Published September 8, 2023. Accessed March 15, 2024. <https://www.linkedin.com/pulse/legal-issues-having-virtual-assistant-patricia-san-jose/>
6. Matsuoka Y, Fukushima M. Time Zones, Shift Working and International Outsourcing. *Int Rev Econ Finance*. Published 2009;19(4):769-778. Accessed February 2024. <https://www.sciencedirect.com/science/article/pii/S1059056010000377>
7. Hazelwood K. Scary Truths about the Graveyard Shift. *Bloomberg*. Published July 10, 2003. Accessed January 18, 2024. <https://www.bloomberg.com/news/articles/2003-07-10/scary-truths-about-the-graveyard-shift>
8. Raja J, Bhasin S. Sleep Quality of Call Handlers Employed in International Call Centers in National Capital Region of Delhi, India. *Int J Occup Environ Med*. Published 2016;7(4):207-214. Accessed February 2024. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6817959/>
9. The National Institute for Occupational Safety and Health. Diseases and Shift Work. Centers for Disease Control and Prevention. Published March 31, 2020. Accessed January 18, 2024. <https://www.cdc.gov/niosh/work-hour-training-for-nurses/longhours/mod3/15.html>
10. Parker K, Horowitz JM. Majority of Workers Who Quit a Job in 2021 Cite Low Pay, No Opportunities for Advancement, Feeling Disrespected. *Pew Research Center*. Published March 9, 2022. Accessed February 22, 2024. <https://www.pewresearch.org/short-reads/2022/03/09/majority-of-workers-who-quit-a-job-in-2021-cite-low-pay-no-opportunities-for-advancement-feeling-disrespected/>
11. Rotenstein LS, Brown R, Sinsky C, Linzer M. The Association of Work Overload with Burnout and Intent to Leave the Job Across the Healthcare Workforce During COVID-19. *J Gen Intern Med*. Published March 23, 2023;1-8. Accessed February 2024. <https://doi.org/10.1007/s11606-023-08153-z>
12. Kim A, Novinson D. Administrative Burden Remains Biggest Driver of Burnout, Doctors Say. *Doximity*. Published August 22, 2022. Accessed June 5, 2023. <https://opmed.doximity.com/articles/administrative-burden-remains-biggest-driver-of-burnout-doctors-say>
13. American Medical Association. Medicare Physician Payments Need Overhaul STAT. *American Medical Association*. Published September 1, 2023. Accessed February 22, 2024. <https://www.ama-assn.org/press-center/press-releases/medicare-physician-payments-need-overhaul-stat>
14. Hill G. How did the COVID-19 Pandemic Affect Healthcare Spending? *Bur Labor Stat*. Published 2023;12(14). Accessed February 22, 2024. <https://www.bls.gov/opub/btn/volume-12/how-did-the-covid-19-pandemic-affect-healthcare-spending.htm>

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-24

Subject: Council on Medical Service Sunset Review of 2014 House Policies

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee G

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- 1 Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of
2 American Medical Association (AMA) policies to ensure that our AMA’s policy database is
3 current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for
4 review and specifying the procedures to follow:
5
- 6 1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A
7 policy will typically sunset after ten years unless action is taken by the House of Delegates to
8 retain it. Any action of our AMA House that reaffirms or amends an existing policy position
9 shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another ten
10 years.
11
 - 12 2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the
13 following procedures shall be followed: (a) Each year, the Speakers shall provide a list of
14 policies that are subject to review under the policy sunset mechanism; (b) Such policies shall
15 be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been
16 asked to review policies shall develop and submit a report to the House of Delegates
17 identifying policies that are scheduled to sunset; (d) For each policy under review, the
18 reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset
19 the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like
20 policy; (e) For each recommendation that it makes to retain a policy in any fashion, the
21 reviewing council shall provide a succinct, but cogent justification; or (f) The Speakers shall
22 determine the best way for the House of Delegates to handle the sunset reports.
23
 - 24 3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier
25 than its 10-year horizon if it is no longer relevant, has been superseded by a more current
26 policy, or has been accomplished.
27
 - 28 4. The AMA councils and the House of Delegates should conform to the following guidelines for
29 sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has
30 been accomplished; or (c) when the policy or directive is part of an established AMA practice
31 that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA
32 House of Delegates Reference Manual: Procedures, Policies and Practices.
33
 - 34 5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
35
 - 36 6. Sunset policies will be retained in the AMA historical archives.

1 RECOMMENDATION

2

3 The Council on Medical Service recommends that the House of Delegates policies that are
4 listed in the appendix to this report be acted upon in the manner indicated and the
5 remainder of this report be filed.

APPENDIX – Recommended Actions

APPENDIX – Recommended Actions

POLICY #	Title	Text	Recommendation
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.	<p>Rescind. Superseded by Policy H-110.987.</p> <p>Pharmaceutical Costs H-110.987</p> <ol style="list-style-type: none"> 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.

POLICY #	Title	Text	Recommendation
			<p>7. Our AMA supports legislation to shorten the exclusivity period for biologics.</p> <p>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.</p> <p>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.</p> <p>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 ten percent 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 ten percent or more each year or per course of treatment.</p> <p>11. Our AMA advocates for policies that prohibit price gouging on prescription</p>

POLICY #	Title	Text	Recommendation
			<p>medications when there are no justifiable factors or data to support the price increase.</p> <p>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.</p> <p>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.</p> <p>14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.</p>
D-120.943	Review of Straddle Drug Pricing Rules for Medicare Part D Participants	Our AMA: (1) urges the Centers for Medicare and Medicaid Services (CMS) to examine how Medicare Part D plans are applying the straddle drug pricing rules and determine whether costs are being inappropriately shifted to beneficiaries whose drug spending totals span multiple coverage phases; and (2) will prepare a report explaining the straddle drug pricing rules and their potential impact on patients, incorporating information that is available from CMS regarding implementation by Part D plans.	Retain.
D-160.929	Patient Education Regarding the Medicare Chronic Care Management Fee	Our AMA will create a model letter that its members may use to explain the Medicare chronic care management fee to their patients.	Retain.
D-160.931	CMS Two Midnight Policy	Our AMA encourages the Centers for Medicare & Medicaid Services to educate the public and develop tools for physicians and patients that outline the financial impact of the two midnight policy.	Retain.
D-160.932	Medicare's Two-Midnight Rule	Our AMA will petition the Centers for Medicare & Medicaid Services to repeal the August 19 rules	Retain.

POLICY #	Title	Text	Recommendation
		regarding Hospital Inpatient Admission Order and Certification.	
D-160.990	Identification of Health Care Providers	Our AMA will encourage all medical facilities to provide reliable identification of health care providers.	Retain.
D-165.937	Health System Reform Resources	Our AMA will continue to develop resources to help physician practices address the ongoing and emerging issues associated with expanding health insurance coverage under the Affordable Care Act.	Retain.
D-165.981	Transitional Issues in Moving Toward a System of Individually Selected and Owned Health Insurance	(1) Our AMA will inform individual physicians and group practice administrators why self-paying patients (e.g., those who have MSA-type coverage or are uninsured) may be at a significant price disadvantage in purchasing health care services.	Retain.
D-180.994	Rescinding Provisions Requiring Physicians to Have Hospital Admitting Privileges	Our AMA will work with the American Association of Health Plans, Health Insurance Association of America, and other appropriate organizations to rescind provisions requiring physicians to have hospital medical staff privileges in order to participate in health plans.	Retain.
D-185.995	Health Plan Coverage of Prescription Drugs	Our AMA will: (1) advocate AMA policies related to health plan coverage of prescription drugs to pharmacy benefit managers, as well as to public and private sector payers; and (2) advocate for the enactment of legislation consistent with AMA policies related to health plan coverage of prescription drugs.	Retain.
D-230.986	Opposition to Proposed Revision of CMS Conditions of Participation that Limit the Autonomy, Self Governance and Quality Oversight of the Organized Medical Staff	1. Our AMA through appropriate means, including but not limited to a formal response during the current comment period for the proposed regulation on conditions of participation (CoP) or necessary legal action, including injunctive relief, will actively oppose any Centers for Medicare & Medicaid Services (CMS) policy that would bypass or remove the clinical quality and safety oversight, and credentialing and privileging responsibilities of the physician	Retain.

POLICY #	Title	Text	Recommendation
		<p>members of the Organized Medical Staff, or that would allow a practitioner to practice at a hospital without being a member of the medical staff.</p> <p>2. Our AMA will actively educate our AMA physician members of the proposed revisions to the CoP by CMS, and the potential adverse effects of such proposals on the quality and safety of patient care, and encourage them to respond individually during the CMS comment period.</p> <p>3. In the name of quality care and patient safety, our AMA will vigorously engage its members, the public, and interested stakeholders to advocate against the proposed revisions to the Medicare CoPs that would bypass or remove the clinical quality and safety oversight, and credentialing and privileging responsibilities of the physician members of the Organized Medical Staff, or that would allow a practitioner to practice at a hospital without being a member of the medical staff.</p> <p>4. (a) Our AMA will update model hospital staff bylaws to address the problem of requiring board recertification to remain on staff; (b) once our AMA develops these model hospital staff bylaw changes with regards to board recertification, they shall be made public in our AMA publications so physicians will recognize this problem of losing staff privileges that may be upon us in the near future; and (c) our AMA representatives to The Joint Commission will convey AMA Policies H-230.986 and H-230.997, which address board certification/recertification and hospital/health plan network privileges, to The Joint Commission.</p>	
D-230.989	Reappointments to the Medical Staff	Our AMA will work with The Joint Commission to change the requirement for reappointments to medical staffs to every four years.	Retain.

POLICY #	Title	Text	Recommendation
D-240.993	Verbal Admission Order Signatures	Our AMA will work with the Centers for Medicare & Medicaid Services to allow authentication of verbal admission orders within 30 days, rather than prior to discharge.	Retain.
D-280.987	Analysis of Place-of-Service Code for Observation Services	Our AMA will advocate with the Centers for Medicare & Medicaid Services that the status of any observation patient who remains confined at a hospital for more than 24 hours be changed automatically to inpatient, and if they had spent a midnight in observation status, that midnight would be counted toward the three-day prior hospitalization requirement for Medicare coverage of skilled nursing facility care.	Retain.
D-280.989	Inclusion of Observation Status in Mandatory Three Day Inpatient Stay	<p>1. Our AMA will continue to monitor problems with patient readmissions to hospitals and skilled nursing facilities and recoding of inpatient admissions as observation care and advocate for appropriate regulatory and legislative action to address these problems.</p> <p>2. Our AMA will continue to advocate that the Centers for Medicare & Medicaid Services explore payment solutions to reduce the inappropriate use of hospital observation status.</p>	Retain.
D-285.977	Excessive Telephone Wait Times for Physician Appeals of Managed Care Decisions on Patient Care	Our AMA advocates that managed care organizations be required to staff physician contact phone numbers concerning appeals for denied care sufficiently to maintain no more than a five minute average wait time.	Retain.
D-330.911	Generic Changes in Medicare (Part D) Plans	<p>1. Our AMA will investigate the incidence and reasoning behind the conversion of one generic drug to another generic drug of the same class in Medicare Advantage drug plans.</p> <p>2. Our AMA will request the Centers for Medicare & Medicaid Services to ensure that pharmaceutical vendors, when they do ask for generic transitions of drugs, list the drugs they believe are more cost effective along with</p>	Retain-in-part. Rescind (1); accomplished with AMA participation in monthly CMS Medicare Part D Workgroup meetings.

POLICY #	Title	Text	Recommendation
		their tier price and alternative drug names.	
D-330.921	Hospital Systems' Practices of Reclassification of Place of Service, Opting Not to Bill Medicare for Hospital and Aggressive Denial of Hospital Days in Reaction to Recovery Audits	<p>1. Our American Medical Association will work with the Centers for Medicare & Medicaid Services, the Government Accountability Office, and other stakeholders to ensure that: (a) when hospitals make reclassifications based on screening criteria in proprietary databases, both the admitting physicians and the patient is immediately notified; (b) Recovery Audit Contractors, are precluded from making recoupments associated with “inappropriate admissions” and/or discrepancies between the hospital and physician's site of service; (c) physicians are intimately involved in the development of the data being used by proprietary databases; (d) a process is put in place whereby physicians can substitute their medical judgment for that of the software programs, and carriers and auditors will ensure that that judgment is considered and evaluated by physicians in the same state and specialty; and (e) the evidence underlying data programs and the processes being employed are completely transparent.</p> <p>2. Our AMA will work with CMS to remove the requirement of linkage of Part A and Part B place of service so that admission or consultation documents that were done prior to a determination or reclassification of a place of service be recognized and not result in a rejection in claim for services.</p>	Retain.
D-330.933	Restoring High Quality Care to the Medicare Part D Prescription Drug Program	<p>Our AMA will:</p> <p>a. work to eliminate prior authorizations under the Medicare Part D Prescription Drug Program which undermine a physician's best medical judgment;</p> <p>b. work with the Centers for Medicare and Medicaid Services (CMS) to enforce the Medicare Part D Prescription Drug Program statutory requirement that all Part</p>	Retain.

POLICY #	Title	Text	Recommendation
		<p>D plans include 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;</p> <p>c. work with CMS to place reasonable copays in the Medicare Part D Prescription Drug Program;</p> <p>d. work with other interested parties to simplify the CMS prior authorization process such that a diagnosis or reason written on the prescription should be accepted as documentation for non-formulary request; and</p> <p>e. work with CMS to develop a one-page form for physicians and patients to utilize in appealing a prescription coverage denial.</p>	
D-330.964	Update to Ambulatory Surgery Procedure List	Our American Medical Association urge the Centers for Medicare and Medicaid Services to immediately update the ambulatory surgery center list of covered procedures.	Rescind. The list of approved ASC procedures is now updated annually .
D-35.988	The Joint Commission Primary Care Home Initiative	<p>1. Our AMA Commissioners to The Joint Commission will strongly advocate that the requirements for any primary care home or medical home initiative of The Joint Commission strictly meet the requirements of the <i>Joint Principles of the Patient-Centered Medical Home</i> and more specifically that (1) each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care and (2) that a personal physician lead a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. The <i>Joint Principles of the Patient-Centered Medical Home</i> were developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association and approved by the AMA.</p> <p>2. Our AMA will continue to support the concept of physician-</p>	<p>Rescind. Superseded by Policy H-160.919.</p> <p>Principles of the Patient-Centered Medical Home H-160.919</p> <p>1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association “Joint Principles of the Patient-Centered Medical Home” as follows:</p> <p>Principles</p> <p>Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.</p> <p>Physician Directed Medical Practice - The personal physician leads a team of</p>

POLICY #	Title	Text	Recommendation
		<p>led teams within the patient centered medical home (PCMH) as outlined in the Joint Principles of the Patient-Centered Medical Home.</p> <p>3. Our AMA will respond to The Joint Commission's interpretation of its primary care medical home certification standards addressing non-physician-led PCMHs.</p> <p>4. Our AMA will oppose any interpretation by The Joint Commission, or any other entity, of primary care medical home or patient centered medical home (PCMH) as being anything other than MD/DO physician led.</p>	<p>individuals at the practice level who collectively take responsibility for the ongoing care of patients.</p> <p>Whole Person Orientation - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.</p> <p>Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.</p> <p>Quality and safety are hallmarks of the medical home:</p> <p>Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.</p> <p>Evidence-based medicine and clinical decision-support tools guide decision making.</p>

POLICY #	Title	Text	Recommendation
			<p>Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.</p> <p>Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.</p> <p>Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.</p> <p>Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.</p> <p>Patients and families participate in quality improvement activities at the practice level.</p> <p>Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.</p> <p>Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:</p> <p>It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.</p>

POLICY #	Title	Text	Recommendation
			<p>It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.</p> <p>It should support adoption and use of health information technology for quality improvement.</p> <p>It should support the provision of enhanced communication access such as secure e-mail and telephone consultation.</p> <p>It should recognize the value of physician work associated with remote monitoring of clinical data using technology.</p> <p>It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).</p> <p>It should recognize case mix differences in the patient population being treated within the practice.</p> <p>It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.</p> <p>It should allow for additional payments for achieving measurable and continuous quality improvements.</p> <p>2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to</p>

POLICY #	Title	Text	Recommendation
			<p>patients without restricting access to specialty care.</p> <p>3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home.</p> <p>4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes.</p> <p>5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home.</p>
D-390.954	Hospital-Based Physicians and the Value-Based Payment Modifier	Our AMA will continue to advocate that the Value-Based Payment Modifier program be repealed or significantly modified.	Rescind. The Merit-based Incentive Payment System (MIPS) under the Quality Payment Program replaced the Physician Feedback/Value-Based Payment Modifier program on January 1, 2019.
D-390.981	Medicare Payment for Services to Skilled Nursing Facility Residents in Physicians' Offices	Our AMA will: (1) inform the Centers for Medicare and Medicaid Services of the problems physicians and their patients experience as a result of the inclusion of the technical component of physicians' office-based services in the consolidated billing protocol for Medicare Skilled Nursing Facility residents; (2) urge the Centers for Medicare and Medicaid Services (CMS) to provide greater oversight of Medicare Skilled Nursing Facilities	Retain.

POLICY #	Title	Text	Recommendation
		<p>(SNFs) in meeting their obligations to pay physicians for the technical component of services those physicians provide in their offices to Medicare SNF residents;</p> <p>(3) advocate to Congress that it exclude from Medicare's Skilled Nursing Facility (SNF) consolidated billing protocol the technical component of medical services provided in physicians' offices to Medicare SNF residents, because of concern with the negative impact on care that could potentially occur;</p> <p>(4) urge the Centers for Medicare and Medicaid Services to require SNFs to clearly identify those patients who fall under the Medicare SNF consolidated billing program, as opposed to non-skilled extended care facility (ECF) patients, prior to sending patients to physicians' offices for care; and</p> <p>(5) communicate to physicians that in order to assure payment whenever a SNF resident receives a service that is subject to SNF consolidated billing, the SNF and the physician are required to enter into an arrangement prior to providing services and the physician must look to the SNF for payment.</p>	
D-390.984	Payment by Health Insurance Plans of Medicare Deductibles and Copayments	<p>Our AMA will: (1) seek legislation to compel all insurers paying secondary to Medicare to be required to pay the deductibles and coinsurance owed after the Medicare payment is made; and (2) seek federal legislation to require that a secondary plan not manage the primary Medicare benefit by imposing limits as if it were primary.</p>	Retain.
D-40.991	Acceptance of TRICARE Health Insurance	<p>Our AMA:</p> <p>1. Encourages state medical associations and national medical specialty societies to educate their members regarding TRICARE, including changes and improvements made to its operation, contracting processes and mechanisms for dispute</p>	Retain.

POLICY #	Title	Text	Recommendation
		<p>resolution.</p> <p>2. Encourages the TRICARE Management Activity to improve its physician education programs, including those focused on non-network physicians, to facilitate increased civilian physician participation and improved coordination of care and transfer of clinical information in the program.</p> <p>3. Encourages the TRICARE Management Activity and its contractors to continue and strengthen their efforts to recruit and retain mental health and addiction service providers in TRICARE networks, which should include providing adequate reimbursement for mental health and addiction services.</p> <p>4. Strongly urges the TRICARE Management Activity to implement significant increases in physician payment rates to ensure all TRICARE beneficiaries, including service members and their families, have adequate access to and choice of physicians.</p> <p>5. Strongly urges the TRICARE Management Activity to alter its payment formula for vaccines for routine childhood immunizations, so that payments for vaccines reflect the published CDC retail list price for vaccines.</p> <p>6. Continues to encourage state medical associations and national medical specialty societies to respond to requests for information regarding potential TRICARE access issues so that this information can be shared with TRICARE representatives as they develop their annual access survey.</p> <p>7. Continues to advocate for changes in TRICARE payment policies that will remove barriers to physician participation and support new, more effective care delivery models, including: (a) establishing a process to allow midlevel providers to receive 100 percent of the TRICARE allowable cost for services rendered while practicing</p>	

POLICY #	Title	Text	Recommendation
		<p>as part of a physician-led health care team, consistent with state law; and (b) paying for transitional care management services, including payment of copays for services provided to TRICARE for Life beneficiaries receiving primary coverage through Medicare.</p> <p>8. Continues to advocate for improvements in the communication and implementation of TRICARE coverage policies to ensure continued patient access to necessary services, including: (a) consistently approving full payment for services rendered for the diagnosis and treatment of common mental health conditions, regardless of the specialty of the treating physician; and (b) clarifying policies with respect to coverage for age appropriate doses of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices.</p>	
D-400.988	PLI-RVU Component of RBRVS Medicare Fee Schedule	Our AMA will: (1) continue its current activities to seek correction of the inadequate professional liability insurance component in the Resource-Based Relative Value Scale Formula; (2) continue its current activities to seek action from the Centers for Medicare & Medicaid Services to update the Professional Liability Insurance Relative Value Units (PLI-RVU) component of the RBRVS to correctly account for the current relative cost of professional liability insurance and its funding; and (3) support federal legislation to provide additional funds for this correction and update of the PLI-RVU component of the RBRVS, rather than simply making adjustments in a budget-neutral fashion.	Retain.
D-450.961	Hospital-Based Physicians and the Value-Based	Our AMA encourages national medical specialty societies to pursue the development of relevant performance measures that	Rescind. The Merit-based Incentive Payment System (MIPS) under the Quality Payment Program replaced the

POLICY #	Title	Text	Recommendation
	Payment Modifier	demonstrate improved quality and lower costs, and work with the Centers for Medicare & Medicaid Services to have those measures incorporated into the Value-Based Payment Modifier program and other quality measurement and improvement programs.	Physician Feedback/Value-Based Payment Modifier program on January 1, 2019.
D-465.999	Critical Access Hospital Necessary Provider Designation	Our AMA: (1) will call on the Centers for Medicare & Medicaid Services to support individual states in their development of rural health networks; (2) opposes the elimination of the state-designated Critical Access Hospital (CAH) “necessary provider” designation; and (3) will pursue steps to require the federal government to fully fund its obligations under the Medicare Rural Hospital Flexibility Program.	Retain.
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.	Retain.
D-70.965	Membership on RVS Update Committee (RUC) and CPT Coding Committee	Our AMA will request that representative societies send delegates or alternate delegates to the American Medical Association/Specialty Society Relative Value Scale Update Committee and the AMA Current Procedural Terminology Editorial Panel and Physician Advisory Committee who are currently engaged for a substantial portion of their professional activities with the practice of medicine either in active patient care or closely related activities.	Retain.
H-130.990	Freestanding Emergency Medical Care	(1) The AMA is concerned that the use of the term “emergency” in the title or description of a medical practice or a hospital center without maintaining specific emergency capabilities is not in the public interest since needed critical emergency service may be delayed. (2) The AMA firmly believes that the optimal provision of emergency	Retain.

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		<p>care requires prompt physical access to the immediate resources of the hospital and that a freestanding emergency center without such access may delay definitive care of critical emergencies. (3) The AMA endorses the following criteria to aid in determining if a full range of emergency services is being offered: hours of operation, staffing and medical direction, relationship to the local emergency medical services system, ancillary service and equipment, protocols, private physician referrals, medical records, and payment for services.</p>	
<p>H-160.944</p>	<p>Defining "Observation Care"</p>	<p>1. The AMA will work with third party payers to establish a uniform definition of "observation care," including the following: (a) The patient should be designated as under "observation care" if the physician's intent for hospital stay is less than 24 hours. If the physician's intent and expectation is for a hospital stay of greater than 24 hours, then the stay should be considered inpatient. The use of 24 hours as a threshold for observation is a guideline. It is not unusual for observation to extend to a few hours beyond 24 hours or for patients to be admitted to inpatient status before 24 hours. (b) Patients classified as under "observation care" require hospital level-of-care. (c) The patient should be registered as under "observation care" after initial physician evaluation of the patient's signs and symptoms and appropriate testing. Post day surgical patients should be registered as under "observation care" if, after a normal recovery period, they continue to require hospital level-of-care as determined by a physician.</p> <p>2. The AMA will establish policy on "observation care" and develop model legislation to ensure that: (a) After initial approval of inpatient admission by insurers, there should be no retrospective reassignment to</p>	<p>Retain.</p>

POLICY #	Title	Text	Recommendation
		<p>“observation care” status by insurers unless the original information given to insurers is incorrect. (b) Insurers should provide 60 days prior notice to providers of changes to “observation care” criteria or the application of those criteria with opportunity for comment. There should be no implementation of criteria or changes without first following these protocols. (c) Insurers’ “observation care” policies should include an administrative appeal process to deal with all utilization and technical denials within a 60-day time frame for final resolution. An expedited appeal process should be available for patients in the admission process, allowing for a decision within 24 hours. (d) Insurers and HMOs should provide clearly written educational materials on “observation care” to subscribers highlighting differences between inpatient and “observation care” benefits and patient appeal procedures.</p> <p>3. Our AMA will work with all appropriate governmental and non-governmental organizations to assure that both patients and physicians are treated fairly in the process of delineating the hospital admission status of patients, and to ensure that the process is transparent and administratively simple.</p>	
H-160.983	Satellite and Commercial Medical Clinics	<p>The AMA believes that (1) in principle, self-regulatory measures are preferable to mandatory state regulation as a mechanism to ensure quality of care in freestanding emergency and urgent care facilities; and (2) recently initiated self-regulatory programs applicable to freestanding facilities should be given ample opportunity to demonstrate their effectiveness in practice.</p>	Retain.
H-165.829	The Future of Employer-	<p>Our AMA: (1) supports requiring state and federally facilitated Small Business Health Options Program</p>	Retain.

POLICY #	Title	Text	Recommendation
	Sponsored Insurance	(SHOP) exchanges to maximize employee choice of health plan and allow employees to enroll in any plan offered through the SHOP; and (2) encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage offered through health insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges.	
H-165.865	Principles for Structuring a Health Insurance Tax Credit	(1) AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles: (a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided. (b) Tax credits should be refundable. (c) The size of tax credits should be inversely related to income. (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people. (e) The size of tax credits should be capped in any given year. (f) Tax credits should be fixed dollar amounts for a given income and family structure. (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums. (h) Tax credits for families should be contingent on each member of the family having health insurance. (i) Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account, and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-income persons who could	Retain.

POLICY #	Title	Text	Recommendation
		<p>not afford the monthly out-of-pocket premium costs.</p> <p>(2) It is the policy of our AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code.</p> <p>(3) Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance.</p>	
H-180.951	Tax Treatment of Health Insurance: Comparing Tax Credits and Tax Deductions	Our AMA supports the use of appropriately structured and adequately funded tax credits as the most effective mechanism for enabling uninsured individuals to obtain health insurance coverage.	Retain.
H-180.953	Decreased Insurance Premiums for Nonsmokers	<p>Our AMA:</p> <p>(1) encourages insurance companies to review and make public their current actuarial experience with respect to smokers and nonsmokers and to consider ways of making available to nonsmokers, at reduced rates, policies for accident, auto, life, homeowners, fire, and health insurance; and</p> <p>(2) supports the concept of health insurance contracts with lower premiums for nonsmokers, reflecting their decreased need for medical services and serving as a financial incentive for smokers (tobacco users) to discontinue this destructive habit.</p>	Retain.
H-185.933	Patient Access to Penile Prosthesis as Legitimate Treatment for Erectile Dysfunction	Our AMA will work in concert with national specialty and state medical societies to advocate for patient access to the full continuum of care of evidence-based erectile dysfunction treatment modalities including oral pharmacotherapy, penile vasoactive injection therapy,	Retain.

POLICY #	Title	Text	Recommendation
		vacuum erection device therapy and penile prosthetics.	
H-185.935	Reference Pricing	<p>Our AMA supports the appropriate use of reference pricing as a possible method of providing health insurance coverage of specific procedures, products or services, consistent with the following principles:</p> <ol style="list-style-type: none"> 1. Practicing physicians must be actively involved in the identification of services that are appropriate for a reference pricing system. 2. Appropriate reference pricing strategies may be considered for elective services or procedures for which there is evidence of a significant variation in cost that does not correspond to a variation in quality of care. Additional considerations include the relative complexity of the service, the potential for variation either across patients or during the course of a treatment, and the sufficient availability of providers in a geographic region. 3. Reference prices should be set at a level that reflects current market conditions and ensures that patients have access to a choice of providers. Prices should be reviewed annually and adjusted as necessary based on changes in market conditions. 4. Hospitals or facilities delivering services subject to reference pricing should avoid cost-shifting from one set of services to another. 5. Information about the services subject to reference pricing and the potential patient cost-sharing obligations must be fully transparent and easily accessible to patients and providers, both prior to and at the point of care. Educational materials should be made available to help patients and physicians understand the incentives and disincentives inherent in the reference pricing arrangement. 6. Insurance companies must notify 	Retain.

POLICY #	Title	Text	Recommendation
		<p>patients of all services subject to reference pricing at the time of health plan enrollment. Patients must be indemnified against any additional charges associated with changes to reference pricing policies for the balance of the contract period.</p> <p>7. Insurers that use reference pricing must develop and maintain systems that allow patients to effectively and appropriately compare prices among providers, including systems that help patients calculate their estimated costs for each provider prior to seeking care.</p> <p>8. Plan sponsors should continually monitor and evaluate the effect of reference pricing policies on access to high quality patient care and ensure that procedures are in place to make plan modifications as necessary.</p>	
H-185.941	Patient Cost-Sharing Requirements for Hospital Inpatient and Observation Services	Our AMA will advocate that patients be subject to the same cost-sharing requirements whether they are admitted to a hospital as an inpatient, or for observation services.	Retain.
H-185.975	Requiring Third Party Reimbursement Methodology be Published for Physicians	<p>Our AMA:</p> <p>(1) urges all third party payers and self-insured plans to publish their payment policies, rules, and fee schedules;</p> <p>(2) pursues all appropriate means to make publication of payment policies and fee schedules a requirement for third party payers and self-insured plans;</p> <p>(3) will develop model state and federal legislation that would require that all third party payers and self-insured plans publish all payment schedule updates, and changes at least 60 days before such changes in payment schedules are enacted, and that all participating physicians be notified of such changes at least 60 days before changes in payment schedules are enacted.</p> <p>(4) seeks legislation that would mandate that insurers make</p>	Retain.

POLICY #	Title	Text	Recommendation
		<p>available their complete payment schedules, coding policies and utilization review protocols to physicians prior to signing a contract and at least 60 days prior to any changes being made in these policies;</p> <p>(5) works with the National Association of Insurance Commissioners, develop model state legislation, as well developing national legislation affecting those entities that are subject to ERISA rules; and explore the possibility of adding payer publication of payment policies and fee schedules to the Patient Protection Act; and</p> <p>(6) supports the following requirements: (a) that all payers make available a copy of the executed contract to physicians within three business days of the request; (b) that all health plan EOBs contain documentation regarding the precise contract used for determining the reimbursement rate; (c) that once a year, all contracts must be made available for physician review at no cost; (d) that no contract may be changed without the physician's prior written authorization; and (e) that when a contract is terminated pursuant to the terms of the contract, the contract may not be used by any other payer.</p>	
H-185.997	Insurance Coverage for Complete Maternity Care	<p>Our AMA (1) reaffirms its policy of encouraging health insurance coverage for care of the newborn from the moment of birth;</p> <p>(2) urges the health insurance industry and government to include in their plans, which provide maternity benefits, coverage for normal obstetrical care, and all obstetrical complications including necessary intrauterine evaluation and care of the unborn infant;</p> <p>(3) urges the health insurance industry to offer such plans on the broadest possible basis;</p> <p>(4) urges the health insurance industry to make available, on an optional basis, coverage for</p>	Retain.

POLICY #	Title	Text	Recommendation
		<p>treatment associated with voluntary control of reproduction;</p> <p>(5) will advocate for expanding coverage of maternity care to dependent women under the age of 26 on their parents' large group plans; and</p> <p>(6) will advocate that individual, small and large group health plans provide 60 days of newborn coverage for all newborns born to participants in the plan.</p>	
H-190.965	Claims Denial and Payment Delays	<p>Our AMA policy is that insurers should not deny payment on lost claims discovered beyond the required filing date when the physician has proof that the electronic or paper claim was filed in a timely manner.</p>	Retain.
H-190.970	Status Report on the National Uniform Claim Committee and Electronic Data Interchange	<p>The AMA advocates the following principles to improve the accuracy of claims and encounter-based measurement systems:</p> <p>(1) the development and implementation of uniform core data content standards (e.g., National Uniform Claim Committee (NUCC) data set);</p> <p>(2) the use of standards that are continually modified and uniformly implemented;</p> <p>(3) the development of measures and techniques that are universal and applied to the entire health care system;</p> <p>(4) the use of standardized terminology and code sets (e.g., CPT) for the collection of data for administrative, clinical, and research purposes; and</p> <p>(5) the development and integration of strategies for collecting and blending claims data with other data sources (e.g., measuring the performance of physicians on a variety of parameters in a way that permits comparison with a peer group).</p>	Retain.
H-190.972	Strategy for Eliminating Delayed Payments to Physicians by	<p>It is the policy of our AMA that delayed payments to physicians and hospitals without justification by third party payers should be prohibited by law.</p>	Retain.

POLICY #	Title	Text	Recommendation
	Third Party Payers		
H-190.975	Universality of CMS 1500 Form	The AMA will undertake the task of asking individual carriers and/or their representative organizations to maintain the universal contents and acceptance of specific data in the CMS 1500 Form so that it will remain as a truly universal form for the patient-doctor claim form.	Retain.
H-190.979	Insurance Company Filing Deadlines	Our AMA will work with the insurance industry so that where there is a specified filing deadline for services, this deadline is reset when insurance companies contend that they have either not received a filed claim or require additional supporting documentation.	Retain.
H-190.981	Required Timely Reimbursements by all Health Insurers	Our AMA will prepare and/or seek sponsorship of legislation calling for all health insurance entities and third-party payers--inclusive of not-for-profit organizations and health maintenance organizations--to pay for "clean" claims when filed electronically within 14 days and paper claims within 30 days, with interest accruing thereafter. These time periods should be considered ceilings, not floors or fixed differentials between paper and electronic claims.	Retain.
H-220.939	Activities of The Joint Commission	1. Our AMA supports continued active AMA participation as a corporate member of The Joint Commission. 2. Pursuant to Policy 220.949 (AMA Policy Database), our AMA: (a) Advocates accountability through voluntary, professionally directed quality assurance mechanisms as part of every system of health care delivery; (b) Monitors the effects of The Joint Commission standards, surveys, and other activities on the quality, cost, and outcomes of care; (c) Retains its current role in The Joint Commission and continue to evaluate that role on a regular basis; and (d) Continues to investigate additional methods to facilitate participation in voluntary accreditation mechanisms. 3. Our	Retain.

POLICY #	Title	Text	Recommendation
		<p>AMA establishes the following goals for AMA participation in The Joint Commission: (a) To assist The Joint Commission to define its mission, long-term goals, and role in the accreditation arena; (b) To assure continued physician involvement in medical decision-making by advocating a requirement for integrated medical delivery systems to have organized medical staffs; (c) To advocate the improvement of the quality and consistency of The Joint Commission accreditation process, surveyors, and survey reports; (d) To urge consideration of cost implications when revising The Joint Commission standards, developing and implementing other activities, and increasing the costs of surveys; (e) To work toward minimal revision of The Joint Commission standards, unless there is a clear need to change them to improve patient care or outcome, once the proposed medical staff standards for the 1996 AMH are finalized; (f) To urge The Joint Commission to focus on its accreditation activities and to provide accountability to the public for health services through private sector accreditation activities; and (g) To work toward The Joint Commission recognition as an accreditation body for integrated health care networks.</p>	
H-220.946	Unreasonable Burden of The Joint Commission Standards and Surveys	<p>The AMA requests The Joint Commission to study and consider the ability of small hospitals, particularly in rural areas, to bear the burden of the increasing demands on staff and financial resources in the implementation of the current and proposed standards; and urges The Joint Commission to eliminate standards that increase health care costs without demonstrably improving the quality of care.</p>	Retain.
H-220.959	Compliance with The Joint Commission	<p>The AMA Commissioners to The Joint Commission oppose the accreditation of hospitals that do</p>	Retain.

POLICY #	Title	Text	Recommendation
	Accreditation Standards	not adhere to The Joint Commission standards prohibiting unilateral amendment of medical staff bylaws by either the governing body or the medical staff.	
H-220.983	The Joint Commission Standard IV Should Not Tie Clinical Privilege Termination to Contract	The AMA does not believe The Joint Commission standards should dictate specific provisions of individual contracts between physicians and hospitals that are mutually agreeable to the parties.	Retain.
H-225.989	AMA Opposes Forcing Medical Staffs to Repay Hill-Burton Obligations of Free Medical Care	The AMA (1) opposes attempts to create new and arbitrary requirements for hospital compliance with the Hill-Burton Act by shifting responsibility for these requirements to hospital medical staffs; (2) believes that a hospital's Hill-Burton Act obligations should be satisfied in a manner that does not interfere with the professional rights of its medical staff; and (3) endorses exploration of means to assure equal access to medical care for the people of the U.S.	Retain.
H-225.991	Communication and Cooperation Between Hospital Management and Medical Staff	The AMA encourages hospitals to make known to physicians the diagnostic codes which are recorded by medical records and business departments so the accuracy of these diagnoses can be confirmed.	Retain.
H-230.970	Proper Notification of a Physician Regarding Possible Loss of Medical Staff Membership or Privileges	Except in the instance of summary suspension, hospital notification of possible loss of medical staff membership and/or privileges must be sent by certified mail, return receipt requested, or its equivalent.	Retain.
H-235.971	Amending Medical Staff Bylaws	The AMA provides the assistance of its legal staff to hospital medical staffs and county and state medical associations when a hospital board of directors unilaterally changes, amends, or substitutes medical staff bylaws, or denies seats to duly elected medical staff officers.	Retain.
H-235.976	Medical Staff Bylaws and	Our AMA reaffirms that (1) medical staff bylaws are a contract	Retain.

POLICY #	Title	Text	Recommendation
	Medical Staff Autonomy	between the organized medical staff and the hospital; and (2) application for medical staff appointment and clinical privileges should provide that each member of the medical staff, as well as the hospital, is bound by the terms of the medical staff bylaws, and the terms of the medical staff bylaws should be incorporated by reference into the application.	
H-235.987	Right of Committees of Medical Staffs to Meet in Executive Sessions	The AMA (1) supports the right of any hospital medical staff committee to meet in executive session, with only voting members of the medical staff present, in order to permit open and free discussion of issues such as peer review and to maintain confidentiality; and (2) encourages individual medical staffs to incorporate provisions in their bylaws to affirm this right.	Retain.
H-235.988	Non-Physicians Voting on the Medical Staff	The AMA opposes any regulation that would mandate voting privileges for non-physician members of medical staffs.	Retain.
H-240.961	Definition of a Hospital Day	Our AMA defines a Hospital Day as a 24-hour period that begins at the hour of admission.	Retain.
H-240.998	Preferential Hospital Rates	Our AMA (1) opposes hospital charge/cost arrangements granting unwarranted advantage to any group of patients; and (2) urges all health care payers, government and private, to pay their equitable share of costs incurred by hospitals and other facilities consistent with a reasonable definition of full financial requirements.	Retain.
H-260.980	Clinical Laboratory Improvement Act of 1988	1. It is the policy of the AMA to (a) continue and intensify its efforts to seek appropriate and reasonable modifications in the proposed rules for implementation of the Clinical Laboratory Improvement Amendments (CLIA) 88; (b) communicate to Congress and to the Centers for Medicare & Medicaid Services (CMS) the positive contribution of physician office laboratory testing to high quality, cost effective care so that through administrative revision of	Retain-in-part. Rescind (2); accomplished by October 2015 sign-on letter to Congress.

POLICY #	Title	Text	Recommendation
		<p>the regulations, clarification of Congressional intent and, if necessary, additional legislation, the negative impact of these proposed regulations on patient care and access can be eliminated; (c) continue to work with Congress, CMS, the Commission on Laboratory Assessment, and other medical and laboratory groups for the purposes of making the regulations for physicians' office laboratories reasonable, based on scientific data, and responsive to the goal of improving access to quality services to patients; (d) protest the reported high costs being considered for certification of laboratories and the limited number of laboratory categories proposed; (e) encourage all components of the federation to express to CMS and members of Congress their concerns about the effect of the proposed rules on access and cost of laboratory services; and (f) protest the very limited list of waived tests.</p> <p>2. Our AMA will send a letter to CMS stating that CLIA requirements regarding provider-performed microscopy procedures and annual competency assessments are overly burdensome for physicians and their practices.</p>	
H-280.964	Medicare Certified Beds in Nursing Facilities	The AMA will work with CMS to eliminate any unnecessary requirements for designating by location Medicare Certified beds within a nursing facility, thus allowing each facility to flexibly apply the certified status to any appropriate bed within the facility.	Retain.
H-285.917	Stop Trial by Health Insurers	1. Our AMA opposes (a) any health insurer's efforts to make determinations regarding whether or not a physician has made a medical mistake; and (b) the practice of health plans using adverse event reporting data for purposes other than quality improvement and learning, as it could shift the focus of such reporting from improving patient	Retain.

POLICY #	Title	Text	Recommendation
		<p>safety to fostering a punitive environment.</p> <p>2. Our AMA will (a) inform all health insurance companies that they are not the appropriate entity for determining medical mistakes; and (b) encourage physicians to be aware of contractual provisions that would allow insurers to deny payment in the event of a medical mistake.</p>	
H-285.918	Mandatory Subspecialty Consultation	<p>Our AMA: (1) opposes the unilateral actions of hospitals and health care organizations to mandate specialty consultation for a patient with a specific disease state, when the mandate specifically denies the physician providing care the ability to determine medical necessity of the consultation and/or the consultation is not requested by the patient, and (2) discourages physicians from requesting hospital medical staff oversight committees, health plans and managed care organizations to mandate specialty consultations when the physician or physician group would gain financially from the mandatory consultation due to increased revenues from consultation billing, unless the consultation is required by law or regulation.</p>	Retain.
H-285.943	Payment for Managed Care Administrative Services	<p>Our AMA: (1) opposes managed care contract provisions that prohibit physician payment for the provision of administrative services; (2) encourages physicians entering into: (a) capitated arrangements with managed care plans to seek the inclusion of a separate capitation rate (per member per month payment) for the provision of administrative services, and (b) fee-for-service arrangements with managed care plans to seek a separate case management fee or higher level of payment to account for the provision of administrative services; and (3) supports the concept of a time-based charge for administrative duties (such as</p>	Retain.

POLICY #	Title	Text	Recommendation
		phone precertification, utilization review activities, formulary review, etc.), to be assessed to the various insurers.	
H-285.974	Residents Working with Managed Care Programs	The AMA encourages managed care plans to allow residents to care for patients under faculty supervision in the inpatient and outpatient setting.	Retain.
H-285.975	Consensus Opinions	Policy of the AMA is that all managed care programs must provide, or offer reimbursement for acquisition of, sufficient opinions necessary to reach a conclusion regarding the management of a given medical condition.	Rescind. Superseded by Policy H-390.917 . Consultation Follow-Up and Concurrent Care of Referral for Principal Care H-390.917 (1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation; and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; he/she may also have the patient referred for care and thus become the principal care physician. (2) The AMA communicate the appropriate use of consultation, evaluation and management, and office medical services codes to third party payers and advocate the appropriate reimbursement for these services in order to encourage high quality, comprehensive and appropriate consultations for patients.
H-290.969	Medicaid Waivers and Maintenance of Effort Requirements	Our AMA opposes any efforts to repeal the Medicaid maintenance of effort requirements in the ACA and American Recovery and Reinvestment Act (ARRA), which mandate that states maintain eligibility levels for all existing adult Medicaid beneficiaries until 2014 and for all children in Medicaid and the Children's Health Insurance Program (CHIP) until 2019.	Rescind. No longer relevant.
H-290.984	Mandatory Enrollment of	The AMA, in keeping with its support for free market competition	Retain.

POLICY #	Title	Text	Recommendation
	Medicare-Medicaid Patients in Managed Care Plans	among all modes of health care delivery and financing, strongly opposes mandatory enrollment of Medicare and/or Medicaid patients in managed care plans.	
H-290.987	Medicaid Waivers for Managed Care Demonstration Projects	<p>(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.</p>	Retain.
H-315.968	Privacy Issues Regarding Insurance Company Explanation of Benefits	<p>1. Our AMA advocates that electronic medical record (EMR) vendors be required to create user-triggered mechanisms that alert health care professionals of confidential medical information that should be safeguarded.</p> <p>2. Our AMA encourages physicians to clearly identify health care information on both paper and electronic records that the patient has requested to be kept private.</p>	Retain.

POLICY #	Title	Text	Recommendation
		<p>3. Our AMA encourages physicians to develop individualized treatment plans for minors aged 12-17, in collaboration with parents or guardians, that outline expectations for the services provided and transitions toward increased privacy as the minor ages into adulthood.</p> <p>4. Our AMA encourages physicians to inform their patients that they can request confidential communications from their office and health insurer by alternate means or locations than the policy holder's contact information, and to provide their patients with a Health Insurance Portability and Accountability Act (HIPAA) Privacy Rights Request Form.</p> <p>5. Our AMA advocates that health insurers be required to develop a method of listing health care services on Explanation of Benefits statements that would preserve confidentiality for all insured individuals.</p> <p>6. Our AMA advocates that health insurers be required to communicate clear procedures to all insured dependents on how to request confidential communications.</p> <p>7. Our AMA advocates that health insurers be required to create privacy protections for all insured individuals on information that is contained on their Internet websites.</p>	
H-315.992	Copying Records for Audits	Our AMA supports taking appropriate action to ensure that the financial responsibility for producing or copying patient records at the request of any regulatory agency having the authority to do so shall be borne entirely by the requesting agency and the request for said records shall be made at least 30 days in advance of any deadline.	Retain
H-320.956	Advance Directives and Utilization Review	The policy of the AMA is that: (1) the prior existence of advance directives (expressions of intent to forgo resuscitative, extraordinary,	Retain.

POLICY #	Title	Text	Recommendation
		<p>unwanted or other care highly unlikely to improve or stabilize health status) should not jeopardize the provision of medically appropriate care, if the care is consistent with agreed upon limits; (2) individual physicians should not be reprimanded by reviewing bodies for abiding by the wishes of patients when providing appropriate care to individuals who have exercised advance directives.</p>	
H-320.965	Responsibility for Hospital Admissions	<p>It is the policy of the AMA that the determination of the medical necessity for hospital admission should be made only by a Doctor of Medicine, or a doctor of osteopathy licensed in the same jurisdiction as the treating physician.</p>	Retain.
H-330.944	New Durable Medical Equipment Requirements	<p>The AMA will work with CMS to develop and implement an exemption policy for low-cost DME supplies that are dispensed by physicians through their offices, based on such factors as current Medicare payment amounts, whether the item is usually disposable, linkage to a particular physician treatment, and specialty society recommendations. Claim for such supplies under these circumstances would not be subject to CMS's DME regulatory requirements and would be submitted to the local Medicare carrier.</p>	Retain.
H-335.973	Reimbursement Violations	<p>Our AMA will urge physicians who experience problems with their Medicare carrier's application of Medicare review criteria to report those problems, issues or concerns to their state medical association and state "Medicare Carrier Advisory Committee" for discussion and resolution.</p>	Retain
H-385.927	Additional Prompt Payment Advocacy	<p>Our AMA continues to support state medical association and national medical specialty society efforts and work independently with federal and state legislators and agencies to provide for a percentage of the financial penalty and/or accrued interest to be paid directly to the physician in the</p>	Retain.

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		cases where payers do not make payment within the specified time frame.	
H-385.948	Reasonable Charge for Preauthorization	The AMA strongly supports and advocates fair compensation for a physician's administrative costs when providing service to managed care patients.	Retain.
H-385.956	Payment for Ethics Consultations	The policy of the AMA is that physician provision of clinical ethics consultations for the guidance of individual patients or physicians, apart from and beyond their duties as members of hospital ethics committees, is an appropriately compensable medical service. Payment for these services should be made when they are reported with the appropriate existing CPT consultation codes (and prolonged physician service codes, if appropriate). The AMA recognizes that this does not address any aspect of payment for ethics consultations by non-physicians.	Retain.
H-385.959	Primary and Consultative Care	The AMA will promulgate policies to recognize the services of internists, pediatricians, family physicians and obstetrician/gynecologists as capable of providing both primary care and consultative care.	Retain.
H-390.867	Medical Rehabilitation Services	The AMA believes: (1) Rehabilitation criteria for reimbursement should be defined by medical needs of patients for rehabilitative care that includes functional, cognitive, social considerations, and cognitive status, specifically the so called "three-hour rule" is not a valid exclusion criterion for entry into a rehabilitation unit nor can it be the basis for denial of ongoing coverage in such a unit. (2) The severity of medical conditions, regardless of settings, must be accounted for, including a case-mix approach adjusted for regional variances to meet individual patient needs for high quality, cost effective medical, rehabilitation services.	Retain.

POLICY #	Title	Text	Recommendation
<p>H-390.976</p>	<p>Delayed Payment of Medical Insurance Claims</p>	<p>Our AMA (1) expresses its concern and displeasure about CMS’s practice of slowing payment of Medicare claims, which places an unwarranted financial burden upon the elderly and the practitioners and facilities which serve senior citizens; (2) supports model state legislation to establish incentives and/or penalties among private and public third party payers to rectify the problem of delayed insurance reimbursements; and (3) believes that reasonable interest should begin on uncontroverted claims not later than 30 days following receipt of a claim by the payer.</p>	<p>Rescind. Superseded by Policies H-190.959 and H-190.981 and AMA Model State Legislation.</p> <p>Physician Reimbursement by Health Insurance and Managed Care Companies H-190.959</p> <p>1. Our AMA shall make it a top priority to seek regulatory and legislative relief to ensure that all health insurance and managed care companies pay for clean claims submitted electronically within fourteen days.</p> <p>2. When electronic claims are deemed to be lacking information to make the claim complete, the health insurance and managed care companies will be required to notify the health care provider within five business days to allow prompt resubmission of a clean claim.</p> <p>3. Our AMA shall advocate for heavy penalties to be imposed on health insurance and managed care companies, including their employees, that do not comply with laws and regulations establishing guidelines for claims payment.</p> <p>4. Our AMA will continue to encourage regulators to enforce existing prompt pay requirements.</p> <p>Required Timely Reimbursements by all Health Insurers H-190.981</p> <p>Our AMA will prepare and/or seek sponsorship of legislation calling for all health insurance entities and third-party payers--inclusive of not-for-profit organizations and health maintenance organizations--to pay for “clean” claims when filed electronically within 14 days and paper claims within 30 days, with interest accruing thereafter. These time periods should be considered ceilings,</p>

POLICY #	Title	Text	Recommendation
			not floors or fixed differentials between paper and electronic claims.
H-390.985	CMS Consultation with Physicians	The AMA encourages CMS to consult with clinically experienced practicing physicians on all determinations affecting medical practice and patient care.	Retain.
H-390.987	Medicare Assignments and Laboratory Reimbursements	The AMA supports educational efforts to assist physicians in differentiating between procedural billing and professional billing, particularly as they relate to billing for the drawing of a specimen and billing for interpreting the laboratory test results.	Retain.
H-450.932	Public Reporting of Quality and Outcomes for Physician-Led Team-Based Care	<p>1. Our AMA will advocate that internal reporting of quality and outcomes of team-based care should be done at both the team and individual physician level.</p> <p>2. Our AMA will advocate that public reporting of quality and outcomes data for team-based care should be done at the group/system/facility level, and not at the level of the individual physician.</p> <p>3. Our AMA reaffirms the intent of the codified mandate in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA 2008) that public reporting of quality and outcomes data for team-based care should be done at the group/system level, and not at the level of the individual physician.</p> <p>4. Our AMA will advocate that the current regulatory framework of public reporting for Meaningful Use also provide “group-level reporting” for medical groups/organized systems of care as an option in lieu of requiring MU reporting only on an individual physician basis.</p>	Retain.
H-450.946	Ensuring Quality in Health System Reform	Our AMA: (1) will discuss quality of care in each of its presentations on health system reform; (2) will advocate for effective quality management programs in health system reform that: (a) incorporate substantial input by actively	Rescind. Superseded by Policies H-450.966 , H-450.970 , H-450.994 , and H-450.944 .

POLICY #	Title	Text	Recommendation
		<p>practicing physicians and physician organizations at the national, regional and local levels; (b) recognize and include key quality management initiatives that have been developed in the private sector, especially those established by the medical profession; and (c) are streamlined, less intrusive, and result in real reduced administrative burdens to physicians and patients; and (3) will take a leadership role in coordinating private and public sector efforts to evaluate and enhance quality of care by maintaining a working group of representatives of private and public sector entities that will: (a) provide for an exchange of information among public and private sector quality entities; (b) oversee the establishment of a clearinghouse of performance measurement systems and outcomes studies; (c) develop principles for the development, testing, and use of performance/outcomes measures; and (d) analyze and evaluate performance/outcomes measures for their conformance to agreed upon principles.</p>	<p>Quality Management, H-450.966</p> <p>(1) continues to advocate for quality management provisions that are consistent with AMA policy;</p> <p>(2) seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures;</p> <p>(3) continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures;</p> <p>(4) emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts;</p> <p>(5) urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures; and</p> <p>(6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts: (a) Standards and measures shall have demonstrated validity and reliability. (b) Standards and measures shall reflect current professional knowledge and available medical technologies. (c) Standards and measures shall be linked to health outcomes and/or access to care. (d) Standards and measures shall be representative of the range of</p>

POLICY #	Title	Text	Recommendation
			<p>health care services commonly provided by those being measured. (e) Standards and measures shall be representative of episodes of care, as well as team-based care. (f) Standards and measures shall account for the range of settings and practitioners involved in health care delivery. (g) Standards and measures shall recognize the informational needs of patients and physicians. (h) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations. (i) Standards and measures shall recognize the importance and implications of patient choice and preference. (j) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured. (k) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured.</p> <p>(BOT Rep. 35, A-94; Reaffirmed: CMS Rep. 10, I-95; Reaffirmed: CMS Rep. 7, A-05; Modified: CMS Rep. 6, A-13; Reaffirmed in lieu of Res. 714, A-14; Reaffirmed in lieu of Res. 814, I-14; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmed in lieu of Res. 203, I-15; Reaffirmed in lieu of Res. 216, I-15; Reaffirmed: BOT Rep. 20, A-16; Reaffirmed: CMS Rep. 02, I-17; Reaffirmation: A-22)</p> <p>Quality Management Principles, H-450.970 Our AMA (1) continues to support the concept that physicians and healthcare organizations should strive</p>

POLICY #	Title	Text	Recommendation
			<p>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. (BOT Rep. AA, A-92; Reaffirmed: CMS Rep. 9, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20)</p> <p>Quality of Care – Essentials and Guidelines for Quality Assessment H-450.995</p> <p>(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</p>

POLICY #	Title	Text	Recommendation
			<p>appropriate technological and professional resources;</p> <p>(f) be provided with sensitivity to the stress and anxiety that illness can generate, and with concern for the patient's overall welfare;</p> <p>(g) make efficient use of the technology and other health system resources needed to achieve the desired treatment goal; and</p> <p>(h) be sufficiently documented in the patient's medical record to enable continuity of care and peer evaluation.</p> <p>(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</p>

POLICY #	Title	Text	Recommendation
			<p>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.</p> <p>(f) Both explicit and implicit criteria are useful in assessing the quality of care.</p> <p>(g) Prior consultation as appropriate, concurrent and retrospective peer review are all valid aspects of quality assessment.</p> <p>(h) Any quality assessment program should be linked with a quality assurance system whereby assessment results are used to improve performance.</p> <p>(i) The quality assessment process itself should be subject to continued evaluation and modification as needed.</p> <p>(CMS Rep. A, A-86; Reaffirmed: CMS Rep. E, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17)</p> <p>Quality Assurance in Health Care H-450.994</p> <p>(1) Accountability through voluntary, professionally directed quality assurance mechanisms should be part of every system of health care delivery. The cost of quality assurance programs and activities should be considered a</p>

POLICY #	Title	Text	Recommendation
			<p>legitimate element in the cost of care. (Reaffirmed: Res. 711, A-94)</p> <p>(2) To fulfill their fundamental responsibility to maximize the quality of services, health care institutions should establish, through their governing bodies, a formal structure and process to evaluate and enhance the quality of their health care services. This should be accomplished by participation of the professional staff, management, patients and the general public. When appropriate, health care institutions should be urged by licensing and accrediting bodies to establish a formal committee to coordinate all quality assurance activities that occur among the various health care professions within the facility.</p> <p>(3) Voluntary accreditation programs with standards that exceed those of state licensure and that focus on quality-of-care issues should be offered to all health care facilities. Various agencies that accredit health care facilities should develop a formal interagency structure to coordinate their activities and to resolve any inter-organizational problems that may arise.</p> <p>(4) Public and private payment programs should limit their coverage for services provided in health care facilities to those that meet professionally acceptable standards of acceptable quality, should structure their reimbursement to support the improvement of quality, and should provide information on quality for the benefit of their subscribers.</p> <p>(5) Educational programs on quality assurance issues for health care professionals should be expanded through the inclusion of such material in health professions education programs, in preceptorships, in</p>

POLICY #	Title	Text	Recommendation
			<p>clinical graduate training and in continuing education programs. (6) Educational programs should be developed to inform the public about the various aspects of quality assurance. Health care facilities and national and local health care organizations should make information available to the public about the factors that determine the quality of care provided by health care facilities, and about the extent to which individual health care facilities meet professionally acceptable standards of quality. (7) Research should be undertaken to assess the effects of peer review programs and payment mechanisms on the overall quality of health care. (BOT Rep. NN, A-87; Modified: Sunset Report, I-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: BOT Rep. 20, A-16; Reaffirmed: BOT Action in response to referred for decision: Res. 718, A-17)</p>
H-450.965	Medical Staff Leadership in Continuous Quality Improvement	The AMA will work with the AHA to assure that hospitals, in their continuous quality improvement/total quality management (CQI/TQM) programs, include practicing physicians in the development and implementation of such programs, especially the development of criteria sets and clinical indicators; provide feedback on CQI/TQM findings to physicians on a confidential basis; and inform all members of the medical staff on the CQI/TQM programs developed.	Retain.
H-450.997	Quality Assurance and Peer Review for Hospital Sponsored Programs	The AMA urges hospital medical staffs to make certain that all hospital sponsored, initiated, or affiliated medical services have appropriate peer review and quality assurance programs.	Retain.

REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (A-24)
Patient Medical Debt
(Resolution 710-A-23 and Resolution 712-A-23)
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates referred Resolutions 710 and 712. Resolution 710-A-23 asked the American Medical Association (AMA) to work with the appropriate national organizations to address the medical debt crisis by advocating for robust policies at the federal and state levels that prevent medical debt, help consumers avoid court involvement, and ensure that court involved cases do not result in devastating consequences to patient's employment, physical health, mental wellbeing, housing, and economic stability. Resolution 712-A-23 asked the AMA to study the causes of medical bankruptcy in the United States and draft a report for presentation at the 2024 Annual House of Delegates meeting, with such a report to include recommendations to the House of Delegates to severely reduce the problem of medical debt.

An estimated 100 million people in the United States (41 percent of adults) have debt related to unpaid medical bills, totaling between \$195-220 billion. A 2021 Census Bureau analysis estimated that 15 percent of households in the United States owed medical debt. Medical debt is the leading cause of bankruptcy in the United States and can take many forms, including past due payments owed directly to a physician or hospital, ongoing payment plans, money owed to a bank or collections that has been assigned or sold the debt, credit card debt, and/or money borrowed from family or friends. Medical debt occurs widely across all demographic groups. Insurance coverage does not protect patients from incurring medical debt and debt is accrued both for patients with chronic medical conditions and as a result of unexpected acute events. Across the United States, approximately 50 million people are on a financing plan to pay off a medical or dental bill and about 25 percent of these individuals are paying interest. A portion of the interest collected may be kept by financing companies who often contract with physicians and hospitals to collect outstanding debt.

Medical financing products, such as medical credit cards and installment plans, can be offered to patients through hospitals or physicians' offices, but they are often serviced through third-party financial services companies. Historically, uninsured and low-income patients have been provided installment plans with zero or low interest rates directly from hospitals or physicians' offices where they received their care. Notably, as more physicians become employed, there is less control and awareness of the debt collection practices of their employers. In recent years, some hospitals and physicians' offices have partnered with financial service or private equity companies to offer more structured loan arrangements, which tend to charge market-level or higher interest rates.

In July 2023, the Biden Administration, the Consumer Financial Protection Bureau, the Department of Health and Human Services, and the Treasury Department issued a Request for Information on medical credit cards and other high-cost specialty financial products to understand their prevalence, patients' experience with them, and incentives driving physicians and other non-physician providers to offer these products.

The Council offers a series of recommendations to reduce patient medical debt.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-24

Subject: Patient Medical Debt
(Resolution 710-A-23 and Resolution 712-A-23)

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee G

1 At the 2023 Annual Meeting, the House of Delegates referred Resolutions 710 and 712. Resolution
2 710-A-23, introduced by the Michigan delegation, asked the American Medical Association (AMA) to
3 work with the appropriate national organizations to address the medical debt crisis by advocating for
4 robust policies at the federal and state levels that prevent medical debt, help consumers avoid court
5 involvement, and ensure that court involved cases do not result in devastating consequences to patient's
6 employment, physical health, mental wellbeing, housing, and economic stability. Resolution 712-A-23,
7 introduced by the New Jersey delegation, asked the AMA to study the causes of medical bankruptcy in
8 the United States and draft a report for presentation at the 2024 Annual House of Delegates meeting, with
9 such a report to include recommendations to the House of Delegates to severely reduce the problem of
10 medical debt.

11 12 BACKGROUND

13
14 An estimated 100 million people in the United States (41 percent of adults) have debt related to unpaid
15 medical bills, totaling between \$195-220 billion.¹ Of this 100 million, approximately 20 million people
16 owe money directly to their physician, hospital, or other non-physician provider.² The remaining 80
17 million people reflect those that have other debts associated with their health care (i.e., credit card debt,
18 loans from family and friends, etc.) The Consumer Financial Protection Bureau (CFPB) estimates that
19 \$88 billion of total medical debt is reflected on Americans' credit reports.³ A 2021 Census Bureau
20 analysis estimated that 15 percent of households in the United States owed medical debt.⁴ Medical debt is
21 the leading cause of bankruptcy in the United States and can take many forms, including past due
22 payments owed directly to a physician or hospital, ongoing payment plans, money owed to a bank or
23 collections that has been assigned or sold the debt, credit card debt, and/or money borrowed from family
24 or friends.⁵ Medical debt can often be masked as other forms of debt when someone falls behind on other
25 expenses (i.e., food, housing, household goods) to pay down their medical bills.⁶ Those with unaffordable
26 medical bills are more likely to skip or delay needed care, cut back on basic household expenses, take
27 money out of retirement or college savings, or increase credit card debt.⁷

28
29 Medical debt occurs across demographic groups, but is more likely if a patient has disabilities, is in worse
30 health, is poor or near poor, is Black, lives in the South, lives in a non-Medicaid expansion state, or is
31 middle aged. Women are more likely to report having medical debt than men (11 percent vs. 8 percent),
32 which is likely due to childbirth-related expenses and lower average incomes.⁸

33
34 COVID-19 exacerbated several hardships associated with increased medical debt, including downstream
35 effects of contracting COVID-19, losing employer-sponsored health insurance, or losing income. The
36 Commonwealth Fund completed a study that found that half of all people ages 19-64 affected by

1 COVID-19 had medical debts or issues tangentially related to medical debt during the study period.
 2 COVID-19 hospitalizations and treatment also contributed to individuals' debt.⁹

3
 4 Besides negative financial impacts, other consequences patients face include being contacted by
 5 collectors or negative credit score impacts, which makes it difficult to buy a vehicle, get a job, or buy or
 6 rent a home. Additionally, there are consequences associated with care: one in seven adults with health
 7 care debt say they have been denied care due to unpaid medical bills.¹⁰

8
 9 *Causes of Medical Debt in the United States*

10
 11 According to a KFF study, 72 percent of patients with medical debt claim the bills were from an
 12 unexpected acute event while 27 percent of those with debt claim that the expenses built up over time
 13 from treatments for chronic conditions.¹¹ Conversely, the Commonwealth Fund reports that the source of
 14 debt for many people is chronic conditions and that about half of adults with debt said it was the result
 15 from treatment received for ongoing health problems.¹² The discrepancy in these findings indicates that
 16 medical debt clearly impacts both patients who experience a one-time acute care event and those with
 17 chronic medical conditions.

18
 19 Approximately 23 million people owe “significant” medical debt, which is considered to be anything
 20 \$250 or greater, according to both KFF and the Survey of Income and Program Participation.¹³ In 2020,
 21 the average amount of medical debt was \$429.¹⁴ Among single-person, privately insured households in
 22 2019, 32 percent did not have liquid assets over \$2,000 and among multi-person households, 20 percent
 23 did not have liquid assets over \$2,000. Sixteen percent of privately insured adults say they would need to
 24 take on credit card debt to meet an unexpected \$400 expense, while seven percent would need to borrow
 25 money from friends or family.¹⁵

26
 27 Adults who are uninsured for six months or more out of the year are more likely to report having
 28 significant medical debt. However, medical debt burden does not solely impact those without health
 29 insurance. Over 90 percent of Americans have some form of health insurance. Even those with private
 30 health insurance may have insufficient liquid assets to meet high deductibles or other cost-sharing
 31 expenses.¹⁶ Many working age adults surveyed by the Commonwealth Fund said it was very or somewhat
 32 difficult to afford their health care, including 43 percent of those with employer-sponsored coverage, 57
 33 percent with Affordable Care Act (ACA) Marketplace or individual plans, 45 percent with Medicaid, and
 34 51 percent with Medicare.¹⁷

35
 36 Insurance coverage does not shield individuals from taking on debt. A substantial portion of people with
 37 insurance still have medical debt including 30 percent of people with employer-sponsored coverage, 37
 38 percent enrolled in an ACA Marketplace or individual plan, 21 percent covered by Medicaid, and 33
 39 percent covered by Medicare.¹⁸ Among those in employer plans, those with low incomes especially
 40 struggled. Fifty-six percent of those with debt enrolled in employer-sponsored plans had incomes under
 41 200 percent of the federal poverty line (FPL) and reported difficulty in paying for their health care.¹⁹
 42 Additionally, those in employer-sponsored plans with incomes below 400 percent FPL reported much
 43 higher rates of delaying or forgoing needed care due to the cost. More than half of these individuals
 44 reported that their health problem had gotten worse as a result of skipping care.

45
 46 One concern with Medicaid specifically is estate recovery for those using Medicaid long-term care.
 47 Medicaid beneficiaries over the age of 55 that have used long-term services, such as a nursing home or
 48 home care, are subject to estate recovery after their death. State agencies will come after any assets,
 49 including the individual's home, in order to recoup the money spent on long-term care for the patient. In
 50 2019, states collected \$733 million in estate recovery, which is about 0.5 percent of Medicaid's total long-
 51 term care expenditures. Patient's families who do not have the assets to pay the expenses owed back to

1 Medicaid are often forced to sell the patient's home to cover the costs. These homes are often the last
2 assets a family has and can further exacerbate existing poverty.²⁰

3
4 Medical debt is a uniquely American problem as nearly half of all working-age Americans struggle with
5 health care costs.²¹ The Commonwealth Fund compared the performance of the United States' health
6 system to those of other high-income countries and ranked it last among 11 nations in several categories
7 including access, efficiency, equity, and health outcomes.²² Health expenditures per person in the United
8 States totaled \$12,555 in 2022, which was over \$4,000 more than any other high-income nation. The
9 average amount spent on health per person in comparable countries is about half of what the United States
10 spends per person (\$6,651).²³ Americans also tend to be unhealthier than those in other countries.
11 However, the comparison is limited due to the variance in health systems in each of the countries that
12 were compared. America's global counterparts either have government health plans (i.e., Britain and
13 Canada) or rely on subsidized private insurers (i.e., Germany and the Netherlands).²⁴ In addition, it would
14 be unfair to compare the health care costs between America and its global counterparts due to the
15 different tax burdens in each of these countries and how that impacts the total paid for health care. While
16 the discrepancies between how these various systems work and serve patients may be of interest, this
17 report specifically focuses on addressing American medical debt within the current health care system.

18 19 *Impact on Physicians*

20
21 An article in the *AMA Journal of Ethics* states that physicians have a responsibility to reduce debt,
22 especially given the impact of patients forgoing care if they are unable to pay. At a minimum, physicians
23 should be aware of their institution's charity care policy or reduced bill payment options.²⁵ However,
24 physicians cannot continue providing care to patients if they are not paid, especially those working in
25 small private practices. Asking patients to pay outstanding and overdue bills is increasingly difficult if
26 there are reduced financial consequences to patients who fail to pay. According to Medscape's 2022
27 Physician Compensation Report, physicians react in the following ways when patients do not pay their
28 outstanding bills: 43 percent continue to treat the patients and develop a payment plan; 13 percent send
29 outstanding bills to third-party collection agencies; 12 percent continue to provide care and write off the
30 balance; 25 percent choose other actions; and eight percent drop patients if they continue not to pay.²⁶

31
32 Physicians are encouraged to have an established payment policy, presented in writing to all patients.
33 These agreements should be clear and easy for all patients to understand. When possible, physicians
34 should try to collect payment at the time of service and provide transparent pricing to patients. This could
35 include explaining that costs for prescribed services (e.g., tests, imaging, medications) are often dictated
36 by the patient's insurance plan and out of the control of the prescribing physician. In the event that unpaid
37 accounts need to be turned over to a third-party collection agency, physicians should be mindful to select
38 agencies that charge reasonable fees, noting that some charge a fee that is 30 to 40 percent of the total
39 amount of debt they collect.

40
41 Physician responsibilities regarding patient medical debt and the cost of care are further codified in the
42 following AMA Code of Ethics opinions: [11.1.1](#), [11.1.4](#), [11.2.1](#), [11.2.2](#), [11.2.4](#), and [11.3.3](#).

43 44 *Patient Financing Programs*

45
46 Medical financing products, such as medical credit cards and installment plans, can be offered to patients
47 through hospitals or physicians' offices, but they are often serviced through third-party financial services
48 companies. Historically, uninsured and low-income patients have been provided installment plans with
49 zero or low interest rates directly from hospitals or physicians' offices where they received their care.
50 Notably, as more physicians become employed, there is less control and awareness of the debt collection
51 practices of their employers. In recent years, some hospitals and physicians' offices have partnered with

1 financial service or private equity companies to offer more structured loan arrangements, which tend to
2 charge market-level or higher interest rates. Some even target patients with low credit scores, while others
3 target specific services, such as fertility treatments.
4

5 Patient financing is a multi-billion-dollar business that includes private equity and banks buying patient
6 debt from hospitals, physicians, and non-physician providers. Hospitals, physicians, and other non-
7 physician providers, who have traditionally put patients in interest free payment plans, have embraced the
8 patient financing model and have entered into contracts with these lenders. Many of these financing plans
9 offer a promotional period where no interest is charged, but if a patient does not pay off the full amount
10 owed during this time, interest is then charged. These loans can deepen inequities. For example, lower
11 income patients without the means to make large monthly payments can face higher interest rates while
12 wealthier patients who are able to take on larger monthly payments can secure lower interest rates.
13 Additionally, patients with higher incomes can usually pay off the debt during the promotional period and
14 avoid accruing any interest.²⁷
15

16 Across the United States, approximately 50 million people are on a financing plan to pay off a medical or
17 dental bill and about 25 percent of these individuals are paying interest. A portion of the interest collected
18 may be kept by financing companies who contract with hospitals to collect outstanding debt. Many
19 hospitals are reluctant to share specific details on their agreements with these companies but have cited
20 the need to offset the cost of offering financing options to patients as a reason why they enter into these
21 partnerships.²⁸
22

23 If patients are unable to keep up with payments to the financing companies, their debt may be sent into
24 collections or returned to the hospital or physician's office where further action may be taken. For
25 example, one of these financing companies, AccessOne, returns patient accounts to the hospital if
26 payments are missed. The hospital can then sue the patient, report them to credit bureaus, or take other
27 collection action. Such actions could also include referring unpaid bills to the state revenue department,
28 which can garnish tax refunds.²⁹ Medical credit cards may also be offered to patients. These accounts tend
29 to charge patients interest rates higher than regular credit cards if patients are unable to pay their balances
30 during the promotional period. In addition, when a patient uses a medical credit card, a physician's office
31 may charge a fee at the time payment is disbursed. One such company, Alphaeon Credit, markets directly
32 to ophthalmology, plastic surgery, dermatology, and dental practices. As an example, in the fine print of
33 their offer to ophthalmology patients, Alphaeon Credit notes that "minimum payments are not guaranteed
34 to pay the promotional plan balance within the promotional period...you may have to pay more than the
35 minimum payment to avoid accrued interest charges." The annual percentage rate (APR) that a patient is
36 charged if they do not pay off their balance within the promotional period is 31.99 percent, well above the
37 average for a typical credit card.³⁰
38

39 *Hospital Charity Care*

40

41 Charity care is offered at most hospitals in the United States. Nonprofit hospitals must provide financial
42 aid as a condition of their tax-exempt status, which is something that saves the hospitals billions of dollars
43 each year. However, standards for aid vary widely across hospitals. Aid at some hospitals is limited to
44 patients below the FPL, while at other hospitals, patients with incomes that are five to six times the FPL
45 can receive assistance. Applying for aid can be complicated for patients, requiring lots of personal
46 financial information and documentation. A Kaiser Health News analysis of tax filings found that nearly
47 one half of nonprofit medical systems were billing patients with incomes low enough to qualify for
48 charity care.³¹

1 Problems associated with charity care are important and closely related to the broader issue of patient
2 medical debt. Notably, the Council will be preparing a report for the 2024 Interim Meeting specifically on
3 charity care and any associated recommendations will be included in the forthcoming report.
4

5 *Recent Federal and State Efforts*

6

7 In July 2023, the Biden Administration, CFPB, the Department of Health and Human Services (HHS),
8 and the Treasury Department issued a Request for Information (RFI) on medical credit cards and other
9 high-cost specialty financing products to understand their prevalence, patients' experience with them, and
10 incentives driving physicians and other non-physician providers to offer these products. In the RFI, the
11 agencies cite that hospitals and financial service companies might not be making reasonable efforts to
12 determine when a patient is eligible for financial assistance before offering a medical financing product.³²
13

14 Additionally, the RFI indicates that a typical APR for a medical credit card is 27 percent, while a typical
15 consumer credit card has an average APR of about 16 percent. With medical credit cards, if a patient is
16 unable to pay the balance within the no- or low-interest promotional period, the patient will then owe
17 interest on the entire amount, not just the remaining balance. As a result, patients incurred a total of about
18 \$1 billion in deferred interest on health care purchases between 2018-2020.³³
19

20 Although national credit reporting agencies agreed not to report medical debts that are less than a year old
21 or under \$500 on Americans' credit reports, using a medical financing product can impact patient credit
22 scores more directly through "[hard](#)" credit checks, increased credit line utilization, decreased account age,
23 or eventual account closure.³⁴ A benefit for hospitals, physicians, and non-physician providers utilizing
24 medical financing products is being paid within days of providing a service and not having to handle
25 disputes, billing, or other administrative work.
26

27 In addition to the RFI, in September 2023, CFPB released a notice that it is developing a rule to bar credit
28 reporting companies from including medical debt in consumer credit reports. CFPB is seeking to prohibit
29 lenders from using medical collections information when evaluating a borrower's application. The agency
30 plans to issue a Notice of Proposed Rulemaking in 2024,³⁵ which was not available at the time that this
31 report was written. As of November 2023, CFPB released a notice stating that it is taking steps to ensure
32 medical debt collectors follow the law, including the Fair Debt Collection Practices Act and the Fair
33 Credit Reporting Act. Specifically, these steps include supervision and enforcement efforts, reminding
34 entities about their obligations, support for state-level action, and education and outreach. Although the
35 Fair Debt Collection Practices Act limits how aggressive debt collectors can be by restricting the ways
36 and times they can contact debtors, it does not limit or prohibit the use of legal remedies like wage
37 garnishment or foreclosure.³⁶ Further, the Fair Debt Collection Practices Act currently only applies to
38 debt collectors and does not include hospitals or other health care entities.
39

40 In addition to recent federal efforts, several states have created policies to protect patients from the
41 consequences of having medical debt. A detailed overview, including maps of which states fall into each
42 category can be found [here](#).³⁷
43

44 A summary of recent state actions include:

- 45 • Charging interest on medical debt
 - 46 ○ Eight states have laws prohibiting or limiting interest on all medical debt.
 - 47 ○ Some states have set a ceiling for interest on all medical debt. Others prohibit charging
 - 48 interest to patients who are at or below 250 percent FPL and are ineligible for public
 - 49 insurance programs.

- 1 • Regulations on sending medical bills to collections
 - 2 ○ Thirty-seven states do not regulate when a hospital can send a bill to collections.
3 ○ However, unlike hospitals, debt collectors do not have a relationship with patients and
4 ○ can be more aggressive when collecting on the debt.
5 ○ Connecticut prohibits hospitals from sending bills of certain low-income patients to
6 ○ collections and Illinois requires hospitals to offer a reasonable payment plan first.7 ○ Maryland and Colorado require hospitals to report debt collection actions with
8 ○ demographic data and New Mexico and Colorado extended the requirements that are
9 ○ applicable to nonprofit hospitals to urgent care clinics, freestanding Emergency
10 ○ Departments, and outpatient clinics.³⁸
- 11 • Sale of medical debt
 - 12 ○ Maryland, New Mexico, and Vermont prohibit the sale of medical debt while California
13 ○ and Colorado regulate debt buyers instead. California prohibits debt buyers from
14 ○ charging interest and Colorado prohibits them from foreclosing on a patient's home.
15 ○ California also recently restricted when hospitals could sell patient debt or report patients
16 ○ to credit bureaus.³⁹ Debt collection is prohibited for 180 days, regardless of financial
17 ○ status.⁴⁰
- 18 • Liens and foreclosures
 - 19 ○ Thirty-three states do not limit hospitals, collection agencies, or debt buyers from placing
20 ○ a lien or foreclosing on a patient's home to recover unpaid medical bills. However,
21 ○ almost all states provide a homestead exemption, which protects some equity in a
22 ○ patient's home from being seized during bankruptcy.
23 ○ Eleven states prohibit or set limits on liens and foreclosures for medical debt.
- 24 ○ New York and Maryland fully prohibit both liens and foreclosures because of medical
-
- 25 ○ debt, while California and New Mexico only prohibit them for certain low-income
-
- 26 ○ populations.
- 27 • Wage garnishment
 - 28 ○ Under federal law, the amount of wages garnished each week may not exceed the lesser
29 ○ of 25 percent of the employee's disposable earnings or the amount by which an
30 ○ employee's disposable earnings are greater than 30 times the federal minimum wage.
31 ○ Twenty-one states exceed the federal ceiling for wage garnishment.
- 32 ○ New York fully prohibits wage garnishment to recover medical debt for all patients, yet
-
- 33 ○ California only extends protections for certain low-income populations.34 ○ New Hampshire does not prohibit wage garnishment, but it does require the creditor to
-
- 35 ○ keep going back to court every pay period to garnish wages, which significantly limits
-
- 36 ○ creditors' ability to garnish wages in practice.

37 38 AMA POLICY AND ADVOCACY

39
40 AMA policy is limited on the issue of patient medical debt directly. Tangentially related policies address
41 uncompensated care, controlling costs of care, price transparency, patient cost-sharing generally, and
42 expanding coverage and improving affordability of coverage.

43
44 Policy D-155.987 states that our AMA: 1) encourages physicians to communicate information about the
45 cost of their professional services to individual patients, taking into consideration the insurance status of
46 the patient or other relevant information where possible; 2) advocates that health plans provide plan
47 enrollees or their designees with complete information regarding plan benefits and real time cost-sharing
48 information associated with both in-network and out-of-network provider services or other plan designs
49 that may affect patient out-of-pocket costs; 3) will actively engage with health plans, public and private
50 entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for

1 patients and physicians, and help ensure that entities promoting price transparency tools have processes in
 2 place to ensure the accuracy and relevance of the information they provide; 4) will work with states and
 3 the federal government to support and strengthen the development of all-payer claims databases; 5)
 4 encourages electronic health record vendors to include features that assist in facilitating price
 5 transparency for physicians and patients; 6) encourages efforts to educate patients in health economics
 6 literacy, including the development of resources that help patients understand the complexities of health
 7 care pricing and encourage them to seek information regarding the cost of health care services they
 8 receive or anticipate receiving; and 7) will request that the Centers for Medicare & Medicaid Services
 9 expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.

10
 11 Policy H-165.846 states that our AMA supports the following principles to guide in the evaluation of the
 12 adequacy of health insurance coverage options: a) any insurance pool or similar structure designed to
 13 enable access to age-appropriate health insurance coverage must include a wide variety of coverage
 14 options from which to choose; b) existing federal guidelines regarding types of health insurance coverage
 15 (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program regulations) should
 16 be used as a reference when considering if a given plan would provide meaningful coverage; c) provisions
 17 must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health
 18 insurance coverage and meeting cost-sharing obligations; and d) mechanisms must be in place to educate
 19 patients and assist them in making informed choices, including ensuring transparency among all health
 20 plans regarding covered services, cost-sharing obligations, out-of-pocket limits, and lifetime benefit caps,
 21 and excluded services. Policy H-165.846 also advocates that the Early and Periodic Screening,
 22 Diagnostic, and Treatment program be used as the model for any essential health benefits package for
 23 children and that the AMA: a) opposes the removal of categories from the essential health benefits (EHB)
 24 package and their associated protections against annual and lifetime limits, and out-of-pocket expenses;
 25 and b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their
 26 associated protections against annual and lifetime limits.

27
 28 Policy D-180.979, which comes from CMS Report 9-A-19, states that the AMA will: 1) support the
 29 development of sophisticated information technology systems to help enable physicians and patients to
 30 better understand financial obligations; 2) encourage states and other stakeholders to monitor the growth
 31 of high deductible health plans and other forms for cost-sharing in health plans to assess the impact of
 32 such plans on access to care, health outcomes, medical debt, and provider practice sustainability;
 33 3) advocate for the inclusion of health insurance contract provisions that permit network physicians to
 34 collect patient cost-sharing financial obligations (e.g., deductibles, co-payments, and co-insurance) at the
 35 time of service; and 4) monitor programs wherein health plans and insurers bear the responsibility of
 36 collecting patient co-payments and deductibles.

37
 38 Policy H-373.996 states that our AMA supports the principles contained in the Medical Debt Relief Act
 39 as drafted and passed by the US House of Representatives to provide relief to the American consumer
 40 from a complicated collections process and supports medical debt resolution being portrayed in a positive
 41 and productive manner.

42
 43 Policy H-160.923 states that our AMA: 1) supports the transitional redistribution of disproportionate
 44 share hospital payments for use in subsidizing private health insurance coverage for the uninsured; 2)
 45 supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose
 46 of supporting physicians that treat large numbers of uninsured patients, as well as the Emergency Medical
 47 Treatment and Active Labor Act-directed care; and 2) encourages public and private sector researchers to
 48 utilize data collection methodologies that accurately reflect the amount of uncompensated care (including
 49 both bad debt and charity care) provided by physicians.

1 Policy H-165.838 states that the AMA is committed to working with Congress, the Administration, and
2 other stakeholders to achieve enactment of health system reforms that include the following seven critical
3 components: health insurance coverage for all Americans; insurance market reforms that expand choice
4 of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps;
5 assurance that health care decisions will remain in the hands of patients and their physicians, not
6 insurance companies or government officials; investments and incentives for quality improvement and
7 prevention and wellness initiatives; repeal of the Medicare physician payment formula that triggers steep
8 cuts and threaten seniors' access to care; implementation of medical liability reforms to reduce the cost of
9 defensive medicine; and streamline and standardize insurance claims processing requirements to
10 eliminate unnecessary costs and administrative burdens.

11 DISCUSSION

12
13
14 Medical debt is a huge burden on many Americans across all demographic groups. Patients face negative
15 outcomes associated with debt, including worse health outcomes, stress from being contacted by debt
16 collectors and negative credit score impacts, and the downstream effects of difficulty getting a job or
17 buying or renting a home.

18
19 Medical debt is accrued by patients with long-term, chronic conditions, as well as those with acute
20 conditions or those suffering from an accident. Insurance coverage does not automatically protect patients
21 from debt. Even with insurance coverage many patients struggle with high cost-sharing and deductibles
22 offered by their insurance plans. Improved patient education on the cost of care and plan details could
23 help patients better prepare for unexpected medical costs. Both insured and uninsured patients have
24 reported delaying or forgoing needed care due to costs, further exacerbating health concerns.

25
26 The growth of high-deductible health insurance plans, which are increasingly offered to patients, have
27 been shown to require deductibles too high for many Americans. In 2021, the average annual deductible
28 for a single worker with employer-based coverage was over \$1,400, which is almost four times greater
29 than it was in 2006. Family deductibles can exceed \$10,000.⁴¹ Out-of-pocket maximums also prove to be
30 too high for many Americans. For example, although the ACA caps out-of-pocket spending for those on
31 Marketplace plans, in 2024, the out-of-pocket maximum for those on a Marketplace plan is \$9,450 for an
32 individual and \$18,900 for a family.^{42,43}

33
34 Many patients are unaware of reduced cost options offered by their hospital or physician's office. These
35 plans should be easy for patients to access and should be discussed with patients at the time of payment.
36 This includes sharing details about interest rates, timelines for payment, and anything else that may
37 impact the patient financially. While physicians should be aware of the charity care policy in their office
38 or institution, it must be understood that physicians cannot continue providing care to patients if they are
39 not paid. This is made more difficult if penalties are reduced for patients who are unable or unwilling to
40 pay their bills. The Council believes that physicians have the opportunity to educate patients on the
41 charity care policy offered by their institution but should be mindful when partnering with third-party
42 collection agencies, especially those who place wage garnishments and property liens on low-wage
43 patients. If possible, physicians should try to handle debts with patients directly, by requiring payment
44 prior to providing services (for non-emergent care), offering flexible payment plans, or forgiveness of
45 debt altogether. Additionally, if a patient's medical bill is part of an ongoing dispute, hospitals and
46 physicians should try to refrain from sending this bill to collections or to a third-party collection agency
47 until the dispute is resolved.

48
49 The Council believes that recent efforts by the Biden Administration, CFPB, HHS, and Treasury
50 Department to explore the causes of and solutions to medical debt provide the AMA with an opportunity

1 to support amendments to laws, such as the Fair Debt Collection Practices Act, to strengthen standards
2 and provide additional clarity to patients about medical billing.
3

4 Several states, counties, and cities have taken a creative approach to managing medical debt for their
5 residents. For example, New York City and Cook County (Chicago) in Illinois have recently partnered
6 with RIP Medical Debt, a nonprofit organization that purchases and forgives medical debt from low-wage
7 individuals. At the time that this report was written, Cook County and RIP Medical Debt have used \$12
8 million of federal funds granted by the American Rescue Plan to forgive up to \$1 billion in medical debt
9 for residents.⁴⁴ New York City is also partnering with RIP Medical Debt and investing \$18 million to
10 purchase and forgive \$2 billion in medical debt for approximately half a million New York residents.⁴⁵ To
11 qualify for relief in both Cook County and New York, a resident must have an annual household income
12 below 400 percent FPL or have medical debt equal to five percent or more of their annual household
13 income. Other states and cities are exploring similar grants and partnerships. The AMA has an
14 opportunity to be further educated on these and other initiatives to reduce medical debt for patients and
15 explore ways to support the missions of these organizations.
16

17 Medical debt impacts many patients in the United States, causing negative health outcomes from delayed
18 or denied care to stress from financial pressures from unpaid bills. When possible, the Council believes
19 that physicians should support patient education on the cost of care, including potential downsides for
20 alternative options for paying down debt, such as high interest rates or penalties for missing payments
21 with third-party collection agencies. Understanding both the serious issue of medical debt for patients and
22 that physicians need to be paid to continue providing care, physicians should be thoughtful when
23 navigating this issue by encouraging patients to be informed about their insurance coverage and to take
24 advantage of charity care when they qualify to reduce the burden of the cost of their care.
25

26 RECOMMENDATIONS

27
28 The Council on Medical Service recommends that the following recommendations be adopted in lieu of
29 Resolution 710-A-23 and Resolution 712-A-23, and the remainder of the report be filed:
30

- 31 1) That our American Medical Association (AMA) encourage health care organizations to manage
32 medical debt with patients directly, considering several options including but not limited to
33 discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt
34 altogether, before resorting to third-party debt collectors or any punitive actions. (New HOD
35 Policy)
36
- 37 2) That our AMA supports innovative efforts to address medical debt for patients, including public
38 and private efforts to eliminate medical debt. (New HOD Policy)
39
- 40 3) That our AMA support amending the Fair Debt Collection Practices Act to include hospitals and
41 strengthen standards within the Act to provide clarity to patients about whether their insurance
42 has been or will be billed, which would require itemized debt statements to be provided to
43 patients, thereby increasing transparency, and prohibiting misleading representation in connection
44 with debt collection. (New HOD Policy)
45
- 46 4) That our AMA opposes wage garnishments and property liens being placed on low-wage patients
47 due to outstanding medical debt at levels that would preclude payments for essential food and
48 housing. (New HOD Policy)
49
- 50 5) That our AMA support patient education on medical debt that addresses dimensions such as:

- 1 a. Patient financing programs that may be offered by hospitals, physicians offices, and other
- 2 non-physician provider offices;
- 3 b. The ramifications of high interest rates associated with financing programs that may be
- 4 offered by a hospital, physician’s office, or other non-physician provider’s office;
- 5 c. Potential financial aid available from a patient’s hospital and/or physician’s office; and
- 6 d. Methods to reduce high deductibles and cost-sharing. (New HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

- ¹Levey, Noam N. 100 Million People in American Are Saddled with Health Care Debt. Kaiser Health News. June 16, 2022. <https://kffhealthnews.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/>
- ²Rakshit, S. et. al. The burden of medical debt in the United States. Peterson-KFF Health System Tracker. February 12, 2024. <https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/#:~:text=This%20analysis%20shows%20that%2020,%24220%20billion%20in%20medical%20debt.>
- ³Shultz, Blake N., et. al. Hospital Debt Collection Practices Require Urgent Reform. Health Affairs. May 2, 2022. <https://www.healthaffairs.org/content/forefront/hospital-debt-collection-practices-require-urgent-reform>
- ⁴*Supra.* Note 2.
- ⁵Kona, Maanasa and Vrudhi Raimugia. State Protection Against Medical Debt: A Look at Policies Across the U.S. Commonwealth Fund. September 7, 2023. <https://www.commonwealthfund.org/publications/fund-reports/2023/sep/state-protections-medical-debt-policies-across-us>
- ⁶Rae, Matthew, et. al. The burden of medical debt in the United States. Peterson-KFF Health System Tracker. March 10, 2022.
- ⁷*Ibid.*
- ⁸*Supra.* Note 6.
- ⁹Commonwealth Fund. New Survey: More Than Half of U.S. Adults who Contracted COVID-19 or Lost Income During the Pandemic Also Struggled with Medical Bill Problems. Press Release. July 16, 2021. <https://www.commonwealthfund.org/press-release/2021/new-survey-more-half-us-adults-who-contracted-covid-19-or-lost-income-during>
- ¹⁰Lopes, Lunna, et. al. Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills. KFF. June 16, 2022. <https://www.kff.org/health-costs/report/kff-health-care-debt-survey/>
- ¹¹*Ibid.*
- ¹²Commonwealth Fund. Paying for it: How Health Care Costs and Medical Debt Are Making Americans Sicker and Poorer. October 26, 2023. <https://www.commonwealthfund.org/publications/surveys/2023/oct/paying-for-it-costs-debt-americans-sicker-poorer-2023-affordability-survey>
- ¹³*Supra.* Note 2.
- ¹⁴Mendes de Leon PhD, Carlos F. and Jennifer Griggs, MD, PhD. Medical Debt as a Social Determinant of Health. JAMA Editorial. July 20, 2021. <https://jamanetwork.com/journals/jama/fullarticle/2782205>
- ¹⁵*Supra.* Note 10.
- ¹⁶*Supra.* Note 10.
- ¹⁷*Supra.* Note 12.
- ¹⁸*Supra.* Note 12.
- ¹⁹*Supra.* Note 12.
- ²⁰Span, P. *When Medicaid Comes After the Family Home.* The New York Times. March 16, 2024. <https://www.nytimes.com/2024/03/16/health/medicaid-estate-recovery-seniors.html?searchResultPosition=1>
- ²¹Kellerman, Arthur L. The U.S. Spends More On Healthcare than Other Wealthy Nations But Ranks Last in Outcomes. Forbes. October 24, 2023. <https://www.forbes.com/sites/arthurkellermann/2023/10/24/the-us-spends-more-on-healthcare-than-other-wealthy-nations-but-ranks-last-in-outcomes/?sh=ae7f0847d350>
- ²²*Ibid.*
- ²³Wager, Emma, et. al. How Does health spending in the U.S. compare to other countries? Peterson-KFF Health System Tracker. January 23, 2024. <https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#Health%20expenditures%20per%20capita,%20U.S.%20dollars,%20PPP%20adjusted,%202022>

- ²⁴Levey, Noam N. American's Struggle with Medical Bills are a Foreign Concept in Other Countries. LA Times. September 12, 2019. <https://www.latimes.com/politics/story/2019-09-11/american-struggle-insurance-deductibles-unique>
- ²⁵Plax, MD Katie and Robert W. Seifert. Medical Debt, Health Care Access, and Professional Responsibility. AMA Journal of Ethics. March 2006. <https://journalofethics.ama-assn.org/article/medical-debt-health-care-access-and-professional-responsibility/2006-03>
- ²⁶Nelson, Jennifer. Patients Who Won't Pay: What's Your Recourse? Medscape. August 15, 2022. <https://www.medscape.com/viewarticle/979032>
- ²⁷Levey, Noam and Aneri Pattani. How Banks and Private Equity Cash In When Patients Can't Pay Their Medical Bills. Kaiser Health News. November 17, 2022. <https://kffhealthnews.org/news/article/how-banks-and-private-equity-cash-in-when-patients-cant-pay-their-medical-bills/>
- ²⁸*Ibid.*
- ²⁹*Supra.* Note 31.
- ³⁰Alphaeon Credit. Estimate Your Payments. Accessed: March 26, 2024. <https://goalphaeon.com/estimate-my-payment-ophthalmology>
- ³¹Levey, Noam. Hundreds of Hospitals Sue Patients or Threaten Their Credit, a KHN Investigation Finds. Does Yours? Kaiser Health News. December 21, 2022. <https://kffhealthnews.org/news/article/medical-debt-hospitals-sue-patients-threaten-credit-khn-investigation/>
- ³²Kona, Maanasa. The Biden Administration Takes Aim at Medical Financing Products. Health Affairs. July 11, 2023. <https://www.healthaffairs.org/content/forefront/biden-administration-takes-aim-medical-financing-products>
- ³³*Ibid.*
- ³⁴*Supra.* Note 10.
- ³⁵PoliticoPro. Medical Debt Solutions Wanted. September 14, 2023.
- ³⁶CFPB Report Highlighting Consumer Protection Issues in Medical Debt Collection. Consumerfinance.gov. November 16, 2023. <https://www.healthaffairs.org/content/forefront/biden-administration-takes-aim-medical-financing-products>
- ³⁷*Supra.* Note 5.
- ³⁸*Supra.* Note 3.
- ³⁹*Supra.* Note 34.
- ⁴⁰*Supra.* Note 3.
- ⁴¹Levey, Noam. Sick and Struggling to Pay, 100 million people in the U.S. live with medical debt. NPR and Kaiser Health News. June 16, 2022. <https://www.npr.org/sections/health-shots/2022/06/16/1104679219/medical-bills-debt-investigation>
- ⁴²*Supra.* Note 40.
- ⁴³Healthcare.gov. Out-of-pocket Maximum/limit. Accessed: March 6, 2024. <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/#:~:text=For%20the%202024%20plan%20year,and%20%2418%2C200%20for%20a%20family>
- ⁴⁴Cook County American Rescue Plan. Medical Debt Relief Initiative. Accessed: March 26, 2024. <https://arpa.cookcountyil.gov/medical-debt-relief-initiative>
- ⁴⁵NYC.gov. Canceling Medical Debt for New Yorkers. Accessed: March 26, 2024. <https://www.nyc.gov/content/getstuffdone/pages/canceling-medical-debt-for-new-yorkers>

Relevant AMA Policy Patient Medical Debt

Price Transparency, D-155.987

1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide enrollees or their designees with complete information regarding plan benefits and real-time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
4. Our AMA will work with states and the federal government to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
6. Our AMA encourages efforts to educate patients in health economic literacy, including the development of resources that help patients understand the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.
(CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res. 213, I-17; Reaffirmed: BOT Rep. 14, A-18; Reaffirmed in lieu of: Res. 112, A-19; Modified: Res. 213, I-19; Reaffirmation: A-23)

Adequacy of Health Insurance Coverage Options, H-165.846

1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:
 - a. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.
 - b. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.
 - c. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.
 - d. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.
2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.
3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.
(CMS Rep. 7, A-07; Reaffirmation: I-07; Reaffirmation: A-09; Reaffirmed: Res. 103, A-09; Reaffirmation: I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19)

Health Plan Payment of Patient Cost-Sharing, D-180.979

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

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.
(Res. 226, I-10; Reaffirmed: BOT Rep. 04, A-20)

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.
(CMS Rep. 8, A-05; Reaffirmation: A-07; Modified: CMS Rep. 01, 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 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 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.
- (Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 02, I-23)

REPORT 6 OF THE COUNCIL ON MEDICAL SERVICE (A-24)
Economics of Prescription Medication Prior Authorization
(Resolution 725-A-23)
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2023 Annual Meeting, the House of Delegates referred Resolution 725, which asked that the American Medical Association (AMA) work with the federal government and third-party payers and surrogates to include economic information on medications that are denied prior authorization.

The Council reviewed information regarding factors that contribute to the current state of prior authorization: formularies, rebates, and prescription drug pricing. Each of these factors contain layers of confusion and lack transparency. Not only are these factors opaque and complicated individually, but each interacts with the evolution of prior authorization. To better understand prior authorization denials, the Council examined information on the history of prior authorization and its current state. The Council found that denials are often issued by payers in a manner that is confusing and inconsistent for both physicians and patients. The Council also reviewed potential solutions to the problem, namely the utilization of real-time prescription benefit tools (RTBTs). These tools allow physicians to access patient coverage information at the time of prescribing, presenting an opportunity to improve the care delivery process and workflow. The current prior authorization system relies on communicating decisions after the prescription has been issued, often leading to care delays and adherence issues. Alternatively, RTBTs present coverage information prior to the prescription being written, allowing prescribers to identify care delivery hurdles earlier and avoiding unexpected prior authorization related delays.

Based on its review, the Council recommends the adoption of new AMA policy that outlines the basic requirements for prior authorization denial letters: a detailed explanation of denial reasoning, access to policies/rules cited as part of the denial, approved alternatives, and what is needed to approve the original prescription. Additionally, the Council recommends the amendment of current RTBT policy, to ensure alignment between patient and physician systems, that alternative prescriptions are offered, and that coverage information is honored by payers. Finally, the Council recommends the reaffirmation of a number of current policies to ensure that Pharmacy Benefit Managers (PBMs) are regulated, formulary data is available to physicians in real-time, that PBM actions do not erode the patient-physician relationship, and that prior authorization is not abused.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-24

Subject: Economics of Prescription Medication Prior Authorization
(Resolution 725-A-23)

Presented by: Sheila Rege, MD Chair

Referred to: Reference Committee G

1 At the 2023 Annual Meeting, the House of Delegates referred Resolution 725-A-23, The
2 Economics of Prior Authorization, which was sponsored by the Organized Medical Staff Section.
3 This resolution asked;

4
5 That our American Medical Association advocate to the federal government that third party
6 payers and surrogates include economic information on the net costs of medication denied
7 prior authorization and, where applicable, comparative net costs of alternative approved or
8 suggested medications for each rejected prior authorization.
9

10 In response to the resolution, this report provides an overview of prior authorization and factors
11 that contribute to prescription medication prior authorization specifically, including formularies,
12 rebates, and drug pricing. The Council also explores that real-time benefit tools (RTBT) have the
13 potential to help solve this issue. The Council presents policy recommendations consistent with the
14 intent of Resolution 725-A-23.
15

16 BACKGROUND

17
18 The Council commends the sponsors of Resolution 725-A-23 for bringing forward this important
19 topic and believes that the spirit of the resolution has the potential to positively impact both
20 physicians and patients. Prior authorization is a complex and often frustrating process that
21 physicians face on a regular basis. While additional information in denial letters is warranted, as
22 suggested in the original resolution, the Council emphasizes that resources like RTBTs have the
23 potential to improve the prior authorization process faced by patients and physicians. These tools
24 allow physicians to access detailed information about the coverage of a prescription medication
25 before the prescription is written, which could reduce the number of denial letters, increase the
26 information accessible to physicians, and allow physicians to focus on patient care instead of
27 appeals. To fully understand prior authorization, its economic impact, and how RTBTs could assist
28 care delivery and workflow, it is necessary to understand some of the factors that contribute to the
29 complexity, such as formularies, rebates, and the lack of prescription drug price transparency.
30

31 Formularies, or the list of prescription drugs covered by a payer, are created via consultation with
32 experts, often supported or directed by pharmacy benefit managers (PBMs) and typically based on
33 clinical outcomes and the relative costs.^{1,2} Formularies are premised on reducing costs and
34 ensuring the appropriate use of pharmaceuticals.³ However, they often have negative impacts on
35 patients and physicians. Specifically, research has demonstrated that among studied formularies at
36 least half of all patient health care utilization and economic outcomes were not beneficial to

1 patients.³ Drugs on a formulary are typically divided into different tiers based on the drug’s price
 2 and the formulary designer’s preference. A drug’s tier position depends on a multitude of factors
 3 and can differ significantly between payers; however, one of the primary factors influencing any
 4 drug’s tier placement is the financial arrangement between the payer and the drug manufacturer for
 5 that drug. Unfortunately, a drug’s efficacy or its appropriateness for a particular patient, and its
 6 cost-effectiveness are often secondary considerations compared to the financial implications of the
 7 drug.

8
 9 Manufacturers offer rebates that are typically negotiated between PBMs and the drug manufacturer
 10 and are typically based on the list price of the drug. Along with prior authorization, rebates are
 11 generally used to encourage a payer to include favorable placement or inclusion on a formulary.⁴
 12 Increased rebates are sometimes used to incentivize placement on a preferred formulary tier.⁵
 13 Rebates are relied on heavily by PBMs and other payers to negotiate more lucrative deals, and to
 14 protect these financial positions, it is critical to PBMs and payers that the specific details of these
 15 arrangements remain confidential. Without access to more detailed information about rebates and
 16 other financial incentives, it is impossible for physicians to fully understand how much a drug truly
 17 costs.

18
 19 Payers often use prior authorization as a tool to discourage physicians from prescribing
 20 medications that are not on the payer’s preferred formulary tier. If a payer prefers that a physician
 21 prescribe one drug over another within the same drug class, the payer can simply apply a prior
 22 authorization requirement to the non-preferred medication. By placing prior authorization on non-
 23 preferred drugs, payers can drive utilization in their desired direction. It is often challenging for
 24 physicians to determine whether a prior authorization is required at all, let alone what the specific
 25 requirements are. The prior authorization process is often so opaque that physicians may not be
 26 notified that a prior authorization is required until they receive a denial letter from the payer, or the
 27 patient is turned away at the pharmacy counter, which can lead to delays and significant
 28 interruptions in ongoing care as well as disruptions to patient adherence. Although these payer
 29 coverage determination delays and/or issues are rarely the physician’s fault, patients may blame the
 30 physician, undermining the patient’s trust in the physician and potentially impacting the patient-
 31 physician relationship long-term.

32
 33 Physicians are often prescribing without access to drug cost and coverage information at the point
 34 of prescribing, making it almost impossible to avoid prescribing a drug that may be unaffordable
 35 under that specific patient’s plan. This can cause the physician to unknowingly prescribe a more
 36 expensive medication when a lower-cost and equally beneficial medication is available and can
 37 cause significant harm to patient outcomes. Specifically, more expensive medications have been
 38 linked to lower treatment adherence, and, in extreme cases, increases in morbidity and/or
 39 mortality.⁶ While there have been efforts from federal regulators and legislators to mitigate some of
 40 the negative impacts from medication prior authorization, the process remains opaque and
 41 complicated and, as a result, patients may not be able to readily access lower-cost alternative
 42 medications. Additionally, there is very little transparency from PBMs and payers regarding
 43 rebates, formulary makeup, and drug costs.⁶ Rebate information is considered proprietary data and
 44 as such is not accessible for scrutiny, making it incredibly difficult for any regulating body to have
 45 accurate data leading to challenges in effective regulation.

46
 47 **PRIOR AUTHORIZATION DENIALS**

48
 49 The roots of prior authorization can be traced back to the original Medicare and Medicaid
 50 legislation from the 1960s which introduced utilization review, or the process of verifying the need
 51 for treatment, often hospital stays, for a confirmed diagnosis.⁷ Over time, this process has expanded

1 to include the coverage of prescription medications and to what is now recognized as prior
 2 authorization.⁷ When introduced, prior authorization was touted as a method to restrict significant
 3 increases in the cost of prescription drugs, however this process has become one that is
 4 burdensome for both patients and physicians.⁸ Prior authorization has resulted in several adverse
 5 consequences ranging from increased administrative burden to patient inability to access necessary
 6 medications.⁸ Additionally, the prior authorization process can undermine the patient-physician
 7 relationship. Physicians and patients frequently have limited knowledge if prior authorization will
 8 be required for a medication, hindering the ability for physicians to ensure affordable, timely
 9 access to the medication they deem the most appropriate.⁹

10
 11 Today, prior authorization has become pervasive throughout the health care system. A recent report
 12 found that 99 percent of Medicare Advantage (MA) plans require prior authorization for at least
 13 some services; most often for Part B drugs.¹⁰ Additionally, a study investigating MA plans found
 14 that prior authorizations are submitted, on average, 1.5 times for each enrollee, adding up to
 15 approximately 35 million requests in one year.¹¹ Of the submitted requests in MA plans this study
 16 found that six percent, or approximately 2 million, were denied. However, this denial rate ranged
 17 greatly among payers with some denial rates as high as double the average. Importantly, this study
 18 found that only 11 percent of denied prior authorizations were appealed by either the patient or
 19 provider. The vast majority of appeals were successful with 82 percent resulting in a full or partial
 20 overturning of the denial. Similar to rates of denials, some payers saw much higher rates of appeal,
 21 some reaching 20 percent of all denials. Further, for some payers, appeals were successful as much
 22 as 94 percent of the time.¹¹ While this study is helpful in beginning to understand the rates of prior
 23 authorization denials, the researchers did not have access to disaggregated data showing the service
 24 type of prior authorization requests and were unable to access reasoning for each denial or
 25 information on the timeliness of requests or appeals. Additionally, these statistics were only based
 26 on MA plans; private plans were not included. It is important to note that physicians who are
 27 forced to appeal prior authorization denials often face significant administrative costs. Physicians
 28 and their offices are often required to hire additional staff and/or spend personal time managing
 29 authorizations and appeals.

30
 31 Legislators and regulators have introduced rules and regulations that are designed to minimize the
 32 struggles that plague the prior authorization process. For example, a recent final regulation from
 33 the Centers for Medicare & Medicaid Services (CMS) requires that as of January 1, 2027, payers,
 34 including MA, Medicaid, Children’s Health Insurance Program, and Qualified Health Plans on the
 35 Federally Facilitated Exchange are required to maintain a prior authorization application
 36 programming interface (API). This API must include information on covered items and services,
 37 identification of documents required for prior authorization, be supportive of prior authorization
 38 requests and payer responses, and communicate approvals, denials, or requests for additional
 39 information.¹² Effective January 1, 2026, payers will be required to report metrics and follow a
 40 stricter response timeline.¹³ While this rule will improve the regulation of prior authorization, it
 41 does not extend to prescription drug prior authorization requests.

42
 43 One of the biggest issues with prior authorization is the opaque and extensive denial process. Not
 44 only is this a frustrating process for the patient looking to access treatment, but it is also
 45 exasperating for physicians who are attempting to support their patients. When a denial letter is
 46 sent out, it may not include effective information to understand and/or appeal the denial itself. For
 47 example, physicians and patients may simply be informed that a medication has not been approved
 48 without providing justification as to why the denial took place or an alternative treatment option.
 49 Without clear information regarding the clinical rationale for the denial, patients and physicians are
 50 often left to the frustrating process of guess work in attempting to find a treatment covered by the
 51 patient’s plan.

1 In order to improve the quantity and quality of information provided in denial letters, CMS has
2 implemented basic requirements for all Medicare health plans.¹⁴ These requirements, outlined in
3 CMS-10003-Notice of Denial of Medical Coverage or Payment form are in place for all medical
4 services and prescription drug denials. Specifically, in denial letters, plans must provide the
5 patient/physician with detailed information as to why the request was denied. Plans are required to
6 include a “specific and detailed” explanation for the denial, applicable coverage rules or plan
7 policies cited in the denial, and specific information as to what needs to be done to approve
8 coverage.¹⁴ These requirements ensure that the Medicare beneficiaries and their physicians are able
9 to have an understanding of the full scope of the denial via the notification letter.

10 11 REAL-TIME BENEFIT TOOL

12
13 To address the underlying concerns of Resolution 725-A-23, the Council worked to better
14 understand available data and what could feasibly be provided to physicians and patients. Not only
15 are there issues related to a lack of transparency due to prior authorization, at present, prior
16 authorization denial systems are not capable of producing specific net cost information on denials.
17 The Council believes that advocacy efforts supporting the betterment of alternative solutions, like
18 RTBTs, instead of the expansion of prior authorization systems better serve physicians and their
19 patients. One potential solution to the challenges faced due to prior authorization are RTBTs,
20 which allow patients and prescribers to access real-time information about coverage, including
21 formularies and benefit information at the point of prescribing.¹⁵ These tools simplify prescribing
22 with real-time information during an appointment. RTBTs allow prescribers to enter prescription
23 details, like type, amount, and intended pharmacy, and be informed, prior to writing the
24 prescription, of the cost and prior authorization requirements. RTBTs also allow physicians and
25 other prescribers to view alternative medications that may be lower cost to the patient and/or not
26 require prior authorization, thus allowing the prescriber to identify and prescribe the most
27 appropriate and accessible medication for a patient.¹⁶

28
29 RTBTs present an opportunity to improve the care delivery process by presenting prescribers with
30 critical prescription coverage and cost information at the point of prescribing. The current prior
31 authorization system relies heavily on relaying information to the patient/prescriber after a
32 prescription has been written and the patient has attempted to get that prescription filled. These
33 “post-prescription written denials,” usually delivered to prescribers via letters, often lead to
34 additional work for prescribers and their staff and result in immense administrative practice
35 burdens. In addition to increased work for physicians and their staff, the current prior authorization
36 process also often leads to patient care delays and adherence issues. RTBTs present all of the cost,
37 coverage, and other pertinent benefit information within the prescriber’s typical prescribing
38 workflow and allow the prescriber to not only identify prior authorization requirements prior to
39 writing the prescription, but also submit the prior authorization request directly to the payer sooner.

40
41 By providing information at the beginning of the prescribing process, RTBTs allow prescribers to
42 identify care delivery impediments earlier so they avoid any unexpected utilization management
43 delays. RTBTs have the potential to mitigate the impact of prior authorization denial letters by
44 informing prescribers of alternative, therapeutically equivalent medications that do not require
45 prior authorization at the point of care. RTBTs allow physicians to see which medications would be
46 covered and thus prior authorizations, and subsequent denial letters, should only be necessary if the
47 prescriber determines that the alternative, covered medication is not clinically appropriate. With
48 fewer denial letters, physicians can spend more time caring for patients and less time on appeals.
49

1 Current CMS regulation requires that all Medicare Part D plans provide at least one RTBT. In
2 practice, for physicians and qualified providers to have access to RTBT information for all patients,
3 they may need to support and integrate multiple RTBT and Electronic Health Records (EHR)
4 systems. This is burdensome and complicated for all physicians to implement, and nearly
5 impossible for smaller practices. Managing multiple systems is not only expensive and complex, it
6 also may lead to confusion on RTBTs. In response to the complications that arose with the need to
7 manage and support multiple RTBT and EHR systems, CMS has proposed a rule that would
8 require Part D plans to implement a standardized system.¹⁷ This standard, the National Council for
9 Prescription Drug Programs RTPB Standard Version 13 would allow for standardized formulary
10 and benefit data in a manner that is reliable, detailed, and effectively integrated into systems.¹⁸ The
11 AMA has been vocal in advocating for and supporting this proposed rule.¹⁹ Should the proposed
12 rule be implemented, starting January 2027, this standardized system would allow for increasingly
13 efficient physician access to clear information at the time of prescribing. Of note, this requirement
14 would not extend to private insurers, however the requirement of this standard system by CMS
15 could lead to future implementation in the private sector.

16

17 AMA ADVOCACY

18

19 The AMA's extensive advocacy efforts work to address each of the systemic factors cited by
20 Resolution 725-A-23, including prior authorization, formularies, rebates, prescription drug pricing
21 transparency, and RTBTs. Regarding prior authorization, the AMA has an ongoing grassroots
22 campaigns "[Fix Prior Auth](#)" to address the harm incurred by patients and physicians by prior
23 authorization,²⁰ and [TruthinRx](#), which aims to educate patients, physicians, providers, and
24 legislators about the issues that arise from the lack of price transparency.²¹ TruthinRx advocates for
25 transparency from PBMs, payers, and manufacturers around formularies and rebates. The goals of
26 these campaigns are to spread awareness, create legislative changes, and serve as an extensive
27 resource for patients, physicians, and employers on these high priority issues.

28

29 Additionally, the AMA conducts regular surveys to track and report the impact of prior
30 authorization on patients and physicians. The survey includes questions aimed at better
31 understanding the impact of prior authorization for generic medication. In addition to this work,
32 AMA advocacy has commented on prior authorization via letters and testimony to state legislators,
33 Congress, and federal agencies 35 times in 2023 alone and has already been active in advocating
34 for these issues in 2024.

35

36 AMA advocacy has commented on relevant transparency issues through 21 letters and testimonies
37 to state legislators, Congress, and federal agencies in 2023. Finally, to support the implementation
38 of RTBTs, AMA advocacy has sent 18 letters and testimonies in 2023 to Congress and federal
39 agencies. Efforts have already been made, and continue to be made, in 2024 to advocate on these
40 issues. Each of these factors contribute to the issues raised in Resolution 725-A-23 and are clearly
41 on the AMA advocacy's ongoing agenda.

42

43 AMA POLICY

44

45 Underscoring the extensive advocacy work on these issues is a robust body of AMA policy aimed
46 at ensuring that prior authorization is monitored and minimized, PBMs are monitored and
47 regulated, the process is transparent, and to support the implementation of adequate RTBT tools.

48

49 Policy H-125.991 outlines the standards that both formulary systems and Pharmacy and
50 Therapeutic Committees should meet. For example, this policy outlines that formulary systems
51 should include oversight from organized medical staff. This policy is reinforced by similar

1 guidelines in Policy H-285.965, which, among other things, outlines that both physicians and
2 patients should have access to clear information about a payer's formulary and that these
3 formularies should be created and maintained with the input of physicians. In addition to these
4 policies dealing directly with the creation and maintenance of formularies, Policy H-110.981
5 details advocacy efforts to ensure that PBMs and regulatory bodies make rebate and discount
6 reports available to the public, ideally, assisting in disentangling the influence rebates have on the
7 complex and opaque process that is formulary creation.

8
9 AMA policy also deals directly with efforts to ensure that PBMs are monitored and that there is an
10 increase in transparency regarding their operation. Specifically, Policy D-110.987 outlines the
11 advocacy efforts that the AMA continues to implement to ensure that PBMs are required to
12 increase transparency in their operating procedures and that they are adequately regulated on both a
13 state and federal level. Additionally, Policy H-125.986 encourages physician engagement in
14 reporting issues with PBMs and indicates efforts to increase PBM oversight and reduce PBM
15 overreach in medical practice. Policy H-110.963 expands the coverage of regulation and
16 monitoring to third-party PBMs. Each of these policies aim to implement adequate oversight of
17 PBMs. Finally, Policies H-125.986 and D-120.933 outline the AMA's support to ensure that
18 PBMs' actions do not impede or negatively impact the patient-physician relationship.

19
20 In addition to AMA policy on contributing factors to prior authorization, the AMA has extensive
21 policy on prior authorization and increasing physician access to real time prescribing information.
22 Policy H-125.979 specifies AMA efforts to work with appropriate parties to ensure that physicians
23 have access to real-time formulary data when prescribing a medication. Additionally, Policy
24 H-120.919 outlines AMA efforts to support the implementation of RTBT tools that are helpful to
25 prescribers and accurate at the time of prescribing. Finally, Policy H-320.945 outlines AMA
26 opposition to prior authorization abuses and outlines the requirement for payers to report accurate
27 statistics on approvals and denials.

28 29 DISCUSSION

30
31 Prior authorization is a tool that was initially introduced to save money and ensure that care given
32 to patients was medically necessary. However, in the years since its introduction it has been
33 overutilized and is now a burden for physicians as well as a barrier to patients accessing care. The
34 opaqueness of both rebates and formularies contribute greatly to the confusion and subsequent
35 frustration that results from denied prior authorization. The AMA continues to make significant
36 efforts on multiple fronts to address this issue and ensure that prior authorization is fixed for
37 patients and physicians.

38
39 Resolution 725-A-23 asked that the AMA work to encourage the inclusion of economic
40 information when prescription drugs are denied prior authorization. The Council believes that this
41 concept would be beneficial to physicians and that alternative solutions, like RTBT tools, should be
42 supported in order to mitigate the need for some prior authorizations. In the spirit of Resolution
43 725-A-23, and to address the confusion that can arise from prior authorization denial letters, the
44 Council recommends that a new policy be adopted to support working with appropriate parties to
45 ensure that denial letters include information that is helpful to physicians and patients in
46 understanding the full scope of denial. Such a policy will benefit ongoing and future AMA
47 advocacy letters and testimony.

48
49 The AMA has worked, and continues to work, extensively on ensuring that the burden of prior
50 authorization is lessened for both physicians and patients. One aspect of this ongoing work has
51 been rooted in policy outlining the AMA's support for RTBT tools. This work advocates for

1 physicians to be able to access systems that are effective, efficient, and accurate. Accordingly, the
2 Council suggests amending Policy H-120.919 to better align the standards and language with CMS
3 policy, and to ensure that these tools provide a justification for the prior authorization requirement,
4 offer alternative(s), and that coverage determinations from the RTBT are honored.

5
6 Finally, the Council recommends that Policies H-110.963; Third-Party Pharmacy Benefit
7 Administrators; H-125.979; Private Health Insurance Formulary Transparency; H-320.945; Abuse
8 of Preauthorization Procedures; H-125.986 Pharmaceutical Benefit Management Companies; and
9 D-120.933 Pharmacy Benefit Managers Impact on Patients be reaffirmed. These policies outline
10 the AMA's efforts to ensure that all PBMs are monitored, regulated, and do not harm the
11 physician-patient relationship, that health insurers are required to be transparent about the creation
12 and maintenance of formularies, and that prior authorization is not abused by payers.

13 14 RECOMMENDATIONS

15
16 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
17 725-A-23, and the remainder of the report be filed:

- 18
19 1. That our American Medical Association (AMA) support working with payers and
20 interested parties to ensure that prior authorization denial letters include at a minimum (1) a
21 detailed explanation of the denial reasoning, (2) a copy of or publicly accessible link to any
22 plan policy or coverage rules cited or used as part of the denial, and (3) what rationale or
23 additional documentation would need to be provided to approve the original prescription
24 and alternative options to the denied medication. (New HOD Policy)

- 25
26 2. That our AMA amend Policy H-120.919 to read as follows:

27
28 That our AMA will: (1) continue to support efforts to ~~publish~~ implement a Real-Time
29 Prescription Benefit (RTPB) Real-Time Benefit Tool (RTBT) standard that meets the
30 needs of all physicians and other prescribers, utilizing any electronic health record (EHR),
31 and prescribing on behalf of any insured patient; (2) support efforts to ensure that provider-
32 facing and patient facing RTBT systems align; and (3) advocate that all payers (i.e., public
33 and private prescription drug plans) be required to implement and keep up to date an RTPB
34 RTBT standard tool that integrates with all EHR vendors, and that any changes that must
35 be made to accomplish RTPB RTBT tool integration be accomplished with minimal
36 disruption to EHR usability and cost to physicians and hospitals; (4) advocate that RTBT
37 systems provide a justification for why prior authorization is required and include
38 approved/covered alternative prescription medications; and (35) develop and disseminate
39 educational materials that will empower physicians to be prepared to optimally utilize
40 RTPB tools RTBT and other health information technology tools that can be used to
41 enhance communications between physicians and pharmacists to reduce the incidence of
42 prescription abandonment; (6) advocate that payers honor coverage information that is
43 based on a RTBT at the time of prescription and that prior authorization approvals should
44 be valid for the duration of the prescribed/ordered treatment; and (7) continue to advocate
45 for the accuracy and reliability of data provided by RTBTs and for vendor neutrality to
46 ensure that it is supportive to physician efforts. (Modify Current HOD Policy)

- 47
48 3. That our AMA reaffirm Policy H-110.963, which addresses the regulation and monitoring
49 of third-party Pharmacy Benefit Managers (PBMs) in an effort to control prescription drug
50 pricing. (Reaffirm HOD Policy)

- 1 4. That our AMA reaffirm Policy H-125.979, which outlines advocacy efforts to ensure that
2 physicians have access to real-time formulary data when prescribing. (Reaffirm HOD
3 Policy)
4
- 5 5. That our AMA reaffirm Policy H-320.945, which details opposition to the abuse of prior
6 authorization and the requirement for payers to accurately report denials and approvals.
7 (Reaffirm HOD Policy)
8
- 9 6. That our AMA reaffirm Policy H-125.986, which outlines the AMA's position that certain
10 actions from PBMs interfere with physician practice and may impact the patient-physician
11 relationship. (Reaffirm HOD Policy)
12
- 13 7. That our AMA reaffirm Policy D-120.933, which encourages the gathering of data to better
14 understand the impact that PBM actions may lead to an erosion of the patient-physician
15 relationship. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

¹ Formulary. 2023. HealthCare.gov

² Werble C. Formularies. 2017. Health Affairs: Health Policy Brief.

³ Park Y, Raza S, George A, Agrawal R, Ko J. The Effect of Formulary Restrictions on Patient and Payer Outcomes: A Systematic Literature Review. *J Manag Care Spec Pharm.* 2017;23(8):893-901. doi:10.18553/jmcp.2017.23.8.893

⁴ Brown NA. It's time to reform the mysterious PBM system - Vertical integration and a lack of transparency are at the heart of the problem. 2023. *MedPage Today.*

⁵ Allan GM, Lexchin J, Wiebe N. Physician awareness of drug cost: a systematic review. *PLoS Med.* 2007;4(9): e283. doi:10.1371/journal.pmed.0040283

⁶ High drug prices and patient costs: Millions of lives and billions of dollars lost. 2020. Council for Informed Drug Spending Analysis.

⁷ The evolution of prior authorizations. 2021. American Case Management Association

⁸ Pestaina K & Pollitz K. Examining prior authorization in health insurance. 2022. Kaiser Family Foundation.

⁹ Pollitz K, Pestaina K, Lopes L, Wallace R, & Lo J. Consumer problems with prior authorization: Evidence from KFF survey. 2023. Kaiser Family Foundation.

¹⁰ Ochieng N, Fuglesten Biniek J, Freed M, Damico A, & Neuman T. Medicare advantage in 2023: Premiums, out-of-pocket limits, cost sharing, supplemental benefits, prior authorization, and star ratings. 2023. Kaiser Family Foundation: Medicare.

¹¹ Fuglesten Biniek & Sroczynski N. Over 35 million prior authorization requests were submitted to Medicare advantage plans in 2021. 2023. Kaiser Family Foundation: Medicare.

¹² CMS interoperability and prior authorization final rule (CMS-0057-F). 2024. Centers for Medicare and Medicaid Services.

¹³ MA Denial Notice. 2023. Centers for Medicare & Medicaid Services.

¹⁴ Fact Sheet: CMS interoperability and prior authorization final rule (CMS-0057-F). 2024. Centers for Medicare and Medicaid Services.

¹⁵ What does CMS' real-time benefit tool final rule mean for the healthcare industry? 2022. Arrive Health.

¹⁶ RTF & RTPB. 2024. The Future of Connected Medicare Prescriber's Digest.

¹⁷ Allows pharmacy benefit payers to continue formulary and benefit information to prescriber systems. 2023. HealthIT.gov

¹⁸ Proposed Rule CMS-4201-P. 2023. National Council for Prescription Drug Programs (NCPDP).

¹⁹ Medicare program; contract year 2025 policy and technical changes to the Medicare advantage program, Medicare prescription drug benefit program, Medicare cost plan program, and programs of all-inclusive care for the elderly; health information technology standards and implementation specifications; CMS-4205-P. 2024. American Medical Association.

²⁰ Fix Prior Auth. American Medical Association. Updated 2023. <https://fixpriorauth.org/>

²¹ TruthinRx. American Medical Association. Updated 2023. <https://truthinrx.org/>

**CMS Report Economics of Prior Authorization
Relevant AMA Policy**

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. (BOT Rep. 45, I-93; Reaffirmed by Sub. Res. 501, A-95; Appended: BOT Rep. 7, I-99; Modified: Sub. Res. 524 and Reaffirmed: Res. 123, A-00; Reaffirmed: Res. 515, I-00; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: Res. 533, A-03; Modified: CMS Rep. 6, A-03; Modified: CSA Rep. 2, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 535, A-05; Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05; Reaffirmed: CMS Rep. 2, I-05; Reaffirmation A-06; Reaffirmation A-08; Reaffirmed: CMS Rep. 2, A-10; Reaffirmed: CMS Rep. 01, A-20)

The Impact of Pharmacy Benefit Managers on Patients and Physicians (D-110.987)

- 1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
- 2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
- 3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
- 4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
- 5. Our AMA supports improved transparency of PBM operations, including disclosing:
 - Utilization information;
 - Rebate and discount information;
 - Financial incentive information;
 - Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization, and step therapy;
 - Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
 - Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
 - Percentage of sole source contracts awarded annually.
- 6. Our AMA encourages increased transparency in how DIR fees are determined and calculated. (CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, I-20)

Pharmaceutical Benefits Management Companies (H-125.986)

Our AMA:

- (1) encourages physicians to report to the Food and Drug Administration's (FDA) MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutic alternates;
- (2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to

- manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate;
- (3) pursues congressional action to end the inappropriate and unethical use of confidential patient information by pharmacy benefits management companies;
 - (4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients;
 - (5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to ensure that they are based on sound science and represent safe and cost-effective medical care;
 - (6) supports efforts to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications; and
 - (7) encourages the FTC and FDA to monitor PBMs' policies for potential conflicts of interests and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest. (BOT Rep. 9, I-97; Appended: Res. 224, I-98; Appended: Res. 529, A-02; Reaffirmed: Res. 533A-03; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: Alt. Res. 806, I-17; Modified: Res. 242, A-18; Reaffirmed: CMS Rep. 08, A-19)

Third-Party Pharmacy Benefit Administrators (H-110.963)

1. Our AMA recommends that third-party pharmacy benefit administrators that contract to manage the specialty pharmacy portion of drug formularies be included in existing pharmacy benefit manager (PBM) regulatory frameworks and statutes, and be subject to the same licensing, registration, and transparency reporting requirements.
2. Our AMA will advocate that third-party pharmacy benefit administrators be included in future PBM oversight efforts at the state and federal levels. (Res. 820, I-22)

Private Health Insurance Formulary Transparency (H-125.979)

1. Our AMA will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.
2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.
3. Our AMA will develop model legislation (a) requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic, (b) requiring insurance carriers to make this information available to consumers by October 1 of each year and, (c) forbidding insurance carriers from making formulary deletions within the policy term.
4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.
5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.
6. Our AMA (a) promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide, and (b) supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans.

7. Our AMA will continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits.
8. Our AMA will develop model state legislation on the development and management of pharmacy benefits. (Sub. Res. 724, A-14; Appended: Res. 701, A-16; Appended: Alt. Res. 806, I-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: BOT Rep. 20, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 2, A-21)

Access to Health Plan Information Regarding Lower-Cost Prescription Options (H-120.919)

Our AMA will: (1) continue to support efforts to publish a Real-Time Prescription Benefit (RTPB) standard that meets the needs of all physicians and other prescribers, utilizing any electronic health record (EHR), and prescribing on behalf of any insured patient; (2) advocate that all payers (i.e., public and private prescription drug plans) be required to implement and keep up to date an RTPB standard tool that integrates with all EHR vendors, and that any changes that must be made to accomplish RTPB tool integration be accomplished with minimal disruption to EHR usability and cost to physicians and hospitals; and (3) develop and disseminate educational materials that will empower physicians to be prepared to optimally utilize RTPB tools and other health information technology tools that can be used to enhance communications between physicians and pharmacists to reduce the incidence of prescription abandonment. (CMS Rep. 2, I-21)

Pharmaceutical Costs (H-110.987)

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by ten percent 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 percent 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)

Price of Medicine (H-110.991)

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

Prescription Drug Price and Cost Transparency (D-110.988)

1. Our AMA will continue implementation of its TruthinRx grassroots campaign to expand drug pricing transparency among pharmaceutical manufacturers, pharmacy benefit managers and health plans, and to communicate the impact of each of these segments on drug prices and access to affordable treatment.
2. Our AMA will report back to the House of Delegates at the 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign. (Alt. Res. 806, I-17)

Abuse of Preauthorization Procedures (H-320.945)

Our AMA opposes the abuse of preauthorization by advocating the following positions:

- (1) Preauthorization should not be required where the medication or procedure prescribed is customary and properly indicated, or is a treatment for the clinical indication, as supported by peer-reviewed medical publications or for a patient currently managed with an established treatment regimen.
- (2) Third parties should be required to make preauthorization statistics available, including the percentages of approval or denial. These statistics should be provided by various categories,

e.g., specialty, medication or diagnostic test/procedure, indication offered, and reason for denial. (Sub. Res. 728, A-10; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed: Res. 709, A-12; Reaffirmed: CMS Rep. 08, A-17; Reaffirmed: Res. 125, A-17; Reaffirmation: A-17 Reaffirmation: I-17; Reaffirmed: CMS Rep. 4, A-21; Reaffirmation: A-22)

Pharmacy Benefit Managers Impact on Patients (D-120.933)

Our AMA will: (1) gather more data on the erosion of physician-led medication therapy management in order to assess the impact pharmacy benefit manager (PBM) tactics may have on patient's timely access to medications, patient outcomes, and the physician-patient relationship; (2) examine issues with PBM-related clawbacks and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts; and (3) request from PBMs, and compile, data on the top twenty-five medication precertification requests and the percent of such requests approved after physician challenge. (Res. 225, A-18)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 701
(A-24)

Introduced by: Medical Student Section

Subject: Opposition to the Hospital Readmissions Reduction Program

Referred to: Reference Committee G

1 Whereas, the Hospital Readmissions Reduction Program (HRRP) was introduced in 2012 and
2 created mechanisms for the Centers for Medicare and Medicaid Services to evaluate and
3 penalize hospitals based on their readmission rates within 30 days for certain conditions such
4 as heart failure, heart attack, and pneumonia¹; and

5
6 Whereas, while the goal of HRRP was to save costs due to reduced readmissions and improve
7 the quality of post-acute care and care coordination services, HRRP disproportionately
8 penalizes resource-limited hospitals that primarily care for socioeconomically disadvantaged
9 patients, further diminishing funding for health and social services for these communities²⁻⁴; and

10
11 Whereas, HRRP historically imposed up to a 3% percent reduction in Medicare payments for
12 failure to meet ceiling readmission metrics relative to other hospitals, though hospitals were later
13 sorted into peer groups to adjust for socioeconomic conditions of patient populations⁵; and

14
15 Whereas, a 2019 study found that even after peer-group stratification, over 75% of hospitals
16 that predominantly care for socioeconomically disadvantaged patients were still penalized⁶; and

17
18 Whereas, multiple studies have found that HRRP was associated with increases in 30-day post-
19 discharge mortality for patients with congestive heart failure, chronic obstructive pulmonary
20 disease, and pneumonia, with thousands of excess deaths estimated⁷⁻⁹; and

21
22 Whereas, a 2019 retrospective cohort analysis found that post-discharge emergency
23 department revisits and observation stays increased over the 3.5 year study period (+0.016 and
24 +0.022 per 100 patient discharges, respectively), exceeding the decline in readmissions (-0.013
25 per 100 patient discharges)¹⁰; and

26
27 Whereas, a 2022 retrospective cohort analysis found that HRRP's purported reduction in
28 readmissions was actually almost entirely due to reclassifications of readmissions as
29 observation stays, and a 2019 analysis found that a significant portion of the reductions could
30 be explained by regression to the mean and not due to any success of HRRP¹¹⁻¹²; and

31
32 Whereas, in 2018 and 2019 the AMA expressed concern to CMS about the need to re-evaluate
33 HRRP "due to emerging evidence that the program and the associated measures may be
34 leading to negative unintended patient consequences"¹³⁻¹⁴; therefore be it

35
36 RESOLVED, that our American Medical Association oppose the Hospital Readmissions
37 Reduction Program. (New HOD Policy)

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

Received: 4/5/2024

REFERENCES

1. Hospital Readmissions Reduction Program (HRRP), Center for Medicare & Medicaid Services. 2023. <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program>
2. Hospital Readmissions Reduction Program. Center for Medicare & Medicaid Services. 2023. <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/hrrp/hospital-readmission-reduction-program>
3. Gilman M, Hockenberry JM, Adams EK, Milstein AS, Wilson IB, Becker ER. The financial effect of value-based purchasing and the hospital readmissions reduction program on safety-net hospitals in 2014: A cohort study. *Ann Intern Med.* 2015;163(6):427-436. doi:10.7326/m14-2813
4. Joynt KE, Jha AK. Characteristics of hospitals receiving penalties under the hospital readmissions reduction program. *JAMA.* 2013;309(4):342. doi:10.1001/jama.2012.94856
5. McIlvennan CK, Eapen ZJ, Allen LA. Hospital readmissions reduction program. *Circulation.* 2015;131(20):1796-1803. doi:10.1161/circulationaha.114.010270
6. McCarthy CP, Vaduganathan M, Patel KV, et al. Association of the new peer group-stratified method with the reclassification of penalty status in the hospital readmission reduction program. *JAMA Netw Open.* 2019;2(4):e192987. doi:10.1001/jamanetworkopen.2019.2987
7. Wadhwa RK, Joynt Maddox KE, Wasfy JH, Haneuse S, Shen C, Yeh RW. Association of the hospital readmissions reduction program with mortality among medicare beneficiaries hospitalized for heart failure, acute myocardial infarction, and pneumonia. *JAMA.* 2018;320(24):2542. doi:10.1001/jama.2018.19232
8. Puebla Neira DA, Hsu ES, Kuo YF, Ottenbacher KJ, Sharma G. Readmissions reduction program: Mortality and readmissions for chronic obstructive pulmonary disease. *Am J Respir Crit Care Med.* 2021;203(4):437-446. doi:10.1164/rccm.202002-0310oc
9. Huckfeldt P, Escarce J, Sood N, Yang Z, Popescu I, Nuckols T. Thirty-day postdischarge mortality among black and white patients 65 years and older in the medicare hospital readmissions reduction program. *JAMA Netw Open.* 2019;2(3):e190634. doi:10.1001/jamanetworkopen.2019.0634
10. Wadhwa RK, Joynt Maddox KE, Kazi DS, Shen C, Yeh RW. Hospital revisits within 30 days after discharge for medical conditions targeted by the Hospital Readmissions Reduction Program in the United States: national retrospective analysis. *BMJ.* 2019;366:l4563. doi:10.1136/bmj.l4563
11. Sabbatini AK, Joynt-Maddox KE, Liao JM, et al. Accounting for the growth of observation stays in the assessment of Medicare's hospital readmissions reduction program. *JAMA Netw Open.* 2022;5(11):e2242587. doi:10.1001/jamanetworkopen.2022.42587
12. Joshi S, Nuckols T, Escarce J. Regression to the Mean in the Medicare Hospital Readmissions Reduction Program. *JAMA Internal Med.* 2019;179(9):1167-1173. doi:10.1001/jamainternmed.2019.1004
13. Mandara, James. Re: Potential Association between CMS Hospital Readmissions Reduction Program and Increased Mortality Outcomes. https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-2-8-Letter-to-Verma-re-HRRP-and-Mortality-v4_ACM.pdf
14. Mandara, James. Re: Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Proposed Policy Changes and Fiscal Year 2020 Rates... <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2019-6-24-Letter-to-Verma-re-IPPS-Proposed-Rule-2020-v4.pdf>

RELEVANT AMA POLICY

H-450.944 Protecting Patients Rights

Our AMA opposes Medicare pay-for-performance initiatives (such as value-based purchasing programs) that do not meet our AMA's "Principles and Guidelines for Pay-for-Performance," which include the following five Principles: (1) ensure quality of care; (2) foster the patient/physician relationship; (3) offer voluntary physician participation; (4) use accurate data and fair reporting; and (5) provide fair and equitable program incentives. [Sub. Res. 902, I-05; Reaffirmation A-06; Reaffirmation I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 702
(A-24)

Introduced by: Organized Medical Staff Section

Subject: The Corporate Practice of Medicine, Revisited

Referred to: Reference Committee G

1 Whereas, primary interests of our American Medical Association include sustaining and
2 improving public health, as well as the sustainability of medical autonomy in practice; and
3

4 Whereas, for decades, the AMA has maintained a policy that deems unprofessional any
5 contractual arrangement that interferes with physician practice and by so stating, bars
6 unlicensed lay entities from owning or controlling medical practices; and
7

8 Whereas, in the current evolution of the healthcare system, increasingly corporate entities
9 including public companies and private equity firms have entered into the arena of healthcare
10 provision with ownership interests; and
11

12 Whereas, those ownership interests have become controlling interests in the vast majority of
13 cases, despite most states maintaining laws against the corporate practice of medicine to one
14 degree or another^(1,2); and
15

16 Whereas, there are a number of subterfuges by which lay entities get around restrictions against
17 the corporate practice of medicine, including but not limited to intermediate organizations known
18 as medical service organizations (MSOs) as well as “friendly private corporation (PC) models,”
19 wherein there is dual participation by a licensed physician in both the practice and the medical
20 service organization^(1,2); and
21

22 Whereas, medical service organizations and other public entities include those of hospital care
23 based organizations, by virtue of medical management oversight, contracting intermediaries,
24 etc. have undue influence on the provision of healthcare by the physician to the patient,
25 essentially dictating type, amount and directions of care^(1,2); and
26

27 Whereas, the justification that consolidation of care and control over clinical operations will
28 improve quality and reduce cost of giving healthcare is not substantiated, even contradicted, by
29 academic research to date⁽¹⁻³⁾; and
30

31 Whereas, in some notable instances, private equity firms that focus on financial bottom line
32 outcomes increasingly resort to substitutions of physicians with nonphysician practitioners, as
33 well as creating environments where there is greater turnover even of physicians (sometimes
34 due to “moral burnout”), which has been shown to reduce the quality of healthcare¹; and
35

36 Whereas, our AMA Advocacy Resource Center posted an issue brief on the corporate practice
37 of medicine in 2015⁴; and
38

39 Whereas, our AMA recently established policy (H-215.981) to “provide guidance, consultation,
40 and model legislation regarding the corporate practice of medicine...[and]...continue to monitor

1 the evolving corporate practice of medicine” but did not establish a mechanism to gather and
2 disseminate that information; and
3

4 Whereas, there is renewed attention paid to the erosion of the firewall represented by the
5 original prohibition of the corporate practice of medicine in several recent studies and
6 articles^(1,2); therefore be it
7

8 RESOLVED, that our American Medical Association revisit the concept of restrictions on the
9 corporate practice of medicine, including private equities, hedge funds and similar entities,
10 review existing state laws and study needed revisions and qualifications of such restrictions
11 and/or allowances, in a new report to our House of Delegates by Annual 2025 that will inform
12 advocacy to protect the autonomy of physician-directed care, patient protections, medical staff
13 employment and contract conflicts, and access of the public to quality healthcare, while
14 containing healthcare costs. (Directive to Take Action)
15

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

Received: 4/17/2024

REFERENCES

1. Perspective: “A Doctrine in Name Only — Strengthening Prohibitions against the Corporate Practice of Medicine”; Jane M. Zhu, M.D., M.P.P., M.S.H.P., Hayden Rooke-Ley, J.D., and Erin Fuse Brown, J.D., M.P.H.; September 14, 2023, N Engl J Med 2023; 389:965-968, DOI: 10.1056/NEJMp2306904
2. Audio interview with Erin Fuse Brown, professor of law, on the role of corporate practice of medicine laws in a changing health care environment;
<https://www.nejm.org/action/showMediaPlayer?doi=10.1056%2FNEJMdo007232&aid=10.1056%2FNEJMp2306904&area=>
3. Utilization, Steering, and Spending in Vertical Relationships Between Physicians and Health Systems; Anna D. Sinaiko, PhD1; Vilsa E. Curto, PhD1; Katherine Ianni, BA2; et al Mark Soto, MA1; Meredith B. Rosenthal, PhD1 ;September 1, 2023; JAMA Health Forum. 2023;4(9):e232875. doi:10.1001/jamahealthforum.2023.2875
4. AMA Advocacy Resource Center
Issue brief: Corporate practice of medicine;
https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwjV56_U4dWBAXV-LFkFHUNPCggQFnoECA8QAQ&url=https%3A%2F%2Fwww.ama-assn.org%2Fmedia%2F7661%2Fdownload&usg=AOvVaw3l0sn8SPujJDC8-wyv9tsD&opi=89978449

RELEVANT AMA POLICY

Corporate Practice of Medicine H-215.981

1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.
2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.
3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.

Citation: Res. 247, A-91; Reaffirmed; Sunset Report, I-09; Reaffirmed: CMS Rep. 7, A-11; Modified: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 07, A-17; Modified Res. 713, A-18; Reaffirmed: CMS Rep. 11, A-19; Reaffirmed: CME Rep. 01, I-22

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.

Citation: CMS Rep. 2, I-22

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.

Citation: CMS Rep. 11, A-19; Appended: CMS Rep. 2, I-22; Reaffirmed: BOT Rep. 14, A-23

Physician-Owned Hospitals D-215.983

1. Our American Medical Association will advocate for policies that remove restrictions upon physicians from owning, constructing, and/or expanding any hospital facility type.

2. Our AMA will study and research the impact of the repeal of the ban on physician-owned hospitals on the access to, cost, and quality of, patient care, and the impact on competition in highly concentrated hospital markets.

3. Our AMA will collaborate with other stakeholders to develop and promote policies that support physician ownership of hospitals.

Citation: Res. 219, A-23

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 703
(A-24)

Introduced by: Resident and Fellow Section

Subject: Upholding Physician Autonomy in Evidence-Based Off-Label Prescribing
and Condemning Pharmaceutical Price Manipulation

Referred to: Reference Committee G

- 1 Whereas, the practice of off-label prescribing, the use of pharmaceutical drugs for an
2 unapproved indication or in an unapproved age group, dosage, or route of administration, is a
3 legal and often necessary aspect of medical practice¹⁻³; and
4
5 Whereas, off-label prescribing is common, accounting for up to one third of all prescriptions and
6 being more common for certain groups including in the treatment of mental health conditions
7 and treatment of the elderly, children, and pregnant people⁴; and
8
9 Whereas, the vast discrepancy in prescription drug pricing places an unreasonable financial
10 burden on underinsured patients, for example, \$25 per month co-pay with some insurers
11 compared to approximately \$1,200 per month without coverage for some GLP-1 medications^{5,6};
12 and
13
14 Whereas, pharmaceutical companies are threatening physicians who prescribe certain
15 medications off-label for medically necessary indications, potentially jeopardizing medical
16 licensure and restricting clinical decision-making^{5,7}; and
17
18 Whereas, such threats interfere with physicians' ability to make appropriate medical judgments
19 for their patients; and
20
21 Whereas, timely action is needed to protect physicians' ability to prescribe off-label based on
22 medical necessity without repercussions, ensuring access for vulnerable patient populations,
23 and protecting these vulnerable patient populations from using potentially hazardous fake
24 compounded versions; and
25
26 Whereas, differential pricing and restricted off-label use of medications can exacerbate
27 healthcare disparities by limiting treatment access for underserved populations; therefore be it
28
29 RESOLVED, that our American Medical Association advocates for transparency, accountability,
30 and fair pricing practices in pharmaceutical pricing, opposing differential pricing of medications
31 manufactured by the same company with the same active ingredient, without clear clinical
32 necessity (Directive to Take Action); and be it further
33
34 RESOLVED, that our AMA condemns interference with a physician's ability to prescribe one
35 medication over another with the same active ingredient, without risk of harassment,
36 prosecution, or loss of their medical license, and calls on regulatory authorities to investigate
37 and take appropriate action against such practices. (New HOD Policy)

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

Received: 4/24/2024

REFERENCES:

1. Furey K and Wilkins K. Prescribing "Off-Label": What Should a Physician Disclose? *AMA J Ethics*. 2016;18(6):587-593. doi: 10.1001/journalofethics.2016.18.6.ecas3-1606. <https://journalofethics.ama-assn.org/article/prescribing-label-what-should-physician-disclose/2016-06>
2. Meadows WA, Hollowell BD. "Off-label" drug use: an FDA regulatory term, not a negative implication of its medical use. *Int J Impot Res*. 2008;20(2):135-144.
3. US FDA. Understanding Unapproved Use of Approved Drugs "Off Label". Updated February 5, 2018. Accessed April 22, 2024. <https://www.fda.gov/patients/learn-about-expanded-access-and-other-treatment-options/understanding-unapproved-use-approved-drugs-label>
4. Van Norman GA. Off-Label Use vs Off-Label Marketing of Drugs. *JACC Basic Transl Sci*. 2023 Feb; 8(2): 224–233.
5. Gibert D. "Insurers clamping down on doctors who prescribe Ozempic for weight loss." *Washington Post*. Published June 12, 2023. Accessed April 22, 2024. "https://www.washingtonpost.com/business/2023/06/11/weight-loss-ozempic-wegovy-insurance/?utm_campaign=KHN%3A%20First%20Edition&utm_medium=email&_hsmi=262066865&_hsenc=p2ANqtz-9rlvynBptFsvvj0doDkQYFbvNOgwtFzvPvqY3Lam5feDA5V4gdYZuELna20MTZAFOD_wqPN6lJvzvmjnl
6. Perez A. How Much is Mounjaro Without Insurance? Ways to Buy. *Medical News Today*. January 30, 2024. Accessed April 22, 2024. <https://www.medicalnewstoday.com/articles/how-much-is-mounjaro-without-insurance>
7. O'Mary L. "Insurers Poised to Crack Down on Off-Label Ozempic Prescriptions" *WebMD.com*. Published June 12, 2023. Accessed April 22, 2024. <https://www.webmd.com/obesity/news/20230612/insurers-poised-crack-down-off-label-ozempic-prescriptions>

RELEVANT AMA POLICY:

Patient Access to Treatments Prescribed by Their Physicians H-120.988

1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary.
2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.
3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.
4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).
5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.
6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act. [Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified by CSA Rep. 3, A-97; Reaffirmed and Modified by Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04; Reaffirmation I-07; Reaffirmed: Res. 819, I-07; Reaffirmation A-09; Reaffirmation I-10; Modified: BOT Rep. 5, I-14; Reaffirmed: Res. 505, A-15; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: Res. 509, I-20; Reaffirmation: I-22; Reaffirmed: CSAPH Rep. 01, A-23; Reaffirmed: CSAPH Rep. 02, A-23]

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 704
(A-24)

Introduced by: American Academy of Pediatrics

Subject: Pediatric Readiness in Emergency Departments

Referred to: Reference Committee G

1 Whereas, there are over 130 million emergency department (ED) visits in the United States
2 annually with nearly 25% of these visits being for infants, children and adolescents¹; and
3

4 Whereas, over 70% of U.S. emergency departments care for less than 10 children per day with
5 over 80% of these visits occurring in a non-children's hospital setting, highlighting the need for
6 emergency care teams to maintain the knowledge, skills, and appropriate resources for
7 immediate assessment and stabilization of children¹; and
8

9 Whereas, the National Pediatric Readiness Project (NPRP) is a multiphase, multidisciplinary,
10 longitudinal quality initiative to improve readiness of US EDs to care for children and is
11 supported by the Health Resources and Services Administration/ Emergency Medical Services
12 for Children Program and cosponsored by the American Academy of Pediatrics, the American
13 College of Emergency Physicians, and the Emergency Nurses Association, with original
14 Institute of Medicine guidelines initially published in 2006 and twice revised through NPRP joint
15 policy statements in 2009 and 2018; and
16

17 Whereas, these joint policy statements, endorsed by our AMA and 22 other national
18 organizations and stakeholders, outline essential policies and procedures, patient safety, staff
19 competencies, quality improvement, medications, equipment, and supplies to safely care for
20 children, with comprehensive open access educational resources, policy templates, tools, and
21 other resources are available as part of the National Pediatric Readiness Project
22 (www.pediatricreadiness.org); and
23

24 Whereas, pediatric readiness of an emergency department is associated with a 60% and 76%
25 reduction in mortality risk for injured and critically ill children, respectively, with a three-fold
26 reduction in disparities for mortality¹; therefore be it
27

28 RESOLVED, that our American Medical Association reaffirm H-130.939 acknowledging the
29 importance of pediatric readiness in all emergency departments with awareness of the
30 guidelines for Pediatric Readiness in the Emergency Department and stand ready to care for
31 children of all ages (Reaffirm HOD Policy); and be it further
32

33 RESOLVED, that our AMA work with appropriate state and national organizations to advocate
34 for the development and implementation of regional and/or state pediatric-ready facility
35 recognition programs. (Directive to Take Action)

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

Received: 4/23/2024

REFERENCES

1. *Remick et al; National Assessment of Pediatric Readiness of US Emergency Departments During COVID-19 Pandemic; JAMA Open Network, 7/7/2023.*

RELEVANT AMA POLICY

H-130.939 Emergency Department Readiness to Care for Children

Our American Medical Association affirms the importance that all emergency departments stand ready to care for children of all ages, and advocates for hospital administrators, emergency department medical directors and emergency department nurse managers to be aware of the guidelines for Pediatric Readiness in the Emergency Department.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 705
(A-24)

Introduced by: Illinois
Subject: 20 Minute Primary Care Visits
Referred to: Reference Committee G

- 1 Whereas, the 20 minute primary care visit has been shown to lead to poor outcomes for patient
2 care and is causing burnout of primary care physicians; therefore be it
3
4 RESOLVED, that our American Medical Association ask that the appropriate AMA Council
5 conduct a study of the adverse effects of direct patient care time limitations on the quality of care
6 provided, as well as on patient and physician dissatisfaction, with a report back at the next AMA
7 Annual Meeting. (Directive to Take Action)

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

Received: 4/24/2024

RELEVANT AMA POLICY

Limitation of Use of Time Component of Current Procedural Terminology (CPT-4) Coding H-70.976

Our AMA (1) adopts as policy that the time element in the new Evaluation and Management codes in the CPT-4 manual may be used to assist physicians and their staffs in determining appropriate levels of coding; (2) opposes the use of the time elements to (a) judge how many of any given type of visit may be performed in any one hour; and (b) deny or downgrade services submitted based on a cumulative time; (3) adopts as policy that there shall be no list of diagnoses used by third party payers to compare against the Evaluation and Management codes in such a fashion as to deny, downgrade, or in any other way seek to limit the submission of any CPT-4 code visit; (4) will monitor attempts by the third party payers to institute such time limits and diagnosis limits; and (5) will work with third party payers to prevent them from attempting to adopt and institute policies that would impose such time and diagnosis criteria.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 706
(A-24)

Introduced by: Association for Clinical Oncology

Subject: Automatic Pharmacy-Generated Prescription Requests

Referred to: Reference Committee G

1 Whereas, while some studies have found that pharmacy-based automatic refill increases
2 medication adherence without additional waste, these studies examine drugs for chronic
3 diseases, and they do not examine settings where a treatment plan may be continually refined;
4 and

5
6 Whereas, individual states have recognized the potential harms of automatic refill programs,
7 including wasted drugs, incorrect dosing, and patient receipt of discontinued prescriptions,
8 among other harms; and

9
10 Whereas, 27 state Medicaid programs have policy prohibiting the auto-refill process that occurs
11 at the point of sale (i.e. the program must obtain the beneficiary's consent prior to enrolling in
12 the auto-refill program); and

13
14 Whereas, automatic pharmacy-generated refills are not necessarily linked to requests from
15 either the patient or the physician and can lead to confusion for both; therefore be it

16
17 RESOLVED, that our American Medical Association advocates that pharmacy-generated
18 requests for changes to a prescription (quantity dispensed, refills, or substitutions) clarify
19 whether these requests are generated by the patient or patient's surrogates, or automatically by
20 the pharmacy. (Directive to Take Action)

21
Fiscal Note: Minimal - less than \$1,000

Received: 4/24/2024

REFERENCES

1. Matlin O, Kymes S, Averbukh A, et al. (2015). Community pharmacy automatic refill program improves adherence to maintenance therapy and reduces wasted medication. The American Journal of Managed Care, 21(11). <https://www.ajmc.com/view/community-pharmacy-automatic-refill-program-improves-adherence-to-maintenance-therapy-and-reduces-wasted-medication>
2. MO HealthNet. FAQs for Bulletin 46-03, "Automatic Refill Program." Missouri Department of Social Services. <https://mydss.mo.gov/mhd/hot-tips/automatic-refill-faqs#:~:text=Automatic%20refill%20programs%20create%20a,unused%20stockpiles%20and%20therapeutic%20duplication>
3. California Board of Pharmacy. (Rev. June 9, 2020). Initial statement of reasons: Automatic refill programs, 16 CCR § 1717.5. https://www.pharmacy.ca.gov/laws_regs/1717_5_isr.pdf
4. Centers for Medicare and Medicaid Services. National Medicaid fee-for-service (FFS) federal fiscal year (FFY) 2021 drug utilization review (DUR) annual report. US Department of Health and Human Services. <https://www.medicaid.gov/sites/default/files/2022-12/2021-dur-ffs-summary-report.pdf>

RELEVANT AMA POLICY

American Pharmacists Association H-120.987

The AMA advocates (1) continued surveillance of mail-order prescriptions; (2) notification by the American Pharmacists Association (APhA) of its members that prescriptions should be refilled only on the physician's order; and (3) that the APhA advise its members to discontinue the practice of assuming a prescription may be refilled unless a form is returned stating that the prescription may not be refilled.

Streamlining the Process for Prescription Refills D-120.984

Our AMA will work with the American Pharmacists Association, the National Community Pharmacists Association, and the National Association of Chain Drug Stores to streamline the process for prescription refills in order to reduce administrative burdens on physicians and pharmacists and to improve patient safety.

Safe and Efficient E-Prescribing H-120.921

Our AMA encourages health care stakeholders to improve electronic prescribing practices in meaningful ways that will result in increased patient safety, reduced medication error, improved care quality, and reduced administrative burden associated with e-prescribing processes and requirements. Specifically, the AMA encourages:

- A. E-prescribing system implementation teams to conduct an annual audit to evaluate the number, frequency and user acknowledgment/dismissal patterns of e-prescribing system alerts and provide an audit report to the software vendors for their consideration in future releases.
- B. Health care organizations and implementation teams to improve prescriber end-user training and on-going education.
- C. Implementation teams to prioritize the adoption of features like structured and codified Sig formats that can help address quality issues, allowing for free text when necessary.
- D. Implementation teams to enable functionality of pharmacy directories and preferred pharmacy options.
- E. Organizational leadership to encourage the practice of inputting a patient's preferred pharmacy at registration, and re-confirming it upon check-in at all subsequent visits.
- F. Implementation teams to establish interoperability between the e-prescribing system and the EHR to allow prescribers to easily confirm continued need for e-prescription refills and to allow for ready access to pharmacy choice and selection during the refill process.
- G. Implementation teams to enhance EHR and e-prescribing system functions to require residents assign an authorizing attending physician when required by state law.
- H. Organizational leadership to implement e-prescribing systems that feature more robust clinical decision support, and ensure prescriber preferences are tested and seriously considered in implementation decisions.
- I. Organizational leadership to designate e-prescribing as the default prescription method.
- J. The DEA to allow for lower-cost, high-performing biometric devices (e.g., fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication.
- K. States to allow integration of PDMP data into EHR systems.
- L. Health insurers, pharmacies and e-prescribing software vendors to enable real-time benefit check applications that enable more up to date prescription coverage information and allow notification when a patient changes health plans or a health insurer has changed a pharmacy's network status.
- M. Functionality supporting the electronic transfer and cancellation of prescriptions.

Patient Privacy and Confidentiality H-315.983

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 707
(A-24)

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

Subject: Alternative Funding Programs

Referred to: Reference Committee G

- 1 Whereas, alternative funding programs (AFPs) are run by third-party, for-profit vendors that
- 2 target self-funded plans; and
- 3
- 4 Whereas, AFPs claim to help companies reduce their healthcare costs by offloading health
- 5 plans' responsibility for covering most or all specialty drugs; and
- 6
- 7 Whereas, AFPs exclude or automatically deny prior authorization for specialty medications and
- 8 instead promise to help patients or providers access those medications through pharmaceutical
- 9 manufacturers' patient assistance programs (PAPs) or other charitable programs; and
- 10
- 11 Whereas, patients are required to work with the AFP vendor or be left paying 100% of the cost
- 12 of their specialty medication; and
- 13
- 14 Whereas, a 2022 study found that 10% of employers with at least 5,000 employees were using
- 15 AFPs and 27% were considering AFPs; and
- 16
- 17 Whereas, PAPs are safety-net programs designed to provide free drugs to uninsured and
- 18 underinsured individuals; and
- 19
- 20 Whereas, AFP vendors require patients to provide proof of income and a limited power of
- 21 attorney to enable the AFP vendor to act on their behalf and apply for manufacturer PAPs; and
- 22
- 23 Whereas, a patient's application for a PAP may be denied because of high income; and
- 24
- 25 Whereas, if a patient's PAP application is denied, the patient's employer could, but is not
- 26 required to, override the denial as a medical necessity or approve the previously denied prior
- 27 authorization; and
- 28
- 29 Whereas, an AFP may attempt to seek financial assistance from a charitable foundation on
- 30 behalf of the patient as an interim measure while awaiting PAP determination; and
- 31
- 32 Whereas, if an AFP cannot get a drug covered by a PAP, the patient may end up owing the full
- 33 amount of the drug cost; and
- 34
- 35 Whereas, regardless of whether the patient is approved for a PAP, the potentially lengthy
- 36 application process can delay access to necessary care; and
- 37
- 38 Whereas, if a patient is approved for a PAP, then PAP funds available for the prescribed
- 39 medication may provide only cover a partial course of treatment; and

1 Whereas, AFPs divert funds intended for individuals who are uninsured or underinsured with
2 limited or no access to medications; and

3
4 Whereas, an ad hoc patient advocacy coalition has sent a letter to the Department of Labor
5 (DOL) expressing concerns about AFPs; and

6
7 Whereas, AFPs steer charitable and other patient-assisting funds away from uninsured and
8 underinsured patients; and

9
10 Whereas, AFPs hinder patient access to specialty drugs; therefore be it

11
12 RESOLVED, that our American Medical Association will educate employers, benefits
13 administrators, and patients on alternative funding programs (AFPs) and their negative impacts
14 on patient access to treatment and will advocate for legislative and regulatory policies that
15 would address negative impacts of AFPs. (Directive to Take Action)

16
Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 4/24/2024

REFERENCES

1. Snively A, Richter A. Alternative Funding Programs. Don't Be Fooled by Promises of 'Free' Specialty Cancer Drugs. ONS Voice. January 2024. <https://voice.ons.org/news-and-views/alternative-funding-programs>
2. Employer Market Trends Report. Gallagher. June 2022. https://www.benfieldresearch.com/pdf/2022%20Gallagher%20Research%20&%20Insights_Employer%20Market%20Trends.pdf
3. Alternative Funding Programs: What Employers Need to Know. Aimed Alliance. February 2024. https://aimedalliance.org/wp-content/uploads/2024/02/AFP-White-Paper_FINAL.pdf
4. Alternative Funding Programs Hinder Access to Medications. Immune Deficiency Foundation. February 2024. <https://primaryimmune.org/resources/news-articles/alternative-funding-programs-hinder-access-medications>
5. Growth in Alternative Funding Programs Threatens Patient Access to Medicines. Biotechnology Innovation Organization. April 2023. https://www.bio.org/sites/default/files/2023-10/bio_afp_factsheet_v4_2.pdf
6. Coalition Sends Letter to the Department of Labor Expressing Concerns About Alternative Funding Programs. Cystic Fibrosis Foundation. September 2023. <https://www.cff.org/statements/2023-09/coalition-concerns-alternative-funding-plans>

RELEVANT AMA POLICY

Third-Party Pharmacy Benefit Administrators H-110.963

1. Our AMA recommends that third-party pharmacy benefit administrators that contract to manage the specialty pharmacy portion of drug formularies be included in existing pharmacy benefit manager (PBM) regulatory frameworks and statutes, and be subject to the same licensing, registration, and transparency reporting requirements.
2. Our AMA will advocate that third-party pharmacy benefit administrators be included in future PBM oversight efforts at the state and federal levels.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 708
(A-24)

Introduced by: National Association of Medical Examiners, American Society for Clinical Pathology, American Society of Cytopathology, College of American Pathologists

Subject: Medicolegal Death Investigations

Referred to: Reference Committee G

- 1 Whereas, forensic pathology is the practice of medicine; and
2
3 Whereas, the practice of forensic pathology in medicolegal death investigations is critical for
4 many aspects of public health, practice, and research, including death certification, surveillance,
5 epidemiology, and injury prevention in areas such as unexpected child deaths, suicide, violence,
6 and substance use; and
7
8 Whereas, the findings noted at a forensic autopsy, as well as the results of ancillary studies,
9 must be interpreted in the context of the medicolegal death investigation to correctly determine
10 the cause and manner of death; and
11
12 Whereas, protecting physicians practicing forensic pathology from undue influence is necessary
13 to ensure the independence of medicolegal death investigations, safeguard medical integrity,
14 preserve public trust and confidence; and
15
16 Whereas, state and local governments must ensure strong institutional and workplace
17 protections to bolster the independence of physicians practicing forensic pathology in the course
18 of medicolegal death investigations; and
19
20 Whereas, state laws and regulations on causes and manner of deaths should not deny or limit
21 physician authority to exercise necessary and appropriate medical judgment in the performance
22 of the forensic autopsy; therefore be it
23
24 RESOLVED, that our American Medical Association supports the independent authority of
25 physicians practicing forensic pathology to provide accurate and transparent postmortem
26 assessments and death investigation reporting in a manner free from undue influence (New
27 HOD Policy); and be it further
28
29 RESOLVED, that our AMA advocate with state and federal governments to ensure laws and
30 regulations do not compromise a physician's ability to use their medical judgement in the
31 reporting of postmortem assessments and medicolegal death investigations. (Directive to Take
32 Action)
33

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

Received: 4/24/2024

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 709
(A-24)

Introduced by: American College of Emergency Physicians

Subject: Improvements to Patient Flow in the U.S. Healthcare System

Referred to: Reference Committee G

1 Whereas, delays in patient care result in increased morbidity and mortality^{1 2 3}; and

2
3 Whereas, misaligned healthcare economics pressure hospitals to maintain high inpatient
4 census levels, often preferencing high-margin patients, leading to delays that compromise
5 emergency department, operative, and inpatient surge capacity⁴; and

6
7 Whereas, lack of surge capacity may compromise our nation's emergency preparedness⁵; and

8
9 Whereas, delayed patient flow through multiple care environments affects many portions of the
10 U.S. healthcare system, including access to post-acute care, emergency department care,
11 hospital-based care, surgical care, and primary care; therefore be it

12
13 RESOLVED, that our American Medical Association work with relevant stakeholders and
14 propose recommendations to appropriate entities to improve patient flow and access to care
15 throughout multiple environments in the U.S. healthcare system. (Directive to Take Action)

16
Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 4/24/2024

REFERENCES

1. Roussel M, Teissandier D, Yordanov Y, et al. Overnight Stay in the Emergency Department and Mortality in Older Patients. *JAMA Intern Med.* 2023;183(12):1378–1385. doi:10.1001/jamainternmed.2023.5961
2. Zahran TE, Al Hassan S, Al Karaki V, Hammoud L, Helou CE, Khalifeh M, Al Hariri M, Tamim H, Majzoub IE. Outcomes of critically ill COVID-19 patients boarding in the emergency department of a tertiary care center in a developing country: a retrospective cohort study. *Int J Emerg Med.* 2023 Oct 13;16(1):73. doi: 10.1186/s12245-023-00551-8. PMID: 37833683; PMCID: PMC10576402.
3. Stretch, Robert MD1; Della Penna, Nicolás BA2; Celi, Leo Anthony MD, MS, MPH3; Landon, Bruce E. MD, MBA, MSc4,5. Effect of Boarding on Mortality in ICUs. *Critical Care Medicine* 46(4):p 525-531, April 2018. | DOI: 10.1097/CCM.0000000000002905
4. Kelen et al. Emergency Department Crowding: The Canary in the Health Care System. *NEJM Catalyst.* 2021. DOI: 10.1056/CAT.21.0217
5. Morgenson G. Senate investigating whether er care has been harmed by growing role of private-equity firms. *NBCNews.com.* April 1, 2024. Accessed April 24, 2024. <https://www.nbcnews.com/health/health-care/senate-questions-private-equity-hospital-emergency-departments-peters-rcna145909>.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 710
(A-24)

Introduced by: American College of Emergency Physicians

Subject: The Regulation of Private Equity in the Healthcare Sector

Referred to: Reference Committee G

1 Whereas, healthcare systems controlled by private equity interest failed, putting access to care
2 for patients at risk; and
3
4 Whereas, these failures also put the livelihoods of healthcare workers, including physicians, at
5 risk; and
6
7 Whereas, in these cases, private equity has frequently saddled healthcare systems with
8 significant debts that cannot be easily repaid; and
9
10 Whereas, these healthcare systems have attempted to cut costs by laying off personnel and not
11 purchasing equipment necessary for patient care¹; and
12
13 Whereas, the lack of appropriate resources to care for patients puts significant stress on
14 healthcare workers and can lead to moral injury as well; and
15
16 Whereas, these practices have now caught the attention of the United States Congress, and
17 several investigations have been opened; and
18
19 Whereas, the FTC has indicated that corporate consolidation of healthcare entities frequently
20 results in increased costs of healthcare without commensurate increases in quality; therefore be
21 it
22
23 RESOLVED, that our American Medical Association propose appropriate guidelines for the use
24 of private equity in healthcare, ensuring that physician autonomy in clinical care is preserved
25 and protected (Directive to Take Action); and be it further
26
27 RESOLVED, that our AMA modify policy H-215.981, Corporate Practice of Medicine, by
28 addition:
29 4. Our AMA will work with the federal government and other interested parties to develop and
30 advocate for regulations pertaining to the use of private equity in the healthcare sector such that
31 physician autonomy in clinical care is preserved and protected. (Modify Current HOD Policy)
32
Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 4/24/2024

REFERENCES

1. Bartlett J. Steward's medical devices were repossessed. Weeks later, a new mother died. - The Boston Globe. BostonGlobe.com. February 2, 2024. Accessed April 24, 2024. <https://www.bostonglobe.com/2024/01/25/business/steward-health-care-mother-death/>.

RELEVANT AMA POLICY

Medical Decision-Making Autonomy of the Attending Physician D-373.994

Our AMA will continue to strongly oppose any encroachment of administrators upon the medical decision making of attending physicians that is not in the best interest of patients. (I-23)

Physician Employment Trends and Principles H-225.947

1. Our AMA encourages physicians who seek employment as their mode of practice to strive for employment arrangements consistent with the following principles: A. Physician clinical autonomy is preserved. B. Physicians are included and actively involved in integrated leadership opportunities. C. Physicians are encouraged and guaranteed the ability to organize under a formal self-governance and management structure. D. Physicians are encouraged and expected to work with others to deliver effective, efficient and appropriate care. E. A mechanism is provided for the open and transparent sharing of clinical and business information by all parties to improve care. F A clinical information system infrastructure exists that allows capture and reporting of key clinical quality and efficiency performance data for all participants and accountability across the system to those measures.

2. Our AMA encourages continued research on the effects of integrated health care delivery models (that employ physicians) on patients and the medical profession. (I-15, last reaff A-19)

Physician Independence and Self-Governance D-225.977

Our AMA will: (1) continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; and (2) promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks and accountable care organizations, in order to assure and be accountable for the delivery of quality health care. (last reaff A-22)

Corporate Investors H-160.891

1. Our AMA encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:

- Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
- Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
- External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
- Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
- 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.
- Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
- Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
- Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
- Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
- Each individual physician should have the ultimate decision for medical judgment in patient care and medical care processes, including supervision of non-physician practitioners.
- 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.

Corporate Practice of Medicine H-215.981

1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.
2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately-owned management service organizations.
3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care and other relevant issues.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 711
(A-24)

Introduced by: Ohio

Subject: Insurer Accountability When Prior Authorization Harms Patients

Referred to: Reference Committee G

1 Whereas, prior authorization (PA) is an advanced approval process that insurers and other
2 payers use as a healthcare utilization management tool to deny payment for covered benefits
3 when the payer deems the benefit clinically unnecessary¹; and
4

5 Whereas, prior authorization requirements are rapidly increasing each year, which leads to not
6 only increased administrative duties for physicians and their practice staff but also delayed care
7 for patients²; and
8

9 Whereas, a 2022 study by our AMA on PA demonstrated that 88% of physicians experience
10 high or extremely high administrative burdens due to prior authorization requirements and that
11 94% of physicians believe prior authorizations delay patient access to necessary care³; and
12

13 Whereas, the process of PA reviews, which health plans are frequently known to delegate to
14 third-party contractors, causes significant delays in appropriate patient care that can lead to
15 prolonged suffering and unnecessary deaths⁴; and
16

17 Whereas, the 2022 physician survey by our AMA found that 89% of physicians believe PA
18 requirements have a negative impact on clinical outcomes for patients, with 33% of physicians
19 reporting that PAs have led to their patients experiencing serious adverse health outcomes,
20 including hospitalization, life-threatening events, or disability⁵; and
21

22 Whereas, other surveys by the American Society of Clinical Oncologists (ASCO), the American
23 Cancer Society Cancer Action Network (ACS CAN), and the American Society for Radiation
24 Oncology (ASRO) have reported similar findings, with nearly all oncologists in the 2023 ASCO
25 reporting a patient experienced harms due to PA, including 35% who specifically attributed a
26 patient's loss of life to prior authorization requirements⁵⁻⁸; and
27

28 Whereas, the data strongly suggests that insurers are denying justified healthcare, with the
29 2022 AMA physician survey reporting that only 1% of physicians believe that PA criteria are
30 always based on evidence-based medicine or specialty society guidelines³; and
31

32 Whereas, capitated payment models like Medicaid Managed Care and Medicare Advantage
33 Organizations (MAOs), in which private companies are paid fixed amounts per enrollee based
34 on expected costs regardless of whether the actual cost was higher or lower, create an
35 incentive to minimize enrollee services and maximize PA denials⁹; and
36

37 Whereas, reporting by the Office of Inspector General (OIG) for the United States Department of
38 Health and Human Services has frequently shown that many denials were inappropriate, with a
39 2022 report finding that 13% of PA denials met Medicare coverage requirements and 18% of
40 payment denials met Medicare coverage rules and internal reimbursement guidelines⁹; and

1 Whereas, a 2023 Kaiser Family Foundation (KFF) study as well as two separate OIG reports
2 found that, although just 11% of PA denials by MAOs are appealed, the vast majority of appeals
3 were either completely or partially overturned¹⁰⁻¹²; and
4

5 Whereas, the KFF study and OIG reports noted that their findings were particularly concerning
6 because the appeals process was largely underutilized by beneficiaries and providers with only
7 1% to 27% of initial denials ever being appealed, meaning insurers are incentivized to deny
8 coverage knowing only a small portion of PA decisions will be formally appealed¹⁰⁻¹²; and
9

10 Whereas, despite increasing evidence of inappropriate PA denials by insurers, there currently is
11 no consensus on how to hold insurers liable for denials that result in preventable injury to
12 patients, with largely unsuccessful litigation strategies ranging from bad faith breach of contract
13 to negligent breach of duty, and at least one effort in Texas preempted by the Employment
14 Income & Retirement Act of 1974 (ERISA)^{4,13-14}; and
15

16 Whereas, even when state statute or case law permits a bad faith claim against an insurance
17 company for a wrongful coverage denial and the claim is not preempted by ERISA, it's often
18 impossible to recover punitive damages, which may require proving that the insurance company
19 acted with a higher degree of intent than that required for compensatory damages¹⁵; and
20

21 Whereas, in a recent New York case in which a delayed PA approval resulted in the
22 preventable, rapid progression of a woman's cancer, the U.S. District Court for the Southern
23 District of New York ruled against the woman when it held that existing New York law does not
24 impose a duty of reasonable care on insurance companies that engage in PA review,
25 highlighting the need for aggressive state legislative reform to increase liability for state-
26 regulated insurers¹⁶; and
27

28 Whereas, efforts to hold insurers liable for PA denials that result in preventable injury have been
29 slowed by the increasing use of mandatory arbitration clauses in beneficiary contracts, which
30 require beneficiaries to settle disputes out of court by an impartial third party rather than before
31 a jury or judge and often include waivers that prevent beneficiaries from bringing class action
32 suits¹⁷⁻¹⁸; and
33

34 Whereas, a 2019 review of arbitration clauses used by Fortune 100 companies found that many
35 of the nation's largest health insurance companies, including UnitedHealth Group, Anthem,
36 Aetna, and Cigna, impose mandatory arbitration clauses with class waivers on consumers¹⁸;
37 and
38

39 Whereas, mandatory arbitration clauses are particularly insidious in health insurance contracts
40 given the wide gap in bargaining power between the insurance company and beneficiary and
41 limited selection of alternate insurers as a result of increasing consolidation in insurance
42 markets¹⁹⁻²⁰; and
43

44 Whereas, while arbitration may be preferred by some individuals, data suggests it is generally
45 bad for consumers, as the median award for medical malpractice claims in Kaiser Permanente's
46 arbitration program is nearly \$400,000 less than median awards for medical malpractice jury
47 trials in California²¹; and
48

49 Whereas, in addition to the federal Improving Seniors' Timely Access to Care Act (H.R.3173),
50 nearly 90 prior authorization reform bills have been proposed in current state legislatures, many
51 of which draw on our AMA's model legislation, but none of these proposed bills that have

1 received AMA support address insurers' legal liability when patients are harmed by prior
2 authorizations²²⁻²⁶; therefore be it

3

4 RESOLVED, that our American Medical Association advocate for increased legal accountability
5 of insurers and other payers when delay or denial of prior authorization leads to patient harm,
6 including but not limited to the prohibition of mandatory pre-dispute arbitration and limitation on
7 class action clauses in beneficiary contracts. (Directive to Take Action)

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

Received: 4/26/2024

REFERENCES

1. Prior authorization practice resources. American Medical Association [web]. Updated May 18, 2023. Accessed August 26, 2023. <https://www.ama-assn.org/practice-management/sustainability/prior-authorization-practice-resources>
2. Ernst C. Virtually all medical groups say payer prior authorization requirements aren't improving. MGMA Stat [web]. Published March, 2, 2022. Accessed August 26, 2023. <https://www.mgma.com/mgma-stats/virtually-all-medical-groups-say-payer-prior-authorization-requirements-aren-t-improving>
3. 2022 AMA prior authorization (PA) physician survey. American Medical Association [web]. Accessed August 26, 2023. <https://www.ama-assn.org/system/files/prior-authorization-survey.pdf>
4. Henry TA. Cancer killed Kathleen Valentini, but prior auth shares the blame. American Medical Association [web]. Published June 16, 2022. Accessed August 26, 2023. <https://www.ama-assn.org/practice-management/prior-authorization/cancer-killed-kathleen-valentini-prior-auth-shares-blame>
5. New survey: utilization management delays cancer care; leads to more stress and contributes to worse outcomes. ACS CAN Press Release [web]. Published March 28, 2019. Accessed August 26, 2023. <https://www.fightcancer.org/releases/new-survey-utilization-management-delays-cancer-care-leads-more-stress-and-contributes>
6. Press kit: prior authorization obstacles to cancer patient care. ASTRO News and Media Center [web]. Updated October 25, 2021. Accessed August 26, 2023. <https://www.astro.org/News-and-Publications/News-and-Media-Center/Press-Kits/2019/priorauthpress>
7. Association for Clinical Oncology. ASCO prior authorization survey summary. ASCO [web]. Published November 2022. Accessed August 26, 2023. <https://old-prod.asco.org/sites/new-www.asco.org/files/ASCO-Prior-Auth-Survey-Summary-November-2022.pdf>
8. Trapani D, Kraemer L, Rugo HS, and Lin NU. Impact of prior authorization on patient access to cancer care. ASCO Educational Book. May 23, 2023; 43. doi: 10.1200/EDBK_100036
9. Grimm CA. Some Medicare Advantage Organization denials of prior authorization requests raise concerns about beneficiary access to medically necessary care. US DHHS Office of Inspector General. April 2022. <https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf>
10. Biniek JF and Sroczynski N. Over 35 million prior authorization requests were submitted to Medicare Advantage plans in 2021. Kaiser Family Foundation [web]. Published February 2, 2023. Accessed August 26, 2023. <https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/>
11. Levinson DR. Medicare Advantage appeal outcomes and audit findings raise concerns about service and payment denials. DHHS Office of Inspector General. September 2018. <https://oig.hhs.gov/oei/reports/oei-09-16-00410.pdf>
12. Murrin S. Some Medicare Part D beneficiaries face avoidable extra steps that can delay or prevent access to prescribed drugs. DHHS Office of Inspector General. September 2019. <https://oig.hhs.gov/oei/reports/oei-09-16-00411.pdf>
13. Mariner WK. The Supreme Court's limitation of managed-care liability. New England Journal of Medicine. 2004;351(13):1347-1352. doi:10.1056/nejmlim042143
14. Stern JB. Will the tort of bad faith breach of contract be extended to health maintenance organizations? Law, Medicine and Health Care. 1983;11(1):12-21. doi:10.1111/j.1748-720x.1983.tb00804.x
15. Bad faith insurance claims: are punitive damages available? Lee Cossell & Feagley, LLP. June 24, 2021. Accessed August 27, 2023. <https://www.nleelaw.com/bad-faith-insurance-and-punitive-damages/>
16. Valentini v. Grp. Health, 20 Civ. 9526 (JPC) (S.D.N.Y. Dec. 27, 2021)
17. Sachs S. The jury is out: mandating pre-treatment arbitration clauses in patient intake. Journal of Dispute Resolution. 2018;2018(2):116-131. <https://scholarship.law.missouri.edu/cgi/viewcontent.cgi?article=1813&context=jdr>
18. Szalai IS. The prevalence of consumer arbitration agreements by America's top companies. UC Davis Law Review. 2019;52:233-259. <https://lawreview.law.ucdavis.edu/online/vol52/52-online-Szalai.pdf>
19. Dafny LS. Evaluating the impact of health insurance industry consolidation: learning from experience. November 20, 2015. Accessed August 26, 2023. <https://www.commonwealthfund.org/publications/issue-briefs/2015/nov/evaluating-impact-health-insurance-industry-consolidation>
20. Cogan JA. Readability, contracts of recurring use, and the problem of ex post judicial governance of health insurance policies. Roger Williams University Law Review. 2010;15(1):93-127. <https://ssrn.com/abstract=1991348>
21. Arbitration clauses in insurance contracts: the urgent need for reform. Public Citizen [web]. Accessed August 26, 2023. <https://www.citizen.org/article/arbitration-clauses-in-insurance-contractsthe-urgent-need-for-reform/>
22. H.R.3173 - 117th Congress (2021-2022): Improving Seniors' Timely Access to Care Act of 2021. Updated September 15, 2022. Accessed August 27, 2023. <https://www.congress.gov/bill/117th-congress/house-bill/3173>

23. O'Reilly KB. Bills in 30 states show momentum to fix prior authorization. AMA [web]. Published May 10, 2023. Accessed August 27, 2023. <https://www.ama-assn.org/practice-management/prior-authorization/bills-30-states-show-momentum-fix-prior-authorization>
24. H.R.3947 - 117th Congress (2021-2022): Justice for Patients Act. Updated June 17, 2021. Accessed August 27, 2023. <https://www.congress.gov/bill/117th-congress/house-bill/3947>
25. H.R.7780 - 117th Congress (2021-2022): Mental Health Matters Act. Updated October 11, 2022. Accessed August 27, 2023. <https://www.congress.gov/bill/117th-congress/house-bill/7780/>
26. S.1376 - 118th Congress (2023-2024): Forced Arbitration Injustice Repeal Act. Updated April 27, 2023. Accessed August 27, 2023. <https://www.congress.gov/bill/118th-congress/senate-bill/1376>

RELEVANT AMA POLICY

H-320.939 Prior Authorization and Utilization Management Reform

1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
4. Our AMA will advocate for health plans to minimize the burden on patients, physicians, and medical centers when updates must be made to previously approved and/or pending prior authorization requests. [CMS Rep. 08, A-17; Reaffirmation: I-17; Reaffirmed: Res. 711, A-18; Appended: Res. 812, I-18; Reaffirmed in lieu of: Res. 713, A-19; Reaffirmed: CMS Rep. 05, A-19; Reaffirmed: Res. 811, I-19; Reaffirmed: CMS Rep. 4, A-21; Appended: CMS Rep. 5, A-21; Reaffirmation: A-22]

D-320.978 Fair Reimbursement for Administrative Burdens

Our AMA will: (1) continue its strong state and federal legislative advocacy efforts to promote legislation that streamlines the prior authorization process and reduces the overall volume of prior authorizations for physician practices; (2) continue partnering with patient advocacy groups in prior authorization reform efforts to reduce patient harms, including care delays, treatment abandonment, and negative clinical outcomes; (3) oppose inappropriate payer policies and procedures that deny or delay medically necessary drugs and medical services; and (4) advocate for fair reimbursement of established and future CPT codes for administrative burdens related to (a) the prior authorization process or (b) appeals or denials of services (visits, tests, procedures, medications, devices, and claims), whether pre- or post-service denials. [Res. 701, A-22]

D-285.960 Promoting Accountability in Prior Authorization

Our AMA will: (1) advocate that peer-to-peer (P2P) prior authorization (PA) determinations must be made and actionable at the end of the P2P discussion notwithstanding mitigating circumstances, which would allow for a determination within 24 hours of the P2P discussion; (2) advocate that the reviewing P2P physician must have the clinical expertise to treat the medical condition or disease under review and have knowledge of the current, evidence-based clinical guidelines and novel treatments; (3) advocate that P2P PA reviewers follow evidence-based guidelines consistent with national medical specialty society guidelines where available and applicable; (4) continue to advocate for a reduction in the overall volume of health plans' PA requirements and urge temporary suspension of all PA requirements and the extension of existing approvals during a declared public health emergency; (5) advocate that health plans must undertake every effort to accommodate the physician's schedule when requiring peer-to-peer prior authorization conversations; and (6) advocate that health plans must not require prior authorization on any medically necessary surgical or other invasive procedure related or incidental to the original procedure if it is furnished during the course of an operation or procedure that was already approved or did not require prior authorization. [CMS Rep. 4, A-21]

D-320.979 Processing Prior Authorization Decisions

Our AMA will advocate that all insurance companies and benefit managers that require prior authorization have staff available to process approvals 24 hours a day, every day of the year, including holidays and weekends. [Res. 712, I-20; Reaffirmation: A-22]

H-185.936 Lung Cancer Screening to be Considered Standard Care

Our AMA: (1) recommends that coverage of screening low-dose CT (LDCT) scans for patients at high risk for lung cancer by Medicare, Medicaid, and private insurance be a required covered benefit; (2) will empower the American public with knowledge through an education campaign to raise awareness of lung cancer screening with low-dose CT scans in high-risk patients to improve screening rates and decrease the leading cause of cancer death in the United States; and (3) will work with interested national medical specialty societies and state medical associations to urge the Centers for Medicare & Medicaid Services and state Medicaid programs to increase access to low-dose CT screening for Medicaid patients at high risk for lung cancer by including it as a covered benefit, without cost-sharing or prior authorization requirements, and increasing funding for research and education to improve awareness and utilization of the screening among eligible enrollees. [Sub. Res. 114, A-14; Appended: Res. 418, A-22; Appended: Res. 112, A-23]

American Medical Association House of Delegate

Resolution:712
(A-24)

Introduced by: New York
Subject: Full Transparency - Explanation of Benefits
Referred to: Reference Committee G

1 Whereas, HIPAA Administrative Simplification Requirements mandate a national standard for the
2 X12 835 electronic remittance advice (ERA), paper explanations of benefits (EOB) suffer from
3 vague, incomplete, and often misleading information; and
4
5 Whereas, EOBs often show vague descriptions of services, which precludes transparency and
6 makes it difficult for the patient to determine if the charges are legitimate; therefore be it
7
8 RESOLVED, that our American Medical Association will advocate legislation and regulations that
9 mandate that explanation of benefits, whether sent to the patient or the physician practice,
10 including the actual CPT codes billed, DRG-codes, CPT descriptions, and optional consumer-
11 friendly descriptions; and EOB must list the actual allowed amount, patient responsibilities (copay,
12 deductible, coinsurance), non-covered and denied amounts with specific X12 reason codes in
13 consumer-friendly explanations, what criteria is used for coverage and non-coverage, and
14 includes detailed explanation on how to appeal, including contact information for plan
15 administrator, applicable laws governing the plan benefits, and contact information to submit
16 external complaints. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 5/8/2024

RELEVANT AMA POLICY

Requiring Third Party Reimbursement Methodology be Published for Physicians H-185.975

Our AMA:

- (1) urges all third party payers and self-insured plans to publish their payment policies, rules, and fee schedules;
- (2) pursues all appropriate means to make publication of payment policies and fee schedules a requirement for third party payers and self-insured plans;
- (3) will develop model state and federal legislation that would require that all third party payers and self-insured plans publish all payment schedule updates, and changes at least 60 days before such changes in payment schedules are enacted, and that all participating physicians be notified of such changes at least 60 days before changes in payment schedules are enacted.
- (4) seeks legislation that would mandate that insurers make available their complete payment schedules, coding policies and utilization review protocols to physicians prior to signing a contract and at least 60 days prior to any changes being made in these policies;
- (5) works with the National Association of Insurance Commissioners, develop model state legislation, as well developing national legislation affecting those entities that are subject to ERISA rules; and explore the possibility of adding payer publication of payment policies and fee schedules to the Patient Protection Act; and

(6) supports the following requirements: (a) that all payers make available a copy of the executed contract to physicians within three business days of the request; (b) that all health plan EOBs contain documentation regarding the precise contract used for determining the reimbursement rate; (c) that once a year, all contracts must be made available for physician review at no cost; (d) that no contract may be changed without the physician's prior written authorization; and (e) that when a contract is terminated pursuant to the terms of the contract, the contract may not be used by any other payer.

Sub. Res. 805, I-95 Appended: Res. 117, A-98 Reaffirmation A-99 Appended: Res. 219, and Reaffirmed: CMS Rep. 6, A-00 Reaffirmation I-01 Reaffirmed and Appended: Res. 704, A-03 Reaffirmation I-04 Reaffirmation A-08 Reaffirmation I-08 Reaffirmed: CMS Rep. 3, I-09 Reaffirmation A-14

American Medical Association House of Delegates

Resolution: 713
(A-24)

Introduced by: New York

Subject: Transparency – Non-Payment for Services to patients with ACA
Exchange Plans with Unpaid Premiums

Referred to: Reference Committee G

1 Whereas, patients can sign up for health insurance without paying for up to 2 months, during
2 which eligibility verification shows active coverage. Yet, health plans have a right to deny payment
3 to physicians if a patient fails to pay premiums, which leaves physicians with uncollectible debt for
4 physician professional services as well as expensive physician-administered and prior-authorized
5 medications that cost thousands of dollars; and
6

7 Whereas, X12 is designated by CMS as a national standards organization that sets national
8 standards for electronic eligibility transaction X12 270/271; therefore be it

9
10 RESOLVED, that our American Medical Association will advocate for legislation to require that
11 health plans inform healthcare providers whether the plan premium has been paid and whether
12 the account is late on payment as part of benefit verification, whether by phone, fax, or electronic
13 transaction, including but not limited to X12 270/271 (Directive to Take Action); and be it further
14

15 RESOLVED, that our AMA will advocate for legislation or regulation to require that health plans
16 inform healthcare providers whether the plan premium has been paid and whether the account
17 is late on payment as part of benefit verification, whether by phone, fax, electronic transaction
18 including but not limited to X12 270/271 (Directive to Take Action); and be it further
19

20 RESOLVED, that our AMA will advocate that X12 includes plan premium payment status as part
21 of X12 270/271 standard transaction code updates (Directive to Take Action); and be it further
22

23 RESOLVED, that our AMA will report on the status of this resolution at the 2025 Annual Meeting.
24 (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 5/8/2024

Informational Reports

Report(s) of the Board of Trustees

- 03 2023 Grants and Donations
- 05 Update on Corporate Relationships
- 06 Redefining AMA's Position on ACA and Health Care Reform
- 07 AMA Performance, Activities, and Status in 2023
- 08 Annual Update on Activities and Progress in Tobacco Control: March 2023 through February 2024
- 10 American Medical Association Health Equity Annual Report
- 12 AMA Efforts on Medicare Payment Reform
- 20 Criminalization of Providing Medical Care
- 22 AMA Public Health Strategy: Update
- 24 Report on the Preservation of Independent Medical Practice
- 27 AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates
- 32 Independent Medical Evaluation
- 34 Demographic Report of the House of Delegates and AMA Membership

Report(s) of the Council on Ethical and Judicial Affairs

- 06 Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

Report(s) of the Council on Long Range Planning and Development

- 02 Scenarios on Collective Action and Physician Unions

Report(s) of the Council on Medical Service

- 04 Health System Consolidation

Report(s) of the Speakers

- 02 Report of the Election Task Force 2
- 03 Updated Parliamentary Authority

REPORT OF THE BOARD TRUSTEES

B of T Report 03-A-24

Subject: 2023 Grants and Donations

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

- 1 This informational financial report details all grants or donations received by the American
- 2 Medical Association during 2023.

**American Medical Association
Grants & Donations Received by the AMA
For the Year Ended December 31, 2023
Amounts in thousands**

Funding Institution	Project	Amount Received
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Building Healthcare Provider Capacity to Screen, Test, and Refer Disparate Populations with Prediabetes	\$ 44
Centers for Disease Control and Prevention (subcontracted to AMA through American College of Preventive Medicine)	Improving Minority Physician Capacity to Address COVID-19 Disparities	257
Centers for Disease Control and Prevention	Improving Health Outcomes through Partnerships with Physicians to Prevent and Control Emerging and Re-Emerging Infectious Disease Threats	1,545
Centers for Disease Control and Prevention	National Healthcare Workforce Infection Prevention and Control Training Initiative Healthcare Facilities	13
Centers for Disease Control and Prevention	Promoting HIV, Viral Hepatitis, STDs, and LTBI Screening in Hospitals, Health Systems, and Other Healthcare Settings	344
Health Resources and Services Administration (subcontracted to AMA through American Heart Association, Inc.)	National Hypertension Control Initiative: Addressing Disparities Among Racial and Ethnic Minority Populations	577
Substance Abuse and Mental Health Services Administration (subcontracted to AMA through American Academy of Addiction Psychiatry)	Providers Clinical Support System Medicated Assisted Treatment	30
Government Funding		<u>2,810</u>
The Physicians Foundation, Inc.	American Conference on Physician Health	28
Nonprofit Contributors		<u>28</u>
Nuance Communications, Inc.	American Conference on Physician Health	12
Contributors less than \$5,000	International Medical Graduates Section Reception	3
Other Contributors		<u>15</u>
Total Grants and Donations		\$ <u><u>2,853</u></u>

REPORT OF THE BOARD OF TRUSTEES

B of T Report 05-A-24

Subject: Update on Corporate Relationships

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

1 PURPOSE

2

3 The purpose of this informational report is to update the House of Delegates (HOD) on the results
4 of the Corporate Review process from January 1 through December 31, 2023. Corporate activities
5 that associate the American Medical Association (AMA) name or logo with a company, non-
6 Federation association or foundation, or include commercial support, currently undergo review and
7 recommendations by the Corporate Review Team (CRT) (Appendix A).

8

9 BACKGROUND

10

11 At the 2002 Annual Meeting, the HOD approved revised principles to govern the AMA’s corporate
12 relationships, HOD Policy G-630.040 “Principles on Corporate Relationships.” These guidelines
13 for American Medical Association corporate relationships were incorporated into the corporate
14 review process, are reviewed regularly, and were reaffirmed at the 2012 and 2022 Annual Meeting.
15 AMA managers are responsible for reviewing AMA projects to ensure they fit within these
16 guidelines.

17

18 YEAR 2023 RESULTS

19

20 In 2023, 109 activities were considered and approved through the Corporate Review process. Of
21 the 109 projects recommended for approval, 54 were conferences or events, 11 were educational
22 content or grants, 32 were collaborations or affiliations, six were member programs, five were
23 business arrangements/licensing programs and one was an American Medical Association
24 Foundation (AMAF) program. See Appendix B for details.

25

26 CONCLUSION

27

28 The Board of Trustees (BOT) continues to evaluate the CRT review process to balance risk
29 assessment with the need for external collaborations that advance the AMA’s strategic focus.

Appendix A

CORPORATE REVIEW PROCESS OVERVIEW

The Corporate Review Team (CRT) includes senior managers from the following areas: Strategy, Finance, Health Solutions (HS), Advocacy, Office of the General Counsel, Medical Education, Publishing, Enterprise Communications (EC), Marketing and Member Experience (MMX), Center for Health Equity (CHE), and Health, Science and Ethics.

The CRT evaluates each project submitted to determine fit or conflict with AMA Corporate Guidelines, covering:

- Type, purpose, and duration of the activity;
- Audience;
- Company, association, foundation, or academic institution involved (due diligence reviewed);
- Source of external funding;
- Use of the AMA name and logo;
- Editorial control/copyright;
- Exclusive or non-exclusive nature of the arrangement;
- Status of single and multiple supporters; and
- Risk assessment for AMA.

The CRT reviews and makes recommendations regarding the following types of activities that utilize AMA name and logo:

- Industry-supported web, print, or conference projects directed to physicians or patients that do not adhere to Accreditation Council for Continuing Medical Education (ACCME) Standards and Essentials.
- AMA sponsorship of external events.
- Independent and company-sponsored foundation supported projects.
- AMA licensing and publishing programs. (These corporate arrangements involve licensing AMA products or information to corporate or non-profit entities in exchange for a royalty and involve the use of AMA's name, logo, and trademarks. This does not include database or Current Procedural Terminology (CPT ®) licensing.)
- Member programs such as new affinity or insurance programs and member benefits.
- Third-party relationships such as joint ventures, business partnerships, or co-branding programs directed to members.
- Non-profit association collaborations outside the Federation. The CRT reviews all non-profit association projects (Federation or non-Federation) that involve corporate sponsorship.
- Collaboration with academic institutions in cases where there is corporate sponsorship.

For the above specified activities, if the CRT recommends approval, the project proceeds. In addition to CRT review, the Executive Committee of the Board must review and approve CRT recommendations for the following AMA activities:

- Any activity directed to the public with external funding.

- Single-sponsor activities that do not meet ACCME Standards and Essentials.
- Activities involving risk of substantial financial penalties for cancellation.
- Upon request of a dissenting member of the CRT.
- Any other activity upon request of the CRT.

All Corporate Review recommendations are summarized annually for information to the Board of Trustees (BOT). The BOT informs the HOD of all corporate arrangements at the Annual Meeting.

Appendix B

SUMMARY OF CORPORATE REVIEW
RECOMMENDATIONS FOR 2023

CONFERENCES/EVENTS

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
21890	March of Dimes Gourmet Gala - Repeat sponsorship with AMA name and logo.	March of Dimes Samsung Proctor and Gamble Abbott Pharmaceuticals Barbour, Griffiths and Rogers Group PhRMA	01/24/2023
21930	Bryce Harlow Foundation 42nd Annual Awards Dinner – Sponsorship with AMA name and logo.	Bryce Harlow Foundation Canadian National Railway Company Society for Human Resource Management Fierce Government Relations AARP Holland & Knight	01/26/2023
21987	HIMSS Global Health Conference & Exhibition - Repeat sponsorship with AMA and CPT names and logos.	Health Information and Management Systems Society	02/02/2023
22011	Public Relations Student Society of America Midwest District Conference – Sponsorship with AMA name and logo.	Public Relations Student Society of America Public Relations Society of America	02/06/2023
22026	NAMSS 47th Annual Educational Virtual Conference and Exhibition - Repeat sponsorship with AMA name and logo.	National Association of Medical Staff Services ABMS Solutions American Board of Physician Specialties Columba Southern University DecisionHealth MD-Staff Medallion PreCheck Qgenda Silversheet Symplr The Greeley Company The Hardenbergh Group	02/07/2023

22039	AHCJ Conference – Repeat sponsorship with AMA and JAMA Network names and logos.	Association of Healthcare Journalists	02/08/2023
22132	IAIABC 109th Convention - Repeat sponsorship with AMA name and logo.	International Association of Industrial Accident Boards and Commissions National Council on Compensation Insurance Optum Sedgwick The Black Car Fund Concentra Aerie EDI Group Safety National Healthsystems Official Disability Guidelines by Milliman Clinical Guidelines Enlyte Ebix Verisk Tybera HealthTech, Inc Rising Medical Solutions	02/14/2023
22123	AAPC HEALTHCON Events - Repeat sponsorship with AMA name and logo.	American Academy of Professional Coders	02/15/2023
22064	National Rx & Illicit Drug Summit - Repeat sponsorship with AMA name and logo.	Operation Unite Police Treatment and Community Collaborative Georgia Council for Recovery Brevard Prevention Coalition Advantage Behavioral Health Emergency Medical Services World	02/16/2023
22120	AMA Research Challenges- AMA branded competition repeat event with Laurel Road sponsored prize.	Laurel Road Bank Key Bank	02/17/2023

22283	National Black Law Students Association Convention – Sponsorship with AMA name and logo.	National Black Law Students Association Haynes Boone Holland & Knight Alston & Bird	02/24/2023
22121	Becker’s Collaborations - Webinar, CEO & CFO Roundtables and Luncheon, and Annual Hospital Review.	Becker’s Hospital Review ASC Communications	02/24/2023
22194	ViVE 2023 Sponsorship – Repeat sponsorship with AMA name and logo.	HLTH Inc College of Healthcare Information Management Executives (CHIME)	03/02/2023
22323	Rock Health Summit – Repeat sponsorship with AMA name and logo.	Rock Health Foundation California Health Care Foundation Google Tulsa Innovation Labs 1501 Health BioReference Laboratories	03/06/2023
22209	AMA International Medical Graduates Section (IMGS) Annual Meeting Desserts Reception – Repeat sponsorship with AMA name and logo.	Association of Physicians of Pakistani Descent of North America Association of Haitian Physicians Abroad Korean American Medical Association National Arab Medical Association	03/09/2023
22353	NLGJA: The Association of LGBTQ Journalists Annual Conference – Repeat sponsorship with AMA name and logo.	AARP Warner Media Pulitzer Center Google News Lab Screen Actors Guild Walton Family Foundation EqualPride Media DotDash Meredith Publishing Craig Newmark Philanthropies Axios Media CoinDesk McClatchy Media Spectrum Networks Southern Newspaper Publishers Association Foundation	03/13/2023

22364	Chicago Cares - Find your Cause Event – Sponsorship with AMA name and logo.	Chicago Cares	03/15/2023
22462	National Hispanic Medical Association 26th Annual Conference – Repeat sponsorship with AMA name and logo.	National Hispanic Medical Association	03/17/2023
22454	Asian American Journalists Association’s Annual Convention – Repeat sponsorship with AMA name and logo.	Asian American Journalists Association	03/20/2023
22540	Credentialing State Shows – Repeat sponsorship with AMA name and logo.	Texas Society for Medical Services Specialists Illinois Association of Medical Staff Services North Carolina Association of Medical Staff Services California Society for Medical Services Specialists MD Staff PreCheck Canadian International Medical Relief Organization Critical Incident Management Response Organization (CIMRO) Hardenbergh Group MD Review Qgenda YS Credentialing American Board of Medical Specialties Solutions	03/23/2023
22603	Reuters Digital Health, Reuters Momentum Events – Conference sponsorships with AMA name and logo.	Reuters Events	04/04/2023
22697	AMA Medical Education AAMC Webinar – Co-branded sponsorship with AMA name and logo.	Association of American Medical Colleges	04/14/2023

22707	National Independent Laboratory Association Annual Meeting – Repeat sponsorship with AMA name and logo.	Agena Bioscience Seegene Technologies Streamline Scientific TELCOR Quarles & Brady LLP	04/17/2023
22899	Rush University Medical Center - West Side Walk for Wellness – Repeat sponsorship with AMA name and logo.	Rush University Medical Center West Side Walk for Wellness	05/02/2023
22842	National Multiple Sclerosis Society 45th Annual Ambassadors Ball – Sponsorship with AMA name and logo.	National Multiple Sclerosis (MS) Society	05/05/2023
23081	Essence Festival – Sponsorship with In Full Health name and logo.	New Voices Foundation Essence Festival	05/23/2023
23152	“Walking Backward into the Future of Chicago’s West Side” Event – Sponsorship with AMA name and logo.	Medical Justice in Advocacy Fellowship Morehouse School of Medicine	05/24/2023
23115	The Systems Summit on Clinical Wellbeing at Princeton University - Sponsorship with AMA name and logo.	Princeton Center for Health and Wellbeing The Samueli Foundation Kahneman-Treisman Center for Behavioral Science & Public Policy at Princeton Healing Works Foundation American College of Graduate Medical Education	06/08/2023
23441	American Society of Bioethics and Humanities Conference – Sponsorship with AMA Journal of Ethics name and logo.	American Society of Bioethics and Humanities	06/26/2023

23394	National Adult and Influenza Immunization Summit – Sponsorship with AMA name and logo.	Centers for Disease Control and Prevention Office of Infectious Disease and HIV/AIDS Policy U.S. Department of Health and Human Services Immunize.org	06/29/2023
23453	NAACOS Fall Conference – Sponsorship with AMA MAP name and logo.	National Association of Accountable Care Organizations	06/30/2023
23420	SNOMED CT Expo – Repeat sponsorship with AMA CPT and AMA names and logos.	Systematized Nomenclature of Medicine (SNOMED) International	07/06/2023
23656	Chief Medical Officer Exchange – Sponsorship with AMA name and logo.	HCPro HealthLeaders Nuance Healthcare Solutions 3M M*Modal Midmark	07/21/2023
23083	ASMAC Fall Conference - Sponsorship with AMA name and logo.	American Society of Medical Association Counsel	07/25/2023
23742	American Conference on Physician Health – Repeat sponsorship with AMA name and logo.	Stanford Medicine Mayo Clinic The Physician’s Foundation Nuance Communications	07/27/2023
23838	WOEMA Conference - Sponsorship with AMA name and logo.	Western Occupational and Environmental Medical Association The Permanente Group Concentra Occupational Health e3 Occupational Health Solutions Novo Nordisk	08/02/2023

23865	GCC eHealth Workforce Development Conference – Repeat sponsorship with AMA name and logo.	Gulf Cooperation Council Emirates Health Services InterSystems Malaffi CyncHealth Dell Technologies	08/07/2023
23891	CFHA Integrated Care Conference – Repeat sponsorship with AMA name and logo.	Collaborative Family Healthcare Association	08/07/2023
23932	Genetic Health Information Network Summit - Repeat sponsorship with AMA name and logo.	Concert Genetics Illumina Sarah Lawrence Genomics Institute	08/14/2023
23939	HMPRG Awards Gala – Sponsorship with AMA name and logo.	Health & Medicine Policy Research Group Crown Family Philanthropies Cook County Health Joseph and Bessie Feinberg Foundation Rush Medical ACLU Illinois Chicago Bulls Chicago Federation of Labor Healthy Communities Foundation AgeOptions Erie Family Health Centers MiMedico Primary Care Thresholds ICAN!	08/15/2023
24037	HLTH Conference - Repeat sponsorship with AMA name and logo	HLTH Inc HLTH Foundation	08/17/2023

24059	Alliance for Health Policy - Annual Dinner – Repeat sponsorship with AMA name and logo.	Kaiser Permanente Otsuka Pharmaceuticals Blue Cross Blue Shield Association Elevance Health PhRMA American Hospital Association Amgen Catholic Health Association Patient Centered Outcomes Research Institute Merck Pharmaceuticals Better Medicare Alliance Amazon Shields Health Solutions Welsh-Carson-Anderson & Stowe ADVI Health	08/22/2023
24103	29th Annual Princeton Conference – Repeat sponsorship with AMA name and logo.	The Council on Health Care Economics and Policy at Brandeis University Association of American Medical Colleges AARP American Hospital Association Arnold Ventures Blue Cross Blue Shield of Massachusetts Foundation Blue Shield of California Foundation Booz Allen Hamilton California Health Benefits Review Program California Health Care Foundation Jewish Healthcare Foundation MAXIMUS Peterson Center on Healthcare The Health Industry Forum The John A. Hartford Foundation	08/25/2023
24096	National Press Club’s Newsmaker Series – Sponsorship with AMA name and logo.	National Press Club	08/28/2023

24036	APHC Conference Sponsorship – Sponsorship with AMA name and logo.	Academy for Professionalism in Health Care Case Western Reserve University Cleveland Clinic: Lerner College of Medicine American Board of Medical Specialties Loma Linda University Health Johns Hopkins Berman Institute of Bioethics Loyola Bioethics American Association of Colleges of Osteopathic Medicine The Arnold P. Gold Foundation American Board of Internal Medicine Foundation Saint Louis University: Albert Gnaegi Center for Health Care Ethics	08/31/2023
23750	NOAH Conference - Sponsorship with AMA name and logo.	National Organization for Arts in Health Cleveland Clinic MetroHealth System Laurie M. Tisch Illumination Fund Museum Exchange Houston Methodist Hospital University of Rochester Stanford Medicine Aesthetics Inc. J.T. & Margaret Talkington College of Visual & Performing Arts at Texas Tech University Northwest Creative & Expressive Arts Institute	08/31/2023
24376	National Addiction Treatment Week - Repeat sponsorship with AMA name and logo.	American Society for Addiction Medicine Association of American Medical Colleges American College of Academic Addiction Medicine American Osteopathic Academy of Addiction Medicine Michigan Cares National Institute on Drug Abuse National Institute on Alcohol Abuse and Alcoholism University of California San Francisco Smoking Cessation Leadership Center	09/21/2023

24703	Black Men in White Coats Youth Summit - Repeat sponsorship with AMA name and logo.	Black Men in White Coats Veradigm Creating Pathways and Access for Student Success (CPASS) Foundation	10/16/2023
24839	Women Business Leaders Annual Summit - Repeat sponsorship with AMA name and logo.	Women Business Leaders Elevance Health Johnson & Johnson McKesson Corporation Tivity Health AMN Healthcare Epstein Becker & Green PC MCG Health Medecision CommonSpirit Health Mintz Law Firm Newport Healthcare ProgenyHealth UnitedHealth Group Aarete Consulting Firm Healthcare Leadership Council Hello Heart	11/03/2023
24773	Hispanic Health Professional Student Scholarship Gala – Sponsorship with AMA name and logo.	National Hispanic Health Foundation National Hispanic Medical Association	11/01/2023
25041	HLTH Foundation Webinar - Sponsorship with AMA name and logo.	HLTH Inc HLTH Foundation	11/20/2023
24941	Consumer Electronics Show Digital Health Conference - Sponsorship with AMA name and logo.	Consumer Technology Association American Psychological Association Connectivity Standards Alliance	11/22/2023
25305	MD-Staff Educational Conference - Sponsorship with AMA name and logo.	Applied Statistics & Management PreCheck The Hardenbergh Group Sterling Infosystems	12/07/2023

EDUCATIONAL CONTENT OR GRANT

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
21752	Words Matter-Making Sense of Health Equity Language Session – Recording for Medscape’s CME & Education platform with AMA name and logo.	Medscape Association of American Medical Colleges	01/10/2023
22334	Parkinson’s Foundation Education Series - AMA EdHub hosted content with AMA name and logo.	Parkinson’s Foundation CVS Health Foundation	03/22/2023
22712	AMA STEPS Forward® Plan-Do-Study-Act (PDSA) Toolkit – Update to toolkit hosted on AMA EdHub with AMA name and logo.	Center for Sustainable Health Care Quality and Equity National Minority Quality Form American College of Physicians	04/18/2023
23035	Advancing AMA’s Telehealth Policy Report – Co-branded research report on telehealth priorities and trends, with AMA name and logo.	Manatt Health	05/30/2023
23094	Future of Health Immersion Program – Collaborators for AMA website program on telehealth.	The Physician’s Foundation American Physical Therapy Association Health Choice Network Academy of Medicine of Cleveland and Northern Ohio	06/06/2023
23810	Disability Inclusion in Undergraduate and Graduate Medical Education Modules - AMA EdHub hosted content with AMA name and logo.	Association of Higher Education and Disability Docs with Disabilities Initiative Association of American Medical Colleges	08/01/2023
24016	National Coalition for Sexual Health - AMA EdHub hosted content with AMA name and logo.	National Coalition for Sexual Health Altarum Institute	09/07/2023

24576	American Health Information Management Association Workshop – Training on clinical documentation coding with AMA name and logo.	American Health Information Management Association	10/10/2023
24628	Collaboration with Med Learning Group - AMA EdHub hosted content with AMA name and logo.	Med Learning Group	10/26/2023
24905	Credentialing School Sponsorship - Repeat sponsorship with AMA name and logo.	Edge-U-Cate Certi-FACTS Symplr Federation of State Medical Boards	11/08/2023
24629	Natural Resources Defense Council - AMA EdHub hosted environmental health content with AMA name and logo.	Natural Resources Defense Council	11/10/2023

COLLABORATIONS/AFFILIATIONS

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
21841	National Academy of Medicine’s Action Collaborative on Clinician Well-Being and Resilience - Sponsorship of stakeholder meeting series with AMA name and logo.	National Academy of Medicine National Academy of Sciences American Association of Colleges of Nursing	01/10/2023

21764	<p>Duke University Health AI Partnership (HAIP) – Sponsorship of consortium and AI ethics training program with AMA name and logo.</p>	<p>Duke University Health Gordon and Betty Moore Foundation DLA Piper LLC Hackensack Meridian Health Jefferson Health Kaiser Permanente Mayo Clinic Michigan Medicine New York-Presbyterian Parkland Center for Clinical Innovation UC Berkeley WellCare North Carolina</p>	01/17/2023
24871	<p>MAP Dashboards for Health Care Organizations – AMA co-branding with healthcare organizations for MAP blood pressure dashboard project.</p>	<p>University of South Alabama CommunityHealth Corewell Health</p>	11/17/2023
21967	<p>American Telemedicine Association Membership – Repeat sponsorship with AMA name and logo.</p>	<p>American Telemedicine Association</p>	01/26/2023
21959	<p>HL7 CodeX Membership – Collaboration for stakeholders on CodeX project with AMA name and logo.</p>	<p>Health Level Seven International</p>	02/06/2023

25521

**Practice Transformation
Survey Assessment Groups** –
AMA co-branding with
healthcare organizations for
physician burnout survey
project.

Intermountain Health – Montana
Entira Family Clinics
AdventHealth
Dayton Children's Hospital
Mountain Area Health Education
Center
ChenMed
Sutter West Bay Medical Group
Baptist Health South Florida
Washington Permanente Medical
Group
CommUnity Care
Sutter Health
Margaret Mary Health
Platte Valley Medical Center
El Rio Health
Children's Health of Orange County
Scripps Health
Cape Cod Hospital
DaVita Health
HealthOne
PeaceHealth
Rady Children's Hospital
TidalHealth
University of Toledo Medical Center
UC Riverside School of Medicine
Emergency Physicians of Tidewater
Avera Health
Arizona Alliance for Community
Health Centers
University of Michigan Health
Providence Regional Medical Center
Thundermist Behavioral Health
Ochsner Health
Cleveland Clinic Florida
Geisinger Health
Moffitt Cancer Center
Gould Medical Group
Beth Israel Deaconess Medical
Center
University of Tennessee Medical
Center
Cedars-Sinai Medical Center
Inova Fairfax Medical Center
The Center for Primary Care
Honor Health
Austin Health Partners
Mercy Medical Center
Oak Street Health
University of Arkansas Health
Center

12/27/2023

25521 Cont'd	Practice Transformation Survey Assessment Groups – AMA co-branding with healthcare organizations for physician burnout survey project.	HarmonyCares Medical Group Franciscan Physician Network San Joaquin General Hospital St. Luke's Health System Baylor Scott and White Health Benefis Health System Hattiesburg Clinic Ridgecrest Regional Hospital Stamford Health Trinity Health Naples Community Healthcare North Country Healthcare Jefferson Health Capital Region Medical Center Dayton Children's Hospital Missouri Association of Osteopathic Physicians and Surgeons Emergency Care Consultants Eskenazi Medical Group Sharp Community Medical Group Sturdy Memorial Hospital Kansas City University Medical School Owensboro Health National Cancer Care Alliance Louisiana State University Medical School Atrium Health Capital Region Medical Center Denver Health Emergency Care Consultants Erie Family Health Centers Health Access Network North Country Hospital Bryan Health Legacy Health Rogers Behavioral Health	
22118	HLTH Foundation – Sponsorship of equity research coalition and conference with AMA name and logo.	HLTH Foundation Ipsos Group S.A.	02/27/2023
22664	MassChallenge HealthTech – Sponsorship of healthcare startup mentorship program with AMA name and logo.	MassChallenge Lyda Hill Philanthropies Accenture Boston Children's Hospital Brigham Health and Women's Hospital	04/12/2023

22833	<p>“The PermanenteDocs Chat” Podcast Program - Collaboration for bi-weekly podcast program with AMA name and logo.</p>	<p>The Permanente Federation Kaiser Permanente</p>	04/20/2023
22820	<p>The Collaborative for Healing and Renewal in Medicine (CHARM) - Charter committed to reducing healthcare worker burnout with AMA name and logo.</p>	<p>Alaska Native Medical Center Allegheny Health Network American Medical Women's Association Brigham & Women's Hospital CareMax ChenMed Children's Hospital of Los Angeles Dayton Children's Hospital Drexel University First Choice Community Healthcare HonorHealth Keck School of Medicine, University of Southern California Luminis Health Mercy Medical Center New York City Health Northwest Permanente PD Olive View-UCLA Medical Center Oregon Health & Science University Palo Alto Foundation Medical Group Piedmont Medical Center Pomona Valley Hospital Medical Center Queen's Health System Rogers Behavioral Health Roper St. Francis Healthcare St. Jude Heritage Medical Group St. Luke's Health System Stamford Hospital University of Michigan Health-West University of Texas Medical Branch US Acute Care Solutions Washington Permanente Medical Group Yale New Haven Hospital</p>	05/01/2023

23018	Rise to Health Coalition Collaborator Update – Co-branded coalition to embed equity in healthcare including toolkits, webinars and guides for healthcare professionals.	National Committee for Quality Assurance American Association of Retired Persons American Nursing Association Bristol Myers Squibb	05/17/2023
23079	National Health Equity Grand Rounds Collaborator Update - Webinar series on health equity with AMA name and logo.	Social Mission Alliance	05/23/2023
23142	National Association of Accountable Care Organizations Alliance Partner – Membership to advance value-based care with AMA name and logo.	Primary Care Collaborative Center for Sustainable Healthcare National Association of Accountable Care Organizations Epic Systems Surescripts Blue Cross Blue Shield of South Carolina	05/25/2023
23292	Improving Health Outcomes Research Collaboration - UCSF feasibility study for wrist worn blood pressure monitoring devices.	University of California San Francisco LiveMetric	06/16/2023
23440	Facility Closure Impact on Access to Maternity Care – Co-branded research report regarding impact of facility closures on access to maternity care in Chicago.	March of Dimes Sinai Urban Health Institute	07/05/2023
23437	Connecting to Coverage Coalition – Outreach program collaboration to promote Medicaid enrollment with AMA name and logo.	America’s Health Insurance Plans Thorn Run Partners	07/10/2023

23542	VeriCre – Pilot program collaboration for new AMA credentialing product with AMA name and logo.	Applied Statistics and Management MD-Staff SC Health Cleveland Clinic Boston Children’s Hospital Mass General Brigham Council for Affordable Quality Healthcare HealthStream	07/14/2023
23512	Health Equity in Organized Medicine Survey - Collaboration on report summarizing survey findings with AMA name and logo.	MyWhy Agency	07/20/2023
23714	Reuters Total Health – Collaboration for report regarding industry challenges with AMA name and logo.	Reuters Kaiser Permanente GE Healthcare Dartmouth Health Sutter Health Ardent Health Center for Medicare Northwell Health	07/26/2023
24025	Advancing Rural Behavioral Health Integration with Telehealth Research Program – Collaborative study with AMA name and logo.	University of Hawaii John A. Burns School of Medicine The Physicians Foundation	08/18/2023

24404	<p>Joy in Medicine Health System Recognition Program - Repeat AMA recognition program for outstanding healthcare organizations.</p>	<p>Baylor Scott & White – The Heart Hospitals (Denton, McKinney, Plano) Corwell Health EvergreenHealth Providence Medical Foundation: St. Joseph Heritage Medical Group St. Jude Heritage Medical Group Sturdy Health WellSpan Health Wellstar Health System Banner Health Connecticut Children’s Dignity Health Arizona Market Family Health Centers of San Diego Hackensack Meridian Health Parkland Health Providence Health (Oregon) Reid Health Rush University Medical Center The Ohio State University Wexner Medical Center</p>	09/25/2023
24250	<p>New MAP BP program distribution channel partner – Collaboration to distribute MAP materials with AMA name and logo.</p>	<p>Altarum Institute</p>	10/02/2023
24306	<p>Joint announcement for Social Needs Assessment Coder – Press release to announce new program with AMA name and logo.</p>	<p>The Gravity Project</p>	10/03/2023
24518	<p>Mathematica Physician Practice Information Survey – Collaborative study on physician costs with AMA name and logo.</p>	<p>Mathematica</p>	10/05/2023
24453	<p>Physician Data Collaborative – Website launch with AMA name and logo.</p>	<p>Association of American Medical Colleges Accreditation Council of Graduate Medical Education</p>	10/09/2023

24616	MATTER Chicago – Repeat sponsorship of nonprofit healthcare startup incubator with AMA name and logo.	Matter Chicago	10/10/2023
24558	Prevention Strategy Collaboration with Health Care Organizations – Update to program with AMA name and logo.	River Valley Family Healthcare	10/13/2023
24593	Embedding Equity in Crisis Preparedness & Response in Health Systems Guide – Update to materials with AMA name and logo.	Planned Parenthood Federation of America Reproductive Health Impact American Public Health Association New York City Pandemic Response Institute For the Culture Consulting, LLC	10/23/2023
24617	VALID AI – Membership in working group on AI in healthcare with AMA name and logo.	University of California Davis Health Moffit Cancer Center Cleveland Clinic Elevance MedStar Microsoft Google	10/23/2023
24714	Physician Innovation Network (PIN) – AMA PIN collaboration agreements with limited AMA name and logo use.	American Academy of Pain Medicine Microsoft Startup Accelerator	11/03/2023
24872	Teaching Case on AMA’s Center for Health Equity – Collaboration to develop a case study with AMA name.	Harvard TH Chan School of Public Health	11/06/2023
24989	Common Health Coalition: Together for Public Health – Collaboration on pandemic preparedness with AMA name and logo.	America’s Health Insurance Plans Alliance of Community Health Plans American Hospital Association Kaiser Permanente	11/15/2023

25403	Henry Schein Cares Foundation “Prevention is Power” Initiative – Collaboration on public health awareness campaign with AMA and Release the Pressure (RTP) names and logos.	Henry Schein Cares Foundation American Dental Association National Association of Community Health Centers CDC Foundation National Medical Association	12/06/2023
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MEMBER PROGRAMS

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
21990	AHI Further –Travel affinity program with AMA name and logo.	AHI Travel AHI Further Certares Management LLC	02/08/2023
23160	PhysicianLoans – Update to mortgage loan affinity program with AMA name and logo.	PhysicianLoans Huntington Bank	06/23/2023
23155	AMBOSS Student & Resident Member Benefit – Program for test prep discounts with AMA name and logo.	AMBOSS	06/29/2023
23376	ClassPass Member Benefit – Program for discounts on fitness classes with AMA name and logo.	ClassPass	06/30/2023
23161	Headspace Member Benefit – New member incentive for discounts on meditation app with AMA name and logo.	Headspace	06/30/2023
24014	UptoDate, Inc. Member Benefit – Program for discounts on software with AMA name and logo.	UptoDate, Inc	09/07/2023

BUSINESS ARRANGEMENTS/LICENSING PROGRAMS

<u>Project Number</u>	<u>Project Description</u>	<u>Corporations</u>	<u>Approval Date</u>
22809	Teton Data Systems - Licensing agreement for AMA content to be available through online reference service.	Teton Data Systems - Stat!Ref Online	05/15/2023
22944	KnowledgeWorks Global PubFactory - Licensing agreement for AMA content to be available through online reference service with AMA and AMA Guides names and logos.	KnowledgeWorks Global PubFactory	06/02/2023
23419	LexisNexis - AMA Guides Content Integration - Licensing agreement for AMA content to be available through online reference service with AMA and AMA Guides names and logos.	LexisNexis	06/29/2023
23827	JAMA Network Content - Licensing agreement for JAMA Network content to be available through online reference services with AMA name and logo.	Dot Lib Information, LLC Scite Inc Scholarly Network Security Initiative	07/31/2023
24369	JAMA Network Worldwide – Update to licensing agreements for AMA and JAMA Network content to be available through online reference services with JAMA Network name and logo.	Accucoms Inc Cactus CPL Data Licensing Alliance Inc USACO Corporation Nankodo Inc iGroup Asia Pacific Limited PSI IPV Limited Reprints Desk	09/26/2023

AMA FOUNDATION

AMA Foundation Corporate Donors – AMAF name and logo association with 2023 corporate donors.

AbbVie
Amgen
Boehringer-Ingelheim
Bristol-Myers Squibb
Daiichi Sankyo
Eli Lilly
Genentech
GlaxoSmithKline
Henry Schein
Merck
Novartis Pharmaceuticals
Novo Nordisk
Pfizer
PhRMA
Sanofi

05/03/2023

REPORT OF THE BOARD OF TRUSTEES

B of T Report 06-A-24

Subject: Redefining AMA’s Position on ACA and Health Care Reform

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

1 INTRODUCTION

2
3 At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy
4 D-165.938, “Redefining AMA’s Position on ACA and Health Care Reform,” which calls on our
5 American Medical Association (AMA) to “develop a policy statement clearly outlining this
6 organization’s policies” on several specific issues related to the Affordable Care Act (ACA) as well
7 as repealing the Sustainable Growth Rate (SGR) and the Independent Payment Advisory Board
8 (IPAB). The adopted policy also calls for our AMA to report back at each meeting of the HOD.
9 Board of Trustees Report 6-I-13, “Redefining AMA’s Position on ACA and Health Care Reform,”
10 accomplished the original intent of the policy. This report serves as an update on the issues and
11 related developments occurring since the most recent meeting of the HOD.
12

13 IMPROVING THE AFFORDABLE CARE ACT

14
15 The AMA continues to engage policymakers and advocate for meaningful, affordable health care
16 for all Americans to improve the health of our nation. The AMA remains committed to the goal of
17 universal coverage, which includes protecting coverage for the now more than 20 million
18 Americans who have acquired it through the ACA. The AMA has been working to fix the current
19 system by advancing solutions that make coverage more affordable and expanding the system’s
20 reach to Americans who fall within its gaps. The AMA also remains committed to improving
21 health care access so that patients receive timely, high-quality care, preventive services,
22 medications, and other necessary treatments.
23

24 The AMA continues to advocate for policies that would allow patients and physicians to be able to
25 choose from a range of public and private coverage options with the goal of providing coverage to
26 all Americans. Specifically, the AMA has been working with Congress, the Administration, and
27 states to advance the AMA plan to cover the uninsured and improve affordability as included in the
28 “2022 and Beyond: AMA’s Plan to Cover the Uninsured.” The COVID-19 pandemic initially led
29 to many people losing their employer-based health insurance. This only increased the need for
30 significant improvements to the ACA. Subsequent data indicated that the uninsured rate eventually
31 decreased during the COVID-19 pandemic, due to the temporary ACA improvements included in
32 the American Rescue Plan Act, continuous Medicaid enrollment, and state Medicaid expansions.
33

34 The AMA also continues to examine the pros and cons of a broad array of approaches to achieve
35 universal coverage as the policy debate evolves.
36

37 *The AMA has been advocating for the following policy provisions:*

38
39 Cover Uninsured Eligible for ACA’s Premium Tax Credits

- 1 • The AMA advocates for increasing the generosity of premium tax credits to improve
2 premium affordability and incentivize tax credit eligible individuals to get covered.
3 Currently, eligible individuals and families with incomes between 100 and 400 percent
4 federal poverty level (FPL) (133 and 400 percent in Medicaid expansion states) are being
5 provided with refundable and advanceable premium tax credits to purchase coverage on
6 health insurance exchanges.
- 7 • The AMA has been advocating for enhanced premium tax credits for young adults. In
8 order to improve insurance take-up rates among young adults and help balance the
9 individual health insurance market risk pool, young adults ages 19 to 30 who are eligible
10 for advance premium tax credits could be provided with “enhanced” premium tax credits—
11 such as an additional \$50 per month—while maintaining the current premium tax credit
12 structure that is inversely related to income, as well as the current 3:1 age rating ratio.
- 13 • The AMA is also advocating for an expansion of the eligibility for and increasing the size
14 of cost-sharing reductions. Currently, individuals and families with incomes between 100
15 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states)
16 also qualify for cost-sharing subsidies if they select a silver plan, which leads to lower
17 deductibles, out-of-pocket maximums, copayments, and other cost-sharing amounts.
18 Extending eligibility for cost-sharing reductions beyond 250 percent FPL, and increasing
19 the size of cost-sharing reductions, would lessen the cost-sharing burdens many individuals
20 face, which impact their ability to access and afford the care they need.

21 Cover Uninsured Eligible for Medicaid or Children’s Health Insurance Program

22 Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for
23 Medicaid or the Children’s Health Insurance Program (CHIP). Reasons for this population
24 remaining uninsured include lack of awareness of eligibility or assistance in enrollment.
25

- 26 • The AMA has been advocating for increasing and improving Medicaid/CHIP outreach and
27 enrollment, including auto enrollment.
- 28 • The AMA has been opposing efforts to establish Medicaid work requirements. The AMA
29 believes that Medicaid work requirements would negatively affect access to care and lead
30 to significant negative consequences for individuals’ health and well-being.
31

32 Make Coverage More Affordable for People Not Eligible for ACA’s Premium Tax Credits

33 Before the COVID-19 pandemic, in 2018, 5.7 million of the nonelderly uninsured were ineligible
34 for financial assistance under the ACA, either due to their income, or because they have an offer of
35 “affordable” employer-sponsored health insurance coverage. Without the assistance provided by
36 ACA’s premium tax credits, this population can continue to face unaffordable premiums and
37 remain uninsured.
38

- 39 • The AMA advocates for eliminating the subsidy “cliff,” thereby expanding eligibility for
40 premium tax credits beyond 400 percent FPL.
 - 41 • The AMA has been advocating for the establishment of a permanent federal reinsurance
42 program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance
43 plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher
44 premiums across the board in anticipation of higher-risk people enrolling in coverage.
45 Section 1332 waivers have also been approved to provide funding for state reinsurance
46 programs.
47
- 48
- 49

- 1 • The AMA also is advocating for lowering the threshold that determines whether an
2 employee’s premium contribution is “affordable,” allowing more employees to become
3 eligible for premium tax credits to purchase marketplace coverage.
- 4 • The AMA strongly advocated for the Internal Revenue Service regulation that was
5 proposed on April 7, 2022 to fix the so-called “family glitch” under the ACA, whereby
6 families of workers remain ineligible for subsidized ACA marketplace coverage even
7 though they face unaffordable premiums for health insurance coverage offered through
8 employers. The Biden Administration finalized the proposed rule on October 13, 2022. The
9 regulation resolved the family glitch by extending eligibility for ACA financial assistance
10 to only the family members of workers who are not offered affordable job-based family
11 coverage.

12 13 EXPAND MEDICAID TO COVER MORE PEOPLE

14
15 Before the COVID-19 pandemic, in 2018, 2.3 million of the nonelderly uninsured found
16 themselves in the coverage gap—not eligible for Medicaid, and not eligible for tax credits because
17 they reside in states that did not expand Medicaid. Without access to Medicaid, these individuals
18 do not have a pathway to affordable coverage.

19 The AMA has been encouraging all states to expand Medicaid eligibility to 133 percent FPL.

20
21 Policy adopted by the AMA HOD during the November 2021 Special Meeting seeks to assist more
22 than two million nonelderly uninsured individuals who fall into the “coverage gap” in states that
23 have not expanded Medicaid—those with incomes above Medicaid eligibility limits but below the
24 FPL, which is the lower limit for premium tax credit eligibility. The new AMA policy maintains
25 that coverage should be extended to these individuals at little or no cost, and further specifies that
26 states that have already expanded Medicaid coverage should receive additional incentives to
27 maintain that status going forward.

28 29 30 AMERICAN RESCUE PLAN OF 2021

31
32 On March 11, 2021, President Biden signed into law the American Rescue Plan (ARPA) of 2021.
33 This legislation included the following ACA-related provisions that:

- 34
35 • Provided a temporary (two-year) five percent increase in the Federal Medical Assistance
36 Percentage (FMAP) for Medicaid to states that enact the Affordable Care Act’s Medicaid
37 expansion and covered the new enrollment period per requirements of the ACA.
- 38 • Invested nearly \$35 billion in premium subsidy increases for those who buy coverage on
39 the ACA marketplace.
- 40 • Expanded the availability of ACA advanced premium tax credits (APTCs) to individuals
41 whose income is above 400 percent of the FPL for 2021 and 2022.
- 42 • Gave an option for states to provide 12-month postpartum coverage under State Medicaid
43 and CHIP.

44
45 ARPA represents the largest coverage expansion since the ACA. Under the ACA, eligible
46 individuals, and families with incomes between 100 and 400 percent of the FPL (between 133 and
47 400 percent FPL in Medicaid expansion states) have been provided with refundable and
48 advanceable premium credits that are inversely related to income to purchase coverage on health
49 insurance exchanges. However, consistent with Policy H-165.824, “Improving Affordability in the
50 Health Insurance Exchanges,” ARPA eliminated ACA’s subsidy “cliff” for 2021 and 2022. As a

1 result, individuals and families with incomes above 400 percent FPL (\$51,520 for an individual
2 and \$106,000 for a family of four based on 2021 federal poverty guidelines) are eligible for
3 premium tax credit assistance. Individuals eligible for premium tax credits include individuals who
4 are offered an employer plan that does not have an actuarial value of at least 60 percent or if the
5 employee share of the premium exceeds 9.83 percent of income in 2021.

6
7 Consistent with Policy H-165.824, ARPA also increased the generosity of premium tax credits for
8 two years, lowering the cap on the percentage of income individuals are required to pay for
9 premiums of the benchmark (second lowest-cost silver) plan. Premiums of the second lowest-cost
10 silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of
11 their income. Notably, resulting from the changes, eligible individuals and families with incomes
12 between 100 and 150 percent of the FPL (133 percent and 150 percent FPL in Medicaid expansion
13 states) qualified for zero-premium silver plans, effective until the end of 2022.

14
15 In addition, individuals and families with incomes between 100 and 250 percent FPL (between 133
16 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they
17 select a silver plan, which reduces their deductibles, out-of-pocket maximums, copayments, and
18 other cost-sharing amounts.

19 20 LEGISLATIVE EXTENSION OF ARPA PROVISIONS

21
22 On August 16, 2022, President Biden signed into law the Inflation Reduction Act of 2022 through
23 the highly partisan budget reconciliation process, which allows both the House and Senate to pass
24 the bill with limits on procedural delays. Most significantly, reconciliation allows the Senate to
25 bypass the filibuster and pass legislation with a 50-vote threshold so long as it meets a series of
26 budgetary requirements. The Inflation Reduction Act included provisions that extended for three
27 years to 2025 the aforementioned ACA premium subsidies authorized in ARPA.

28
29 The Inflation Reduction Act did not include provisions to close the Medicaid “coverage gap” in the
30 states that have not chosen to expand.

31 32 ACA ENROLLMENT

33
34 According to the U.S. Department of Health and Human Services (HHS), 21.3 million people
35 selected an Affordable Care Act Health Insurance Marketplace plan during the 2024 Open
36 Enrollment Period. Total plan selections include more than five million people—about a fourth—
37 who are new to the Marketplaces and 16 million people who renewed their coverage.

38 39 CONTINUOUS MEDICAID ENROLLMENT

40
41 During the COVID-19 pandemic, the Families First Coronavirus Response Act required states to
42 provide continuous coverage to nearly all Medicaid/CHIP enrollees as a condition of receiving a
43 temporary federal medical assistance percentage (FMAP) increase. With disenrollments frozen,
44 churn out of the program effectively ceased and enrollment increased nationally by 35 percent,
45 from 70,875,069 in February 2020 to 93,876,834 in March 2023, after which the continuous
46 enrollment requirement was lifted. Most of this growth was in the Medicaid program, which
47 increased by 22,634,781 individuals (35.3 percent), while CHIP enrollment increased during this
48 period by 366,984 individuals (5.4 percent). The Consolidated Appropriations Act of 2023 (CAA),
49 which was signed into law in December 2022, established March 31, 2023, as the end date for the
50 Medicaid continuous enrollment requirement and phased down the enhanced FMAP amount
51 through December 2023.

1 The CAA established new requirements that states must meet to receive the phased-down FMAP
2 increase and gave CMS authority to require states to submit monthly unwinding data, such as the
3 number of people whose coverage was terminated, the number of those terminated based on
4 eligibility criteria versus for procedural reasons, plus call center volume and wait times. The CAA
5 also authorized several enforcement mechanisms including corrective action plans, financial
6 penalties, and requiring states to temporarily pause terminations.

7
8 The AMA continues to advocate that CMS ensure that states are maintaining Medicaid rate
9 structures at levels that ensure sufficient physician participation, so that Medicaid patients can
10 access appropriate, necessary care, including specialty and behavioral health services, in a timely
11 manner and within a reasonable distance to where they live.

12 13 SGR REPEAL

14
15 The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealing and replacing
16 the SGR was signed into law by President Obama on April 16, 2015.

17
18 The AMA is now working on unrelated new Medicare payment reduction threats and is currently
19 advocating for a sustainable, inflation-based, automatic positive update system for physicians.

20 21 INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

22
23 The Bipartisan Budget Act of 2018 signed into law by President Trump on February 9, 2018,
24 included provisions repealing the Independent Payment Advisory Board (IPAB). Currently, there
25 are not any legislative efforts in Congress to replace the IPAB.

26 27 CONCLUSION

28
29 Our AMA will remain engaged in efforts to improve the health care system through policies
30 outlined in Policy D-165.938 and other directives of the HOD. Given that most of the ACA fixes
31 that led to calls in 2013 for this report at every HOD meeting have been accomplished, our primary
32 goal now related to health care reform is stabilization of the broken Medicare physician payment
33 system, including the need for inflation-based positive annual updates and reform of budget
34 neutrality rules.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 07-A-24

Subject: AMA Performance, Activities, and Status in 2023

Presented by: Willie Underwood III, MSc, MPH, MD, Chair

1 Policy G-605.050, “Annual Reporting Responsibilities of the AMA Board of Trustees,” calls for
2 the Board of Trustees to submit a report at the American Medical Association (AMA) Annual
3 Meeting each year summarizing AMA performance, activities, and status for the prior year.
4

5 INTRODUCTION 6

7 The AMA’s mission is to promote the art and science of medicine and the betterment of public
8 health. As the physician organization whose reach and depth extend across all physicians, as well
9 as policymakers, medical schools, and health care leaders, the AMA uniquely can deliver results
10 and initiatives that enable physicians to improve the health of the nation.
11

12 *Representing physicians with a unified voice* 13

14 If the last few years have taught us anything it is that threats to the practice of medicine can come
15 unexpectedly and from many fronts. In 2023 the AMA vigorously defended physicians and
16 medicine in state and federal courts on a variety of issues threatening physicians and their patients.
17 The AMA, in partnership with state medical associations and national medical specialty societies,
18 won more than 100 state-level scope of practice cases.
19

20 Through research, advocacy and education, the AMA continued to defend the practice of medicine
21 against scope of practice expansions that threaten patient safety. We promoted physician-led care
22 and helped defeat legislation across the country that would have allowed:
23

- 24 • Physician assistants to practice independently without physician oversight
- 25 • Pharmacists to prescribe medications
- 26 • Optometrists to perform surgery
- 27 • Scope of practice expansion for nurse practitioners and other APRNs
28

29 The AMA facilitated 226,000+ contacts to Congress from patients and physicians as part of our
30 FixMedicareNow.org grassroots campaign. To ensure more transparency in health care, the AMA
31 worked with multiple state medical associations to introduce new or strengthen existing “Truth in
32 Advertising” laws so that patients know if the person providing care to them is a physician—or not.
33 Georgia and North Dakota enacted laws in 2023.
34

35 AMA’s critical voice was represented in federal and state courts around the country on a broad
36 range of issues, including in several cases before the U.S. Supreme Court. The AMA filed
37 amicus briefs in: *Braidwood Management v. Becerra*, *Alliance for Hippocratic Medicine v. FDA*,
38 and *Murthy v. Missouri*. Working with state and federal policymakers, the AMA continued to
39 oppose legislation and laws that interfere with the practice of medicine, including in cases where
40 physicians face criminal, civil, or administrative penalties for providing necessary care. In cases

1 ranging from surprise billing, to firearm regulations to scope of practice, the AMA has aggressively
2 fought back to protect physicians.

3
4 The AMA elevated the voice of physician leadership on critical issues of public health, securing
5 more than 100 press releases, 125 billion media impressions representing nearly \$1.2 billion in
6 estimated ad value, achieving a commanding voice among healthcare entities in the media.

7
8 *Removing obstacles that interfere with patient care*

9
10 Physician burnout remains an ongoing epidemic in the U.S. and the AMA is fiercely committed to
11 understanding the challenges physicians face and to restoring their well-being and optimism. We
12 know that reducing burnout and promoting physician well-being are inextricably linked to the
13 delivery of high-quality patient care and health system sustainability.

14
15 The AMA pushed forward in tackling the causes of burnout and in developing effective research
16 and resources needed to help physicians achieve improved satisfaction and joy in their work. AMA
17 published more than 25 peer-reviewed studies and over 2,000,000 users accessed the AMA STEPS
18 Forward® program to prevent burnout and improve patient care and practice efficiency. AMA
19 provided over 100 new or updated AMA STEPS Forward® resources – including toolkits,
20 webinars, podcast episodes, and the new Wellness-Centered Leadership Playbook. AMA co-
21 sponsored the 2023 American Conference on Physician Health with Stanford Medicine and Mayo
22 Clinic in Palm Desert, California for over 600 attendees.

23
24 The AMA continued to expand its work in promoting physician wellness through its Joy in
25 Medicine™ Health System Recognition Program. This program is committed to advancing the
26 science of physician burnout and recognizes those systems that are dedicated to organizational
27 well-being. In 2023 the AMA recognized 72 health systems – bringing the total number of
28 recognized organizations to 96.

29
30 In 2023 the AMA worked with state medical associations across the country to enact prior
31 authorization reform using AMA model legislation, data, testimony, and other resources that
32 resulted in more than 30 states introducing legislation - and at least nine new states enacting prior
33 authorization laws including AK, DC, IN, LA, MT, ND, NJ, RI, TN, and WA.

34
35 The AMA successfully piloted VeriCre, a cross-industry collaboration to improve the complex
36 credentialing process for physicians, healthcare institutions, and health plans alike. VeriCre
37 addresses inefficiencies in credentialing by providing centralized, trusted, and authoritative data
38 that can be used to pre-populate applications. VeriCre is designed to be integrated into vendor
39 software solutions within healthcare organizations.

40
41 The AMA worked to remove the barriers and end the stigma that all too frequently deters
42 physicians from getting the mental health care they need. Our work with 15 state medical boards,
43 health systems and credentialing bodies resulted in the removal of stigmatizing questions about
44 mental illness from their applications.

45
46 *Driving the future of medicine*

47
48 The AMA achieved passage of legislation to extend Medicare telehealth coverage through 2024.
49 The 2024 Medicare payment rule preserves key telehealth policies, ensuring Medicare patients
50 from all areas of the country (not only rural) will continue to receive access to telehealth.

1 The AMA advanced a conceptual model for precision medical education: a system that can
2 leverage technology and data to improve education personalization and learning efficiency across
3 the continuum, in support of students, residents, fellows, physicians, and ultimately the
4 needs of patients. Innovation Grants were awarded to 13 sites applying precision education
5 approaches in medical school, residency and continuing professional development.

6
7 The AMA ChangeMedEd® initiative and the University of Michigan developed a seven-part
8 online learning module series introducing learners to foundational principles in artificial
9 intelligence and machine-learning. The first of the series, Introduction to Artificial Intelligence
10 (AI) in Health Care, launched on October 31 and was highlighted in a plenary session at the
11 Association of American Medical Colleges Learn Serve Lead annual conference, spurring over
12 1600 page views and 65 course completions within the month of November alone.

13
14 AMA's influence continues through the Health Systems Science Scholars Program and the
15 Coaching Implementation Workshop, with each program now having trained over 200 faculty
16 members from across the US to advance these innovations in medical schools and residency
17 programs.

18
19 AMA Ed Hub™ continued to expand its educational offering by signing on 14 new partners in
20 2023 - bringing the total number of partners to 50. The new partners include: American
21 Association for Physician Leadership; American College of Occupational and Environmental
22 Medicine; American College of Osteopathic Family Physicians; American Thoracic Surgery;
23 Boston University; Docs with Disabilities; Endocrine Society; Mary Ann Liebert Publishers;
24 Michigan State University; Parkinson's Foundation; Society of Critical Care Medicine; Radiology
25 Health Equity Coalition; University of California, San Francisco, and Altarum Institute - National
26 Coalition for Sexual Health.

27
28 AMA Ed Hub™, in collaboration with Advocacy and Health Science & Ethics, rapidly delivered
29 an educational offering to help physicians and clinicians meet new DEA requirements on substance
30 use disorders and addiction. Including education from the AMA and their partners, this offering
31 was deployed within 24 hours of the new regulation issuance and significantly contributed to
32 increased AMA Ed Hub™ engagement.

33
34 To better meet the needs of academic researchers, *JAMA*® optimized the publication pathway by
35 promising to move accepted manuscripts to publication within four weeks of submission for select
36 manuscripts of high importance. *JAMA*® also launched a new video and podcast series on "AI and
37 Clinical Practice" to keep physicians informed on AI's promise to transform treatment, training,
38 research and publishing. *JAMA*® hosted its first JAMA Summit™ that brought together 60 experts
39 from across the country and world to talk about why there is a big gap between the generation of
40 evidence and what physicians do in clinical practice including what could we do to make it better.

41
42 The AMA's Center for Health Equity continues to strengthen physician and health system
43 understanding and engagement around advancing equity. We launched the National Health Equity
44 Grand Rounds, engaging almost 11,000 viewers around a variety of important topics and strategies
45 to advance health equity and published 43 social justice education modules in the AMA Ed Hub™.

46
47 *Leading the charge to confront public health crises*

48
49 The AMA successfully advocated to make naloxone available over the counter and continued to
50 advocate for responsible pricing and insurance coverage for this life-saving medication. We also
51 successfully advocated for revisions to the Center for Disease Control's (CDC) opioid prescribing

1 guidelines that resulted in the CDC removing its dose and quantity thresholds for treating patients
2 with pain.

3
4 The AMA collaborated with three partners to increase access to AMA MAP™ metrics to improve
5 the quality-of-care physicians provide to their patients with hypertension. Access to the metrics
6 helps identify gaps, track progress, and support quality improvement efforts to reach approximately
7 5.5 million additional patients across 683 organizations inclusive of health systems, Federally
8 Qualified Health Centers, community health centers and medical groups.

9
10 To help close a gap in blood pressure measurement training that exists within medical schools, the
11 AMA awarded financial grants to eight academic institutions representing 18 total training
12 programs for healthcare professionals allowing them to meaningfully engage in AMA's eLearning
13 series, BP Measurement Essential: Student Edition.

14
15 The AMA's Enterprise Social Responsibility (ESR) program has strategically integrated and
16 aligned to the health equity strategic framework with the goal to reduce health inequities in
17 partnership with communities. The ESR program hosted over 30 events, supported nearly 70
18 organizations, and donated almost \$100,000 to community partners. AMA employees, representing
19 every business unit and office location, achieved 32 percent employee volunteer participation, far
20 exceeding the industry average of 20 percent, to build healthy, thriving, equitable communities.

21 *AMA Task Forces*

22
23
24 The task force to Preserve the Patient-Physician Relationship was formed and has convened. The
25 Board will submit an Informational Report at the 2024 Interim Meeting that will summarize the
26 activities of this task force that have taken place to date.

27
28 The TRHT (Truth, Racial Healing, Transformation) task force was formed and has convened. The
29 TRHT task force is on track to submit its recommendations to the AMA Board of Trustees by June
30 2025.

31
32 The Firearm Injury Prevention task force is convening and updates on its work are summarized in
33 Board of Trustees Report 22-A-24.

34
35 The Substance Use and Pain Care task force is convening and updates on its work are summarized
36 in Board of Trustees Report 22-A-24.

37
38 The Cannabis task force is convening and its work is focused on developing evidence-based
39 education for physicians.

40 *Membership*

41
42
43 Overall, the organization's advocacy efforts and mission activities were supported by another
44 strong year of financial performance. In 2023 the AMA experienced a 3.4% increase in overall
45 dues-paying membership.

46 *EVP Compensation*

47
48
49 During 2023, pursuant to his employment agreement, total cash compensation paid to James L.
50 Madara, MD, as AMA Executive Vice President was \$1,346,453 in salary and \$1,117,107 in
51 incentive compensation, reduced by \$2,680 in pre-tax deductions. Other taxable amounts per the

1 contract are as follows: \$23,484 imputed costs for life insurance, \$24,720 imputed costs for
2 executive life insurance, and \$4,000 paid for an executive physical, and \$3,000 paid for parking
3 and other. An \$81,000 contribution to a deferred compensation account was also made by the
4 AMA. This will not be taxable until vested and paid pursuant to provisions in the deferred
5 compensation agreement.

6

7 For additional information about AMA activities and accomplishments, please see the “AMA 2023
8 Annual Report.”

REPORT OF THE BOARD OF TRUSTEES

B of T Report 08-A-24

Subject: Annual Update on Activities and Progress in Tobacco Control: March 2023 through February 2024

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

1 This report summarizes trends and news on tobacco usage, policies, and tobacco control advocacy
2 activities from March 2023 through February 2024. The report is written pursuant to American
3 Medical Association (AMA) Policy D-490.983, “Annual Tobacco Report.”

4
5 TOBACCO USE AT A GLANCE

6
7 In the 1960s the adult smoking rate was at its highest at 42 percent.¹ Today that rate has been cut
8 by more than half to an all-time low in 2022 of 11 percent. Despite this decline, tobacco use
9 remains the leading cause of preventable disease, disability, and death in the United States.
10 According to the Centers for Disease Control and Prevention (CDC) cigarette smoking accounts for
11 more than 480,000 deaths every year, or about 1 in 5 deaths. More than 16 million Americans live
12 with a smoking-related disease.²

13
14 An annual review of tobacco use among adults, published in the May 5, 2023, Morbidity and
15 Mortality Weekly Report (MMWR), summarizes National Health Interview Survey (NHIS) data to
16 assess recent national estimates of commercial tobacco use among U.S. persons aged ≥18 years.
17 NHIS is an annual, nationally representative household survey of the noninstitutionalized U.S.
18 civilian population. Current smokers are defined as people who reported smoking at least 100
19 cigarettes during their lifetime and who, at the time they participated in a survey about this topic,
20 reported smoking every day or some days. This analysis found an estimated 46 million U.S. adults
21 (18.7 percent) reported currently using any tobacco product, including cigarettes (11.5 percent), e-
22 cigarettes (4.5 percent), cigars (3.5 percent), smokeless tobacco (2.1 percent), and pipes (including
23 hookah) (0.9 percent). Although cigarette smoking decreased, e-cigarette use increased, from 3.7
24 percent in 2020 to 4.5 percent in 2021, largely driven by higher prevalence in use among persons
25 aged 18–24 years.³

26
27 Nearly one in five adults who currently used tobacco products used two or more products, with
28 nearly one third of these individuals (31.4 percent) reporting use of cigarettes and e-cigarettes.
29 Dual use of tobacco products may have overlapping adverse health effects. While smoking and
30 vaping may share similar harmful cardiovascular effects, each appears to cause some potentially
31 damaging effects that the other does not. This suggests that dual product use may be more harmful
32 than using either product alone.^{3,4}

33
34 The CDC and FDA analyzed data from the 2023 National Youth Tobacco Survey (NYTS) to assess
35 tobacco product use patterns among U.S. middle school (grades 6–8) and high school (grades 9–
36 12) students. This analysis was published in the November 3, 2023, MMWR.⁵ The NYTS is a
37 cross-sectional, school-based, self-administered web-based survey of U.S. middle and high school
38 students. A stratified, three-stage cluster sampling procedure was used to generate a nationally
39 representative sample of U.S. students attending private or public middle (grades 6–8) and high

1 (grades 9–12) schools. In 2023, data were collected during March 9–June 16; a total of 22,069
2 students from 179 schools participated, with an overall response rate of 30.5 percent.

3
4 Current use of any use of any tobacco product by high school students declined by an estimated
5 540,000, from 2.51 million in 2022 to 1.97 million in 2023. Declines were also reported for current
6 e-cigarette use among high school students during that same period from 14.1 percent to 10.0
7 percent. While these declines demonstrate the effectiveness of tobacco control legislation and
8 regulations, there is still cause for concern. E-cigarette products were the most used tobacco
9 product of middle and high school students with 7.7 percent reporting current e-cigarette use
10 followed by cigarettes at 1.6 percent. Among students who had ever used an e-cigarette, 46.7
11 percent reported current use and 89.4 percent of them used flavored products and 25.2 percent used
12 an e-cigarette daily. Given the number of middle and high school students that use tobacco
13 products, sustained efforts to prevent initiation of tobacco product use among young persons and
14 strategies to help young tobacco users quit are critical to reducing U.S. youth tobacco product
15 use.**Error! Bookmark not defined.**

16 17 *Sales Use of E-Cigarettes Dominated by Flavored Products*

18
19 E-cigarette unit sales increased by 46.6 percent during January 2020–December 2022 according to
20 a study released by the truth initiative®. The study E-cigarette Unit Sales by Product and Flavor
21 Type, and Top-Selling Brands, United States, 2020–2022 was published in the June 23, 2023,
22 MMWR.⁶ From January 26, 2020, to December 25, 2022, unit shares of tobacco-flavored and
23 mint-flavored products decreased (from 28.4 percent to 20.1 percent and from 10.1 percent to 5.9
24 percent, respectively), whereas shares of other flavor sales increased (from 29.2 percent to 41.3
25 percent).⁶

26
27 The study authors also looked at types of e-cigarettes. Disposable e-cigarettes are the preferred
28 delivery device for vaped tobacco. Sales of fruit- and mint-flavored disposable products saw a
29 significant rise compared to refillable cartridge devices. During the study period, January 2020–
30 December 2022, sales of prefilled cartridges decreased from 75.2 percent to 48.0 percent, and
31 disposable e-cigarette sales increased from 24.7 percent to 51.8 percent. The authors attributed this
32 to an announcement in January 2020 by the U.S. Food and Drug Administration (FDA) that the
33 agency would prioritize enforcement against prefilled e-cigarettes in flavors other than tobacco and
34 menthol based on the prevalence of use of these products by youth.

35
36 In the United States, the prevalence of e-cigarette use is markedly higher among youths and young
37 adults than it is among adults overall. In 2021, 4.5 percent of all adults aged ≥ 18 years (an
38 estimated 11.1 million) and 11.0 percent of young adults aged 18–24 years (an estimated 3.1
39 million) currently (≥ 1 day during the previous 30 days) used e-cigarettes; during 2022, 14.1 percent
40 of high school students (an estimated 2.14 million) currently used e-cigarettes. The unit share of
41 menthol-flavored product sales remained relatively stable, while non-menthol flavor unit shares
42 changed.⁶

43 44 EFFORTS TO ADDRESS TOBACCO CONTROL

45 46 *AMA Litigation Center joins with public health groups to protect tobacco regulation*

47
48 In the courts, the AMA has continued to be very active in supporting efforts to further regulate and
49 limit tobacco products and electronic nicotine delivery systems (ENDS). The AMA has joined
50 numerous amicus briefs around the country in cases involving the federal government’s efforts to
51 regulate and remove flavored ENDS from the market, which have contributed to favorable

1 outcomes in several federal circuit courts. In addition, the AMA has supported state and local
2 governments with friend-of-the-court briefs after their laws banning flavored tobacco products and
3 ENDS have been challenged by the tobacco and vaping industry. Finally, the AMA continues to
4 monitor the federal government's efforts to eliminate the manufacture and sale of tobacco products
5 with characterizing flavors, including menthol, as the AMA was one of the named plaintiffs in a
6 lawsuit requiring the FDA to take long-overdue action on this issue.

7
8 The AMA Litigation Center joined amicus briefs in Oregon supporting the ability of two counties
9 to regulate flavored tobacco products beyond the state-level restrictions. The court cases centered
10 on whether a county ordinance banning the sale of flavored tobacco products conflicts with a state
11 law regulating the sale of tobacco and nicotine. One of the counties received a favorable ruling, and
12 the other matter remains pending.

13
14 The Litigation Center also joined an amicus brief supporting the use of graphic warnings on
15 tobacco products. The issue in *R.J. Reynolds v. FDA* is whether an FDA rule regarding graphic
16 warnings on cigarettes is lawful. That case remains pending.

17
18 *AMA urged the FDA to investigate violations of federal law in California*

19
20 In December 2022 California's law prohibiting the sales of menthol cigarettes and other flavored
21 tobacco products prevailed despite legal challenges. California became the largest state in the
22 country banning these products and became the target for release of new products designed to
23 circumvent the law. R.J. Reynolds announced two new brands, Camel Crisp Non-Menthol and
24 Camel Crush Oasis Non-Menthol Capsule.

25
26 The Tobacco Control Act, which gives the FDA authority to regulate the tobacco industry prohibits
27 the introduction of new products that have not undergone remarket review by the FDA. The
28 introduction and marketing of the R.J. Reynolds products and others as "substitutes" for menthol
29 cigarettes rather than "new" products suggests that the industry believes it has found a loophole.

30
31 In March 2023 the AMA joined by other medical, public health and community organizations
32 urged the FDA to use its authority and begin an investigation.

33
34 *Helping Tobacco Users Quit Act would expand and ensure cessation coverage*

35
36 In July 2023 Congresswoman Lisa Blunt Rochester (D-Del.) and Congressman Brian Fitzpatrick
37 (R-Penn.) introduced the Helping Tobacco Users Quit Act. This bi-partisan bill, supported by the
38 AMA, calls for expanded comprehensive Medicaid tobacco cessation coverage in every state with
39 no cost-sharing or access barriers for beneficiaries. The bill would also help states conduct outreach
40 campaigns to educate providers and beneficiaries about Medicaid's coverage of cessation services.

41
42 The bill was referred to the House Energy and Commerce Subcommittee on Health waiting for a
43 hearing and further consideration. Medicaid enrollees smoke at twice the rate of those with private
44 insurance, meaning that expanding cessation coverage in Medicaid would improve health outcomes
45 while lowering government spending.⁷

46
47 *American Lung Association Releases its 2024 State of Tobacco Report*

48
49 The American Lung Association's 2024 "State of Tobacco Control" report reveals the continued
50 impact of tobacco use, including menthol cigarettes, on individuals and families across the country,
51 and underscores the urgent need for the White House to finalize the rules to end the sale of menthol

1 cigarettes and flavored cigars to save lives.⁸ The report highlighted the tobacco industry and its
2 allies' influence to successfully convince the White House to delay finalizing the menthol
3 cigarettes and flavored cigars rules.

4 Since the 1950s, Black individuals have been successfully targeted by aggressive marketing
5 campaigns. According to a study in the 2023 April issue of *Nicotine & Tobacco Research*, an
6 estimated 80 percent of Black individuals in the U.S. who smoke prefer menthol cigarettes. The
7 authors also noted that target marketing was having an impact on Hispanic adults. During the study
8 period the use of menthol went from 34 percent in 2008 to 51 percent in 2020.⁹

9
10 At the local level, Chicago, IL and Milwaukee, WI were highlighted in the report for actions taken
11 to restrict where new tobacco retailers can locate. This legislative action takes aim at the increased
12 concentration of tobacco product retailers in low-income neighborhoods.

¹ Giovino GA, Schooley MW, Zhu BP, Chrismon JH, Tomar SL, Peddicord JP, et al. Surveillance for Selected Tobacco-Use Behaviors - United States, 1900–1994. Centers for Disease Control and Prevention. CDC Surveillance Summaries, 1994. MMWR. 1994;43(SS-3):1–50

² https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm (accessed February 19, 2024)

³ Cornelius, M. E., Loretan, C. G., Jamal, A., Davis Lynn, B. C., Mayer, M., Alcantara, I. C., & Neff, L. (2023). Tobacco product use among adults – United States, 2021. *MMWR. Morbidity and Mortality Weekly Report*, 72(18), 475–483. <https://doi.org/10.15585/mmwr.mm7218a1>

⁴ Mohammadi, L., Han, D. D., Xu, F., Huang, A., Derakhshandeh, R., Rao, P., Whitlatch, A., Cheng, J., Keith, R. J., Hamburg, N. M., Ganz, P., Hellman, J., Schick, S. F., & Springer, M. L. (2022). Chronic e-cigarette use impairs endothelial function on the physiological and cellular levels. *Arteriosclerosis, Thrombosis, and Vascular Biology*, 2022;42(11), 1333–1350. <https://doi.org/10.1161/atvbaha.121.317749>

⁵ Birdsey, J., Cornelius, M., Jamal, A., Park-Lee, E., Cooper, M. R., Wang, J., Sawdey, M. D., Cullen, K. A., & Neff, L. (2023). Tobacco product use among U.S. middle and high school students — National Youth Tobacco Survey, 2023. *MMWR. Morbidity and Mortality Weekly Report*, 72(44), 1173–1182. <https://doi.org/10.15585/mmwr.mm7244a1>

⁶ Ali, F. R., Seidenberg, A. B., Crane, E., Seaman, E., Tynan, M. A., & Marynak, K. (2023). E-cigarette unit sales by product and flavor type, and top-selling brands, United States, 2020–2022. *MMWR. Morbidity and Mortality Weekly Report*, 72(25), 672–677. <https://doi.org/10.15585/mmwr.mm7225a1>

⁷ Creamer MR, Wang TW, Babb S, Cullen KA, Day H, Willis G, Jamal A, Neff L. Tobacco product use and cessation indicators among adults—United States, 2018. [PDF – 219 KB] *MMWR Morb Mortal Wkly Rep* 2019;68:1013-1019

⁸ <https://www.lung.org/research/sotc> (accessed February 22, 2024)

⁹ Renee D Goodwin, Ollie Ganz, Andrea H Weinberger, Philip H Smith, Katarzyna Wyka, Cristine D Delnevo, Menthol Cigarette Use Among Adults Who Smoke Cigarettes, 2008–2020: Rapid Growth and Widening Inequities in the United States, *Nicotine & Tobacco Research*, Volume 25, Issue 4, April 2023, Pages 692–698, <https://doi.org/10.1093/ntr/ntac214>

REPORT 10 OF THE BOARD OF TRUSTEES (A-24)
American Medical Association Health Equity Annual Report
(Informational)

EXECUTIVE SUMMARY

Background: At the 2018 Annual Meeting, the House of Delegates adopted the recommendations of Policy D-180.981 directing our AMA to “develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities” and instructing the “Board to provide an annual report to the House of Delegates regarding AMA’s health equity activities and achievements.” The HOD provided additional guidance via Policy H-180.944: “Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.” HOD policy was followed by creation of the AMA Center for Health Equity (“Center”) in April 2019, the AMA’s Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity for 2021-2023 (“Plan”) in May 2021, and the successor 2024-2025 Plan in June 2024. In 2022, updated Policy H-65.946 specified that this report will also include “updates on [the AMA’s] comprehensive diversity and inclusion strategy.”

Discussion: The AMA has steadfastly enhanced efforts over recent years to further embed equity in our work. The Plan serves as a guide for this work. This report outlines the activities conducted by our AMA during calendar year 2023, divided into the five (5) strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3) Ensure Equity in Innovation; (4) Push Upstream; and (5) Foster Truth, Reconciliation, and Racial Healing. The diversity and inclusion strategy updates are included within the Embed Equity section.

Conclusion: This report captures only a fraction of the work accomplished and lessons learned in 2023. AMA staff have devoted time and resources to collaboratively advancing equity within and outside the organization. AMA continues in its quest to advance health equity and embed racial and social justice, making significant progress towards fulfilling its commitments outlined in its Strategic Plan.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-A-24

Subject: American Medical Association Health Equity Annual Report

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

1 BACKGROUND

2

3 At the 2018 Annual Meeting, the House of Delegates adopted Policy D-180.981, directing our American
4 Medical Association (AMA) to “develop an organizational unit, e.g., a Center or its equivalent, to
5 facilitate, coordinate, initiate, and track AMA health equity activities” and instructing the “Board to
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7 achievements.” The HOD provided additional guidance via Policy H-180.944: “Health equity, defined as
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13 (“Plan”) in May 2021, and the successor 2024-2025 Plan in June 2024. In 2022, updated Policy H-65.946
14 specified that this report will also include “updates on [the AMA’s] comprehensive diversity and
15 inclusion strategy.”

16

17 DISCUSSION

18

19 Our AMA has committed itself to advancing health equity, advocating for racial and social justice, and
20 embedding equity across the organization and beyond. In 2023, the Center continued to collect enterprise-
21 wide equity related work and track progress toward the five strategic approaches detailed in the AMA’s
22 Plan. This report outlines the activities conducted by our AMA during calendar year 2023, divided into
23 five strategic approaches detailed in the Plan: (1) Embed Equity; (2) Build Alliances and Share Power; (3)
24 Ensure Equity in Innovation; (4) Push Upstream; and (5) Foster Truth, Reconciliation, and Racial
25 Healing. Updates on diversity and inclusion strategy updates are included within the Embed Equity
26 section.

27

28 *Embed Equity*

29

30 Ensuring a lasting commitment to health equity by our AMA involves embedding equity using anti-
31 racism, structural competency, and trauma-informed lenses as a foundation for transforming the AMA’s
32 staff and broader culture, systems, policies, and practices, including training, tools, recruitment and
33 retention, contracts, budgeting, communications, publishing, and regular assessment of organizational
34 change. The following are some of the relevant accomplishments during 2023:

35

- 36 • At the 2023 Annual and Interim House of Delegates Meetings, there were various equity-focused
37 reports, resolutions, and educational sessions. The adopted Council on Ethical & Judicial Affairs
38 (CEJA) Report on “[Responsibilities to Promote Equitable Care](#)” will be added to the AMA *Code*
39 *of Medical Ethics*. Other notable reports included: [Ensuring Equity in Interview Processes for](#)

1 [Entry to Undergraduate and Graduate Medical Education](#), [Decreasing Bias in Assessments of](#)
 2 [Medical Student Clinical Clerkship](#), [Support Removal of BMI as a Standard Measure in](#)
 3 [Medicine](#), [Leave Policies for Medical Students, Residents, Fellows, and Physicians](#), [Financial](#)
 4 [Burdens and Exam Fees for International Medical Graduates](#), [Challenges to Primary Source](#)
 5 [Verification of International Medical Graduates Resulting from International Conflict](#), [Federally](#)
 6 [Qualified Health Centers and Rural Health Care](#), and [Medicaid Unwinding Update](#). The Council
 7 on Science and Public Health (CSAPH) and National Academy of Medicine (NAM) co-hosted an
 8 educational session at the Interim Meeting on climate crisis and health care decarbonization.
 9 Health Equity Open Fora were held at the Annual Meeting, highlighting the [Rise to Health](#)
 10 [Coalition](#), [LGBTQ leadership](#), and [truth and reconciliation](#), and the Interim Meeting, focused on
 11 the [Health Equity in Organized Medicine survey report](#) and the next Equity Strategic Plan. Each
 12 forum had over 300 individuals in attendance.

- 13 • AMA strives toward the enterprise’s goal to raise its visibility in health equity and demonstrate its
 14 commitment to institutional and community partners. Website traffic related to health equity
 15 search was roughly 730,000 users. AMA published 127 news articles with health equity focus,
 16 representing 15 percent of its total production from the news team. Membership from users
 17 consuming health equity content increased 25 percent and referrals to health equity modules on
 18 Ed Hub from the AMA website increased 24 percent compared to the previous year. AMA update
 19 podcast downloads featuring health equity discussions increased 50 percent compared to the
 20 previous year, including more than 1,200 downloads. Approximately 15,000 learners completed
 21 AMA health equity courses for graduate and undergraduate medical education competency
 22 education programs (GCEP and UCEP). Major 2023 health equity announcements included the
 23 [Rise to Health Coalition](#) and the launch of the AMA’s Truth, Reconciliation, Healing and
 24 Transformation (TRHT) taskforce initiative.
 - 25 ○ The Council of Science and Public Health (CSAPH) presented a report on equity in
 26 precision medicine, with a four-episode podcast series in development for release in
 27 2024.
 - 28 ○ To support reimagining the future of health equity and racial justice in medical education
 29 and improving the diversity of the health workforce, as directed by the [Council on](#)
 30 [Medical Education's Report 5](#) from June 2021, our AMA externally commissioned a
 31 diverse group of subject matter experts as editors who announced a call for authors,
 32 receiving over 150 submissions. Over 60 abstracts were published by the AMA in the
 33 compendium *MedEd’s horizon: Just, merciful, diverse and equitable*. The final forward-
 34 looking study with recommendations for action will be a book with approximately 18
 35 chapters entitled *Reimagining Medical Education*, to be published by Elsevier in 2024,
 36 and intended for medical school and health system leaders, medical educators in
 37 undergraduate and graduate medical education (UME and GME), policy makers, change
 38 agents, and advocates.
 - 39 ○ *AMA Journal of Ethics* published [four health equity-centered issues in 2023](#): Segregation
 40 in Health Care, Patient-Centered Transgender Surgical Care, How We Over Rely on BMI
 41 and Palliative Psychiatry, with the first issue including an article led by AMA staff:
 42 [Training to Build Antiracist, Equitable Health Care Systems](#).
 - 43 ○ To help embed equity within public health, the AMA published, in collaboration with the
 44 U.S. Centers for Disease Control and Prevention’s (CDC) Project Firstline, 12 episodes
 45 of the [Stories of Care](#) podcast about health care equity and infection control, including:
 46 [Race, Research, and Health Care Associated Infections](#), [Fighting Ableism: What Do You](#)
 47 [Need?](#), and [Fighting Stigmas Associated With Infectious Diseases](#). Through October
 48 2023, the Stories of Care podcast had a total of 1,311 downloads and 701 continuing
 49 medical education (CME) completions.
 - 50 ○ The AMA continues to partner with the CDC and the Ad Council to encourage the
 51 public, with an emphasis on Black and Latinx/Hispanic audiences, to get vaccinated

1 against influenza (flu). The donated media value for the most recent flu season was about
2 \$4.8 million. The public service announcement (as of October 2023) reached 53 percent
3 among Black and 48 percent among Hispanic respondents. We held two media tours in
4 2023, both in English and Spanish, with spokespeople from AMA and CDC securing
5 nearly 400 placements across TV, radio, and digital.

- 6 ○ The AMA published playbooks and other educational resources for physicians, practices,
7 physician provider organizations, and health systems: as part of STEPS Forward,
8 [Wellness-Centered Leadership](#) with a chapter on Racial and Health Equity; and with
9 America's Health Insurance Plans (AHIP) and National Association of Accountable Care
10 Organizations [The Future of Sustainable Value-Based Payment: Voluntary Best Practices](#)
11 [to Advance Data Sharing](#), incorporating the promotion of health equity as a key cross-
12 cutting issue (particularly related to health-related social needs) and establishing a
13 specific “best practice category” focused on health equity (“Improve Data Collection and
14 Use to Advance Health Equity”). Additionally, AMA STEPS Forward published a
15 toolkit, [Collective Trauma: Respond Effectively as an Organization](#), and four podcasts
16 focused on social determinants of health and racial and health equity.
- 17 ○ AMA STEPS Forward® hosted the first-ever free in-person Saving Time Boot Camp,
18 intended for Federally Qualified Health Centers (FQHC) staff, offering evidence-based
19 time management strategies to provide quality patient care.
- 20 ○ Private Practice Simple Solutions (PPSS) learning collaboratives were created in support
21 of practices in communities that may lack financial resources to engage with consultants
22 or other external partners.
- 23 ○ The AMA produced six Prioritizing Equity episodes, including: [Examining Physician](#)
24 [Gender Inequity in Medicine](#), [The SCOTUS Affirmative Action ruling: The Cost to the](#)
25 [Physician Workforce and Historically Marginalized Communities](#), and [Advocating for](#)
26 [Change in Native Health Policy](#).

- 27
- 28 ● The AMA provided a detailed internal report to all staff on the first year of cross-enterprise and
29 Business Unit (BU)-specific Equity Action Plans, including some 200 goals across BUs.
30 Leadership approved moving forward with an Embedding Equity dashboard in 2024 starting with
31 the 2020 Employee Equity and Engagement Survey data, moving forward with the next
32 Employee Equity and Engagement Survey (slated to deploy in 2025), and implementing in 2024
33 the first enterprise-wide equity goals to be included in every BU’s goals, focused on workforce
34 and learning.
- 35 ● The annual update to the Current Procedural Terminology (CPT) code set for 2024 included
36 Spanish language consumer-friendly descriptors for the first time, which will help CPT users
37 better engage and assist the Latinx community.
- 38 ● For more than 50 years of the CPT Professional book being published and in circulation, every
39 medical illustration that showed skin tone depicted a white person. In 2023, to address the past
40 exclusion of images that represent the full diversity and identities of the people in our society, the
41 book updated 19 illustrations, including changes to skin tone, facial features, hair, and sex. The
42 2024 edition updated and diversified 11 illustrations as well as reworked and made additional
43 improvements to three illustrations from 2023. A large diverse group of internal and external
44 reviewers provided feedback prior to publication. There is a three-year plan to update 75-100
45 more illustrations to depict authentic and diverse illustrations in the over 200,000 copies sold
46 each year.

47

48 The AMA’s employee life cycle and internal diversity, equity, and inclusion (DEI) framework help to
49 operationalize DEI initiatives across the enterprise. Within the embedding equity strategic approach,
50 updates on the AMA’s diversity and inclusion strategy included a number of efforts and initiatives:
51

- 1 • Across AMA, hundreds of staff in 2023 engaged in training and educational opportunities with
2 over 60 percent reporting an increase in knowledge, attitudes, skills, or behaviors. Training
3 included the two-day Racial Equity Institute (REI) Phase 1, the Interaction Institute for Social
4 Change (IISC) Facilitative Leadership for Social Change, the Equity & Results Antiracist
5 Results-Based Accountability series, four new skills-based inclusion modules designed,
6 developed, piloted, implemented and evaluated, and Business Unit-specific offerings led by their
7 Health Equity Action Team.
- 8 • Individual Business Units have, with the leadership of their respective Health Equity Action
9 Teams, pursued a variety of strategies to operationalize equity: had every team member commit
10 to one of four committees and one goal from their Equity Action Plan, meeting at least monthly;
11 designed and implemented internal monthly reporting to support transparency, dialogue, and
12 decision-making; launched an internal monthly digest to educate colleagues; defined and shared a
13 safe-space framework, rules, and expectations for town hall meetings and issues that arise;
14 implemented community agreements across meetings and incorporated them into a project
15 management playbook (with 79% finding the brave space community agreement beneficial);
16 piloted Racial Healing Circles as a tool for team building across cultural divides; weaved meeting
17 with the Health Equity Action Team about their Equity Action Plan and its progress into the new
18 hire onboarding process; helped clients to consider embedding equity principles throughout
19 projects (e.g., what language is being used, whether the team is diverse, is there a consideration of
20 the project's impact on minoritized or marginalized communities, and other essential questions);
21 and developed a process to ensure research proposals are evaluated for design bias and equity
22 impact.
- 23 • The AMA is analyzing existing IT documentation in shared repositories for identification and
24 removal of racially demeaning terms.
- 25 • Starting in 2023, several JAMA Network journals revamped and expanded their editorial
26 fellowship programs to be part-time and fully remote to increase accessibility and inclusivity. The
27 JAMA Network Equity Action Team (JNEAT) established guidelines for staff at every level to
28 understand how to meet individual goals for improving Diversity, Equity, Inclusion, and
29 Belonging – from supporting hiring managers in seeking a diverse candidate base for job
30 openings to providing educational opportunities for staff. JAMA Network DEI editors continued
31 quarterly discussions within their individual journals. The team will be publishing results of an
32 inter-departmental survey of editors and editorial boards that highlight staff demographics,
33 including self-identified gender, race, and ethnicity.
- 34 • The AMA made its offices more equitable, installing privacy strips in the restrooms, stocking
35 menstrual supplies in all restrooms, facilitating hybrid meetings with necessary accommodations,
36 and installing or ordering sit/stand desks and other ergonomic office equipment. The organization
37 continues to work towards ensuring AMA offices are accessible for differently abled individuals.

38 Build Alliances and Share Power

39
40 Building strategic alliances and partnerships and sharing power with historically marginalized
41 and minoritized physicians and other stakeholders is essential to advancing health equity. This
42 work centers previously excluded people, expertise and knowledge, builds advocacy coalitions,
43 participates in national networks, and establishes the foundation for true accountability and
44 collaboration. The following are some of the relevant accomplishments during 2023:

- 45 • AMA's sponsorship plan reflected outreach to diverse audiences, including The National
46 LGBTQ+ Journalists Association (NLGJA) and Asian American Journalists Association (AAJA)
47 Journalists conferences.
48

- 1 • Three new health equity-oriented content partners were signed to AMA’s Ed Hub: Docs with
2 Disabilities, Radiology Health Equity Coalition (RHEC), and UCSF Center for Climate Health
3 Equity. The AMA collaborated with HealthBegins to launch six modules of [Upstream Training
4 and Education](#).
- 5 • To further leverage existing resources and partnerships, AMA participated in four meetings with
6 the Association of American Medical Colleges (AAMC) and the Accreditation Council for
7 Graduation Medical Education (ACGME) about diversifying the physician workforce; attended
8 three ACGME Diversity Officers Forums; delivered two webinars (Removing barriers and
9 facilitating access: Supporting trainees with disabilities across the medical education continuum
10 and Enhancing Diversity Among Academic Physicians: Recruitment, Retention and
11 Advancement), two presentations to Academic Physicians Section on equity, diversity and
12 belonging focused on medical education and minoritized physician burnout and wellbeing, and
13 three presentations on the implications of the Supreme Court (SCOTUS) decision of Students for
14 Fair Admissions v. Harvard University and the University of North Carolina at Chapel Hill; and
15 completed a review of configurative mapping on diversity in medical education.
- 16 • Continuing its work around physician workforce data, the AMA is collaborating with the AAMC
17 and the ACGME to establish a common understanding for the categorization, reporting, and
18 sharing of sociodemographic data, beginning with race and ethnicity. This collaborative
19 completed a study and is finalizing a guide on the addition of the Middle Eastern North African
20 (MENA) category, identifying best practices in aggregation and reporting. Categorization has
21 been provided by the AMA to the American Board of Medical Specialties, Federation of State
22 Medical Boards, Council for Affordable Quality Healthcare, Massachusetts Medical Society, and
23 Workgroup for Electronic Data Interchange health equity work group. MedBiquitous, a standards
24 development organization in the academic medicine space, has expressed interest in adopting the
25 categorization being developed by the collaborative in lieu of creating their own.
- 26 • The AMA, alongside AHIP, the Alliance of Community Health Plans, the American Hospital
27 Association, and Kaiser Permanente, launched the Common Health Coalition: Together for
28 Public Health. The coalition is focused on translating the hard-won lessons and successes of the
29 COVID-19 pandemic response into actionable strategies that will strengthen the partnership
30 between our health care and public health systems. In 2024, the coalition will publish
31 recommendations informed by technical advisory groups of subject matter experts and an
32 advisory council of public health leaders, focused on four initial priority areas: spearheading
33 greater coordination between the public health and health care systems; building shared, well-
34 maintained emergency preparedness plans; establishing national standards for health care data
35 that help identify health disparities; and modernizing infectious disease detection.
- 36 • AMA continues to work in partnership with the March of Dimes (MOD) and has contracted with
37 MOD and Sinai Urban Health Institute to identify the impact of facility closures and loss of
38 services on the South and West side of Chicago, with the goal of producing a final report in 2024.
39 AMA aims to continue its engagement with and participation in the MOD workgroups
40 (Dismantle Racism, Increasing Access to Care, and Engage Communities).
- 41 • AMA staff continue to volunteer locally and build meaningful relationships with community
42 organizations. The Enterprise Social Responsibility (ESR) team has aligned with the health equity
43 strategic framework by valuing and uplifting the variety and diversity of work and careers that
44 address social determinants of health and contributes to wellness. ESR piloted a co-design
45 process with three community partners to develop a signature service model to address emerging
46 community needs while aligning with AMA’s mission and equity goals. ESR identified and
47 hosted about 35 community engagement opportunities to build healthy, thriving, equitable
48 communities, including My Block, My Hood, My City; Gardeneers; and the Erie House.
- 49 • The second cohort of the Medical Justice in Advocacy Fellowship, an educational initiative in
50 collaboration with Morehouse School of Medicine’s Satcher Health Leadership Institute,

1 culminated at the Interim meeting of the House of Delegates, where 11 physician leaders were
2 celebrated and presented their health equity project concepts.

- 3 • The AMA launched its inaugural Summer Health Law Internship, an eight-week paid summer
4 internship program for a third year or master's law student to learn more about health equity and
5 health law; continued working with The Urban Alliance by hosting a summer internship program
6 that exposes Chicago students to medical publication to provide career exposure; hired a summer
7 intern from Chicago Public Schools in Finance; and partnered with University of Chicago's Youth
8 Internship Program, hosting an onsite a panel discussion with 23 IT-interested high school
9 students, and are exploring further IT mentoring opportunities.
- 10 • The AMA completed a total of 32 burnout assessments with FQHCs and/or community health
11 centers, all organizations serving patients from predominantly historically marginalized
12 communities. Twenty of the 32 assessments were conducted for the organizations in the Arizona
13 Alliance, a consortium of FQHCs, as well as several virtual workshops and reporting sessions to
14 provide insight into interventions to reduce medical staff burnout. Several participating FQHCs
15 were recognized through the AMA's [Joy in Medicine™ Health System Recognition Program](#).
- 16 • Minority and/or woman owned businesses were identified and recommended for several projects,
17 including one with an estimated value in excess of \$250,000. Additionally, three West Side
18 United (WSU) vendors were recommended for requests for proposals with more than \$700,000
19 spent with Local Vendors reported in monthly WSU Anchor Partner meetings. The AMA
20 released a DEI survey to professional services vendors with material levels of spending in 2023 to
21 collect information about the vendors and their policies regarding marginalized populations and
22 DEI.
- 23 • The AMA set a five-year goal to scale and improve programs to five million patients diagnosed
24 with hypertension (HTN) to achieve a 10 mm Hg drop in systolic blood pressure (SBP) or reach
25 BP goal, and one million patients identifying as Black, Latina/e/o/x/Hispanic, Asian, Indigenous,
26 and other historically marginalized groups. As of the end of 2023, approximately 71,723 patients
27 had been impacted, with 51percent from historically marginalized populations. This number
28 includes patients from two large health care organizations located in the West Side of Chicago.
29 Additionally, the AMA initiated projects to embed and advance equity within its AMA MAP
30 HTN™ program to better understand the impact of the program on historically marginalized
31 populations and identify opportunities to reduce inequities.

32 Push Upstream

33
34
35 Pushing upstream requires looking beyond cultural, behavioral, or genetic reasons to understand structural
36 and social drivers of health and inequities, dismantle systems of oppression, and build health equity into
37 health care and broader society. The following are some of the relevant accomplishments during 2023:
38

- 39 • AMA continues to embed equity in its state and federal advocacy work and continues to elevate
40 this and other equity-related work accomplished among AMA members and Federation Societies.
41 Equity-related policy priorities can be seen throughout the AMA's engagement with Congress,
42 the Administration, state legislatures, and other policymakers, in the form of advocacy letters,
43 presentations and testimony to state legislatures, national and medical organizations, and
44 countless additional opportunities that engaged organized medicine and policymakers. In 2023,
45 the AMA continued to actively voice support for:
 - 46 ○ International medical graduates (IMGs);
 - 47 ○ Deferred Action for Childhood Arrivals (DACA) recipients;
 - 48 ○ Migration and refugee population health and safety;
 - 49 ○ Nutrition programs expansion and culturally respectful dietary guidelines;
 - 50 ○ Medicaid coverage expansion;

- Medicaid and Children’s Health Insurance Program (CHIP) coverage extension;
- Maternal and child health programs;
- Protecting reproductive health;
- Advancing data privacy principles and protecting the abuse/misuse of sensitive health data;
- [Enhanced revisions to the federal race and ethnicity data standards](#);
- Mental health and substance use disorder parity laws;
- Removing racial and gender inequities for treatment of substance use disorders;
- Protections for physicians who seek care for wellness and burnout;
- Evidence-based gender affirming care;
- Prohibition of the so-called conversion therapy;
- Fair student loan efforts;
- Increased funding for graduate medical education;
- Elimination of harmful race-based clinical algorithms;
- Telehealth flexibilities in Medicare;
- Reducing the prior authorization burden on patients; and
- Addressing quality and administrative barriers in Medicare Advantage and other insurance plans.

- In late May, in partnership with Institute for Healthcare Improvement (IHI), and in collaboration with Race Forward, HealthBegins, Groundwater Institute, and a variety of other organizations, the AMA [formally announced the launch](#) of Rise to Health: A National Coalition for Equity in Health Care. The goal of the Rise to Health Coalition is to bring together individuals and organizations across five key audiences (pillars) including: individual practitioners, health care organizations, professional societies, payers, and pharma, research, biotech organizations, to advance health equity by identifying shared solutions, common frameworks, and best practices for spread and scale.
- The AMA continues to publish highly engaging health equity content on the AMA Ed Hub site with 176 activities published in 2023. Uptake of equity content in 2023 far exceeded 2022, with 213,982 engagements (compared to 161,189) and 53,117 course completions (compared to 32,453). Four [National Health Equity Grand Rounds](#) sessions were held, which brought 10,189 registrations (8,254 new registrants) to the Ed Hub site: [The History of Racism in US Health Care](#); [Follow the Money](#); [Breaking Down the Ivory Tower](#); and [Creating Accountability Through Data](#). Each session was designed to maximize accessibility for viewers.
- The AMA is a founding member of The Gravity Project, a Health Level 7 Fast Healthcare Interoperability Resources Accelerator focusing on social determinants of health (SDOH) data interoperability. The AMA contributes funding and staff time, for leadership and co-development of the SDOH terminology and data exchange standards. The newly released White House “[US Playbook to Address Social Determinants of Health](#)” for federal initiatives recognized the Gravity Project throughout the document. The AMA provided education to physicians on the utility of CPT codes to document and provide services based upon identified SDOH.

Ensure Equity in Innovation

The AMA is committed to ensuring equitable health innovation by embedding equity in innovation, centering historically marginalized and minoritized people and communities in development and investment, and collaborating across sectors. The following are some of the relevant accomplishments during 2023:

- The AMA continues to strive toward the adoption, optimization, and sustainability of responsible, impact and equitable digitally enabled innovations. This includes highlighting organizations that

1 are championing and implementing health equity on the Physician Innovation Network (PIN) and
2 providing a place for the Principles of Equitable Innovation to engage in important conversations
3 through PIN. The AMA connected stakeholders and fostered collaboration to improve the
4 development, evidence base, and quality of digital health solutions.

- 5 • The AMA's In Full Health initiative, in collaboration with The New Voices Foundation, provided
6 five microgrants to Black healthcare/health tech entrepreneurs to attend The New Voices
7 Foundation Health Innovator Hub at ESSENCE Festival 2023. The Black health innovators
8 created solutions through tech, community partnerships, and medicine – building businesses that
9 meet critical needs in the Black community and advance health equity. The healthcare/health tech
10 entrepreneurs exhibit at the Innovator Hub at the ESSENCE Festival, which is visited by over
11 500,000 people each year.
- 12 • At the May CPT Editorial Panel Meeting, they approved adding eight questions to the CPT Code
13 Change Application to help the Panel make informed decisions about AI CPT applications and
14 apply the AI Taxonomy (Appendix S in the CPT Code Set) consistently. One question asks the
15 applicant to explain how bias factors into the algorithm data.

16 17 Foster Truth, Racial Healing, Reconciliation, and Transformation

18
19 The AMA recognizes the importance of acknowledging and rectifying past injustices in advancing health
20 equity for the health and well-being of both physicians and patients. Truth, racial healing, reconciliation,
21 and transformation is a process and an outcome, documenting past harms, amplifying and integrating
22 narratives previously made invisible, and creating collaborative spaces, pathways, and plans. The
23 following are some of the relevant accomplishments during 2023:

- 24
25 • The AMA launched the Truth, Reconciliation, Healing and Transformation (TRHT) Taskforce,
26 comprised of 19 people: AMA Board of Trustees liaisons, members of the AMA House of
27 Delegates, physicians from historically marginalized communities, and external subject-matter
28 experts from key fields such as medical history and education, policy, ethics, philanthropy, and
29 economics. Facilitated dialogues took place in New Mexico and on Chicago's West Side ([at the](#)
30 [Hatchery](#)), with educational sessions at the 2023 [Annual](#) and Interim Meetings of House of
31 Delegates (HOD). The Hatchery and HOD sessions are being made available on Ed Hub in 2024.

32 33 Challenges and Opportunities

34
35 Commonly noted challenges to advancing health equity, in order of most frequently cited to least,
36 include: 1) limited staff time and capacity for content engagement and external collaborations, 2)
37 competing operational and scheduling priorities, 3) budgetary limitations for sustainability and scaling up,
38 4) lack of guidance and standardization across enterprise, and 5) uncertainty around implementation and
39 evaluation of processes and projects. Additional progress has been made this year to promote diversity
40 within the AMA, and continuation and scaling of these efforts are vital to advancement of equitable work
41 and workplace.

42
43 Many of AMA's BUs reported exploring initiatives to foster space and engagement around diversity,
44 inclusivity, transparency, and accountability among their unit. Other BUs reported relying on their Health
45 Equity Action Team ("HEAT") staff leaders to lead and advance their respective unit's equity efforts, and
46 while these leaders' expertise have made great strides toward spearheading initiatives and setting
47 structures for equitable work, staff are faced with limited time, capacity, resources on top of competing
48 priorities with tight deadlines. Some BUs have identified these issues, and a few have created
49 opportunities for cross unit engagements to foster collaboration and reignite responsibility toward AMA's

1 equity goals. As an organization, there is a keen interest in solidifying an enterprise-wide equitable
2 workplace foundation and investing efforts toward strategic operationalizing of AMA's equity goals.

3
4 CONCLUSION

5
6 The highlighted accomplishments in this report capture only a fraction of the work accomplished and
7 lessons learned within 2023. AMA staff have devoted countless hours to not only learning how they can
8 work together to advance health equity but also to applying what they have learned within and outside the
9 organization. AMA continues to push forward in its quest to advance health equity and embed racial and
10 social justice, making significant progress towards fulfilling its commitments outlined in its 2021-2023
11 Strategic Plan.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-A-24

Subject: AMA Efforts on Medicare Payment Reform

Presented by: Willie Underwood, III, MD, MSc, MPH, MD, Chair

1 BACKGROUND

2

3 At the 2023 American Medical Association (AMA) Annual Meeting of the House of Delegates
4 (HOD), the HOD adopted Policy – D-385.945, “Advocacy and Action for a Sustainable Medical
5 Care System” and amended Policy D-390.922, “Physician Payment Reform and Equity.” Together,
6 they declare Medicare physician payment reform as an urgent advocacy and legislative priority, call
7 on the AMA to implement a comprehensive advocacy campaign, and for the Board of Trustees (the
8 Board) to report back to the HOD at each Annual and Interim meeting highlighting the progress of
9 our AMA in achieving Medicare payment reform until predictable, sustainable, fair physician
10 payment is achieved. The Board has prepared the following report to provide an update on AMA
11 activities for the year to date. (Note: This report was prepared in mid-March based on approval
12 deadlines, so more recent developments may not be reflected in it.)

13

14 AMA ACTIVITIES ON MEDICARE PHYSICIAN PAYMENT REFORM

15

16 The AMA’s Medicare physician payment reform efforts were initiated early in 2022, following the
17 development of a set of principles outlining the “Characteristics of a Rational Medicare Payment
18 System” that was endorsed by 124 state medical associations and national medical specialty
19 societies. These principles identified strategies and goals to: (1) ensure financial stability and
20 predictability for physician practices; (2) promote value-based care; and (3) safeguard access to high
21 quality care.

22

23 Subsequently, the AMA worked with Federation organizations to identify four general strategies to
24 reform the Medicare payment system, including:

25

- 26 • Automatic annual payment updates based on the Medicare Economic Index (MEI);
- 27 • Updated policies governing when and how budget neutrality adjustments are made;
- 28 • Simplified and clinically relevant policies under the Merit-based Incentive Payment System
29 (MIPS); and
- 30 • Greater opportunities for physician practices wanting to transition to advanced alternative
31 payment models (APMs).

32

33 At the heart of the AMA’s unwavering commitment to reforming the Medicare physician payment
34 system lie four central pillars that underscore our strategic approach: legislative advocacy,
35 regulatory advocacy, federation engagement, and grassroots, media, and outreach initiatives.
36 Grounded in principles endorsed by a unified medical community, our legislative efforts drive the
37 advancement of policies that foster payment stability and promote value-based care. We actively
38 champion reform through regulatory channels, tirelessly engaging with crucial agencies such as the
39 Centers for Medicare & Medicaid Services (CMS) and the White House to address impending
40 challenges and ensure fair payment policies. Our federation engagement fosters unity and consensus

1 within the broader medical community, pooling resources and strategies to amplify our collective
2 voice. Lastly, our continued grassroots, media, and outreach efforts bridge the gap between
3 policymakers and the public, ensuring our mission is well-understood and supported from all
4 quarters. Together, these pillars fortify our endeavors to achieve a more rational Medicare physician
5 payment system that truly benefits all.

6
7 *Legislative Advocacy*

8
9 As a result of the continued advocacy efforts of the AMA and larger physician community and
10 direct engagement with Congress, a collection of influential Dear Colleague letters and
11 commonsense legislative reforms have been introduced that build upon “Characteristics of a
12 Rational Medicare Physician Payment System” including:

13
14 H.R. 2474, the Strengthening Medicare for Patients and Providers Act, introduced on April 14, 2023
15 by Reps. Raul Ruiz, MD (D-Calif.), Larry Bucshon, MD (R-Ind.), Ami Bera, MD (D-Calif.) and
16 Mariannette Miller-Meeke, MD (R-Iowa), would automatically update the Medicare physician
17 payment schedule each year by Medicare’s annual estimate of practice cost inflation, the MEI. H.R.
18 2474 currently has 126 bipartisan cosponsors.

19
20 On July 28, 2023, a bipartisan group of 101 U.S. House of Representatives members sent a letter to
21 House leadership on the need to prioritize Medicare physician payment reform, following extensive
22 grassroots support from the AMA and members of the Federation.

23
24 H.R. 6371, the Provider Reimbursement Stability Act, introduced on November 13, 2023 by Rep.
25 Greg Murphy, MD (R-N.C.) and 14 original cosponsors, would reform the Medicare Physician Fee
26 Schedule (MPFS) budget neutrality policies by: (1) requiring CMS to reconcile inaccurate
27 utilization projections based on actual claims and prospectively revise the conversion factor (CF)
28 accordingly; (2) raise the threshold that triggers a budget neutrality adjustment from \$20 million to
29 \$53 million and increase it every five years by the cumulative increase in the MEI; (3) require the
30 direct inputs for practice expense relative value unit (i.e., clinical wages, prices of medical supplies
31 and prices of equipment) to be reviewed concurrently and no less often than every five years; and
32 (4) require CMS to limit positive or negative budget neutrality adjustments to the CF to 2.5 percent
33 each year. In November of 2023, the House Committee on Energy and Commerce advanced select
34 provisions of H.R. 6371 to reform fee schedule budget neutrality policies.

35
36 H.R. 5013/S. 3503, the Value in Health Care (VALUE) Act, introduced on July 28, 2023 by Reps.
37 Darin LaHood (R-Ill.) and Suzan DelBene (D-Wash.) in the House and Senators Whitehouse (D-
38 R.I.) and Barrasso (R-Wyo.) in the Senate on December 13, 2023, would extend the 5 percent APM
39 bonus and maintain the 50 percent revenue threshold for two years.

40
41 In November of 2023, the Senate Committee on Finance and the House Committee on Energy and
42 Commerce advanced legislation to offset a portion (1.25 percent) of the 2024 CF cuts as well as to
43 partially extend the APM bonus and maintain the current revenue threshold required for the
44 bonuses. During these markups, members of both committees discussed the need for Medicare
45 payment reform at length and secured pledges from the chairs to address the issue in earnest in
46 2024.

47
48 H.R. 6683, the Preserving Seniors’ Access to Physicians Act, introduced on December 8, 2023 by
49 Reps. Greg Murphy, MD (R-N.C.), Danny Davis (D-Ill.), Brad Wenstrup (R-Ohio), Michael
50 Burgess, MD (R-Texas), Jimmy Panetta (D-Calif.) and Larry Bucshon, MD (R-Ind.), would provide

1 full, short-term relief from the 3.37 percent cut imposed in 2024 due to the budget neutrality policies
2 medicine is seeking to reform.

3
4 Nearly 200 bipartisan members of Congress cosigned a Dec. 13 [letter](#) led by Representatives
5 Mariannette Miller-Meeks, MD (R-IA), Ami Bera, MD (D-CA), Larry Bucshon, MD (R-IN) and
6 Kim Schrier, MD (D-WA) urging House and Senate leadership to expeditiously pass legislation to
7 address looming 2024 Medicare payment cuts. Absent congressional intervention, Medicare
8 physician payments will be reduced by 3.37 percent on Jan. 1, 2024, due to budget neutrality
9 requirements within the Calendar Year 2024 MPFS Final Rule.

10
11 On Feb. 9, Senators Cortez Masto (D-NV), Blackburn (R-TN), Thune (R-SD), Barrasso (R-WY),
12 Stabenow (D-MI) and Warner (D-VA) announced the formation of a bipartisan Medicare payment
13 reform working group. The primary goal of this working group is to explore the current problems
14 with the MPFS, propose long-term solutions and make the necessary updates to the Medicare
15 Access and Chip Reauthorization Act (MACRA), which sets physician payment policies in the
16 Medicare program. The AMA will serve as a resource to the Senate working group.

17
18 On February 23, 2024, Senators John Boozman (R-AR) and Peter Welch (D-VT) along with 30
19 Senators colleagues sent a Dear Colleague [letter](#) calling on Senate leadership to advance a
20 legislative solution to create stability in the Medicare program by addressing the 2024 cut to
21 Medicare payments and ensure that physicians and clinicians have the necessary financial support to
22 care for the nation's seniors.

23
24 The Consolidated Appropriations Act, 2024, H.R. 4366, which passed the House of Representatives
25 and the Senate and was signed into law by President Biden on March 8, included provisions
26 reducing by about half —1.68 percent —of the 3.37 percent across-the-board Medicare physician
27 pay cut that took effect on January 1. The new pay rate took effect on March 9.

28
29 The legislation also included an extension of incentive payments for participation in eligible
30 alternative payment models at a reduced rate of 1.88 percent and maintained the threshold
31 requirements to qualify for such payments.

32
33 The AMA issued a statement expressing extreme disappointment that about half of the 2024
34 Medicare physician payment cuts required by the Medicare Fee Schedule will be allowed to
35 continue. The AMA conveyed that failure to reverse these cuts will impact access to high quality
36 care and physicians will find it more difficult to accept new Medicare patients.

37
38 The AMA will continue to work with Congress and the administration to build bipartisan support in
39 Congress for a proposal that will put an end to the annual cycle of Medicare cuts that threaten
40 seniors' access to care. Bipartisan support for the aforementioned legislative proposals continues to
41 grow among rank-and-file Members of Congress. However, the need for further advocacy remains
42 to push the relevant Committees and Congressional leadership to make Medicare physician payment
43 reform a top priority.

44
45 The AMA is also in the process of finalizing legislative language that would: (1) simplify MIPS
46 reporting and improve its clinical relevance; (2) reduce the potential severity of penalties (currently
47 as much as -nine percent) for those scoring poorly under MIPS; (3) provide support to smaller
48 practices that tend to score lower under the program; and (4) provide timely and meaningful
49 performance feedback to physicians and expand the use of clinical data registries.

1 In addition to regular interactions with members of Congress and their staff by Advocacy staff, the
2 AMA has sent a number of letters and statements to Capitol Hill, including the following:

- 3
- 4 • 1/2/23 - signed on a physician/allied health professions [letter](#) to Congressional committees
- 5 requesting MACRA oversight hearings;
- 6 • 2/13/23 - signed on a coalition [letter](#) to committees on value-based care;
- 7 • 3/15/23 - a sign on [letter](#) developed by the AMA was sent to Congress regarding the
- 8 Medicare Payment Advisory Committee (MedPAC) recommendation for an inflation-based
- 9 update;
- 10 • 3/20/23 - an AMA [statement](#) was filed for the Senate Health, Education, Labor and Pensions
- 11 Committee’s health care workforce hearing, highlighting the impact of declining Medicare
- 12 payments on the physician workforce;
- 13 • 4/19/23 - a sign on [letter](#) developed by the AMA was sent to the House expressing support
- 14 for H.R. 2474;
- 15 • 5/3/23 - signed on a physician/allied health professions [letter](#) to Congress in support of H.R.
- 16 2474;
- 17 • 6/21/23 - the AMA submitted a [letter](#) for the record for a hearing by the House Energy &
- 18 Commerce Oversight & Investigations Subcommittee on MACRA;
- 19 • 10/5/23 - the AMA [responded](#) to the Ways & Means Committee’s Request for Information
- 20 on ways to improve health care in rural and underserved areas;
- 21 • 10/19/23 - the AMA submitted a [statement](#) for the Record to the U.S. House of
- 22 Representatives Committee on Energy and Commerce Subcommittee on Health as part of
- 23 the hearing entitled “What’s the Prognosis? Examining Medicare Proposals to Improve
- 24 Patient Access to Care & Minimize Red Tape for Doctors.”
- 25 • 12/11/23 - the AMA [wrote](#) in strong support of H.R. 6683, the “Preserving Seniors’ Access
- 26 to Physicians Act,” bipartisan legislation that blocks another round of damaging Medicare
- 27 payment cuts;
- 28 • 1/17/24 - the AMA organized national medical organizations and state medical societies to
- 29 write a [letter](#) strongly urging Congress to quickly pass legislation to reverse the 3.37 percent
- 30 Medicare physician payment cuts that took effect on January 1, 2024.

31
32 *Regulatory Advocacy*

33
34 In anticipation of a new round of budget neutrality adjustments expected in 2024 due to
35 implementation of the G2211 code for complex office visits, the AMA had a multitude of meetings
36 with officials at CMS, the Department of Health and Human Services (HHS), and the White House
37 to discuss options for reducing the severity of the adjustment—and to argue whether any adjustment
38 is needed at all.

39
40 The proposed rule on the 2024 Medicare physician fee schedule that was released on July 13 revised
41 the utilization estimate for G2211 that they used to calculate the budget neutrality adjustment from
42 the 90 percent previously announced in 2021 to 38 percent, significantly reducing the impact on
43 payments.

44
45 The AMA also secured another hardship exemption that physicians can claim under MIPS to avoid
46 up to -nine percent in performance penalties in 2025.

47
48 On November 2, 2023, the CMS released the 2024 Medicare Physician Payment Schedule final rule
49 reducing the 2024 Medicare CF by 3.37 percent. These cuts result from a -1.25 percent reduction in
50 the temporary update to the CF under current law and a negative budget neutrality adjustment
51 stemming in large part from the adoption of the new G2211 office visit add-on code. Unfortunately,

1 these cuts coincide with ongoing growth in the cost to practice medicine as CMS projects a 4.6
2 percent Medicare Economic Index (MEI) increase for 2024.

3
4 Despite comments from the AMA and others that the G2211 add-on code is ambiguous and there is
5 uncertainty about when to report it, CMS did not further reduce the utilization estimate or the
6 associated budget neutrality impact. Specifically, CMS maintained its estimate from the proposed
7 rule that the add-on code will be reported with 38 percent of office visits in 2024.

8
9 Notably, in response to organized medicine’s advocacy, CMS maintained the performance threshold
10 to avoid a penalty in the Merit-based Incentive Payment System (MIPS) at 75 points in 2024. As a
11 result, 78 percent of eligible clinicians are expected to avoid a MIPS penalty in 2026, a significant
12 improvement from CMS’ earlier projection that just over half of eligible clinicians would avoid a
13 penalty in the proposed rule.

14 15 *Federation Engagement*

16
17 A Medicare Reform Workgroup comprised of staff from national medical specialty societies and
18 state medical associations was organized in 2022 and has continued to meet to develop consensus on
19 medicine’s reform proposals and advocacy strategies. The AMA also participates in a second
20 coalition, organized by the American College of Radiology, which involves non-physician clinicians
21 who bill under the Medicare fee schedule to expand our reach and minimize potential for divergent
22 proposals and strategies.

23
24 Periodic telephone conference calls are held with staff for Federation organizations to keep them
25 apprised of developments in Washington and to elicit their support for grassroots efforts.

26 27 *Grassroots, Media, and Outreach*

28
29 The AMA has maintained a continuous drumbeat of grassroots contacts through its Physicians
30 Grassroots Network, Patients Advocacy Network, and its Very Influential Physicians program. Op
31 eds have been placed in various publications from AMA leaders, as well as from “grasstops”
32 contacts in local newspapers. Digital advertisements are running, targeted specifically to
33 publications read on Capitol Hill, and media releases have been issued to highlight significant
34 developments.

35
36 The AMA relaunched a dedicated Medicare payment reform web site, www.FixMedicareNow.org,
37 which includes a range of AMA-developed advocacy resource material, updated payment graphics
38 and a new “Medicare basics” series of papers describing in plain language specific challenges
39 presented by current Medicare payment policies and recommendations for reform.

40 41 2023 Fix Medicare Now Campaign Top Line Results

- 42
43 • 425,900+ FixMedicareNow.org Page views
44 • 173,60000+ FixMedicareNow.org Site Visitors
45 • 40,679,400+ Impressions
46 • 498,000+ Engagements
47 • 1,200+ #FixMedicareNow Social Media Mentions
48 • 450+ FixMedicareNow.org Advocacy Hub User Submissions
49 • 288,000+ Contacts to Congress

1 Message testing of arguments made in support and opposition to Medicare payment reform was
2 completed in late 2023. Focus groups of U.S. voters were conducted in June, and a national poll was
3 launched in late July. The results of this message testing have been utilized to refine language used
4 in earned and paid media, as well as patient grassroots outreach.

5
6 CONCLUSION

7
8 As we forge ahead in continued partnership with the Federation to advance organized medicine's
9 collective goals in our strategic mission to reshape the Medicare physician payment system, the
10 AMA remains unwavering in its commitment to successfully pursuing the four pillars discussed in
11 this report. Our steadfast dedication ensures that our members' voices are heard, and that we
12 advocate for a system that is fair, sustainable, and reflective of the value physicians bring to patient
13 care.

14
15 Facing a nearly 10 percent reduction in Medicare payments over the past four years, physicians are
16 at a breaking point and are struggling to maintain access to care for the Medicare beneficiaries they
17 treat. Rising practice costs, workforce shortages, and financial uncertainty coupled with the
18 continued lack of positive Medicare payment updates is threatening the viability of physician
19 practices. This is unsustainable and unacceptable.

20
21 While there has been some progress so far in 2024, significant advocacy work remains in the year
22 ahead and beyond to achieve our vision of Medicare physician payment reform.

23
24 Please follow Advocacy Update, join the Physicians Grassroots Network, visit
25 www.FixMedicareNow often for updated material and alerts, and follow other AMA
26 communications vehicles to stay up to date and engaged on this topic.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 20-A-24

Subject: Criminalization of Providing Medical Care
(Res. 015-A-23)

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

1 At the 2023 Annual Meeting of the House of Delegates (HOD), the HOD adopted Resolution 015 -
2 A-23 entitled, “Report Regarding the Criminalization of Providing Medical Care,” which instructed
3 the American Medical Association (AMA) to:

4
5 [S]tudy the changing environment in which some medical practices have been
6 criminalized including the degree to which such criminalization is based or not
7 based upon valid scientific findings, the degree to which this is altering the actual
8 practice of medicine due to physician concerns and personal risk assessment, and
9 the degree to which hospitals and health care systems are responding to this rapidly
10 changing environment, with report back to the HOD no later than the November
11 2023 Interim meeting.

12
13 This report is submitted for the information of the HOD.

14
15 BACKGROUND

16
17 *Abortion*

18
19 On June 24, 2022, the U.S. Supreme Court issued its landmark decision in *Dobbs v. Jackson*
20 *Women’s Health Organization*, holding that the U.S. Constitution does not confer a constitutional
21 right to abortion and returned the authority to regulate abortion to the states. As of the writing of
22 this report in March 2024, 14 states (Alabama, Arkansas, Idaho, Indiana, Kentucky, Louisiana,
23 Mississippi, Missouri, North Dakota, Oklahoma, South Dakota, Tennessee, Texas, and West
24 Virginia) prohibit the provision of nearly all abortions, two states (Georgia and South Carolina)
25 prohibit abortion after fetal cardiac activity is detected around six weeks of pregnancy, and nine
26 states (Arizona, Florida, Iowa, Kansas, Nebraska, North Carolina, Ohio, Utah, and Wisconsin)
27 prohibit abortion later in pregnancy, but before the point at which a fetus is generally considered
28 viable. Many of those latter nine states have passed laws prohibiting abortion earlier in pregnancy
29 that have been blocked in court. Importantly, the status of state abortion laws is fluid. Legal
30 challenges are ongoing in nearly two dozen states and the legality of abortion in those states is
31 subject to change.

32
33 At the time the *Dobbs* decision was published, 13 states had abortion prohibitions that predated the
34 *Roe v. Wade* decision or so-called “trigger laws” that became effective upon the overruling of *Roe*,
35 including several that were enacted in 2022 just prior to the *Dobbs* decision. In August 2022, the
36 Indiana legislature became the first in the country to pass a post-*Dobbs* abortion ban. West Virginia
37 followed in September 2022, and in 2023, seven states enacted new abortion bans. North Dakota
38 and Wyoming enacted near-total bans; Florida, Iowa, and South Carolina enacted six-week bans;

1 and Nebraska and North Carolina enacted 12-week bans. Not all the newly enacted laws are in
2 effect.

3
4 Some, but not all, state abortion bans are punishable with criminal penalties. In other states,
5 violations are subject to professional discipline up to mandatory revocation of the health care
6 professional's license. Some also authorize civil enforcement of abortion bans by private citizens,
7 though courts have declined to authorize those suits.

8
9 Each state abortion ban contains an exception or affirmative defense, under specified conditions,
10 when abortion is necessary to preserve the life of pregnant women and other pregnant patients.
11 Most, but not all of the states' laws, also contain exceptions or affirmative defenses when abortion
12 is necessary to prevent serious health consequences (e.g., "serious and irreversible impairment of a
13 major bodily function"). Some laws also contain exceptions or affirmative defenses in cases where
14 the pregnancy was due to rape or incest or when the fetus is diagnosed with a serious condition
15 incompatible with life.

16
17 These exceptions, however, are not crafted in a way that aligns with the complexity of medical
18 practice and have led to significant confusion about how to practice medicine when pregnancy
19 complications arise. As a result, physicians report significant uncertainty in navigating the new
20 restrictions and describe a chilling effect on the practice of medicine that extends beyond obstetrics
21 and gynecology into a range of specialties including emergency medicine, oncology, rheumatology,
22 cardiology, psychiatry, and others. The AMA is not aware of data that can reliably quantify the
23 degree to which medical practice has been altered in response to abortion restrictions but
24 understands the impact on physicians, their practice, and their patients to be immense. Media
25 reports have profiled numerous patients who describe harrowing experiences in which they
26 suffered preventable medical complications because legal restrictions prevented medical
27 professionals from providing recommended treatment. Similarly, in a lawsuit seeking to clarify the
28 scope of Texas' medical emergency exception, 22 women describe being denied medically
29 necessary and potentially lifesaving treatment when they were experiencing medical emergencies
30 during their pregnancies.¹ To better track these cases, researchers at the University of California in
31 San Francisco have undertaken a study, "*The Care Post-Roe Study*," to collect stories from
32 clinicians about how abortion laws have altered the usual standard of care. In May 2023,
33 preliminary findings described 50 cases in which abortion laws resulted in delays, worsened health
34 outcomes, and increased the cost and logistic complexity of care.² Additionally, qualitative research
35 published in January 2024 reported on obstetrician-gynecologists' perceived impacts of abortion
36 bans.³ The 54 research participants described delays in medical care, institutional restrictions on
37 referrals and patient counseling, and inability to provide appropriate medical care. The research
38 also reported high rates of moral distress and other personal impacts among the participants.

39
40 Risk-averse hospitals and institutional policies are also likely to contribute to changes in medical
41 practice. In May 2023, the Centers for Medicare & Medicaid Services announced investigations
42 into two Missouri hospitals that allegedly withheld necessary stabilizing care to a pregnant patient
43 experiencing preterm premature rupture of membranes in violation of the Emergency Medical
44 Treatment and Labor Act.⁴ The government's announcement stated that, in one situation, although
45 the patient's doctors advised her that her pregnancy was no longer viable and her condition could
46 rapidly deteriorate, they could not provide her with the care that would prevent infection,
47 hemorrhage, and potentially death due to hospital policies. Physicians have described other similar
48 hospital policies in which non-clinicians determine whether and at what point abortion care may be
49 provided.

1 Though abortion bans may be altering the treatment of pregnancy complications, available data
2 indicate that abortion bans have not reduced the total number of abortions provided but have
3 shifted the geographic distribution of abortion care. The #WeCount initiative led by the Society for
4 Family Planning reported that from July 2022 to June 2023 the number of clinician-provided
5 abortions increased modestly, with a monthly average of 82,115 abortions before the *Dobbs*
6 decision and a monthly average of 82,298 in the 12 months after the *Dobbs* decision.⁵ As
7 anticipated, states with abortion bans reported significant declines in the number of abortions
8 provided after *Dobbs*, with 14 states experiencing a 100 percent decrease. Accordingly, the number
9 of live births has risen in places that ban abortion. Research published in November 2024 estimated
10 that, in the first six months of 2023, births rose by an average of 2.3 percent in ban states compared
11 to states where abortion remained legal.⁶ The authors estimated that roughly one-fifth to one-fourth
12 of people seeking abortions did not receive them due to bans. Another study from the Johns
13 Hopkins Bloomberg School of Public Health estimated that nearly 9,800 additional live births
14 occurred in Texas in the year after the state's abortion ban took effect.⁷

15
16 Conversely, health care professionals in states that do not severely restrict access to abortion have
17 reported an increase in demand for abortion care from out-of-state patients, as well as greater
18 complexity of cases and abortion care, sought later in pregnancy. The #WeCount initiative reported
19 in October 2023 that the increase in abortions provided in these states was greater than the decrease
20 of abortion provided in restrictive states and notes that much of the increase has been in states that
21 border restrictive states.

22
23 Abortion bans are also likely to impact the physician workforce. Though data is not available, there
24 have been anecdotal reports of individual physicians opting to leave states with restrictive laws.
25 Similarly, two hospitals in Idaho closed their labor and delivery units, citing difficulties in
26 recruiting staff and the hostile legal environment.⁸ The American Association of Medical Colleges
27 (AAMC) also reported that obstetrics and gynecology residency applications declined significantly
28 in states that have banned abortion.⁹ AAMC posits that restrictive abortion laws may deter
29 applicants from applying to programs in those jurisdictions.

30
31 The AMA is not aware of any investigation, criminal prosecution, or medical board disciplinary
32 action taken against a physician for the illegal provision of abortion in a state with a strict
33 prohibition. The lack of enforcement action coupled with the data described above from restrictive
34 states suggests that physicians are complying with the laws and have ceased providing prohibited
35 abortion care except when a legally recognized exception applies.

36 37 *Gender-affirming Care for Minor Patients*

38
39 As of the writing of this report in March 2024, 23 states have enacted bans on gender-affirming
40 care for minor patients. Twenty-one states (Alabama, Arkansas, Florida, Georgia, Iowa, Idaho,
41 Indiana, Kentucky, Louisiana, Mississippi, Montana, Missouri, North Carolina, North Dakota,
42 Ohio, Oklahoma, South Dakota, Tennessee, Texas, Utah, and West Virginia) broadly prohibit the
43 provision of gender-affirming care to minor patients, including medications to delay puberty,
44 hormonal therapy, and surgeries. Two states (Arizona and Nebraska) prohibit surgical interventions
45 on patients younger than 18 years of age but do not ban non-surgical interventions. Legislative
46 prohibitions on gender-affirming care have been relatively recent developments. The Arkansas
47 legislature enacted the first such law in 2021, followed in 2022 with legislation in Alabama and
48 Arizona and administrative action in Florida and Texas. Twenty-two states then enacted bans in
49 2023 and 2024.

1 Among the 23 states that prohibit providing gender-affirming care to minors, some, but not all,
2 impose criminal penalties for violations. In other states, violations are subject to professional
3 discipline, including, in some places, mandatory revocation of the health care professional's
4 license. Several state laws also authorize patients and their families to bring civil suits against
5 health care professionals for decades after the care was provided.

6
7 Some laws have been successfully challenged in court. Arkansas's law has been permanently
8 enjoined, and laws in Florida, Idaho, and Montana have been temporarily enjoined in whole or part.
9 Like abortion laws, the status of laws regulating the provision of gender-affirming care is subject to
10 change as legal challenges progress.

11
12 At the start of 2023, no law was in effect that broadly prohibited gender-affirming care for minors,
13 though some clinicians and institutions, including in Texas and Tennessee, paused care for minors
14 in response to political pressure.¹⁰ Many laws have since gone into effect, but the full impact is not
15 yet known. It is reasonable to expect that physicians will cease to provide gender-affirming care to
16 their minor patients in compliance with state law. It is also expected that the impact may extend to
17 services provided to transgender adults, as well. For instance, the University of Mississippi
18 Medical Center, which also treated adults, recently closed its gender clinic in response to legislative
19 activity.¹¹ Conversely, health care professionals in states that protect gender-affirming care may
20 experience increased demand for services. In contrast to abortion services, however, gender-
21 affirming care generally requires ongoing treatment and monitoring, which could complicate
22 patients' ability to travel to distant locations for care. Additionally, while the impact of state laws
23 on patients and the LGBTQ+ community is immense, those patient outcomes are beyond the scope
24 of this report.

25 *Treatment of Patients with Pain and those with a Substance Use Disorder*

26
27
28 The nation's overdose and death epidemic was—and continues to be—driven by a complex set of
29 factors, including the current dominance of illicitly manufactured fentanyl; illicit use of drugs such
30 as heroin, cocaine, and methamphetamine; new toxic adulterants such as xylazine and nitazenes;
31 and a lack of access to evidence-based care for pain or a substance use disorder. The history of the
32 epidemic also includes actions of physicians and other health care professionals essentially
33 engaging in drug dealing through what is colloquially termed, “pill mills.”¹² As part of its
34 enforcement efforts, several years ago, the U.S. Department of Justice Criminal Division launched
35 a “Prescription Strike Force,” which targets “Medicare Part-D fraud and other schemes involving
36 false or fraudulent representations related to prescription medications, in addition to the illegal
37 prescribing, distribution, and diversion of pharmaceutical-grade controlled substances.”¹³ The U.S.
38 Drug Enforcement Administration (DEA) regularly issues news releases highlighting convictions
39 and other actions against physicians, nurse practitioners and pharmacists for crimes related to
40 “illegally prescribing opioids.”¹⁴

41
42 The AMA continues to be concerned about how the actions of the DEA and others in law
43 enforcement have led to what has been referred to as a “chilling effect” in treating patients with
44 pain. In a qualitative review of interviews with 20 West Virginia physicians, the review authors
45 found that physicians' feared discipline even as opioid prescribing was decreasing. Specifically,
46 physicians “felt that taking on patients who legitimately required opioids could jeopardize their
47 career.”¹⁵ Stories of patient harm and physician fear are abundant and disturbing to read.¹⁶ But it is
48 important to note that government intrusion into the practice of treating patients with pain or with a
49 substance use disorder has existed for more than 100 years.¹⁷ The Board of Trustees feels strongly
50 that the AMA must continue its decades-long tradition of strongly advocating against third-party

1 intrusion, which includes but is not limited to government intrusion, into the patient-physician
2 relationship.

3
4 Notably, ensuring access to evidence-based care for patients with pain or with a substance use
5 disorder remains top priorities for the work of the AMA and the AMA Substance Use and Pain Care
6 Task Force (SUPCTF). AMA advocacy was vital to securing revisions to the 2016 Centers for
7 Disease Control and Prevention (CDC) opioid prescribing guideline. AMA advocacy remains
8 critical in advocating against misapplication of the 2016 CDC opioid prescribing guideline by
9 payers, states, pharmacy chains, pharmacy benefit managers, and others. AMA advocacy also
10 continues to work to remove all barriers to treatment for substance use disorders. This includes
11 helping to lead the national discussion that unequivocally advocates for the understanding that
12 substance use disorders are medical diseases and not moral failings. The Board of Trustees is
13 grateful to the organizations in the SUPCTF for their partnership in furthering these efforts.

14
15 Ultimately, it is difficult to specifically quantify the degree to which fear of law enforcement in
16 treating pain or substance use disorders has altered the actual practice of medicine. There is ample
17 anecdotal evidence, but limited research about physician concerns and personal risk assessment.
18 The fear is real, and our colleagues and patients have suffered as a result. In response, AMA will
19 continue to advance its policy opposing third-party/government intrusion into individualized
20 patient care decisions.

21 22 DISCUSSION

23
24 Opposing third-party intrusion into the practice of medicine (including but not limited to
25 governmental intrusion) has long been a core priority for the AMA. The AMA continues to execute
26 a multifaceted strategy, including engagement with policymakers at the state and federal levels,
27 judicial advocacy, and more, to counter the deleterious impact of legislative efforts to criminalize
28 the practice of medicine. The AMA Advocacy Resource Center continues to work extensively with
29 state medical associations and national medical specialty societies, both publicly and behind-the-
30 scenes, to oppose state laws and regulations targeting the practice of medicine.

31
32 Additionally, development of the AMA Task Force to Preserve the Patient-Physician Relationship
33 When Evidence-Based, Appropriate Care Is Banned or Restricted (Task Force), established by the
34 HOD during the 2022 Annual Meeting, is in progress and the Task Force will update the HOD on
35 its activities, as instructed in Policy D-5.998, "Support for Physicians Practicing Evidence-Based
36 Medicine in a Post Dobbs Era." The Task Force is well-suited to address the issues raised in this
37 report and will help guide organized medicine's response to the criminalization of medical practice,
38 as well as identify and create implementation-focused practice and advocacy resources on the
39 issues identified in Policy G-605.009, "Establishing A Task Force to Preserve the Patient-Physician
40 Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted," including but not
41 limited to:

- 42
43 1. Health equity impact, including monitoring and evaluating the consequences of abortion
44 bans and restrictions for public health and the physician workforce and including making
45 actionable recommendations to mitigate harm, with a focus on the disproportionate impact
46 on under-resourced, marginalized, and minoritized communities;
- 47
48 2. Practice management, including developing recommendations and educational materials
49 for addressing reimbursement, uncompensated care, interstate licensure, and provision of
50 care, including telehealth and care provided across state lines;

- 1 3. Training, including collaborating with interested medical schools, residency and fellowship
2 programs, academic centers, and clinicians to mitigate radically diminished training
3 opportunities;
4
- 5 4. Privacy protections, including best practice support for maintaining medical records
6 privacy and confidentiality, including under HIPAA, for strengthening physician, patient,
7 and clinic security measures, and countering law enforcement reporting requirements;
8
- 9 5. Patient triage and care coordination, including identifying and publicizing resources for
10 physicians and patients to connect with referrals, practical support, and legal assistance;
11
- 12 6. Coordinating implementation of pertinent AMA policies, including any actions to protect
13 against civil, criminal, and professional liability and retaliation, including criminalizing
14 and penalizing physicians for referring patients to the care they need;
15
- 16 7. Anticipation and preparation, including assessing information and resource gaps and
17 creating a blueprint for preventing or mitigating bans on other appropriate health care, such
18 as gender affirming care, contraceptive care, sterilization, infertility care, and management
19 of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications; and
20
- 21 8. Making recommendations including policies, strategies, and resources for physicians who
22 are required by medical judgment and ethical standards of care to act against state and
23 federal laws.
24

25 CONCLUSION

26
27 The Board of Trustees reiterates its support and gratitude for physicians and all health care
28 professionals who confront the reality of law enforcement or other government intrusion into
29 the practice of medicine. These intrusions have sometimes caused irreparable harms to
30 physicians and patients across the United States. The AMA recognizes that law enforcement
31 plays an important role in our society, but it should not in the exam room, operating suite, or
32 any other patient-physician encounter. Whether it is through the Task Force to Preserve the
33 Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or
34 Restricted to protect access to reproductive rights and gender-affirming care, the Substance Use
35 and Pain Care Task Force to enhance evidence-based care for patients with pain or a substance
36 use disorder; or other areas that must confront the criminalization of health care, the AMA will
37 continue to fight to protect and preserve the sacred nature of the patient-physician relationship.

REFERENCES

- ¹ Plaintiffs' Second Amended Verified Petition for Declaratory Judgment and Application for Temporary and Permanent Injunction, *Zurawski v. State of Texas*, No. D-1-GN-23-000968 (Dist. Ct. Travis County).
- ² Daniel Grossman, Carole Joffe, Shelly Kaller, et al., Care Post-Roe: Documenting cases of poor-quality care since the Dobbs decision, preliminary findings (May 2023), available at <https://www.ansirh.org/sites/default/files/2023-05/Care%20Post-Roe%20Preliminary%20Findings.pdf>.
- ³ Erika L. Sabbath, Samantha M. McKetchnie, Kavita S. Arora & Mara Buchbinder, US Obstetrician-Gynecologists' Perceived Impacts of Post-Dobbs v Jackson State Abortion Bans, 7 JAMA Network Open 1 (Jan. 2024).
- ⁴ Press release, U.S. Department of Health and Human Services, HHS Secretary Xavier Becerra Statement on EMTALA Enforcement (May 1, 2023), <https://www.hhs.gov/about/news/2023/05/01/hhs-secretary-xavier-becerra-statement-on-entala-enforcement.html>.
- ⁵ Society of Family Planning, #WeCount Report April 2022 to June 2023 (Oct. 24, 2023), available at https://societyfp.org/wp-content/uploads/2023/10/WeCountReport_10.16.23.pdf.
- ⁶ Daniel Dench, Mayra Pineda-Torres, Caitlin Myers, The Effects of the Dobbs Decision on Fertility, IZA – Institute of Labor Economics Discussion Paper No. 16608 (Nov. 2023), available at <https://docs.iza.org/dp16608.pdf>.
- ⁷ Suzanne Bell, Elizabeth Stuart & Alison Gemmill, Texas' 2021 Ban on Abortion in Early Pregnancy and Changes in Live Births, 330 JAMA 3, 281-2 (Jun. 2023).
- ⁸ Press release, Conner General Health, Discontinuation of Labor & Delivery Services at Bonner General Hospital (Mar. 17, 2023), <https://bonnergeneral.org/wp-content/uploads/2023/03/Bonner-General-Health-Press-Release-Closure-of-LD-3.17.2023.pdf>; press release, Valor Health, Discontinuation of Labor & Delivery Services at Valor Health Hospital (Mar. 29, 2023), <https://www.valorhealth.org/wp-content/uploads/2023/03/Press-Release-3.29-scaled.jpg>.
- ⁹ Kendal Orgera, Hasan Mahmood & Atul Grover, Association of American Medical Colleges, Training Location Preferences of U.S. Medical School Graduates Post Dobbs v. Jackson Women's Health Organization Decision (Apr. 13, 2023), available at <https://www.aamc.org/advocacy-policy/aamc-research-and-action-institute/training-location-preferences>.
- ¹⁰ Rep. Jason Zachary (@JasonZacharyTN), Twitter (Oct. 22, 2022 2:57 PM), <https://twitter.com/JasonZacharyTN/status/1578474545131888640>; Joint statement, University of Texas Southwestern Medical Center & Children's Health (Mar. 28, 2022), <https://www.utsouthwestern.edu/newsroom/articles/year-2022/gender-dysphoria-care.html>; Eleanor Klibanoff & Alex Nguyen, Texas Tribune, Austin doctors who treated trans kids leaving Dell Children's clinic after AG Paxton announces investigation (May 13, 2023), <https://www.texastribune.org/2023/05/13/austin-dell-childrens-gender-affirming>.
- ¹¹ Molly Minta, Mississippi Today, UMMC to shut down LGBTQ+ clinic amid political pressure (Jun. 1, 2023), <https://mississippitoday.org/2023/06/01/ummc-shut-down-team-clinic>.
- ¹² Rigg KK, March SJ, Inciardi JA. Prescription Drug Abuse & Diversion: Role of the Pain Clinic. *J Drug Issues*. 2010;40(3):681-702. doi: 10.1177/002204261004000307. PMID: 21278927; PMCID: PMC3030470.
- ¹³ "Prescription Strike Force." U.S. Department of Justice. Criminal Division. Last Updated October 10, 2023. Available at <https://www.justice.gov/criminal/criminal-fraud/arpo-strike-force>
- ¹⁴ See, U.S. Drug Enforcement Administration. <https://www.dea.gov/taxonomy/term/136>
- ¹⁵ Sedney CL, Haggerty T, Dekeseredy P, Nwafor D, Caretta MA, Brownstein HH, Pollini RA. "The DEA would come in and destroy you": a qualitative study of fear and unintended consequences among opioid prescribers in WV. *Subst Abuse Treat Prev Policy*. 2022 Mar 10;17(1):19. doi: 10.1186/s13011-022-00447-5. PMID: 35272687; PMCID: PMC8908632.
- ¹⁶ 'Not Allowed to Be Compassionate.' Human Rights Watch. December 18, 2018. <https://www.hrw.org/report/2018/12/18/not-allowed-be-compassionate/chronic-pain-overdose-crisis-and-unintended-harms-us>
- ¹⁷ Singer, Jeffrey; Burris, Trevor. "Cops Practicing Medicine." Cato Institute. November 29, 2022. Available at <https://www.cato.org/white-paper/cops-practicing-medicine>

EXECUTIVE SUMMARY

BACKGROUND: Policy D-440.922, “Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems,” adopted by House of Delegates at I-21 directed our American Medical Association (AMA) to 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. Policy D-145.992, “Further Action to Respond to the Gun Violence Public Health Crisis” has called for the AMA to 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. This informational report is an effort to provide regular updates on the status of the AMA’s mission critical public health work to the HOD. Note that updates on the AMA’s work on climate change, firearm violence, and the mental health crisis were provided at I-23.

DISCUSSION

The AMA’s current priorities around public health are as follows:

1. Promote evidence-based clinical and community preventive services.
2. Respond to public health crises impacting physicians, patients, and the public. This includes addressing the threat of climate change, preventing firearm injuries and deaths, being prepared for emerging and remerging infectious disease threats, and ending the nation’s drug overdose epidemic.
3. Strengthen the health system through improved collaboration between medicine and public health.
4. Combat the spread of misinformation and disinformation.

CONCLUSION

The AMA continues to advance its mission, to promote the art and science of medicine and the betterment of public health. The highlighted accomplishments in this report capture a fraction of the work accomplished from March of 2023 – March of 2024 related to the AMA’s public health strategy.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 22-A-24

Subject: AMA Public Health Strategy: Update

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

1 BACKGROUND

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

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

10
11 Policy D-145.992, “Further Action to Respond to the Gun Violence Public Health Crisis” has also
12 called for the AMA to report annually to the House of Delegates on our AMA’s efforts relating to
13 legislation, regulation, and litigation at the federal, state, and local levels to prevent gun violence.

14
15 This informational report is an effort to provide regular updates on the status of the AMA’s mission
16 critical public health work to the HOD. Note that updates on the AMA’s work on climate change,
17 firearm violence, and the mental health crisis were provided at I-23.

18
19 DISCUSSION

20
21 *What is Public Health?*

22
23 Since its founding in 1847, the AMA’s mission has been “to promote the art and science of
24 medicine and the betterment of public health.” According to the Centers for Disease Control and
25 Prevention (CDC), public health is “the science and art of preventing disease, prolonging life, and
26 promoting health through the organized efforts and informed choices of society, organizations,
27 public and private communities, and individuals.”¹ Public health promotes and protects the health
28 of people and the communities where they live, learn, work and play.² Public health practice is a
29 different field than clinical medicine with different motivating values, responsibilities, and goals.³
30 While a doctor treats people who are sick, those working in public health try to prevent people
31 from getting sick or injured in the first place. A public health professional’s duty is to the
32 community rather than an individual patient.

33
34 *Connection with Health Equity*

35
36 It is important to acknowledge that health equity is a central concept in public health and is
37 essential to improving the health of populations. The AMA’s health equity strategy recognizes that
38 structural and social drivers of health inequities shape a person’s and community’s capacity to
39 make healthy choices, noting that downstream opportunities provided by the health care system

1 and individual-level factors are estimated to only contribute 20 percent to an individual’s overall
2 health and well-being, while upstream opportunities of public health and its structural and social
3 drivers account for 80 percent of impact on health outcomes.⁴ The AMA develops an annual report
4 on health equity activities. Progress towards the health equity strategy is reported in the BOT’s
5 annual health equity report. (See BOT Report 10, “Center for Health Equity Annual Report.”)
6

7 AMA PUBLIC HEALTH AND PREVENTION ACTIVITIES

8 9 **1. Promote evidence-based clinical and community preventive services.**

10
11 *A. Serve as a liaison to the U.S. Preventive Services Task Force (USPSTF), the Advisory*
12 *Committee on Immunization Practices (ACIP), and the Community Preventive Services Task Force*
13 *(CPSTF) and support the dissemination of recommendations to physicians.*
14

15 In addition to representing the AMA at meetings of these committees and task forces over the last
16 year, the AMA continues to disseminate information on evidence-based preventive services.

17 Examples include:

- 18
- 19 • The Journal of the American Medical Association (JAMA) publishes the recommendations
- 20 of the U.S. Preventive Services Task Force. These recommendations are also featured in
- 21 the AMA Morning Rounds newsletter.
- 22 • On March 6, 2024, Michael Barry, MD, Chair of the USPSTF, joined AMA Update to talk
- 23 about the most impactful final recommendations (new topic to the portfolio, a change in
- 24 grade, or topics that address the prevention of leading causes of death, and garnered
- 25 significant attention) and published between January 1, 2023, and December 31, 2023.
- 26 • Sandra Fryhofer, MD, the AMA’s ACIP Liaison joined the AMA Update podcast
- 27 throughout the year to provide updates to physicians.
 - 28 ○ On June 27, 2023, she shared what physicians need to know about the new
 - 29 recommendations from CDC’s ACIP for RSV vaccines for adults 60 years of age
 - 30 or older.
 - 31 ○ On August 10, 2023, she discussed the details of the new monoclonal antibody
 - 32 immunization recommended to protect babies from RSV. She discussed the details
 - 33 of the immunization including who should get it and what the side effects are.
 - 34 ○ On September 18, 2023, she discussed the ACIP’s recommendation that everyone
 - 35 six months and older receive a dose of the new updated COVID vaccine, the
 - 36 XBB.1.5 monovalent version is the 2023-2024 COVID vaccine.
 - 37 ○ On September 28, 2023, she reviewed the ACIP’s recommendation on RSV
 - 38 vaccine for pregnant people that would protect infants against the respiratory virus.
 - 39 The vaccine is recommended for use in weeks 32 through 36 of pregnancy, using
 - 40 seasonal administration during September through January.
 - 41 ○ On January 16, 2024, she reviewed the new adult vaccine schedule for 2024.
 - 42 ○ On March 8, 2024, she discussed ACIP’s new recommendation in favor of an
 - 43 additional dose of the updated COVID vaccine for all adults 65 and older.
- 44 • On November 6, 2023, Jesse Ehrenfeld, MD, MPH participated in a media event with CDC
- 45 Director, Mandy Cohen, MD, MPH in Chicago to speak with the media about the
- 46 upcoming respiratory virus season and the immunizations available this year to protect
- 47 people from COVID, RSV and flu.
- 48 • The AMA has also submitted amicus briefs in the case of *Braidwood Management v.*
- 49 *Becerra*, a case that challenges the Affordable Care Act’s requirement for private health
- 50 plans to provide people access to free preventive services. Our AMA advocates for (1)

1 health care reform that includes evidence-based prevention insurance coverage for all; (2)
2 evidence-based prevention in all appropriate venues, such as primary care practices,
3 specialty practices, workplaces, and the community.
4

5 *B. Help prevent chronic diseases, with a focus on cardiovascular disease, by addressing major risk*
6 *factors (AMA Strategic Priority led by the Improving Health Outcomes Group)*
7

8 The AMA is committed to improving the health of the nation and reducing the burden of chronic
9 diseases. Our primary focus is preventing cardiovascular disease (CVD), the leading cause of death
10 in the U.S., accounting for 1 in 4 deaths among adults.⁵⁻⁷ Two major risk factors for CVD are
11 hypertension and type 2 diabetes. An estimated 122 million adults have hypertension; 98 million
12 have prediabetes and are at increased risk for developing type 2 diabetes.^{7,8}
13

14 CVD risk factors and associated morbidity and mortality inequitably impact Black,
15 Hispanic/Latinx, Indigenous, Asian/Pacific Islanders, and other people of color. Black adults are
16 more than twice as likely to die of CVD relative to white adults.⁹ Black adults have higher
17 prevalence rates for diabetes compared to Hispanic (22 percent compared to 19 percent).¹⁰ While
18 specific causes of the inequities vary by each respective group; structural and societal barriers are
19 attributed as primary reasons.
20

21 To prevent CVD and address related health inequities, the AMA is developing and disseminating
22 CVD prevention solutions in collaboration with health care and public health leaders. These
23 solutions educate clinical care teams and patients, guide health care organizations (HCOs) in
24 clinical quality improvement and promote policy changes to remove barriers to care. The AMA
25 disseminates these solutions through strategic alliances with various organizations including the
26 CDC, the American Heart Association (AHA), and West Side United in Chicago.
27

28 The AMA MAP™ Hypertension clinical quality improvement program was designed to improve
29 hypertension management and control. The program has been provided to 46 HCOs across 20
30 states since 2019. Among those HCOs, 38 percent were in systems that provide free or low-cost
31 care to historically marginalized populations. The AMA MAP™ set of solutions is expanding to
32 include management for other cardiovascular disease risk factors, including cholesterol,
33 prediabetes, and post-partum hypertension.
34

35 Additionally, in response to the high prevalence of uncontrolled blood pressure and to support
36 physicians in managing their patients' high blood pressure, the AMA, in collaboration with AHA,
37 developed Target: BP™, a national initiative offering a series of online resources, using the latest
38 evidence-based information. Target: BP™ recognizes organizations that have achieved milestones
39 in their commitments to improving blood pressure control. In 2023, Target: BP™ 1,709 HCOs
40 participated in the Target: BP™ Achievement Awards including 868 HCOs that reported control
41 rates greater than or equal to 70 percent and/or 1,493 HCOs that attested to evidence-based blood
42 pressure measurement practices, like using the US Validated Blood Pressure Device Listing
43 (VDL™). Participants came from 47 states or U.S. territories and served about 33 million patients,
44 including 8.6 million people with hypertension.
45

46 AMA Prevent Diabetes houses a suite of tools and resources designed to help organizations build
47 and integrate diabetes prevention strategies into their organizations. AMA has worked with more
48 than 80 health care organizations across the country to increase identification and management of
49 patients with prediabetes. This suite of tools and resources and AMA's related expertise served as
50 the basis for the Bright Spot Model, which provided structure for local initiatives in Philadelphia
51 and North Carolina to advance diabetes prevention. AMA has since transitioned the Bright Spot

1 model to the CDC who is now expanding the reach of the model by funding four organizations
2 with \$10 million for implementation. As part of this implementation, CDC is requiring funded
3 organizations to work with HCOs to implement the AMA Prediabetes Quality Measures. AMA
4 will continue to make our suite of tools and resources available to support this effort.

5
6 In 2023, the AMA in its partnership with the AHA, closed Medicaid coverage gaps to ensure that
7 beneficiaries could receive home blood pressure devices and have their condition monitored by
8 physician-led care teams. The AMA was also successful in closing a Medicare coverage gap;
9 hemoglobin A1c lab tests are now a covered screening test which could result in more high-risk
10 individuals getting screened, diagnosed, and referred to a preventive intervention.

11
12 Another CVD risk is obesity which is associated with cardiovascular disease mortality independent
13 of other cardiovascular risk factors.¹¹ The AMA is working with Federation members including the
14 American College of Physicians and Obesity Medicine Association to identify opportunities to
15 improve access to evidence-based obesity treatments.

16
17 *C. Collaborate with CDC to improve the implementation of routine screening for HIV, STI, Viral*
18 *Hepatitis and latent tuberculosis (LTBI).*

19
20 Through funding from the CDC, the AMA has been engaged in a project entitled, “Promoting HIV,
21 Viral Hepatitis, STDs and LTBI Screening in Hospitals, Health Systems and Other Healthcare
22 Settings.” The scope of this project includes developing, piloting and launching a toolkit that
23 outlines ways to increase routine screening for HIV, STIs, viral hepatitis and LTBI. The toolkit
24 consists of a series of webpages on the AMA’s website. Information and strategies are organized
25 along the screening and testing continuum and offer helpful resources and best practices from the
26 AMA, CDC and other organizations. The toolkit contains two different sets of strategies – one
27 targeted to community health centers and a second to emergency departments.

28
29 On October 1, 2023, the AMA launched a pilot with four emergency departments, after completing
30 a community health center pilot earlier in the year. The emergency department pilot cohort
31 includes: Harris Health Ben Taub Hospital (staffed by Baylor College of Medicine physicians and
32 residents), Mayo Clinic, University of Colorado and Valleywise Health. Each pilot site selected 2-3
33 quality improvement strategies outlined in the routine screening toolkit to implement in their
34 emergency department. Sites also provided tangible feedback to the AMA on the effectiveness of
35 these strategies and ease of implementation in addition to providing input on the overall toolkit
36 itself. The AMA held a series of telementoring sessions for the pilot sites, which were moderated
37 by Megan Srinivas, MD, MPH and Marc Mendelsohn, MD. The pilot sites will conclude their
38 implementation work and post-pilot assessment activities by the end of April 2024.

39
40 Upon addressing critical feedback we received on the toolkit during a mid-point usability study
41 with the emergency department pilot sites, we launched the toolkit to the public with a press release
42 on March 6, 2024.¹² In conjunction with the launch of the toolkit, we are hosting a three-part
43 webinar series that highlights key strategies to improve routine screening. The series will be hosted
44 by AMA President Jesse Ehrenfeld, MD, MPH. The first episode in the series will feature Jonathon
45 Mermin, MD, MPH, director, National Center for HIV, STIs, Viral Hepatitis and LTBI at the
46 CDC.¹³

47
48 *D. Promote evidence-based preventive services to the public in collaboration with the Ad Council*
49 *and other health partners.*

1 While the AMA's primary audience is physicians, there are limited instances where the AMA has
2 partnered on public information campaigns on select priority issues. This work has been made
3 possible through partnerships with other health-related organizations and the Ad Council. The
4 AMA will explore opportunities for future campaigns on an ongoing basis, with recognition that
5 we must prioritize our efforts and engaging in these campaigns alone is not feasible due to cost.
6

7 Get My Flu Shot. The Ad Council, AMA, CDC and the CDC Foundation have partnered since the
8 2020-2021 flu season through an annual campaign to motivate more people to get vaccinated
9 against seasonal influenza (flu) to protect themselves and their loved ones. During a severe season,
10 flu has resulted in as many as 41 million illnesses and 710,000 hospitalizations among the U.S.
11 population. The Get My Flu Shot campaign PSAs are launched nationwide to reach people with the
12 message that a flu shot can help you stay healthy, reduce risk of severe outcomes, such as
13 hospitalization and death, and avoid missing work, school, or special moments with family and
14 friends. PSAs are available to run in English and Spanish across all platforms, in donated time and
15 space throughout flu season. The campaign ads direct audiences to [GetMyFluShot.org](https://www.getmyflushot.org) for more
16 information, including where to get a flu vaccine in their area. Some highlights from the 2023-24
17 flu campaign are as follows:
18

- 19 • The donated media value for the current Flu season reached nearly \$8.8M. The most
20 support has come from out of home (OOH - \$4,500,471), closely followed by TV support
21 (\$3,794,079).
- 22 • A media tour was held on September 19, 2023, in English and Spanish, featuring
23 spokespeople from the AMA, including Willie Underwood, MD, MSc, MPH and Madelyn
24 Butler, MD, and representatives from the CDC. Nearly 300 placements were secured
25 across TV, radio, and digital, with a reach of 2 million viewers (18 years of age or older),
26 53.8 million digital impressions, and 2.3 million broadcast impressions.
- 27 • A second media tour was held on December 12, 2023, in English and Spanish, with
28 spokespeople from the AMA, including Willie Underwood, MD, MSc, MPH and the CDC.
29 Nearly 100 placements across TV, radio, and digital were secured with a reach of 3.2
30 million viewers (18 years of age or older), 191.1 million digital impressions, and 3.5
31 million broadcast impressions.
- 32 • We partnered with Influential and Black Girl Digital for our trusted messenger activation
33 on social media. There was a total of 11M impressions, an estimated reach of 2.5M, 65k
34 engagements, and 9k link clicks. There was an overall positive sentiment (81 percent)
35 towards the posts.
- 36 • PSA awareness is now 56 percent in Black and Hispanic respondents based off our most
37 recent December 2023 tracking study.
38

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

40

41 The AMA's public health work has also been focused around responding to public health crises.
42 These crises are often associated with significant health risk for patients, raising concerns among
43 physicians. However, these crises are unlikely to be solved in a clinical setting alone. The AMA's
44 response to public health crises are typically focused on (1) ensuring physicians and trainees have
45 the data and resources needed; (2) identifying evidence-based policies and interventions; (3)
46 elevating the voices of physician leaders through AMA channels and platforms; and (4) convening
47 and collaborating with stakeholders to advance priority policies and interventions.
48

49 *A. Address the public health crisis of climate change.*

1 At the 2022 Annual Meeting of the House of Delegates, policy was adopted declaring “climate
2 change a public health crisis that threatens the health and well-being of all individuals.” Since the
3 A-23 meeting, AMA has accomplished the following activities and is developing a formal strategy
4 to address climate change and health (anticipated release is the AMA I-24 meeting):
5

- 6 • The AMA has made climate change education available via the Ed Hub™ from a variety of
7 sources including the AMA Journal of Ethics (JOE), the Journal of the American Medical
8 Association (JAMA), and the American Public Health Association (APHA).
- 9 • AMA's Chief Health & Science Officer, Frederick Chen, MD, MPH, joined the August 24,
10 2023, PermanenteDocs Chat podcast on heat waves and health, with a focus on how
11 physicians can adjust to prepare to care for heat-related conditions brought on by climate
12 change.
- 13 • JAMA announced the introduction of its new climate change and health series.¹⁴ The new
14 series is intended to inform readers about the associations between climate change and
15 health and “to stimulate improved knowledge and understanding of the health effects of
16 climate change to help foster commitment to timely action to prevent adverse health events
17 from climate change.”
- 18 • The AMA is in the process of developing a new CME module for physicians and trainees
19 on climate change and health which is anticipated to be available in summer 2024. The
20 focus of the module is to bring awareness to physicians about the impact of climate change
21 on the nation’s health and to empower physicians to begin conversations with their patients
22 about how climate change is affecting their health and what they can do about it.
- 23 • The AMA created a new webpage on AMA’s website, *Advocacy in action: Combating*
24 *health effects of climate change*, to highlight AMA’s position on this issue, how it is
25 engaged, and resources for physicians.¹⁵
- 26 • On November 2, 2023, AMA Update featured Victor Dzau, MD, President of the National
27 Academy of Medicine (NAM), to discuss how their Action Collaborative on
28 Decarbonizing the U.S. Health Sector is bringing together organizations across health care
29 to take action on climate change.¹⁶
- 30 • At the Interim 2023 meeting, the Health, Science, and Ethics business unit, in collaboration
31 with NAM, hosted an educational session entitled *The Climate Crisis: Pathways to*
32 *Decarbonizing the U.S. Health Sector*. The session featured four speakers who spoke to
33 ways that health care professionals can lead meaningful and measurable changes in
34 combating climate change, identified common barriers to decarbonization, and provided
35 available resources to support action towards decarbonization. Although overall attendance
36 was not counted, 48 individuals claimed CME credit for attending the event and the
37 average quality rating was 4.8/5.0.
- 38 • In early spring 2024, the AMA STEPS Forward® Podcast featured Jerry Abraham, MD,
39 MPH, who discussed the intersections between the social determinants of health and
40 climate change impacts.
- 41 • The AMA submitted an abstract to the American Public Health Association (APHA)
42 annual conference to be held in October 2024 to present on the findings from the listening
43 sessions held with physicians in May 2023 on climate change and health.
- 44 • The AMA continues to engage in the Medical Society Consortium on Climate and Health
45 (Consortium), which brings together associations representing over 600,000 clinical
46 practitioners.¹⁷ The AMA sits on the executive committee of this group, represented by Ilse
47 Levin, DO, MPH & TM. Additionally, the AMA was a sponsor of the MSCCH Annual
48 Meeting held in February 2024 in Washington, DC. Dr. Levin and AMA staff attended the
49 meeting.

- 1 • The AMA is also a member of the NAM Action Collaborative on Decarbonizing the
2 Health Sector as a member of the Steering Committee and co-lead of the Health Care
3 Delivery Workgroup.
 - 4 ○ The first phase (2021-2023) of the Action Collaborative's work has been focused
5 on identifying key opportunities and challenges to climate action, decarbonization,
6 and building resiliency across the health sector and developing resources and tools
7 to meet those needs. The collaborative, through the work of the members have
8 completed over thirty resources to accelerate climate action across the health
9 sector.
 - 10 ○ The second phase (2024-2025) will consist of accelerating a national climate and
11 health movement, as well as advancing the successes of the existing working
12 groups and launching an accelerator pilot program.
- 13 • The AMA is represented on the APHA Center for Climate, Health, and Equity Advisory
14 Board. In February 2024, the Advisory Board organized a roundtable of public health
15 experts to discuss the health, climate and equity priorities for consideration of the
16 reauthorization of the federal transportation bill, which is scheduled to be renewed in 2025.
- 17 • The AMA was also represented at APHA's first Climate, Health and Equity Summit in late
18 February 2024, which brought together professionals from across multiple disciplines to
19 explore the intersectionality of climate, health and equity and strategize how professionals
20 can advance public health and climate justice.

21

22 In terms of advocacy, the AMA participates in the American Lung Association's Healthy Air
23 Partners campaign, which is a coalition of 40 national public health, medical, nursing and health
24 care organizations engaged in healthy air advocacy efforts.¹⁸ The Coalition is united in its calling
25 for strong federal laws and policies to slash air pollution and address climate change, recognizing
26 climate change can affect air quality, and certain air pollutants can affect climate change. Since
27 June 2023, the AMA has joined partners on the following letters:

- 28 • A letter to Environmental Protection Agency (EPA) on their proposed ruling regarding
29 Pollutant Emissions Standards for Model Years 2027 and Later Light- Duty and Medium-
30 Duty Vehicles, urging them to pass the most stringent emission standards possible with
31 existing technologies.
- 32 • A letter to EPA on their proposed ruling regarding National Emission Standards for
33 Hazardous Air Pollutants: Coal- and Oil-Fired Electric Utility Steam Generating Units
34 Review of the Residual Risk and Technology Review.
- 35 • A letter to EPA on their proposed ruling in the Reconsideration of the National Ambient
36 Air Quality Standards for Particulate Matter, calling for the most protective standards to
37 protect the health of the most vulnerable populations. To note, EPA finalized their
38 particulate matter rule on February 7, 2024.¹⁹ While the new rule did not set particulate
39 matter at the more protective standard as advocated for by the Healthy Air Partners group,
40 the revised rule did address several of our comments and the new standards will result in
41 significantly reduced particular matter pollution in the future.
- 42 • A letter to EPA on their draft Revised Technical Guidance for Assessing Environmental
43 Justice in Regulatory Analysis, which included the addition of climate change as a factor of
44 vulnerability when conducting environmental justice analysis.

45

46 *B. Prevent firearm injuries and deaths.*

47

48 In the 1980's the AMA recognized firearms as a serious threat to the public's health as weapons are
49 one of the main causes of intentional and unintentional injuries and deaths. At the 2016 Annual
50 Meeting, following the Pulse nightclub shooting, policy was adopted declaring that "gun violence

1 represents a public health crisis which requires a comprehensive public health response and
2 solution." Since that time firearm injuries and deaths have increased and disparities have
3 widened.²⁰

- 4
- 5 • The AMA is participating in the Health Professional Education and Advocacy/Policy
6 committees of the Healthcare Coalition for Firearm Injury Prevention, which is being led
7 by American Academy of Pediatrics (AAP), American College of Emergency Physicians
8 (ACEP), American College of Physicians (ACP), American College of Surgeons (ACS),
9 and the Council of Medical Specialty Societies (CMSS).²¹
- 10 • On October 25–26, 2023, Alexander Ding, MD, MS, MBA, represented the AMA at the
11 Milken Institute’s Innovation Forum on Preventing Gun Violence in San Francisco. This
12 first-of-its-kind convening explored how technologies, expanded community collaboration,
13 and innovative models could unlock real progress to prevent gun violence and address its
14 societal repercussions.
- 15 • On December 14, 2023, the AMA convened the Firearm Injury Prevention task force for
16 an in-person meeting held at AMA Headquarters in Chicago. Willie Underwood, MD,
17 MSc, MPH, Chair of the AMA Board of Trustees and the task force led the meeting along
18 with task force Co-Vice Chairs Toluwalasé (Lasé) Ajayi, MD, and Alexander Ding, MD,
19 MS, MBA. Representatives to the task force discussed their organization priorities on
20 firearm injury prevention, examined the possibility of creating a resource center on firearm
21 injury prevention for physicians that would include information for patients and resources
22 on evidence-based interventions, and discussed the development of a toolkit for physicians
23 on extreme risk protection orders.
- 24 • On February 7, 2024, the AMA was represented by Willie Underwood, MD, MSc, MPH,
25 at the Northwell Health’s Gun Violence Prevention Forum in New York City.
- 26 • On March 4, 2024, the AMA convened a virtual meeting of the Firearm Injury Prevention
27 task force, where the members had the opportunity to hear from the Ad Council both about
28 their ongoing gun violence work as well as their new campaign, funded by members of the
29 National Health Care CEO Council on Gun Violence Prevention and Safety. The new
30 campaign seeks to elevate the issue of gun violence in America and its impact on youth,
31 shifting away from divisive, politically charged conversations to those focused on public
32 health approaches that have proven effective in combating this epidemic.
- 33

34 In terms of advocacy, the AMA has advocated for Congress to appropriate increased funding for
35 research to prevent firearm violence. The AMA is working with medical specialties, including the
36 AAP, to support funding for the CDC and the National Institutes of Health (NIH), and the National
37 Institute of Justice (NIJ) to conduct public health research on firearm morbidity and mortality
38 prevention.

- 39 • On April 19, 2023, the AMA joined more than 400 national, state, and local medical,
40 public health, and research organizations in a letter to the leadership of the House and
41 Senate Committees on Appropriations asking that for Fiscal Year (FY) 2024 they
42 appropriate \$35 million for the CDC, \$25 million for the NIH, and \$1 million for the NIJ to
43 conduct public health research into firearm morbidity and mortality prevention.
- 44

45 On the state level, the AMA wrote a letter to the leadership of the Maine Health and Human
46 Services and Judiciary Committees on March 4, 2024, expressing our support for legislation that
47 will address the epidemic of firearm violence in Maine and across the country, this includes:

- 48 • Legislative Document (LD) 2237 - An Act to Strengthen Public Safety, Health and Well-
49 being by Expanding Services and Coordinating Violence Prevention Resources. AMA
50 policy supports many of the initiatives in this comprehensive legislation, and applauds the

1 investment in violence prevention strategies, access to behavior health services, suicide
2 prevention, and crisis intervention programs. (Policies H-145.975, D-345.972, H-345.972,
3 and H-60.937)

- 4 • LD 2086 - An Act to Amend the Law Governing the Disposition of Forfeited Firearms.
5 The AMA supports removal of firearms from prohibited persons. (Policy H-145.972)
- 6 • LD 2224 - An Act to Strengthen Public Safety by Improving Maine's Firearm Laws and
7 Mental Health System. AMA Policy advocates for a waiting period and background check
8 for all firearm purchasers and policies that prevent transfer of firearms without adhering to
9 background checks. The AMA also applauds efforts to expand access to mental health and
10 substance use disorder treatment. (Policies H-145.996 and H-145.975)
- 11 • LD 2238 - An Act to Address Gun Violence in Maine by Requiring a Waiting Period for
12 Certain Firearm Purchase. AMA Policy supports legislation that enforces a waiting period
13 and background check for all firearm purchasers. (Policy H-145.996)

14
15 Through the AMA's litigation center, we work to represent the interests of the medical profession
16 on this issue in the courts by providing support or becoming actively involved in litigation of
17 importance to physicians.

- 18
19 • On August 21, 2023, the AMA was joined by the AAP, the ACS, the AP HA and the Texas
20 Medical Association in submitting an amicus brief in the case of *U.S. vs. Rahimi*, which
21 was argued on November 7, 2023, before the U.S. Supreme Court. The case challenges a
22 1994 law adopted by Congress to keep firearms out of the hands of people who are the
23 subject of a domestic violence restraining order (DVRO). The brief shares firsthand
24 accounts from 17 physicians who have witnessed the devastating injuries and deaths
25 caused by domestic abusers with firearms, as well as the often-lifelong psychological terror
26 inflicted upon victims, their children, and others.
- 27 • On December 26, 2023, the AMA was joined by the AAP, ACP, and ACS in submitting an
28 amicus brief in the case of *Garland v. Cargill*. The case involves firearms, namely whether
29 a bump stock device is a machinegun under federal law, as it allows users to convert a
30 semiautomatic firearm into a weapon that fires continuously with a single trigger pull. The
31 brief presents the firsthand experiences of physicians who treat victims of firearm violence
32 and explains why semi-automatic weapons with bump stocks are a critical public health
33 hazard, and prohibiting bump stocks saves lives.

34
35 The AMA has created a website broadly outlining the organization's advocacy efforts on gun
36 violence prevention.²²

37
38 *C. Respond to emerging and remerging infectious disease threats and prepare for future*
39 *pandemics.*

40
41 Infectious diseases continue to evolve and advance throughout the U.S. Pathogens that were once
42 geographically limited are now advancing beyond those traditional borders. Blastomycosis,
43 Histoplasmosis and Coccidioidomycosis are all fungal infections that have pushed past expected
44 boundaries. In addition to organisms known to be found in the U.S., tropical diseases like malaria,
45 dengue and Leishmaniasis have all been found in the U.S. in nontravelers. Re-emerging pathogens
46 like measles continue to find footholds across the country. While it's unclear what the next
47 infectious diseases outbreak will bring, the U.S. health system must be ready. Because the AMA is
48 relied upon as a source of information by physicians and patients, the AMA must maintain the
49 ability to respond and share information and advocate for physicians, patients, and the public in
50 line with AMA policies.

1 The AMA is a collaborator in Project Firstline, the CDC's National Training Collaborative for
2 Healthcare Infection Control. Project Firstline offers educational resources in a variety of formats
3 to meet the diverse learning needs and preferences of the health care workforce.²³

- 4 • Over the last year, AMA has developed 10 *Stories of Care* podcast episodes exploring
5 inequalities in infection prevention and control (IPC). The podcast series is hosted by
6 Megan Srinivas, MD, MPH, and has featured episodes on IPC Challenges in Rural Health
7 Care; Race, Research, and Health Care Associated Infections; TB or Not TB: Caring for a
8 Special Population; Fighting Ableism: What Do You Need?; The Hidden Inequities of
9 Dialysis-Related Infections; and Partners in Care: Environmental Services on the Front
10 Line.
- 11 • The AMA provided funding to 7 state and specialty medical societies to develop training
12 and IPC content for the membership and disseminate Project Firstline content.
- 13 • The AMA has partnered with the CDC on webinars addressing re-emerging pathogens and
14 the end of the COVID-19 public health emergency.
- 15 • On December 12, 2023, Sandra Fryhofer, MD, hosted a fireside chat to discuss
16 vaccinations and other tools that can keep everyone safer against influenza, COVID-19,
17 and respiratory syncytial virus (RSV) this respiratory virus season. Participants included
18 CDC Director Mandy Cohen, MD, MPH and Demetre Daskalakis, MD, MPH.
- 19 • The AMA hosted a five-part webinar series with the CDC on its Hospital Sepsis Program
20 Core Elements, which offer guidance to help clinicians, hospitals and health systems
21 implement, monitor and optimize their sepsis programs and outcomes. The series included
22 real-life examples, strategies and best practices and offers continuing education credit.
- 23 • A tele-mentoring series will kick off in April of 2024 that will explore the nuances of
24 infection prevention in facility types outside of the acute care hospital. Settings will
25 include acute rehabilitation hospitals, ambulatory surgery centers, behavioral health units,
26 post-acute long-term care facilities, dialysis facilities, and pediatric units.
- 27 • A CME module is under development that will present patient cases outlining
28 transmission-based precautions so that physicians and other health care professionals can
29 recognize how to protect themselves in any situation.

30
31 *D. End the nation's drug overdose epidemic.*

32
33 Ending the nation's drug overdose epidemic will require increased physician leadership, a greater
34 emphasis on overdose prevention and treatment, and better coordination and amplification of the
35 efforts and best practices already occurring across the country.

36
37 The AMA makes education available to physicians on this topic via the AMA Ed Hub™ to help
38 physicians gain critical knowledge around acute and chronic pain management, substance use
39 treatment, overdose prevention, and pain treatment to meet the regulatory requirements. Courses
40 are developed by AMA as well as by other partners. The AMA is also a member of the Providers
41 Clinical Support System (PCSS), which is made up of a coalition of major health care
42 organizations all dedicated to addressing this health care crisis and is led by the American
43 Academy of Addiction Psychiatry. PCSS provides evidence-based training and resources to give
44 health care providers the skills and knowledge they need to treat patients with opioid use disorders
45 and chronic pain.²⁴

- 46
47 • In 2023 the AMA worked to update content and resources for the physician education
48 series of module *Practical Guidance on Pain Management*. This content was made
49 available to help physicians meet the DEA's MATE Act requirements.

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- The AMA continues to convene the Substance Use and Pain Care Task Force, which supports and guides the development of the annual Overdose Epidemic Report on the overdose epidemic outlining current data, policy, updates, clinical accomplishments and what still needs to be done.²⁵
 - In 2023, the AMA developed physician education podcast series on *The Opioid Overdose Epidemic*. Hosted by Bobby Mukkamala, MD, Chair of the Substance Use and Pain Care Task Force, episodes feature experts who shared relevant research, insights, and experience to help physicians of all specialties in addressing the opioid overdose epidemic. As of November 2023, the podcast episode course completions have shown a high interest in the topics, which include: *Opioid Prescribing and Appropriate Pain Management, Opioid Overdose Prevention, and Opioid Use Disorder Treatment*.
 - The AMA is planning additional episodes as a part of this series for 2024, which will consist of four episodes including: *Opioid Use Disorder and Pregnancy, Opioid Utilization in Hospice and Palliative Care, Disparities in Access to Medication for Opioid Use Disorder, and Opioid Use a Prevention Approach*.
 - The AMA continues to participate as a member of the NAM Action Collaborative on Countering the U.S. Opioid Epidemic. The Action Collaborative uses a systems approach to convene and catalyze public, private, and non-profit stakeholders to develop, curate, and disseminate multi-sector solutions designed to reduce opioid misuse, and improve outcomes for individuals, families, and communities affected by the opioid crisis.

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

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The AMA is collaborating with leading health care organizations to strengthen the interface between public health and health care.

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- In November 2023, AMA and health care partners announced the Common Health Coalition: Together for Public Health, a partnership between AMA and four other leading healthcare organizations, including: AHIP (formerly America’s Health Insurance Plans), Alliance of Community Health Plans (ACHP), American Hospital Association (AHA), and Kaiser Permanente (KP).²⁶ The Common Health Coalition is focused on translating the hard-won lessons and successes of the COVID-19 pandemic response into actionable strategies that will strengthen the partnership between our health care and public health systems.
 - On March 13, 2023, the Common Health Coalition announced a set of commitments that will better equip U.S. health care organizations to collaborate with public health systems in preparing for the next public health emergency. Dave Chokshi, MD, MPH, Chair of the Coalition announced the commitments at the Politico Health Summit. The Coalition's founding members, including the AMA, committed to action in four priority areas:
 - Coordination between health care and public health
 - Always-on emergency preparedness
 - Real-time disease detection
 - Exchange of actionable data, particularly to advance equity
 - The Coalition’s founding members have called on health care and public health organizations across the country to consider joining this effort. Interested organizations can learn more, connect with us, and take steps to join us by going to our website, <https://commonhealthcoalition.org/>.
 - On April 11, 2024, the AMA was represented on a panel at the KP Health Summit in Washington, D.C., focused on *Building a Strong Public Health Ecosystem*. This session

1 explained the commitments the Coalition has made and actions each organization will take
2 to create a strong public health system and healthier future for all.
3

4 **4. Combat the spread of misinformation and disinformation.**
5

6 The AMA remains engaged in external collaborations to address mis- and disinformation, such as
7 the Coalition for Trust in Health & Science and the recently rebranded physician-focused coalition,
8 Mitigating Medical Misinformation Workgroup.
9

- 10 • The Coalition for Trust in Health & Science’s vision is for all people to have equitable
11 access to accurate, understandable, and relevant information to make personally
12 appropriate health choices and decisions. The AMA is an active member, engaging with
13 leadership and participating in programming.
- 14 • The AMA is also an active participant in the Mitigating Medical Misinformation
15 Workgroup and supported its recent research that found primary care physicians were
16 viewed as the most trusted source for medical information. The AMA will work with this
17 group to disseminate these findings to a broader audience in 2024 and will continue to
18 coordinate efforts internally to ensure alignment.
- 19 • The AMA filed an amicus brief with the U.S. Supreme Court in the case of *Murthy v.*
20 *Missouri*. The brief focuses on how disinformation diminished uptake of COVID-19
21 vaccines, which then limited the vaccines’ ability to save lives by controlling the spread of
22 disease—thereby creating a compelling interest for the government to act. The high court
23 will hear oral arguments in the case on March 18, 2024.
24

25 **CONCLUSION**
26

27 The AMA continues to advance its mission, to promote the art and science of medicine and the
28 betterment of public health. The highlighted accomplishments in this report capture a fraction of
29 the work accomplished from March of 2023 – March of 2024 related to the AMA’s public health
30 strategy.

REFERENCES

1. Introduction to Public Health|Public Health 101 Series|CDC. Published August 3, 2022. Accessed February 19, 2024. <https://www.cdc.gov/training/publichealth101/public-health.html>
2. What is public health? Accessed February 19, 2024. <https://www.apha.org/What-is-public-health>
3. Lee LM, Zarowsky C. Foundational values for public health. *Public Health Rev.* 2015;36(1):2. doi:10.1186/s40985-015-0004-1
4. American Medical Association. *Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity.*; 2021. <https://www.ama-assn.org/system/files/ama-equity-strategic-plan.pdf>
5. CDC. Heart Disease Facts | cdc.gov. Centers for Disease Control and Prevention. Published May 15, 2023. Accessed February 19, 2024. <https://www.cdc.gov/heartdisease/facts.htm>
6. American Heart Association. *2023 Heart Disease and Stroke Statistics Update Fact Sheet.*; 2023. https://professional.heart.org/-/media/PHD-Files-2/Science-News/2/2023-Heart-and-Stroke-Stat-Update/2023-Statistics-At-A-Glance-final_1_17_23.pdf
7. Martin SS, Aday AW, Almarzooq ZI, et al. 2024 Heart Disease and Stroke Statistics: A Report of US and Global Data From the American Heart Association. *Circulation.* 0(0). doi:10.1161/CIR.0000000000001209
8. National Diabetes Statistics Report | Diabetes | CDC. Published November 29, 2023. Accessed February 19, 2024. <https://www.cdc.gov/diabetes/data/statistics-report/index.html>
9. National Center for Health Statistics, Centers for Disease Control and Prevention. *Health, United States Spotlight: Racial and Ethnic Disparities in Heart Disease.*; 2019. https://www.cdc.gov/nchs/hus/spotlight/HeartDiseaseSpotlight_2019_0404.pdf
10. Cheng YJ, Kanaya AM, Araneta MRG, et al. Prevalence of Diabetes by Race and Ethnicity in the United States, 2011-2016. *JAMA.* 2019;322(24):2389-2398. doi:10.1001/jama.2019.19365
11. Obesity and Cardiovascular Disease: A Scientific Statement From the American Heart Association | *Circulation.* Accessed February 19, 2024. <https://www.ahajournals.org/doi/full/10.1161/CIR.0000000000000973>
12. AMA launches toolkit to increase screenings for HIV, STIs. American Medical Association. Published March 6, 2024. Accessed March 14, 2024. <https://www.ama-assn.org/press-center/press-releases/ama-launches-toolkit-increase-screenings-hiv-stis>
13. Routine Screening. Accessed March 14, 2024. <https://edhub.ama-assn.org/science-medicine-public-health/video-player/18858006>
14. Ebi KL, Hess JJ. Introduction to JAMA Climate Change and Health Series. *JAMA.* 2024;331(5):436-437. doi:10.1001/jama.2023.25878

15. Advocacy in action: Combatting health effects of climate change. American Medical Association. Published November 9, 2023. Accessed February 19, 2024. <https://www.ama-assn.org/delivering-care/public-health/advocacy-action-combatting-health-effects-climate-change>
16. National Academy of Medicine Action Collaborative is combating climate change with Victor Dzau, MD. American Medical Association. Published November 2, 2023. Accessed February 19, 2024. <https://www.ama-assn.org/delivering-care/public-health/national-academy-medicine-action-collaborative-combating-climate>
17. Home. The Medical Society Consortium on Climate and Health (MSCCH). Accessed February 19, 2024. <https://medsocietiesforclimatehealth.org/>
18. American Lung Association. About Fighting for Healthy Air. Accessed February 19, 2024. <https://www.lung.org/policy-advocacy/healthy-air-campaign/about-healthy-air-campaign>
19. US EPA O. Final Reconsideration of the National Ambient Air Quality Standards for Particulate Matter (PM). Published January 24, 2024. Accessed February 19, 2024. <https://www.epa.gov/pm-pollution/final-reconsideration-national-ambient-air-quality-standards-particulate-matter-pm>
20. CDC. Firearm Deaths Grow, Disparities Widen. Centers for Disease Control and Prevention. Published June 6, 2022. Accessed February 19, 2024. <https://www.cdc.gov/vitalsigns/firearm-deaths/index.html>
21. American College of Surgeons. Proceedings Released from Second ACS Medical Summit on Firearm Injury Prevention. ACS. Accessed February 19, 2024. <https://www.facs.org/for-medical-professionals/news-publications/news-and-articles/acs-brief/march-7-2023-issue/proceedings-released-from-second-acs-medical-summit-on-firearm-injury-prevention/>
22. American Medical Association. AMA advocates to prevent gun violence and to increase gun safety. American Medical Association. Published December 13, 2022. Accessed February 19, 2024. <https://www.ama-assn.org/delivering-care/public-health/ama-advocates-prevent-gun-violence-and-increase-gun-safety>
23. CDC. CDC's National Training Collaborative for Infection Control. Centers for Disease Control and Prevention. Published December 13, 2023. Accessed February 19, 2024. <https://www.cdc.gov/infectioncontrol/projectfirstline/index.html>
24. Partner Organizations - Providers Clinical Support System. Providers Clinical Support System- Medications for Opioid Use Disorders. Accessed February 20, 2024. <https://pcssnow.org/about/program-partners/>
25. 2023 Overdose Epidemic Report. AMA End the Epidemic. Accessed February 20, 2024. <https://end-overdose-epidemic.org/highlights/ama-reports/2023-report/>
26. AMA, health care partners announce the Common Health Coalition. American Medical Association. Published November 9, 2023. Accessed February 20, 2024. <https://www.ama-assn.org/press-center/press-releases/ama-health-care-partners-announce-common-health-coalition>

REPORT OF THE BOARD OF TRUSTEES

B of T Report 24-A-24

Subject: Report on the Preservation of Independent Medical Practice

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

1 BACKGROUND

2

3 At its 2022 Annual Meeting, the House of Delegates (HOD) adopted Resolution 602, “Report on
4 the Preservation of Independent Medical Practice,” which directed the American Medical
5 Association (AMA) to issue a report every two years communicating AMA efforts to support
6 independent medical practices.

7

8 Resolution 602 appended AMA policy D-405.988, The Preservation of the Private Practice of
9 Medicine, which among other things affirmed the Association’s support for the preservation of
10 private practice and the acknowledgement of its value to the practice of medicine and its benefit to
11 patients.

12

13 This report serves as the first instance of a biennial accounting of the activities the AMA has
14 engaged in since 2022 to support independent practices.

15

16 DISCUSSION

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18 The AMA’s efforts to promote and advocate for independent practice physicians can be
19 summarized in three key strategic efforts:

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26 The AMA’s newest section, the Private Practice Physicians Section (PPPS), was officially
27 established at the November 2020 Special Meeting of the HOD and held its first meeting in
28 conjunction with the June 2021 Special Meeting of the HOD. Though certainly not the only unit
29 within the Association working on behalf of independent practices, the PPPS is the primary vehicle
30 for addressing the concerns of private practice physicians within the HOD, thus helping to ensure
31 that independent practice concerns are considered when determining policy.

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The PPPS maintains a roster of 367 certified members. Membership is open to any AMA member who is in a practice consisting of 50 or fewer physicians and in which the physicians maintain a controlling interest in the practice. Physicians must independently elect to join the section; they are not at this time proactively asked if they want to join, though they are made aware of the Section’s existence. Membership in the PPPS has grown significantly since 2022, with the Section adding 53 new members in 2022 (+20%), and 44 new members in 2023 (+14%).

1 The Section has held formal Business Meetings at all AMA Annual and Interim meetings since
2 June of 2021. Attendance has been strong, fluctuating between approximately 40 and 60 members
3 attending each meeting. The PPPS has advanced 18 resolutions to the House of Delegates since the
4 2022 Annual Meeting on topics such as reexamining laws around physician self-referrals, limiting
5 corporate ownership of private practices, improving Medicare reimbursement, and developing
6 guidelines for the use of virtual and overseas administrative assistants, among many others.

7
8 The AMA has championed issues important to private practice in its advocacy efforts, particularly
9 at the federal level. Key among these issues is reforming Medicare payment rates to ensure
10 practices can continue to thrive. The AMA believes the need to stop the annual cycle of pay cuts
11 and patches and enact permanent Medicare payment reforms could not be clearer. The AMA was
12 successful in getting Congress to introduce H.R. 2474, the Strengthening Medicare for Patients and
13 Provider Act, which would provide automatic, annual payment updates to account for inflation as
14 reflected in the Medicare Economic Index (MEI). The AMA and our Physician Grassroots
15 Network and Patient Advocacy Network consider the passage of H.R. 2474 to be among its highest
16 priorities.

17
18 The AMA is also engaging directly with federal decision-makers on fixing prior authorization,
19 limiting scope creep, supporting telehealth, surprise billing, and protecting against government
20 intrusion in areas such as abortion care and gender-affirming care. The AMA has submitted
21 comments on the Federal Trade Commission’s proposed rule on noncompete agreements and
22 Department of Justice antitrust merger guidelines. The AMA also advocates before Congress and
23 the Centers for Medicare and Medicaid Services that the Stark exemption for physician-owned
24 hospitals needs to be restored.

25
26 The cyber security attack on Change Healthcare in March 2024 has left many independent
27 physician practices struggling to stay on top of their operations. The AMA is working closely with
28 members who have experienced disruptions to share instructions for getting federal emergency
29 funds, guides for managing impact, and connecting physicians’ experiences directly to the United
30 States Department of Justice.

31 32 *Outreach to Independent Physicians*

33
34 For the past three years, the PPPS has hosted a virtual Private Practice Townhall each March or
35 April, serving as an open forum for independent physician members to raise issues they may be
36 experiencing in their practices and share ideas for addressing them. The Townhall not only
37 provides valuable real-world intelligence about the issues private practices are experiencing to the
38 leadership of the PPPS, but it also affords an opportunity for physicians to connect as peers to share
39 tips and best practices. Additionally, the Townhall typically inspires ideas for education sessions at
40 PPPS Business Meetings as well as generates new policy proposals.

41
42 The PPPS has also collaborated with the AMA’s Professional Satisfaction and Practice
43 Sustainability (PS2) team. The two are currently planning a private practice “bootcamp” to be held
44 in advance of the 2024 Annual Meeting. The “bootcamp” will be a multi-hour training session on
45 the business of private practice, giving attendees opportunities to better understand how to
46 effectively manage their business while continuing to provide care to patients. The program stems
47 from ideas raised in previous PPPS Townhalls as well as open discussions at PPPS Business
48 Meetings and other AMA events.

1 *Promoting Resources for the Advancement of Independent Practices*

2
3 The AMA's STEPS Forward® initiative, part of its Innovation Academy, has made a suite of
4 interactive open-access resources tailored for independent practices available through the AMA
5 EdHub™, many of which are available for continuing medical education credit. These include
6 podcasts, toolkits, and webinars available online to members and non-members.

7
8 Specifically, STEPS Forward® has crafted a series of tools and materials designed to help
9 physicians who are either new to private practice or who simply seek to better operationalize their
10 practice. Key examples include:

- 11
- 12 • 7 STEPS to Starting a Private Practice visual guide
- 13
- 14 • Private Practice Playbook – a repository of sample forms including a model new patient
15 packet, routine patient documents such as medical release and patient payment plans,
16 administrative documents such as refund requests and medication logs, employee
17 documents for job descriptions and expense reimbursement, and new hire documents such
18 as model confidentiality agreements and drug screen consent forms.
- 19

20 Independent physicians who are AMA members also have access to a range of experiential
21 sessions in the form of webinars to help physicians better capitalize on their practices' regular
22 financial and operational tasks. This programming is offered through the AMA's Private Practice
23 Simple Solutions sessions, of which 17 programs have been offered since 2022. Key examples of
24 programming for independent practices include sessions on practice marketing, conducting market
25 research to better understand the needs of the community, public relations and establishing
26 community trust, and maximizing referral strategies. These programs are operated and promoted by
27 the AMA's PS2 team.

28
29 The PPPS has offered additional educational programming at its Annual and Interim meetings.
30 Designed and curated to address issues that PPPS members most frequently raise as key issues for
31 their practice, the Section routinely works with internal and external subject matter experts to share
32 strategies and information to attendees. Recent examples of educational sessions offered at PPPS
33 meetings include a legal analysis of employment contracting from the perspective of both the
34 employer and employee, an unpacking of innovative business model strategies from three different
35 independent physician practices, a strategic assessment of methods for transitioning a practice, and
36 a breakdown of best practices for branding and marketing.

37
38 **CONCLUSION**

39
40 The AMA continues to be mindful of the rate of change in the physician practice setting with
41 greater numbers of physicians opting to leave private practice each year. The strategies and
42 initiatives outlined here represent the foundations the AMA will build upon to continue to ensure
43 that independent physician practices have the support they need to thrive. The AMA will continue
44 to promote the resources it has while expanding its menu of services and tools geared toward
45 physicians in private practice.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 27-A-24

Subject: AMA Reimbursement of Necessary HOD Business Meeting Expenses for Delegates and Alternates (Resolution 606-A-23)

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

1 At the 2023 Annual Meeting of the American Medical Association (AMA) House of Delegates
2 (HOD) Resolution 606, “AMA Reimbursement of Necessary HOD Business Meeting Expenses for
3 Delegates and Alternates” was referred to the Board of Trustees for a report back to the HOD. The
4 reference committee heard mixed testimony, including compelling testimony from the Board of
5 Trustees regarding their fiduciary responsibility to our AMA and the need to allow sufficient time
6 to identify and fully assess the impact on our AMA.

7
8 Resolution 606 asked:

9
10 That our American Medical Association develop a reimbursement policy consistent with
11 established AMA travel policies for reasonable travel expenses that any state or national
12 specialty society is eligible to receive reimbursement for its delegate’s and alternate delegate’s
13 actual expenses directly related to the necessary business functions required of its AMA
14 delegates and alternate delegates in service to the AMA at HOD meetings, including travel,
15 lodging, and meals; and

16
17 That each state or national specialty society requesting such reimbursement for its delegate’s
18 and alternate delegate’s reasonable travel expenses will submit its own aggregated
19 documentation to the AMA in whatever form is requested by the AMA.

20
21 BACKGROUND

22
23 Resolution 606 highlighted the significance of the AMA HOD as a policy making body with
24 diverse voices being represented through the delegations. The resolution focuses on the costs that
25 are incurred by the organizations sending delegates and alternates to the meetings without
26 discussing the costs of the meeting to the AMA. The resolution pointed out that several state and
27 specialty medical societies are facing financial hardships due to several factors, including declining
28 membership. As these organizations are looking to cut costs, not sending the full delegations or
29 alternate delegates to the AMA HOD meetings could be seen as a savings. In some instances,
30 delegates pay their own expenses at AMA HOD meetings so they can be a part of the robust policy
31 making process. In addition, medical students and residents expressed issues with obtaining
32 funding and are seeking inclusion in the development of an AMA reimbursement policy.

33
34 *Costs*

35
36 A fiscal note of \$8.1 million was the estimate of the ongoing additional annual costs that would be
37 incurred by the AMA if this resolution were adopted. This would be in addition to the \$12 million
38 the AMA is spending already to hold HOD meetings and provide staff support for councils,

1 sections and special groups. That does not include costs related to responding to and implementing
2 resolutions from the HOD.

3
4 While our AMA has experienced above normal operating income over the last several years due to
5 a reduction in expenses during the pandemic office closures and a record number of open positions
6 due to tight labor markets, it is expected that the Association will return to full employment and
7 regular operations by 2024, with a reversion to normal budgeted income.

8
9 *AMA Budget and Reserve Policies*

10
11 In the early 2000's, AMA's financial picture was very poor evidenced by questions raised at the
12 HOD about the long-term viability of the organization. The AMA Board took action in 2000 to
13 implement financial policies that would provide for ongoing sustainable operations and
14 programmatic activities for both the short-and long-term. The goal was two-fold: 1) ensure that
15 AMA would be able to withstand short-term volatility in revenue without requiring elimination of
16 programs or personal that would be harmful to AMA's reputation and 2) create reserve assets that
17 could serve as a quasi-endowment fund to help ensure long-term fiscal stability of the organization.
18 The annual budget policy was in answer to the first goal and that policy requires that AMA budget
19 a surplus equal to the inflationary impact on two- to three-year's operating expenses. The reserve
20 policy prohibits the use of reserves for ongoing operating expenses in order to avoid drawing down
21 the reserves on an annual basis and thus impairing the ability to maintain and grow reserves for the
22 long-term stability of the organization, i.e., AMA's quasi-endowment fund.

23
24 The two policies cited above mean that any expenditures above the current budget levels will
25 require reducing expenses from other areas of the annual budget, i.e., other programmatic
26 activities. If this resolution were adopted, that would result in an ongoing annual \$8 million cost
27 reduction in other programs, which at the current rate of inflation would cost almost \$100 million
28 over the next ten years. In addition, the size of the HOD continues to increase and this will drive
29 total costs of delegates and alternate delegates attending in-person meetings higher than levels cited
30 above, regardless of whether it is paid by AMA or the societies.

31
32 Financial and Tax Implications

33
34 AMA's tax-exempt status and the regulations under which it operates to maintain that status is a
35 key consideration when determining if or how to provide benefits or contributions to individuals or
36 organizations. As an example, AMA's tax counsel has advised that generally the IRS has found
37 that the provision of financial benefits to members in certain situations will constitute private
38 inurement which will result in the loss of tax-exempt status. Counsel did advise that the IRS has
39 consistently viewed paying the reasonable travel expenses of volunteers, particularly those who
40 participate in governance, as being acceptable and not treated as compensation which in this case
41 would cover delegates and alternate delegates and thus led to the language of the resolution
42 submitted to the HOD.

43
44 Additional discussions with tax counsel have resulted in another potential alternative, i.e.,
45 providing travel grants to societies in the HOD to cover or partially cover direct out-of-pocket
46 expenses for delegates and alternate delegates based on financial need. Under this alternative,
47 counsel recommended the following criteria: 1) the travel grants be limited to societies that
48 demonstrate financial need; 2) the travel grants should be specifically identified as grants to cover
49 travel reimbursement only for voting delegates and alternate delegates who participate in the HOD
50 meetings, enabling delegates to participate in discussions regarding important issues affecting
51 AMA and the medical profession; 3) the grant agreement between AMA and the society should

1 require that the funds are for reimbursement of incurred travel expenses in a manner that is
2 consistent with 501(c)(6) purposes; and 4) that AMA should establish a cap on the amount that any
3 one society can receive for reimbursement of travel expenses.

4

5 Based on the above alternative, AMA performed an analysis of the financial status of those
6 societies seated in the HOD. The 2022 Form 990's submitted to the Internal Revenue Services
7 were obtained for 178 constituent and specialty societies. Form 990's were not available for seven
8 societies.

9

10 In 2022, the combined revenues and assets of the 178 societies total \$3.2 billion and \$7 billion
11 respectively, and although there is wide disparity in the resources of these societies, is substantially
12 more than AMA's revenue or assets. The estimated average cost of a delegate and alternate
13 delegate attending the AMA meetings is approximately \$11,400. At revenue levels of \$2.5 million
14 and above, the total average cost for delegates and alternates would range from 0.04% to 2.1% of
15 annual revenue. In comparison, AMA currently spends 2.6% of its total annual revenue on HOD
16 activities.

17

18 The AMA realizes the importance of representation and participation in the policy-making process
19 and the strength of organized medicine, are the organizations who send representatives to our HOD
20 meetings to participate in the policy making process. Your Board of Trustees presents this report as
21 informational as we continue to study options for strengthening the participation of the Federation
22 in House of Delegates meetings. Your Board will submit a report at the 2025 Annual Meeting.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 32-A-24

Subject: Independent Medical Evaluation

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

1 At the 2023 Annual Meeting, the House of Delegates referred Resolution 007, “Independent
2 Medical Evaluation,” to the Board of Trustees. Resolution 007 specifically asked:

3
4 That our American Medical Association study and report back at the 2024 Annual Meeting on
5 the Independent Medical Evaluation (IME) process and recommend standards and safeguards
6 to protect injured and disabled patients. (Directive to Take Action)

7
8 The resolution was referred to the Board of Trustees for decision in September 2023. At that
9 meeting, the Board of Trustees reviewed the Management report and decided to complete the
10 study, as outlined in the report.

11
12 The following study, presented as an informational report, examines IME standards, processes and
13 procedures that impact the rights of examinees and physicians throughout the IME process, as set
14 forth in the resolution. Topics discussed include professional qualifications, ethics, objectivity,
15 safety, and access.

16
17 Despite their widespread use, IME processes and approaches can significantly vary across different
18 jurisdictions, which may impact the rights and responsibilities of examinees and physicians.
19 Examining specific jurisdictional regulation protocols such as codes of ethics, educational
20 requirements and licensure protocols are beyond the purview of this report.

21 22 PURPOSE AND DEFINITION OF INDEPENDENT MEDICAL EVALUATIONS (IME)

23
24 In general, an IME is “a usually one-time evaluation performed by an independent medical
25 examiner who is not treating the patient or claimant, to answer questions posed by the party
26 requesting the IME”.¹ The most common purpose of an IME is to provide a timely, impartial, and
27 objective assessment of an examinee’s medical condition to determine appropriate diagnoses,
28 causality, the extent of injuries or disabilities, and need for accommodation. This is often required
29 in the context of legal or insurance matters. Unless a limited scope IME is stipulated by the
30 requesting party or refused by the examinee, an IME includes the essential element of a medical
31 assessment, specific to the defined scope of the requested evaluation, including history,
32 examination, and review of relevant records and diagnostic studies.³

33
34 The goal of the IME physician is to provide an unbiased, evidence-based assessment regarding the
35 individual's medical status, including the nature and extent of injuries or disabilities. During an
36 IME, the examinee’s relevant medical history, current condition, test results, functional status, and
37 any relevant medical records are assessed. The *AMA Guides to the Evaluation of Permanent*
38 *Impairment* (AMA Guides) provide a reliable measurement framework for assessing permanent
39 impairment and are required in many jurisdictions.^{1,2} An impairment rating may be a component of

1 the IME, which is defined as a “consensus-derived percentage estimate of loss of activity, which
2 reflects severity of impairment for a given health condition, and the degree of associated limitations
3 in term of Activities of Daily Living (ADLs)”.¹ The AMA Guides Editorial Panel ensures the AMA
4 Guides are up to date with the latest evidence-based medicine and science.

5
6 While IMEs and corresponding processes vary among different contexts and jurisdictions, one
7 commonality is that there is no patient-physician relationship, and many jurisdictions avoid using
8 the term “patient” in the context of IMEs because this can be construed to establish a patient-
9 physician relationship. Instead, the term “examinee” is used.^{1,3,4}

10 11 *Common Scenarios for IMEs*

12
13 The applications and requirements of an IME can differ significantly based on different scenarios.
14 For example, in workers' compensation, IMEs commonly evaluate the nature and extent of
15 occupational-related injuries, care-related issues and authorizations, physical work capabilities, and
16 causality. For insurance claims, particularly those involving personal injury, bodily injury, and
17 automobile accidents, IMEs can verify the legitimacy and extent of the alleged injuries and medical
18 status. In many jurisdictions, an injured party’s failure to comply with insurer requests for an IME
19 or a claim investigation to support a claims determination may be grounds for a denial of the claim
20 and benefits. Additionally, IMEs are utilized in legal disputes or tort litigation involving alleged
21 bodily, physical, mental, or other injury claims. Petitioner filings, court or other findings may result
22 in an IME order to obtain an objective assessment of injuries, disabilities, and/or other issues.

23 24 PROFESSIONAL QUALIFICATIONS FOR INDEPENDENT MEDICAL EVALUATORS

25
26 The selection of the medical professional with the appropriate qualifications is a fundamental
27 aspect that can determine the examination's thoroughness and impact the outcome of claims,
28 benefits, and legal disputes. Judges or juries critically assess the qualifications and expertise of the
29 physician to ensure that their evaluation is reliable and based on sound medical judgment. The
30 presence of established standards and resources for IME training and certification underscores the
31 importance of having skilled, ethical, and unbiased medical professionals conduct these
32 examinations within their scope of practice.

33
34 Jurisdictional regulations or protocols may include specific criteria for physician qualifications.
35 The following qualifications are commonly recommended across most jurisdictions:

- 36
37
- 38 • Unrestricted license to practice medicine in the jurisdiction.
 - 39 • Relevant board-certification in a specialty recognized by the American Board of Medical
40 Specialties.
 - 41 • Competency in report-writing and the ability to provide deposition and expert testimony
42 are essential. These skills ensure that the physician can effectively communicate their
43 medical findings and rationale in legal or insurance contexts.
 - 44 • Professional history should be free from adverse events that could compromise their
45 credibility or impartiality in performing an IME.

46 Specialized credentials or certification may be required on a jurisdictional-specific basis.

47 48 *Objectivity and Bias*

49
50 The IME process should be objective, independent and unbiased with the substantiation of findings
51 and recommendations based upon available information and evidence.^{3,4} Physician transparency in

1 reporting and testimony can reinforce impartiality. Having IMEs performed in a timely manner in
2 an appropriately situated and appointed environment is in the best interest of the examinee and
3 involved parties. However, there may be conflicts of interest to consider.

4
5 The *AMA Code of Ethics*^{5,6} addresses the ethical considerations for physicians employed by
6 businesses or insurance companies, as well as independent medical examiners assessing health or
7 disability. The IME physician may obtain personal information about patients outside an ongoing
8 patient-physician relationship, such as assessments for employers or insurers. It is also important to
9 obtain written consent, as required by law, to provide disclosure to third parties.⁶

10
11 While practicing in these roles, physicians have dual responsibilities to both the patient and the
12 employer or third party. However, there is also the additional duty to uphold the obligations of a
13 medical professional. Therefore, the following should be considered:⁵

- 14
- 15 • Disclose the nature of the relationship with the employer or third party before gathering
- 16 health information from the patient.
- 17 • Explain that the goal is to assess the patient's health or disability independently and
- 18 objectively, distinguishing it from the traditional fiduciary role of a physician.
- 19 • Protect patients' personal health information according to professional confidentiality
- 20 standards.
- 21 • Inform the patient about significant findings during the examination, suggesting follow-up
- 22 care from a qualified physician when appropriate.
- 23

24 PROTECTIONS FOR THE EXAMINEE

25 *Informed Consent*

26
27
28 It is important for examinees to understand their jurisdictionally specific rights and the potential
29 implications of the examination's findings on their claims or legal cases. This information should
30 be communicated to the examinee via the informed consent process. The examiner must explain
31 that there is no physician-patient relationship involved and the evaluation is not a traditional
32 medical evaluation conducted by their treating physician.^{3,4} Additionally, the examinee must advise
33 the examiner immediately if any problems are encountered during the evaluation and a report will
34 be provided to the requesting client.

35
36 Additional best practices for the informed consent process are as follows:⁴

- 37
- 38 • Discuss the importance of the examinee's reading and signing of a written informed
- 39 consent with the examinee prior to the evaluation.
- 40 • Establish the ground rules for the performance of the service.
- 41 • Provide the opportunity for the examinee to understand the rationale for the IME, who is
- 42 requesting the evaluation, and where the report will be sent.
- 43 • Ensure the examinee understands what the IME provider can and cannot do.
- 44 • Acknowledge that the examinee understands that there will be no physician-patient
- 45 relationship established.
- 46 • Confirm that there will not be a discussion regarding diagnoses nor any recommendations
- 47 for treatment.
- 48 • Indicate that the examinee is consenting to having their history taken and that an
- 49 examination will occur.
- 50 • Clearly state that the IME physician is independent and that any opinions developed are
- 51 given irrespective of anyone else involved in the claim (a third-party evaluation).

- 1 • State that there is an understanding that the results of the evaluation (the report) will only
2 be given to the requesting party (unless there is a jurisdictional rule that requires something
3 else).
- 4 • Spend an appropriate amount of time on the informed consent process to ensure that the
5 IME physician can answer questions or clarify points that are not well understood.

6 7 *IME Report Access*

8
9 An examinee may have the right to access their IME report, but the process and ease of access can
10 vary based on jurisdiction, the specific policies of the requesting entity (such as an insurance
11 company or employer), and the purpose of the IME. There might be a specific timeframe within
12 which the IME report must be requested or provided.

13
14 Examinees should be encouraged to inquire about the request process or seek assistance from their
15 legal representative to understand their rights and the best approach to obtain the IME report. These
16 rights are often outlined in health information privacy laws or regulations concerning workers'
17 compensation and personal injury cases. For IMEs conducted as part of an insurance claim or
18 workers' compensation case, the report is typically part of the claim file. In the context of legal
19 disputes, IME reports may become part of the discovery process, allowing the examinee or their
20 attorney to access the report as part of the case proceedings.

21 22 *Third-Party Observation*

23
24 Some jurisdictions may have specific regulations or guidelines that address whether third-party
25 observers are allowed during IMEs. Examinees and their representatives should clarify the rules
26 and policies regarding third-party observers in advance. This might involve consulting with legal
27 counsel, reviewing the request for the IME, and directly communicating with the requesting
28 organization, insurance company, or physician coordinating the examination.

29
30 The presence of a third-party observer raises issues of patient privacy, confidentiality, and integrity
31 of the examination process, and research shows that it will bias the evaluation to the extent that in
32 most cases, the results are invalid.^{4,7} If a third party is allowed because of jurisdictional rule, the
33 individual undergoing the IME and the third party should agree to confidentiality terms. Any
34 observer will need to agree to not interfere with the examination.

35 36 PROTECTIONS FOR PHYSICIANS

37
38 The IME physician may be asked to render an opinion based upon incomplete information,
39 inadequate records, a limited in person evaluation, or an examinee who is uncooperative or
40 misrepresenting their true status for potential secondary gain. The examiner may be requested to
41 report on the nature and extent of alleged, documented or observed injuries, and function based
42 upon the available information and findings, within a reasonable degree of certainty.

43
44 Despite challenges that may arise during an IME, the evaluating physician's goal remains to
45 provide an unbiased, objective opinion regarding the examinee's medical and/or physical status.
46 When possible, physicians should identify and request additional records and information if needed
47 to objectively provide their report. Indicating that conclusive findings cannot be rendered with the
48 available information may be necessary in some circumstances.

49
50 In addition to examinee rights, the following list outlines best practices for minimizing professional
51 risks for physicians conducting IMEs:

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- Detailed record-keeping of the IME process, findings, and the basis for conclusions to safeguard against potential disputes or allegations of misconduct. Documentation should be clear, factual, and free of any speculation.
- Safeguarding all IME-related documents and records, including during transport.
- Clear, professional communication with all parties involved. This includes the ability to explain medical terms and findings in layman's terms, which can reduce misunderstandings and conflicts.
- Only performing IMEs in their respective area of specialty and board certification. If an examination or interpretation of findings falls outside expertise, consult with other specialists.
- Having appropriate professional liability insurance that covers IMEs to provide financial and legal protection in case legal claims arise.
- Staying informed about the latest developments and any changes in laws or guidelines related to IMEs to avoid practices may cause exposure to liability.
- Seeking advice, when in doubt, on complex issues related to IMEs from legal professionals or a professional association.
- Identifying, disclosing and avoiding conflicts of interest, such as evaluating family members.
- Taking precautions disclosing information to third parties, limiting it to the minimum necessary for the intended purpose and remove individually identifying information before releasing aggregate data or statistical health information.⁶

STRUCTURAL BARRIERS IMPACTNG PHYSICIANS AND EXAMINEES

There is a national shortage of qualified physicians to meet the market demands for IMEs and associated timely report submissions. The shortage impacts timely decision making and authorization of care and subsequent appeals, creating an extra burden on examinees. The shift towards health care delivery consolidation and away from independent practice further contributes to the difficulty of scheduling and administering IMEs. Interstate and compact licensing affording physicians the right to perform IMEs beyond the boundaries of their jurisdiction could increase the pool of available qualified physicians to perform IMEs and promote access to care.

CONCLUSION

It is important for physicians to implement standards and safeguards when performing IMEs to protect examinees, themselves, and all other involved parties. Regulations, professional requirements, and protocols for IMEs differ both by jurisdiction and context in which the IME is being sought. However, despite myriad differences across jurisdictions, this report outlines numerous best practices for conducting IMEs that can enhance the quality of the examinee experience, as well as the scientific and evaluative rigor of the evaluating physician within this vital process. Additionally, critical elements like a thorough informed consent process, clear communication with the patient, and practicing within one's clinical expertise are some of the methods that can be deployed to protect both the IME physician and the examinee.

1 REFERENCES

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1. American Medical Association. *Guides to the Evaluation of Permanent Impairment*. 6th ed. 2023. Accessed March 10, 2024. <https://ama-guides.ama-assn.org/books/book/11/AMA-Guides-to-the-Evaluation-of-Permanent>
2. American Medical Association. AMA Guides Sixth 2023: Current medicine for permanent impairment ratings. Accessed, March 9, 2024. <https://www.ama-assn.org/delivering-care/ama-guides/ama-guides-sixth-2023-current-medicine-permanent-impairment-ratings>
3. Brigham C, Direnfeld LK, Feinberg S, Kertay L, Talmage JB. Independent Medical Evaluation Best Practices. *AMA Guides Newsletter*. 2017; 22 (5): 3–18.
4. Martin DW. Independent Medical Evaluations- A Practical Guide. Cham, Switzerland. Springer International Publishing AG; 2018.
5. American Medical Association. AMA Code of Medical Ethics. Chapter 1: Opinions on Patient-Physician Relationships, section 1.2, Special Issues in Patient-Physician Relationships, 1.2.6, Work-Related and Independent Medical Examinations. Accessed March 8, 2024. <https://www.ama-assn.org/system/files/code-of-medical-ethics-chapter-1.pdf>.
6. American Medical Association. AMA Code of Medical Ethics. Chapter 3: Privacy, Confidentiality & Medical Records, section 3.2, Special Issues in Patient-Physician Relationships, 3.2.3, Industry-Employed Physicians & Independent Medical Examiners. Accessed March 13, 2024. <https://code-medical-ethics.ama-assn.org/ethics-opinions/industry-employed-physicians-independent-medical-examiners>
7. Barth R. Observation compromises the credibility of an evaluation. *AMA Guides Newsletter*. 2007; 12(4): 1-3, 8-9.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 34-A-24

Subject: Demographic Report of the House of Delegates and AMA Membership

Presented by: Willie Underwood III, MD, MSc, MPH, Chair

1 INTRODUCTION

2

3 This informational report, “Demographic Report of the House of Delegates and AMA
4 Membership,” is prepared pursuant to Policy G-600.035, “House of Delegates Demographic
5 Report,” which states:

6

7 A report on the demographics of our AMA House of Delegates will be issued annually and
8 include information regarding age, gender, race/ethnicity, education, life stage, present
9 employment, and self-designated specialty.

10

11 In addition, this report includes information pursuant to Policy G-635.125, “AMA Membership
12 Demographics,” which states:

13

14 Stratified demographics of our AMA membership will be reported annually and include
15 information regarding age, gender, race/ethnicity, education, life stage, present employment,
16 and self-designated specialty.

17

18 This document compares the House of Delegates (HOD) with the entire American Medical
19 Association (AMA) membership and with the overall United States physician and medical student
20 population. Medical students are included in all references to the total physician population
21 throughout this report to remain consistent with the bi-annual Council on Long Range Planning and
22 Development report. In addition, residents and fellows endorsed by their states to serve as sectional
23 delegates and alternate delegates are included in the appropriate comparisons for the state and
24 specialty societies. For the purposes of this report, AMA-HOD includes both delegates and
25 alternate delegates.

26

27 DATA SOURCES

28

29 Lists of delegates and alternate delegates are maintained in the Office of House of Delegates
30 Affairs and are based on official rosters provided by the relevant society. The lists used in this
31 report reflect 2023 year-end delegation rosters.

32

33 Data on individual demographic characteristics are taken from the AMA Physician Professional
34 Data, which provides comprehensive demographic, medical education, and other information on all
35 United States and international medical graduates (IMGs) who have undertaken residency training
36 in the United States. Data on AMA membership and the total physician and medical student
37 population are taken from the Masterfile and are based on 2023 year-end information.

38

39 Some key considerations must be kept in mind regarding the information captured in this report.
40 Vacancies in delegation rosters mean that the total number of delegates is less than the 705 allotted

1 at the November 2023 Interim Meeting, and the number of alternate delegates is nearly always less
 2 than the full allotment. As such, the total number of delegates and alternate delegates is 1091 rather
 3 than the 1410 allotted. Race and ethnicity information, which is provided directly by physicians, is
 4 missing for approximately 15 percent of AMA members and approximately 19 percent of the total
 5 United States physician and medical student population, limiting the ability to draw firm
 6 conclusions. Efforts to improve AMA data on race and ethnicity are part of Policy D-630.972.
 7 Improvements have been made in collecting data on race and ethnicity, resulting in a decline in
 8 reporting race/ethnicity as unknown in the HOD and the overall AMA membership.

9
 10 **CHARACTERISTICS OF AMA MEMBERSHIP AND DELEGATES**

11
 12 Table 1 presents basic demographic characteristics of AMA membership and delegates along with
 13 corresponding figures for the entire physician and medical student population.

14
 15 Data on physicians’ and students’ current activities appear in Table 2. This includes life stage as
 16 well as present employment and self-designated specialty.

Table 1. Basic Demographic Characteristics of AMA Members & Delegates, December 2023

2023	AMA Members	All Physicians and Medical Students	AMA Delegates & Alternate Delegates 1,2
Total	282,952	1,514,092	1,091
Mean Age (Years)	46.7	52.8	54.2
Age			
Under Age 40	52.9%	30.5%	19.1%
40-49 Years	11.1%	17.2%	18.1%
50-59 Years	9.5%	15.8%	20.2%
60-69 Years	9.0%	15.6%	25.8%
70 or More	17.5%	20.8%	16.9%
Gender			
Male	58.9%	61.9%	60.8%
Female	40.5%	37.2%	39.0%
Unknown	0.6%	0.9%	0.2%
Race/Ethnicity			
American Indian or Alaskan Native	0.17%	0.17%	0.2%
Asian	17.5%	16.7%	14.8%
Black or African American	5.3%	4.5%	5.8%
Hispanic	4.1%	4.5%	3.3%
Mixed Race/Ethnicity	5.8%	4.0%	3.1%
Native Hawaiian or Other Pacific Islander	0.05%	0.04%	0.0%
White	50.4%	49.9%	62.9%
Unknown	14.9%	18.5%	8.3%
Other	1.8%	1.7%	1.6%
Education			
US or Canada	81.3%	77.2%	90.6%
IMG	18.7%	22.8%	9.4%

¹ There were 319 vacancies as of year’s end.

² Numbers include medical students and residents endorsed by their states for delegate and alternate delegate positions.

³ Age as of December 31. Mean age is the arithmetic average.

⁴ Includes other self-reported racial and ethnic groups.

Table 2. Life Stage, Present Employment and Self-Designated Specialty⁵, December 2021

2023	AMA Members	All Physicians and Medical Students	AMA Delegates & Alternate Delegates 1,2
Life Stage			
Student	18.2%	7.7%	6.1%
Resident	29.0%	11.5%	6.9%
Young (under 40 or first 8 years in practice)	10.0%	15.3%	6.5%
Established (40-64)	20.8%	36.7%	49.9%
Senior (65+)	22.0%	28.7%	30.6%
Present Employment			
Self-Employed Solo Practice	5.8%	7.2%	10.5%
Two physician practice	1.3%	1.7%	1.6%
Group practice	23.5%	38.9%	38.5%
HMO	0.2%	0.1%	0.8%
Medical School	0.8%	1.3%	3.4%
Non-government hospital	3.0%	4.2%	8.2%
State or local government hospital	3.4%	5.6%	10.4%
US government	0.8%	1.5%	2.5%
Locum Tenes	0.1%	0.2%	0.3%
Retired/Inactive	11.0%	12.8%	7.3%
Resident/Intern/Fellow	29.1%	11.6%	6.9%
Student	18.3%	7.8%	6.1%
Other/Unknown	2.8%	7.1%	3.6%
Specialty			
Family Medicine	7.9%	10.3%	10.8%
Internal Medicine	21.0%	22.8%	20.3%
Surgery	12.8%	12.8%	20.0%
Pediatrics	5.5%	8.6%	4.0%
Obstetrics & Gynecology	4.9%	4.4%	6.8%
Radiology	3.4%	4.3%	4.9%
Psychiatry	4.4%	5.1%	4.5%
Anesthesiology	3.5%	4.4%	3.4%
Pathology	1.7%	2.2%	2.1%
Other Specialty	16.6%	17.4%	17.0%
Students	18.2%	7.7%	6.1%

⁵ See Appendix for a listing of specialty classifications.

⁶ Students and residents are categorized without regard to age.

Appendix

Specialty classification using physician's self-designated specialties.

Major Specialty Classification	AMA Physician Masterfile Classification
Family Practice	General Practice, Family Practice
Internal Medicine	Internal Medicine, Allergy, Allergy and Immunology, Cardiovascular Diseases, Diabetes, Diagnostic Laboratory Immunology, Endocrinology, Gastroenterology, Geriatrics, Hematology, Immunology, Infectious Diseases, Nephrology, Nutrition, Medical Oncology, Pulmonary Disease, Rheumatology
Surgery	General Surgery, Otolaryngology, Ophthalmology, Neurological Surgery, Orthopedic Surgery, Plastic Surgery, Colon and Rectal Surgery, Thoracic Surgery, Urological Surgery
Pediatrics	Pediatrics, Pediatric Allergy, Pediatric Cardiology
Obstetrics/Gynecology	Obstetrics and Gynecology
Radiology	Diagnostic Radiology, Radiology, Radiation Oncology
Psychiatry	Psychiatry, Child Psychiatry
Anesthesiology	Anesthesiology
Pathology	Forensic Pathology, Pathology
Other Specialty	Aerospace Medicine, Dermatology, Emergency Medicine, General Preventive Medicine, Neurology, Nuclear Medicine, Occupational Medicine, Physical Medicine and Rehabilitation, Public Health, Other Specialty, Unspecified

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 6-A-24

Subject: Judicial Function of the Council on Ethical and Judicial Affairs – Annual Report

Presented by: David A. Fleming, MD, Chair

1 At the 2003 Annual Meeting, the Council on Ethical and Judicial Affairs (CEJA) presented a
2 detailed explanation of its judicial function. This undertaking was motivated in part by the
3 considerable attention professionalism has received in many areas of medicine, including the
4 concept of professional self-regulation.

5
6 CEJA has authority under the Bylaws of the American Medical Association (AMA) to disapprove
7 a membership application or to take action against a member. The disciplinary process begins when
8 a possible violation of the Principles of Medical Ethics or illegal or other unethical conduct by an
9 applicant or member is reported to the AMA. This information most often comes from statements
10 made in the membership application form, a report of disciplinary action taken by state licensing
11 authorities or other membership organizations, or a report of action taken by a government tribunal.

12
13 The Council rarely re-examines determinations of liability or sanctions imposed by other entities.
14 However, it also does not impose its own sanctions without first offering a hearing to the physician.
15 CEJA can impose the following sanctions: applicants can be accepted into membership without any
16 condition, placed under monitoring, or placed on probation. They also may be accepted, but be the
17 object of an admonishment, a reprimand, or censure. In some cases, their application can be
18 rejected. Existing members similarly may be placed under monitoring or on probation, and can be
19 admonished, reprimanded or censured. Additionally, their membership may be suspended or they
20 may be expelled. Updated rules for review of membership can be found at [https://www.ama-](https://www.ama-assn.org/governing-rules)
21 [assn.org/governing-rules](https://www.ama-assn.org/governing-rules).

22
23 Beginning with the 2003 report, the Council has provided an annual tabulation of its judicial
24 activities to the House of Delegates. In the appendix to this report, a tabulation of CEJA's activities
25 during the most recent reporting period is presented.

APPENDIX

CEJA
*Judicial Function
 Statistics*

APRIL 1, 2023 – MARCH 31, 2024

Physicians Reviewed	<u>SUMMARY OF CEJA ACTIVITIES</u>
14	Determinations of no probable cause
22	Determinations following a plenary hearing
18	Determinations after a finding of probable cause, based only on the written record, after the physician waived the plenary hearing

Physicians Reviewed	<i>FINAL DETERMINATIONS FOLLOWING INITIAL REVIEWS</i>
14	No sanction or other type of action
3	Monitoring
17	Probation
4	Revocation
5	Suspension
1	Denied
1	Suspension lifted
0	Censure
7	Reprimand
3	Admonish

Physicians Reviewed	<u>PROBATION/MONITORING STATUS</u>
20	Members placed on Probation/Monitoring during reporting interval
15	Members placed on Probation without reporting to Data Bank
10	Probation/Monitoring concluded satisfactorily during reporting interval
0	Memberships suspended due to non-compliance with the terms of probation
10	Physicians on Probation/Monitoring at any time during reporting interval who paid their AMA membership dues
7	Physicians on Probation/Monitoring at any time during reporting interval who did not pay their AMA membership dues

REPORT 2 OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT (A-24)
Scenarios on Collective Action and Physician Unions

EXECUTIVE SUMMARY

The AMA estimated in 1998 that between 14,000 and 20,000 physicians were union members. By 2014, that number grew to 46,689 (5.7 percent) of 820,152 actively practicing physicians in the United States; in 2019, there were 67,673 physician union members, 7.2 percent of the 938,156 physicians actively practicing in the United States and an approximate 26 percent increase from 2014 in the percentage of physicians belonging to unions. Additionally, in April 2022, In Piedmont Health Services, Inc. and Piedmont Health Services Medical Providers United, Case No. 10-RC-286648, Region 10 of the National Labor Relations Board (Region) issued a Decision and Direction of Election (DDE) in which it held that physicians are not supervisors under the National Labor Relations Act (NLRA) simply by virtue of their position in the health care institution and thus are eligible for union representation.

As more physicians and physicians in training enter large systems, employment and unions, their needs from professional organizations and trusted voices will change. For the AMA to continue most effectively in its role as the largest advocate for physicians in the United States, it will be essential to adapt to the changing practice environment and consider how to provide its constituents with timely and useful education and support.

To that end, the Council on Long Range Planning and Development (CLRPD) conducted a scenario-building exercise to consider how changes in the macro environment in which health care is delivered may impact the capabilities and goals of physician collective bargaining. The focal question considered by the Council was: How can our AMA support the empowerment of physicians and physicians in training through collective bargaining to provide the best possible care for patients?

This informational report presents the findings of that exercise, which focused on four critical uncertainties in the macro environment that were likely to impact physician needs: the overall strength of the U.S. economy, patient perception of quality of care, consequences/ethics of work stoppages, and working conditions.

The goals of this exercise were multifaceted. It allowed the Council to consider an extremely complex issue through the lenses of specific factors rather than generalities. It allowed the Council to consider how the capabilities and goals of collective bargaining would be likely to change based on overarching factors affecting the United States and health care environments. Finally, it allowed for dynamic consideration of how the needs of physicians and physicians in training, as well as the role of the AMA would necessarily change based on the shifting environments in which physicians will practice medicine.

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 2-A-24

Subject: Scenarios on Collective Action and Physician Unions

Presented by: Gary Thal, MD, Chair

1 BACKGROUND

2
3 The AMA estimated in 1998 that between 14,000 and 20,000 physicians were union members. By
4 2014, that number grew to 46,689 (5.7 percent) of 820,152 actively practicing physicians in the
5 United States; in 2019, there were 67,673 physician union members, 7.2 percent of the 938,156
6 physicians actively practicing in the United States and an approximate 26 percent increase from
7 2014 in the percentage of physicians belonging to unions.¹ Over the same time period (1998-2019),
8 the percentage of all U.S. workers in unions fell from 13.9 percent to 10.3 percent;² the proportion
9 of physicians, residents and fellows in unions is increasing against the national trend of all workers.

10
11 Additionally, in April 2022, In *Piedmont Health Services, Inc. and Piedmont Health Services*
12 *Medical Providers United*, Case No. 10-RC-286648, Region 10 of the National Labor Relations
13 Board (Region) issued a Decision and Direction of Election (DDE) in which it held that physicians
14 are not supervisors under the National Labor Relations Act (NLRA) simply by virtue of their
15 position in the health care institution and thus are eligible for union representation.³

16
17 In its reasoning, the Region focused on the fact that the physician’s primary role is to provide
18 health care to patients, not participate in the administrative and personnel functions reserved for
19 other lead medical providers (who were excluded from the petitioned-for unit). The Region found
20 that the physicians are not held responsible for the performance of other employees and provide
21 only sporadic supervision. The Region specifically disputed the fact that some of the petitioned-for
22 physicians were found to be the “supervising physician” of another credentialed provider, as
23 required by North Carolina’s professional licensing law. The Region based this finding on a prior
24 NLRB decision, which held that a governmental requirement that a health care provider be
25 supervised by a physician does not necessarily establish the physician as a supervisor under the
26 NLRA. This DDE confirmed that physicians will not automatically be considered supervisors
27 under the NLRA and may seek union representation. Piedmont’s physicians and providers
28 subsequently voted in favor of union representation. Prior to this decision, unionization among
29 physicians had largely been confined to medical residents and public-sector physicians.⁴

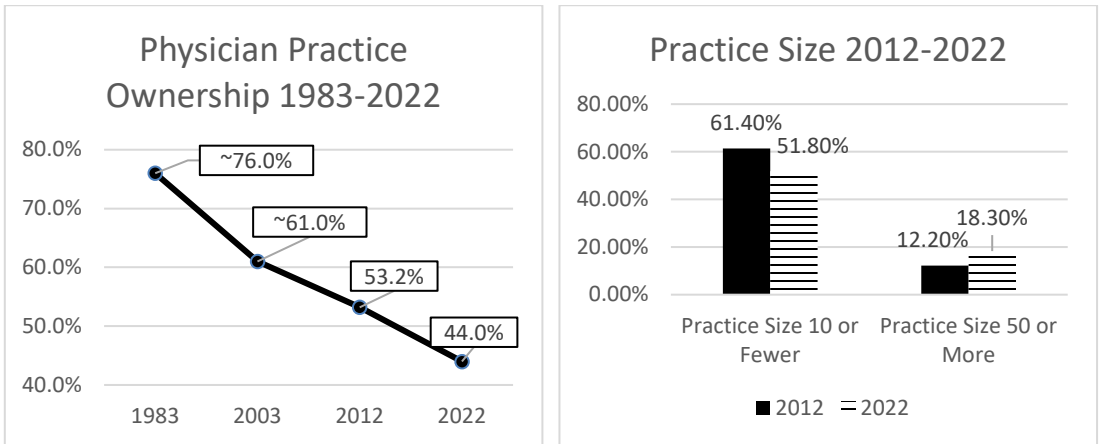
30
31 Since that decision, frequent occurrences of unionizing among physicians, residents, and fellows
32 have been observed:

- 33
34 • Roughly 400 primary and urgent-care providers across more than 50 clinics operated by
35 the Allina Health System in Minnesota and Wisconsin voted to unionize in October 2023,
36 appearing at the time to be the largest group of unionized private-sector physicians in the
37 United States. More than 150 nurse practitioners and physician assistants at the clinics
38 were also eligible to vote and became members of the union.⁵ Further appeals by Allina
39 were unsuccessful.⁶

- 1 • Physicians at six Legacy Health hospitals in Oregon and Washington voted to unionize; the
2 vote was certified by the National Labor Relations Board November 17, 2023. The
3 hospitalists’ decision to unionize had the stated goals of improving local health care and
4 giving frontline physicians a voice in the decisions that impact their patients’ care,
5 communities’ health and hospital working conditions. Approximately 200 hospitalists
6 employed by Legacy Health joined the approximately 700 Oregon Nurses Association
7 nurses and mental and behavioral health professionals already employed by the system,
8 making it one of the largest hospitalist union groups in the country.⁷
9
- 10 • In January 2024, residents and fellows at Northwestern University's McGaw Medical
11 Center voted to unionize, citing concerns with a lack of information around pay increases
12 and benefits from the health system. More than 1,300 residents and fellows were set to join
13 the Committee of Interns and Residents/Service Employees International Union after
14 nearly 800 voted in favor of the move. The Committee of Interns and Residents (CIR) is
15 the largest housestaff union in the United States, representing over 32,000 resident
16 physicians and fellows as of March 2024.^{8,9}
17

18 The most recently available list of hospital residency programs that have joined CIR has been
19 included as an appendix. This list does not represent all unionized residency programs, and the
20 number of unionized residency programs has continued to grow.
21

22 Among the most significant drivers of increased unionization among physicians and physicians in
23 training are undoubtedly the dramatic decrease in physician practice ownership, the related increase
24 in the number of employed physicians, and the shift away from small practices. While current
25 estimates on the number of employed physicians vary, with one recent study finding 73.9 percent
26 of physicians to be employed by hospitals, health systems, or corporate entities,¹⁰ an AMA Policy
27 Research Perspective published in July 2023 found that, in 2022, 49.7 percent of physicians were
28 employees, 44.0 percent were owners, and 6.4 percent were independent contractors. This
29 represented a significant contrast to 2012 when 53.2 percent of physicians were owners, to the
30 early and mid-2000s, when around approximately 61 percent of physicians were owners
31 (Wassenaar and Thran 2003; Kane 2009), and the early 1980s when the ownership share was
32 around 76 percent (Kletke, Emmons, and Gillis 1996). Practice size continued a redistribution of
33 physicians from small practices to large ones. The percentage of physicians in practices with 10 or
34 fewer physicians fell from 61.4 percent in 2012 to 51.8 percent in 2022. In comparison, the
35 percentage in practices with 50 or more physicians grew from 12.2 percent to 18.3 percent.¹¹



Source: Kane C. Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022. American Medical Association.

1 The analysis also found that in 2012, 44.3 percent of physicians under the age of 45 were owners.
2 By 2022, only 31.7 percent of physicians under the age of 45 were owners. This suggests that a
3 smaller percentage of each successive class of physicians has started their post-residency career in
4 an ownership position. Furthermore, the employment status of young physicians is different than
5 that of older physicians. In 2022, 51.3 percent of physicians aged 55 and over compared to 31.7
6 percent of physicians under age 45 were owners. This indicates that when physicians retire, owners
7 are not replaced in the workforce on a one-to-one basis; they are more likely to be replaced by
8 physicians who are employees.¹²

9
10 The moves away from practice ownership and into employment, and away from small practices
11 and into large ones, seem likely to continue, if not accelerate, in the foreseeable future. As such, so
12 too will the prevalence of physicians, residents and fellows who may consider unionization.

13 14 SCENARIO DEVELOPMENT

15
16 As more physicians and physicians in training enter large systems, employment and unions, their
17 needs from professional organizations and trusted voices will change. For the AMA to continue
18 most effectively in its role as the largest advocate for physicians in the United States, it will be
19 essential to adapt to the changing practice environment and consider how to provide its constituents
20 with timely and useful education and support.

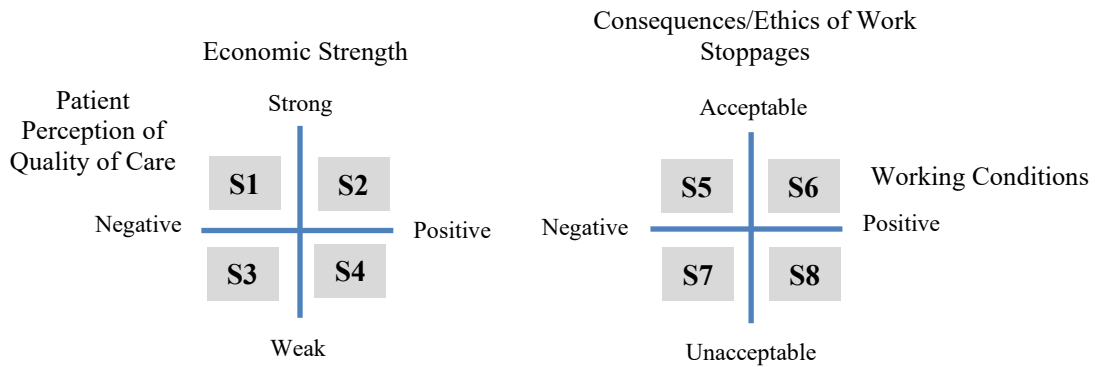
21
22 To that end, CLRPD conducted a scenario-building exercise to extrapolate on how changes in the
23 macro environment in which health care is delivered may impact the capabilities of physician
24 collective bargaining. The Council identified the following focal question for this exercise:

25
26 *How can our AMA support the empowerment of physicians and physicians in training*
27 *through collective bargaining to provide the best possible care for patients?*

28
29 Based on this question, the Council identified a list of driving forces and factors in the overall
30 environment that would influence the needs of physicians in different environmental scenarios.
31 From this list, members were asked to rank each driver based on two metrics: (1) how important
32 each one was to the focal question and (2) how uncertain the outcome of each driver was. The goal
33 of this step was to identify both the most important and most uncertain driving forces (“critical
34 uncertainties”). The Council identified the following critical uncertainties:

- 35
36
- Overall strength of the U.S. economy
 - Patient perception of quality of care
 - Consequences/ethics of work stoppages
 - Working conditions
- 37
38
39
40

41 These driving forces were subsequently combined into two matrices, from which were created
42 eight distinct scenario spaces (S1-S8):



1 The Council considered what the implications of each scenario space would be for physicians and
 2 patient care, and, subsequently, what role the AMA could play in supporting physicians in each
 3 scenario. The goals of this exercise were multifaceted. It allowed the Council to consider an
 4 extremely complex issue through the lenses of specific factors rather than generalities. It allowed
 5 the Council to consider how the capabilities and goals of collective bargaining would be likely to
 6 change based on overarching factors affecting the United States and health care environments.
 7 Finally, it allowed for dynamic consideration of how the needs of physicians and physicians in
 8 training, as well as the role of the AMA would necessarily change based on the shifting
 9 environments in which physicians will practice medicine.

10
 11 In the following section, the Council contemplated the world of each scenario space including the
 12 connections between the two driving forces; how the interplay between those forces would affect
 13 patients, physicians, and the health care environment; what the needs of physicians might be to
 14 support the delivery of the best possible patient care; and how the AMA might be best positioned to
 15 support those needs.

16
 17 **SCENARIO SPACES**

18
 19 **Scenario 1 – Strong Economy & Negative Patient Perception of Quality of Care**

20 In a scenario in which the economy is strong, but patients have a negative perception of quality of
 21 care, the Council identified several challenges and opportunities. In terms of opportunities, the
 22 Council noted that in times of economic prosperity, the position of unions, and the overall position
 23 from which physicians could collectively bargain would be enhanced. Most obviously, employers
 24 in such a scenario would have opportunities to make payment concessions. This could be of
 25 particular benefit to residents and fellows, to whom payment and quality of life relative to working
 26 hours is an ongoing concern. More directly related to the negative perception of quality of care,
 27 physicians in such a scenario would likely be able to advocate and negotiate toward changes in
 28 health systems and care delivery that would enhance patient satisfaction. For instance, physicians
 29 negotiations could work toward allowing physicians to spend more time with individual patients,
 30 which can lead to increased patient satisfaction.¹³ Furthermore, improvements in how a clinic is
 31 run, e.g., adequate staffing, setting and managing expectations, facilitating streamlined and
 32 personalized communication between physicians, staff and patients might all be negotiated for in a
 33 strong economic environment, which could have the twofold benefit of improving patient
 34 satisfaction and improving working conditions in the future. CLRPD identified study,
 35 communication, and messaging as primary roles of the AMA in such a scenario. It would be
 36 essential to understand the drivers of the poor perception of quality of care and communicate those
 37 to physician groups as bases for negotiations. Additionally, identifying and sharing practices that
 38 lead to improved patient satisfaction could help unions and other physicians engaged in

1 negotiations to self-assess and pinpoint potential points of action that have been proven to improve
2 the patient experience. On a high level, the AMA’s most valuable roles in such an environment
3 would be to help physicians understand the patient experience, identify solutions that have been
4 shown to improve those experiences, and communicate those solutions to aid in collective
5 bargaining during a time when physicians would be expected to be in a stronger position to make
6 appreciable gains through negotiation.

7 8 **Scenario 2 – Strong Economy & Positive Patient Perception of Quality of Care**

9 The Council noted that when organizations hit weak economic times, physicians are often overseen
10 and restricted in greater ways. Health systems with strong finances, however, tend to allow
11 physicians greater autonomy. Autonomy, raises, and improved working conditions were identified
12 as the primary objectives in Scenario 2. If a health system is in a strong financial situation, and
13 patients are satisfied with the quality of care they receive, physicians will be in the strongest
14 position possible to demonstrate their successes and leverage those successes into personal gains
15 and health system improvements that acknowledge and reward their expertise and achievements. In
16 such a scenario, physicians in negotiation would likely work to demonstrate the positive outcomes
17 of their work and use those data points to leverage their employers to make decisions that increase
18 patient and physician satisfaction. The AMA-RAND study, “Factors Affecting Physician
19 Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health
20 Policy,” noted that drivers of physician satisfaction include providing high-quality care or working
21 at practices that facilitate the delivery of such care; income stability; payment arrangements that
22 were perceived as fair, transparent, and aligned with good patient care; and reducing the
23 cumulative burden of rules and regulations.¹⁴ The AMA’s work on physician satisfaction and
24 practice sustainability could prove a major asset in such a scenario by providing data points to both
25 physicians and health systems to demonstrate how satisfied physicians improve patient care and
26 perception of care, the hidden costs of physician burnout, and the value of system and working
27 condition improvements. It was also noted that in recent times, physicians often see pay reductions
28 and pay increases are much more infrequent. In a scenario when measurables demonstrate high
29 patient satisfaction, and the overall economy is strong, physicians would be in a strong position to
30 collectively bargain for pay increases.

31 32 **Scenario 3 – Weak Economy & Negative Perception of Patient Care**

33 The converse of Scenario 2, this scenario imagined an environment in which the economy is weak,
34 and patients have a poor perception of the quality of care they receive. In such a scenario, it was
35 noted that everyone would be struggling, i.e., patients, physicians, and employers. This could be
36 described as a “stop the bleeding” scenario in which negotiations would focus on preventing the
37 weakening of the position of physicians. Among the focal points the Council identified as
38 particularly significant in such a scenario were scope of practice and burnout. Health systems in
39 weak financial situations will look for opportunities to reduce costs, which may include increasing
40 the use of non-physician providers. It would be essential in such a scenario for physician unions
41 and physician negotiators to push back against scope creep through collective bargaining. In health
42 systems where patient care was already being delivered by mid-level providers, poorly perceived
43 quality of care could act as an argument against scope creep. Conversely, health systems in which
44 patient care was predominantly being delivered by physicians may attempt to leverage patient
45 dissatisfaction to push for increased utilization of mid-level providers. Physicians would need data
46 demonstrating the true effects of scope creep as it relates to both cost and quality. Other tendencies
47 in such an environment would likely be to push physicians, residents and fellows into working
48 longer hours, shorter and higher quantities of patient visits, and cost cutting measures, all factors
49 likely to lead to even further reduced quality of care, poorer quality of life and worse educational
50 environments for physicians in training, and increased burnout. The AMA’s work on burnout could

1 be of value in this environment, providing support to struggling physicians and demonstrating to
2 employers the mechanisms to and the value of reducing burnout.

3 4 **Scenario 4 – Weak Economy & Positive Patient Perception of Quality of Care**

5 The Council noted that in this scenario, most of the issues related to a poor economy would still be
6 relevant, as employers in a weak economy would still likely attempt to cut costs and get more for
7 less. In theory, physicians in this scenario should be better positioned to negotiate against cost-
8 cutting measures such as scope creep, as high patient perception of quality of care should be a
9 focus of collective bargaining and a strong argument against such measures. However, several
10 complicating scenarios were noted, including the possibility that in such an environment,
11 employers may be more willing to take risks in care delivery, viewing the positive patient
12 perception of quality as a backstop against possible declines. Additionally, the Council noted the
13 distinction between patient perception of quality and quality care itself, and that some patients
14 receiving direct care from mid-level providers may have a higher perception of the quality of care
15 they receive (for instance, if mid-level providers spend more time with their patients than
16 physicians can). It was also noted that by replacing one physician with two mid-level providers,
17 health systems could charge more, thereby increasing revenue at the expense of both physicians
18 and quality of care. Still, in an environment in which patient perception of quality is positive, the
19 AMA could examine the causes of that positive perception, identify best practices to reduce costs
20 while preserving quality of care, and communicate those best practices to health systems and
21 physicians.

22 23 **Scenario 5 – Negative Working Conditions & An Acceptable View of Work Stoppages**

24 A complicating scenario related to physician unionization is the idea of work stoppages and the
25 potential impacts of work stoppages on the health of patients. Section 1.2.10 in the Code of
26 Medical Ethics states that physicians who participate in advocacy should “[a]void using disruptive
27 means to press for reform. Strikes and other collection actions may reduce access to care, eliminate
28 or delay needed care, and interfere with continuity of care and should not be used as a bargaining
29 tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of
30 calling attention to the need for changes in patient care.”¹⁵ As unionization becomes more prevalent
31 among physicians, unions will explore all possible tactics to increase leverage during collective
32 bargaining. In January 2024, thousands of junior physicians in the United Kingdom (UK) engaged
33 in a six-day strike over low wages leading to the postponement of more than 110,000
34 appointments.¹⁶ Senior doctors and other medical professionals were available to cover emergency
35 services, critical care, and maternity services. This represented the longest strike in the history of
36 the UK’s National Health Service (NHS).¹⁷ The NHS national medical director said it would take
37 hospitals “weeks and months” to recover from the stoppage.¹⁸ Despite the obvious impacts
38 physician work stoppages have on health care delivery, it is impossible to ignore the possibility that
39 they may become a reality in the United States in an environment with a more highly unionized
40 physician workforce. There are obvious parallels to be drawn between junior physicians in the
41 United Kingdom and residents and fellows in the United States, who earn significantly less than
42 their more senior colleagues, while working potentially more hours per week.

43
44 Scenario 5 imagines a situation in which physician working conditions are poor and the
45 consequences of work stoppages are viewed as an acceptable tactic in collective bargaining. While
46 what is “acceptable” will always vary between groups, individuals, organizations, etc., this scenario
47 is one where the opportunity for work stoppage or the threat of work stoppage and other forms of
48 collective action is most realistic. The Council noted that in such a scenario, it would be essential
49 for the AMA to provide a backstop of support demonstrating the moral and ethical duty of
50 physicians to act in the best interest of patient care and communicate that work stoppages are not
51 and should not be about money, but about physicians doing what they can to fulfill their duty to

1 their oath and to their patients. Members also noted that work stoppages can take a variety of
2 forms, such as—like in the case of the NHS strike—predetermined and preannounced periods of
3 unavailability by physicians in an effort to highlight system inadequacies (rather than, for instance,
4 a strike of indeterminable duration) and that this types of collective action could more easily be
5 viewed as action toward improving patient care and not harming it. On a high level, this scenario
6 made apparent the likelihood of a future in which physician work stoppages of some form, and the
7 downstream consequences of those stoppages, would become a reality, and the AMA’s most
8 effective means of supporting physicians in such an environment will need to be considered,
9 particularly as it relates to potential conflict with AMA policy and the Code of Medical Ethics. In
10 response to policy adopted at the 2023 Annual Meeting of the House of Delegates (H-405.946,
11 “Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization)
12 the Council on Ethical and Judicial Affairs (CEJA) is developing a report for the 2024 Interim
13 Meeting “to review the advisory restricting collective action in section 1.2.10 of its Code of
14 Medical Ethics to allow for more flexibility on the part of physicians who have exhausted other
15 non-disruptive methods for reform.” Current AMA policy on unions and collective bargaining has
16 been appended to this memo.

17

18 **Scenario 6 – Positive Working Conditions & An Acceptable View of Work Stoppages**

19 The Council viewed Scenario 6 as an ideal time for the AMA to engage in organizing, preparation
20 and analysis. While work stoppages in such a scenario would be less likely to be necessary, laying
21 the groundwork to preserve desirable working conditions and keeping them heading in the right
22 direction can occur during this time, as well as can the preparation for a future in which work
23 stoppages may become a necessary/useful tool. Such a scenario would present the AMA with an
24 opportunity to analyze progress that has been made and by what mechanisms and communicate
25 those successes to other physician groups attempting to improve their own conditions. This
26 scenario could also present an opportunity to analyze the overall status of unionization and
27 collective bargaining and successful organizational structures and negotiation tactics with the hope
28 of working toward scenarios where improvements continue without the need for work stoppages or
29 the threats of work stoppages. As one member put it, this scenario is “time to get to work.”

30

31 **Scenario 7 – Negative Working Conditions & An Unacceptable View of Work Stoppages**

32 In Scenario 7 it becomes essential to identify solutions and collective bargaining strategies to push
33 toward improved conditions without the threat of work stoppage. If the public and/or physicians
34 themselves determine that any level of disruption to care delivery cannot occur, unions will
35 necessarily find themselves in a weakened position for negotiation. The AMA could aid physicians
36 in such a scenario by identifying, or proliferating already identified, successes that have occurred
37 without the need for work stoppages. The Council also noted that in a scenario in which working
38 conditions are deteriorating, but work stoppages are not an option, physicians may simply choose
39 to quit, leading to a worsening physician shortage and poorer access to quality care. The Council
40 noted that this scenario space is not unlike what physicians encountered during the worst of the
41 COVID-19 pandemic, during which working conditions were as bad as they could have been, but
42 no physician group would have been willing to threaten a strike even if they were already in a
43 union or looking to join one. That situation led to early retirements and physicians considering
44 alternative career paths, along with rises in physician mental health issues and suicides. Non-
45 compete clauses also present a significant challenge in such an environment, as physicians dealing
46 with declining working conditions who have signed such clauses cannot simply change systems but
47 must either relocate or remain and suffer. Providing support and resources to physicians in
48 challenging situations represents another area where the AMA could make a significant impact.

Scenario 8 – Positive Working Conditions & An Unacceptable View of Work Stoppages

Not unlike Scenario 6, unions in Scenario 8 would likely be focused on attempting to “lock in” the progress being made. Such a scenario may present opportunities to establish metrics to better quantify improvements in working conditions. The Council observed that more opportunities may exist for medical associations including the AMA to engage in benchmarking and best practice research and sharing. In this scenario, techniques other than the threat of work stoppages have clearly been effective, evidenced by improving working conditions. However, it was noted that it is unlikely that conditions would be improving among all physicians and across all employers, so this would be a time to work through unions and organizations to identify and implement best practices as widely as possible and to include experienced physicians, residents, and fellows. It was also noted that both the overall quality of working conditions, as well as the trend in working conditions (i.e., improving or declining) are relevant; good working conditions can decline just as poor working conditions can improve, making the establishment of benchmarks even more useful in allowing physicians and systems to assess the overall state of conditions as well as making changes easier to assess.

DISCUSSION

As part of its deliberations, the Council considered not only how the needs of physicians and physicians in training will change in an increasingly employed and unionized workforce, but how those changes in workforce trends would impact the AMA, its membership and its mission, i.e., what does unionization mean for the AMA and other medical associations? The goals and capabilities of these organizations remain consistent—regardless of how physicians work and organize—and include advocating for physicians and trainees, communicating on their behalf, convening groups to facilitate collaboration, providing timely educational resources, and identifying and sharing best practices to help physicians achieve their practice and career goals. Organized medicine provides value to all physicians, whether or not they join a specific association or a union. As has been observed with the move away from private practice and towards employment, the challenges physicians and trainees face as practice models evolve do not become apparent immediately, but often do so suddenly and urgently; organizations working on their behalf must remain nimble and responsive to their evolving needs to provide effective support and membership value. On the rapidly developing issue of physician collective bargaining and unionization, it will be essential to monitor changes in the space, maintain awareness of difficulties and successes as they occur, and identify the most effective roles of the AMA in the context of the changing workforce and macro environment.

The Council believes that an open forum at an upcoming HOD meeting through which physicians, residents and fellows who have encountered unionization directly could share their experiences would be extremely useful in expanding the Association’s understanding of the impacts such efforts have on grassroots members and facilitate discussion and idea sharing among those currently involved in these initiatives. It will also be essential for stakeholders throughout AMA membership and staff who are either involved in or likely to be impacted by the growing trend of unionization to find opportunities for collaboration to maximize understanding and impact.

This analysis assumes a future in which a greater proportion of physicians and physicians in training choose employed practice models and join unions. While the exercise focused on specific factors in the overall environment to assess how the needs of physicians and physicians in training would be impacted, and how the AMA could aid negotiating physicians in such environments, the needs and wishes of physicians are relatively consistent regardless of work setting and include providing high-quality care; working environments that facilitate high-quality care; stable, fair, and transparent pay arrangements; and reduced regulatory burdens. However, the mechanisms available

1 to work toward these goals will change along with environmental factors and changing models of
2 care delivery and organizational structures. The Council will continue to monitor this evolving
3 area.

REFERENCES

¹ American Medical Association. ARC Issue brief: Collective bargaining for physicians and physicians-in-training.

<https://www.ama-assn.org/system/files/advocacy-issue-brief-physician-unions.pdf>. Accessed January 29, 2024.

² U.S. Bureau of Labor Statistics. Union membership rate fell by 0.2 percentage point to 10.1 percent in 2022. <https://www.bls.gov/opub/ted/2023/union-membership-rate-fell-by-0-2-percentage-point-to-10-1-percent-in-2022.htm>. Accessed January 29, 2024.

³ Following the Doctor's Orders: NLRB Decision Prescribes Union Election for Physicians. JD Supra. <https://www.jdsupra.com/legalnews/following-the-doctor-s-orders-nlr-7925443/>. Accessed January 29, 2024.

⁴ Ibid.

⁵ Scheiber M. Doctors Unionize at Big Health Care System. The New York Times. <https://www.nytimes.com/2023/10/13/business/economy/doctors-union.html>. Accessed January 29, 2024.

⁶ Gooch K. Allina loses challenge to physicians' union. Becker's Hospital Review. <https://www.beckershospitalreview.com/hr/allina-loses-challenge-to-physicians-union.html>. Accessed February 13, 2024.

⁷ Coles A. Hospitalists in Oregon and Washington vote to unionize. The American Federation of Teachers. <https://www.aft.org/news/hospitalists-oregon-and-washington-vote-unionize>. Accessed January 29, 2024.

⁸ Devereaux M. Medical residents at Northwestern vote to unionize. Modern Healthcare. <https://www.modernhealthcare.com/labor/northwestern-medicine-residents-unionize-seiu>. Accessed January 29, 2024.

⁹ Who We Are. The Committee of Interns and Residents. <https://www.cirseiu.org/who-we-are/>. Accessed January 29, 2024.

¹⁰ PAI-Avalere Health Report on Trends in Physician Employment and Acquisitions of Medical Practices: 2019-2021. Physician Advocacy Institute. <https://www.physiciansadvocacyinstitute.org/PAI-Research/Physician-Employment-and-Practice-Acquisitions-Trends-2019-21>. Accessed March 5, 2024.

¹¹ Kane C. Recent Changes in Physician Practice Arrangements: Shifts Away from Private Practice and Towards Larger Practice Size Continue Through 2022. American Medical Association. <https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf>. Accessed January 29, 2024.

¹² Ibid.

¹³ Two simple ways to improve patient satisfaction with visit length. AAFP. https://www.aafp.org/pubs/fpm/blogs/inpractice/entry/visit_length.html#:~:text=Researchers%20found%20that%20satisfaction%20with,and%20better%20perceived%20health%20status. Accessed February 9, 2024.

¹⁴ Factors Affecting Physician Professional Satisfaction and Their Implications for Patient Care, Health Systems, and Health Policy. RAND. https://www.rand.org/pubs/research_reports/RR439.html. Accessed February 9, 2024.

¹⁵ 1.2.10 Political Action by Physicians. Policyfinder. AMA. <https://policysearch.ama-assn.org/policyfinder/detail/1.2.10?uri=%2FAMADoc%2FEthics.xml-E-1.2.10.xml>. Accessed February 9, 2024.

¹⁶ National Health Service. Data on the impact of the industrial action by junior doctors from the British Medical Association (BMA) and the Hospital Consultants and Specialists Association (HCSA). <https://www.england.nhs.uk/publication/preparedness-for-potential-industrial-action-in-the-nhs/#heading-3>. Accessed February 9, 2024.

¹⁷ Lawless J. Associated Press. Thousands of doctors in Britain walk off the job in their longest-ever strike. <https://apnews.com/article/uk-doctors-strike-disruption-nhs-a5c550eaa82d22b91805f5e29da047c6>. Accessed February 9, 2024.

¹⁸ Junior doctors' strike led to more than 110,000 patients in England having care cancelled. The Guardian. <https://www.theguardian.com/society/2024/jan/10/junior-doctors-strike-led-to-130000-patients-in-england-having-care-cancelled>. Accessed February 9, 2024.

Appendix 1 – Committee of Interns and Residents Unionized Hospitals

CALIFORNIA		
Alameda Health System / Highland Hospital	Oakland	CA
California Hospital Medical Center	Los Angeles	CA
Harbor-UCLA Medical Center	Torrance	CA
Kern Medical Center	Bakersfield	CA
LAC+USC Medical Center	Los Angeles	CA
Santa Clara Valley Medical Center	San Jose	CA
St. Mary Medical Center – Long Beach	Long Beach	CA
St. Mary’s Medical Center – San Francisco	San Francisco	CA
Sutter Santa Rosa Regional Hospital	Santa Rosa	CA
UC-Irvine Medical Center	Orange	CA
UCSF Medical Center	San Francisco	CA
UCSF Benioff Children’s Hospital	Oakland	CA
Valley Consortium for Medical Education	Modesto	CA
Zuckerburg San Francisco General (formerly SFGH)	San Francisco	CA
FLORIDA		
Jackson Memorial Hospital	Miami	FL
Illinois		
University of Illinois-Chicago	Chicago	IL
MASSACHUSETTS		
Boston Medical Center	Boston	MA
Cambridge Health Alliance	Cambridge	MA
NEW JERSEY		
Bergen Regional Medical Center	Paramus	NJ
Christ Hospital	Jersey City	NJ
Hoboken University Medical Center	Hoboken	NJ
Jersey City Medical Center	Jersey City	NJ
Rowan University SOM (Kennedy/Lourdes)	Stratford	NJ
Rutgers University – NJMS	Newark	NJ
Rutgers University – RWJMS	New Brunswick	NJ
St. Michael’s Medical Center	Newark	NJ
NEW MEXICO		
University of New Mexico	Albuquerque	NM
NEW YORK		
Bellevue Hospital Center	New York	NY
Bronx Lebanon Hospital Center	Bronx	NY

Brookdale Medical Center	Brooklyn	NY
Brooklyn Hospital Center	Brooklyn	NY
Coney Island Hospital	Brooklyn	NY
Elmhurst Hospital Center	Queens	NY
Flushing Hospital Medical Center	Queens	NY
Harlem Hospital Center	Manhattan	NY
Institute for Family Health	Manhattan	NY
Interfaith Medical Center	Brooklyn	NY
Jacobi Medical Center	Bronx	NY
Jamaica Hospital Medical Center	Queens	NY
Kings County Hospital Center	Brooklyn	NY
Kingsbrook Jewish Medical Center	Brooklyn	NY
Lincoln Medical & Mental Health Center	Bronx	NY
Maimonides Medical Center	Brooklyn	NY
Metropolitan Hospital Center	Manhattan	NY
Montefiore Medical Center North	Bronx	NY
New York Methodist Hospital	Brooklyn	NY
St. Barnabas Hospital	Bronx	NY
St. John's Episcopal Hospital	Queens	NY
St. Luke's-Roosevelt Hospital	Manhattan	NY
Westchester County Health Care	Valhalla	NY
Woodhull Hospital Center	Brooklyn	NY
Wyckoff Heights Medical Center	Brooklyn	NY
Vermont		
University of Vermont	Burlington	VT
WASHINGTON, DC		
Children's National Medical Center	Washington	DC
Howard University Hospital	Washington	DC
St. Elizabeths Hospital	Washington	DC

Appendix 2 – AMA Policies Related to Unionization and Collective Bargaining

Code of Medical Ethics Opinion 1.2.10 Political Action by Physicians

Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However, they have a responsibility to do so in ways that are not disruptive to patient care.

Physicians who participate in advocacy activities should:

- (a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.
- (b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.
- (c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians' primary and overriding commitment to patients.
- (d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

Investigation into Residents, Fellows and Physician Unions D-383.977

Our AMA will study the risks and benefits of collective bargaining for physicians and physicians-in-training in today's health care environment.

Implementation

Our AMA continues to study the risks and benefits of collective bargaining for physicians and physicians-in-training and works closely with state and national medical specialty societies interested in the issues raised in this Resolution.

Our AMA developed an advocacy issue brief that studies the risks and benefits of collective bargaining for physicians and physicians-in-training and shared this document with all state and national medical specialty societies. Our AMA will continue to work closely with state and national medical specialty societies interested in the issues raised in this Resolution.

Employee Associations and Collective Bargaining for Physicians D-383.981

Our AMA will study and report back on physician unionization in the United States.

Collective Bargaining: Antitrust Immunity D-383.983

Our AMA will: (1) continue to pursue an antitrust advocacy strategy, in collaboration with the medical specialty stakeholders in the Antitrust Steering Committee, to urge the Department of Justice and Federal Trade Commission to amend the "Statements of Antitrust Enforcement Policy in Health Care" (or tacitly approve expansion of the Statements) and adopt new policy statements

regarding market concentration that are consistent with AMA policy; and (2) execute a federal legislative strategy.

Collective Bargaining and the Definition of Supervisors D-383.988

Our AMA will support legislative efforts by other organizations and entities that would overturn the Supreme Court's ruling in *National Labor Relations Board v. Kentucky River Community Care, Inc., et al.*

Update

2022: In *Piedmont Health Services, Inc. and Piedmont Health Services Medical Providers United*, Case No. 10-RC-286648, Region 10 of the National Labor Relations Board (Region) issued a Decision and Direction of Election (DDE) in which it held that physicians are not supervisors under the National Labor Relations Act (the Act) simply by virtue of their position in the healthcare institution.

This DDE is notable, as it confirms that physicians will not automatically be considered supervisors under the Act and may seek union representation. Indeed, Piedmont's physicians and providers ultimately voted in favor of union representation. Healthcare employers should consider reviewing their physicians' job descriptions and job duties to determine whether they potentially can be considered supervisors under the Act.

Antitrust Relief as a Priority of the AMA H-380.987

Our AMA will continue its aggressive efforts to achieve appropriate negotiations rights and opportunities and necessary antitrust relief for physicians, by whatever means. Achieving this important goal will remain a top priority for the Association.

Physicians' Ability to Negotiate and Undergo Practice Consolidation H-383.988

Our AMA will: (1) pursue the elimination of or physician exemption from anti-trust provisions that serve as a barrier to negotiating adequate physician payment; (2) work to establish tools to enable physicians to consolidate in a manner to insure a viable governance structure and equitable distribution of equity, as well as pursuing the elimination of anti-trust provisions that inhibited collective bargaining; and (3) find and improve business models for physicians to improve their ability to maintain a viable economic environment to support community access to high quality comprehensive healthcare.

Antitrust Relief for Physicians Through Federal Legislation H-383.990

Our AMA:

(1) encourages state medical associations and national medical specialty societies to support federal antitrust reform bills, such as H.R. 1409, as originally introduced in the 112th Congress, and consider sending in letters of support for such antitrust reform legislation to their respective Congressional delegations and select Congressional leaders;

(2) supports the intent of antitrust reform bills, such as H.R. 1409, as originally introduced in the 112th Congress, that put access to quality patient medical care and patient rights ahead of health insurer profits;

(3) continues to advocate for the principles that support that any health care professional, including a physician or a physician group, which is engaged in negotiations with a health plan regarding the terms of any contract under which the professional provides health care items or services for which benefits are provided shall, in connections with such negotiations, be exempt from federal antitrust laws;

(4) continues to advocate for the concepts and limitations incorporated in H.R. 1409, as originally introduced in the 112th Congress, including: no new rights for collective cessation of service to patients, no amendments to the National Labor Relations Act; and no application of H.R. 1409, as originally introduced in the 112th Congress, to the Medicare program under Title XVIII, the Medicaid program under Title IX, the SCHIP program under Title XXI of the Social Security Act; or programs related to medical services for members of the uniformed service, veterans, federal employees health benefit program or Indian Health Services;

(5) will send a letter of support to Congress of the principles contained in H.R. 1409 as originally introduced in the 112th Congress; and

(6) will work with members of Congress to promote antitrust reform in light of Accountable Care Organization (ACO) development.

Antitrust Relief H-383.992

Our AMA will: (1) redouble efforts to make physician antitrust relief a top legislative priority, providing the necessary foundation for fair contract negotiations designed to preserve clinical autonomy and patient interest and to redirect medical decision making to patients and physicians; and (2) affirm its commitment to undertake all appropriate efforts to seek legislative and regulatory reform of state and federal law, including federal antitrust law, to enable physicians to negotiate effectively with health insurers.

Resident Physicians, Unions and Organized Labor H-383.998

Our AMA strongly advocates for the separation of academic issues from terms of employment in determining negotiable items for labor organizations representing resident physicians and that those organizations should adhere to the AMA's Principles of Medical Ethics which prohibits such organizations or any of its members from engaging in any strike by the withholding of essential medical services from patients.

Collective Bargaining for Physicians H-385.946

The AMA will seek means to remove restrictions for physicians to form collective bargaining units in order to negotiate reasonable payments for medical services and to compete in the current managed care environment; and will include the drafting of appropriate legislation.

Physician Collective Bargaining H-385.976

Our AMA's present view on the issue of physician collective negotiation is as follows:

(1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians.

(2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature.

(3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively.

(4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients.

(5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care.

Supporting Efforts to Strengthen Medical Staffs Through Collective Actions and/or Unionization H-405.946

1. Our American Medical Association will: (1) reevaluate the various efforts to achieve collective actions and/or unionization for physicians nationally; and (2) request CEJA to review the advisory restricting collective action in section 1.2.10 of its Code of Medical Ethics to allow for more flexibility on the part of physicians who have exhausted other non-disruptive methods for reform.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-24

Subject: Health System Consolidation

Presented by: Sheila Rege, MD, Chair

1 At the 2023 Annual Meeting, the House of Delegates adopted Policy D-160.907, Health System
2 Consolidation, which directed the American Medical Association (AMA) to: 1) assess and report
3 annually on nationwide health system and hospital consolidation, as well as payer consolidation, to
4 assist policymakers and the federal government; 2) that the annual report on nationwide hospital
5 consolidation be modeled after the “Competition in Health Insurance: A comprehensive study of
6 U.S. Markets” in its comprehensiveness to include for example data and analyses as: a) a review of
7 the current level of hospital and/or health system consolidation at the level of all metropolitan
8 statistical areas, state, and national markets; b) a list of all mergers and acquisition transactions
9 valued above a set threshold amount resulting in hospital and/or health system consolidation;
10 c) analyses of how each transaction has changed or is expected to change the level of competition
11 in the affected service and geographic markets; and d) analyses of how health care costs and price
12 have changed in affected markets after large consolidation transaction has taken place; 3) that the
13 AMA report the initial findings of this study to the House of Delegates by the 2024 Annual
14 Meeting; and 4) that the AMA report the findings of this study to its members and stakeholders,
15 including policymakers and legislators, to inform future health care policy.

16
17 The Board of Trustees assigned only the third Resolve clause of Policy D-160.907 to the Council
18 for a report back at the 2024 Annual Meeting. The balance of the directive was assigned to AMA
19 staff to implement (i.e., the AMA’s Division of Economic and Health Policy Research). Data were
20 used primarily from the American Hospital Association (AHA) to assess competition in hospital
21 markets. As directed by Policy D-160.907, the requested analysis was modeled after the AMA’s
22 Competition in Health Insurance study.

23
24 This informational Council report serves as notice to the House of Delegates regarding the report
25 from the AMA’s Division of Economic and Health Policy Research. Here we share topline findings
26 from the Policy Research Perspective titled: “[Competition in Hospital Markets, 2013-2021](#)” and
27 encourage interested members to reference the full analysis for a more robust discussion of the
28 findings.

29
30 **BACKGROUND**

31
32 The economic study was conducted using the AHA’s 2013, 2017, and 2021 Annual Survey
33 Databases. These databases were used to calculate shares and concentration levels in markets
34 across the United States. The Herfindahl-Hirschman Index (HHI) indicates the level of market
35 concentration and was calculated for each Metropolitan Statistical Area (MSA). The HHI is
36 calculated as a sum of the squared market shares for all firms found within a market. A higher HHI
37 indicates higher concentration. For example, if a market consisted of four firms and each firm held
38 a 25 percent share, the HHI for that market would be 2,500:

39
40
$$25^2 + 25^2 + 25^2 + 25^2 = 2,500$$

1 If the number of firms in a market increased, the HHI would generally decrease, and vice versa.

2
3 Appendices A1 and A2 show that in the majority of MSA-level markets, hospitals (or systems)
4 have large market shares. In 97 percent of markets, at least one hospital (system) had a market
5 share of 30 percent or greater in 2021, and 77 percent of markets had one hospital (system) with a
6 share of 50 percent or more in 2021 – up from 70 percent or more in 2013. In 43 percent of
7 markets, a single hospital (system) had a market share of 70 percent or more in 2021 – an increase
8 from 37 percent in 2013. The fraction of hospitals that are a part of a system has also been
9 increasing over time, increasing from 70 percent in 2013 to 76 percent in 2017 to 78 percent in
10 2021.

11
12 Appendix B shows that, on average, hospital markets are highly concentrated and market
13 concentration has been increasing over time. Virtually all hospital markets (99 percent) are highly
14 concentrated.

15
16 A complete list of the two largest hospitals' (or systems') market shares and the HHIs by MSA can
17 be found in the full analysis.

18 19 AMA POLICY

20
21 The AMA has several policies, and the Council has presented several recent reports to the House of
22 Delegates on hospital consolidation and health care mergers and acquisitions.

23
24 CMS Report 8-A-23, Impact of Integration and Consolidation on Patients and Physicians,
25 recommended that the AMA: 1) continue to monitor the impact of hospital-physician practice and
26 hospital-hospital mergers and acquisitions on health care prices and spending, patient access to
27 care, potential changes in patient quality outcomes, and physician wages and labor; 2) continue to
28 monitor how provider mix may change following mergers and acquisitions and how non-compete
29 clauses may impact patients and physicians; 3) broadly support efforts to collect relevant
30 information regarding hospital-physician practice and hospital-hospital mergers and acquisitions in
31 states or regions that may fall below the Federal Trade Commission (FTC)/Department of Justice
32 review threshold; 4) encourage state and local medical associations, state specialty societies, and
33 physicians to contact their state's attorney general with concerns of anticompetitive behavior; and
34 encourage physicians to share their experiences with mergers and acquisitions, such as those
35 between hospitals and/or those between hospitals and physician practices, with the FTC via their
36 online submission form.

37
38 CMS 2-I-22, Corporate Practice of Medicine, recommended that the AMA: 1) acknowledge that
39 the corporate practice of medicine has the potential to erode the patient-physician relationship;
40 2) acknowledge that the corporate practice of medicine may create a conflict of interest between
41 profit and best practices in residency and fellowship training; and 3) amend Policy H-160.891 by
42 addition of two new clauses stating that each individual physician should have the ultimate
43 decision for medical judgment in patient care and medical care processes, including the supervision
44 of non-physician practitioners and physicians should retain primary and final responsibility for
45 structured medical education inclusive of undergraduate and graduate medical education including
46 the structure of the program, program curriculum, selection of faculty and trainees, as well as
47 educational and disciplinary issues related to these programs.

48
49 CMS 3-I-22, Health System Consolidation, was an informational report and the first in a series the
50 Council has on this and related topics. CMS 3-I-22 shared background information on vertical and
51 horizontal mergers and acquisitions and highlighted notable transactions from 2020. The Council

1 will continue its work on this issue and provide additional reports for the consideration of the
2 House of Delegates when appropriate.

3
4 Policy D-160.907, established by the adoption of Resolution 727-A-23 as amended, states that the
5 AMA will: assess and report annually on nationwide health system and hospital consolidation as
6 well as payer consolidation, to assist policymakers and the federal government; model this report
7 on nationwide hospital consolidation after the “Competition in Health Insurance” study in its
8 comprehensiveness to include for example, data and analyses such as: a) a review of the current
9 level of hospital and/or health system consolidation at the level of all metropolitan statistical areas,
10 state, and national markets; a list of all mergers and acquisition transactions valued above a set
11 threshold amount resulting in hospital and/or health system consolidation; analyses of how each
12 transaction has changed or is expected to change the level of competition in the affected service
13 and geographic markets; analyses of how health care costs and prices have changed in affected
14 markets after a large consolidation transaction has taken place.

15
16 Policy H-160.884 states that the AMA opposes not-for-profit firm immunity from FTC competition
17 policy enforcement in the health care sector, supports appropriate transaction value thresholds,
18 including cumulative transaction values, for merger reporting in health care sectors to ensure that
19 vertical acquisitions in health care do not evade antitrust scrutiny, and supports health care-specific
20 advocacy efforts that will strengthen antitrust enforcement in the health care sector through
21 multiple mechanisms.

22
23 Policy H-215.960 states that the AMA: affirms that a) health care entity mergers should be
24 examined individually, taking into account case-specific variables of market power and patient
25 needs; b) the AMA strongly supports and encourages competition in all health care markets; c) the
26 AMA supports rigorous review and scrutiny of proposed mergers to determine their effects on
27 patients and providers; and d) antitrust relief for physicians remains a top AMA priority. The AMA
28 will continue to support actions that promote competition and choice, including (a) eliminating
29 state certificate of need laws; (b) repealing the ban on physician-owned hospitals; (c) reducing
30 administrative burdens that make it difficult for physician practices to compete; and (d) achieving
31 meaningful price transparency; and (3) will work with interested state medical associations to
32 monitor hospital markets, including rural, state, and regional markets, and review the impact of
33 horizontal and vertical health system integration on patients, physicians, and hospital prices.

34
35 Policy H-215.969 states that it is the policy of the AMA that, in the event of a hospital merger,
36 acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be
37 established to resolve at least the following issues: a) medical staff representation on the board of
38 directors; b) clinical services to be offered by the institutions; c) process for approving and
39 amending medical staff bylaws; d) selection of the medical staff officers, medical executive
40 committee, and clinical department chairs; e) credentialing and recredentialing of physicians and
41 limited licensed providers; f) quality improvement; g) utilization and peer review activities;
42 h) presence of exclusive contracts for physician services and their impact on physicians’ clinical
43 privileges; i) conflict resolution mechanisms; j) the role, if any, of medical directors and physicians
44 in joint ventures; k) control of medical staff funds; l) successor-in-interest rights; m) that the
45 medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals;
46 and that the AMA will work to ensure, through appropriate state oversight agencies, that where
47 hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the
48 merging entity shall be responsible for ensuring continuing community access to these services.

49
50 Policy D-215.984 states that the AMA will study nationwide health system and hospital
51 consolidation in order to assist policymakers and the federal government in assessing health care

1 consolidation for the benefit of patients and physicians who face an existential threat from health
2 care consolidation and regularly review and report back on these issues to keep the House of
3 Delegates apprised on relevant changes that may impact the practice of medicine, with the first
4 report no later than the 2023 Annual meeting.

5
6 Policy D-225.995 states that the AMA will continue to monitor and report on current numbers of
7 mergers and break-ups of mergers of hospitals in this country. Policy D-383.980 states that the
8 AMA will study the potential effects of monopolistic activity by health care entities that may have
9 a majority of market share in a region on the patient-doctor relationship and develop an action plan
10 for legislative and regulatory advocacy to achieve more vigorous application of antitrust laws to
11 protect physician practices which are confronted with potentially monopolistic activity by health
12 care entities.

13
14 DISCUSSION

15
16 As expected, the majority of markets in the United States are characterized by hospitals with large
17 market shares. Virtually all hospital markets are highly concentrated, and, on average, this
18 concentration has been increasing over time.

19
20 REFERENCES

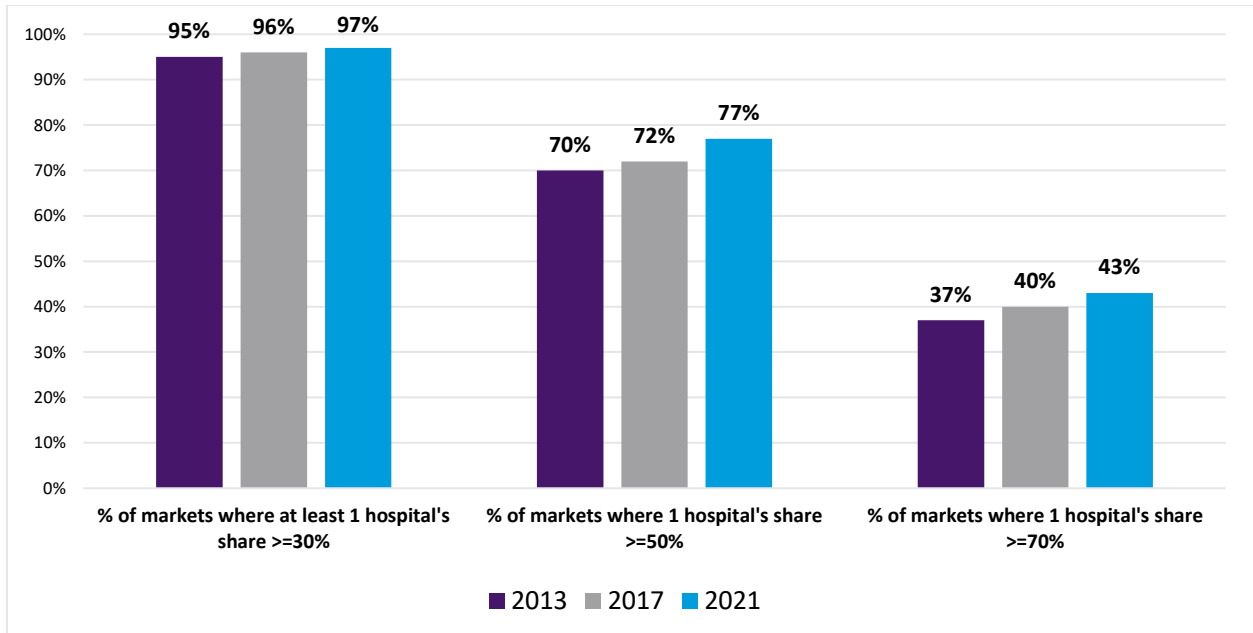
¹Guardado, José R., PhD. AMA Policy Research Perspectives. *Competition in Hospital Markets, 2013-2021*.
American Medical Association. 2024.

Appendix A1
Hospital Market Shares and System Membership, 2013-2021

Variable	2013	2017	2021
% of Markets where at least 1 hospital's share >=30%	95%	96%	97%
% of Markets where 1 hospital's share >=50%	70%	72%	77%
% of Markets where 1 hospital's share >=70%	37%	40%	43%
% of Hospitals that are members of systems	70%	76%	78%
Number of hospitals	1946	2021	2002
Number of systems	276	273	268
Number of markets	363	387	389

1. Source: Author's calculations of data from the 2013, 2017 and 2021 American Hospital Association Annual Surveys.
2. This paper defines geographic markets as metropolitan statistical areas (MSAs). For MSAs that are very large (e.g. New York, Chicago), markets are defined as smaller parts of those MSAs called metropolitan divisions.
3. A "hospital" in the first three rows of this Exhibit relating to market shares can either refer to a hospital or a hospital system. Some hospitals belong to systems, while others do not. If there is more than 1 one hospital belonging to the same system in an MSA, the admissions are aggregated up to the system level. Market shares are calculated from system-wide admissions in an MSA. In those cases, the "hospital's" market share here refers to the system's share.

Appendix A2 Hospital Market Shares, 2013-2021



1. Source: Author's calculations of data from the 2013, 2017 and 2021 American Hospital Association Annual Surveys.
2. This paper defines geographic markets as metropolitan statistical areas (MSAs). For MSAs that are very large (e.g. New York, Chicago), markets are defined as smaller parts of those MSAs called metropolitan divisions.
3. A "hospital" in the first three rows of this Exhibit relating to market shares can either refer to a hospital or a hospital system. Some hospitals belong to systems, while others do not. If there is more than one hospital belonging to the same system in an MSA, the admissions are aggregated up to the system level. Market shares are calculated from system-wide admissions in an MSA. In those cases, the "hospital's" market share here refers to the system's share.

Appendix B
Hospital Market Concentration, 2013-2021

Variable	2013	2017	2021
Weighted average HHI	3722	3853	4062
% of Markets that are highly concentrated	97%	98%	99%
Number of markets	363	387	389

1. Source: Author's calculations of data from the 2013, 2017 and 2021 American Hospital Association Annual Surveys.
2. This paper defines geographic markets as metropolitan statistical areas (MSAs). For MSAs that are very large (e.g. New York, Chicago), markets are defined as smaller parts of those MSAs called metropolitan divisions.
3. HHI is the Herfindahl-Hirschmann Index, which is a measure of market concentration. The average HHI is weighted by metropolitan-area population.

Relevant AMA Policy Health System Consolidation

Health System Consolidation, D-160.907

1. Our American Medical Association (AMA) will assess and report annually on nationwide health system and hospital consolidation, as well as payer consolidation, to assist policymakers and the federal government.
2. Our AMA annual report on nationwide hospital consolidation will be modeled after the “Competition in Health Insurance: A Comprehensive Study of U.S. Markets” in its comprehensiveness to include for example data and analyses as:
 - a) A review of the current level of hospital and/or health system consolidation at the level of all metropolitan statistical areas, state, and national markets;
 - b) A list of all mergers and acquisition transactions valued above a set threshold amount resulting in hospital and/or health system consolidation;
 - c) Analyses of how each transaction has changed or is expected to change the level of competition in the affected service and geographic markets;
 - d) Analyses of health care costs and prices have changed in affected markets after a large consolidation transaction has taken place.
3. Our AMA will report the initial findings of this study to the House of Delegates by Annual 2024.
4. Our AMA will report the findings of this study to its members and stakeholders, including policymakers and legislators, to inform future health care policy.
(Res. 727, A-23)

Strengthening Efforts Against Horizontal & Vertical Consolidation, H-160.884

1. Our AMA opposes not-for-profit firm immunity from FTC competition policy enforcement in the health care sector.
2. Our AMA supports appropriate transaction value thresholds, including cumulative transaction values, for merger reporting in health care sectors to ensure that vertical acquisitions in health care do not evade antitrust scrutiny.
3. Our AMA supports health care-specific advocacy efforts that will strengthen antitrust enforcement in the health care sector through multiple mechanisms.
(Res. 813, I-23)

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.
(CMS Rep. 07, A-19; Reaffirmation, I-22)

Hospital Merger Study, H-215.969

1. It is the policy of the AMA that, in the event of a hospital merger, acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues:
 - (A) medical staff representation on the board of directors;

- (B) clinical services to be offered by the institutions;
 - (C) process for approving and amending medical staff bylaws;
 - (D) selection of the medical staff officers, medical executive committee, and clinical department chairs;
 - (E) credentialing and recredentialing of physicians and limited licensed providers;
 - (F) quality improvement;
 - (G) utilization and peer review activities;
 - (H) presence of exclusive contracts for physician services and their impact on physicians' clinical privileges;
 - (I) conflict resolution mechanisms;
 - (J) the role, if any, of medical directors and physicians in joint ventures;
 - (K) control of medical staff funds;
 - (L) successor-in-interest rights;
 - (M) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals; and
2. Our AMA will work to ensure, through appropriate state oversight agencies, that where hospital mergers and acquisitions may lead to restrictions on reproductive health care services, the merging entity shall be responsible for ensuring continuing community access to these services.
(CMS Rep. 4, I-01; Reaffirmed: CMS Rep. 7, A-11; Appended: Res. 3, I-13; Reaffirmed: CMS Rep. 07, A-19)

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 health care consolidation for the benefit of patients and physicians who face an existential threat from health care 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.
(Res. 702, A-22)

Hospital Merger Study, D-225.995

Our AMA will: (1) urge its AMA Commissioners to the Joint Commission to seek the inclusion of a standard in The Joint Commission hospital accreditation program requiring a medical staff successor-in-interest standard in the hospital medical staff bylaws; (2) seek inclusion of medical staff bylaw successor-in-interest provisions in the Medicare Conditions of Participation and in the rules and regulations of other public and private hospital accreditation agencies; and (3) continue to monitor and report on current numbers of mergers and break-ups of mergers of hospitals in this country.
(CMS Rep. 7, I-00; Modified: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 01, A-20)

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. (BOT Rep. 8, I-15)

REPORT OF THE SPEAKERS

Speakers' Report 2-A-24

Subject: Report of the Election Task Force 2

Presented by: Lisa Bohman Egbert, MD, Speaker; and John A. Armstrong, MD, Vice Speaker

1 BACKGROUND

2

3 At the 2023 Interim Meeting, the Election Task Force 2 (ETF2) submitted Speakers' Report 3-I-23
4 which included multiple recommendations, many of which were ultimately referred back. The
5 ETF2 subsequently met February 10, 2024, to review these items and testimony heard at I-23. The
6 task force will hold an open forum on Sunday, June 9, 2024, at 3:00 pm CT to gather additional
7 feedback on these items and will then develop a report with final recommendations to be presented
8 at Interim 2024. The topics of consideration listed on this report will be the basis for discussion at
9 the open forum.

10

11 ITEMS FOR DISCUSSION

12

13 The ETF 2 noted that there was a general lack of clear definitions related to items surrounding
14 AMA elections. Therefore, they developed the definitions in the Glossary shown below. In
15 addition, the ETF 2 reviewed all items that were referred back for further consideration and
16 suggested changes shown as additions and deletions and the rationale for these suggestions in the
17 grid that follows. The ETF 2 asks that delegations review and make comments on the Glossary and
18 Proposed Changes at the Open Forum.

19

20 The final topic for consideration at the open forum will be a consideration of endorsements. This
21 will be an open topic and all input is encouraged.

22

23 **Glossary**

24

25 Active campaign window – period of time after the speaker's notice of the opening of active
26 campaigning until the Election Session during the House of Delegates meeting at which elections
27 are being held

28

29 Active campaigning – Outreach by candidates or their surrogate(s), including but not limited to
30 members of their campaign team, to members of the House of Delegates with the goal of being
31 elected by the AMA House of Delegates

32

33 Announced candidate – person who has indicated their intention to run for elected position;
34 announcement can be made only by sending an electronic announcement card to the Speakers via
35 the HOD office by email to hod@ama-assn.org

36 Campaign manager(s) – person(s) identified by the candidate to the HOD Office as the person(s)
37 responsible for running the campaign

- 1 Campaign team – campaign manager(s) and/or staff identified by the candidate to the HOD Office
- 2
- 3 Campaign-related – any content that includes reference to an announced candidate in the context of
- 4 their candidacy for an elected position within the AMA
- 5
- 6 Digital – relating to, using, or storing data or information in the form of digital signals; involving or
- 7 relating to the use of computer technology; this includes but is not limited to social media and
- 8 communication platforms
- 9
- 10 Elected position(s) – Council or Officer position within the AMA elected by the House of
- 11 Delegates of the AMA
- 12
- 13 Featured – identification of a candidate at an event by the host or organizer of the event including
- 14 but not limited to written or verbal announcement of the candidate or their candidacy

ETF 2 Proposed Language <i>(Proposed changes to current policy or items from ETF 2 I-23 report shown in red)</i>	Rationale
<p><i>Proposed changes to current policy:</i></p> <p>Campaign stickers, pins, buttons and similar campaign materials are disallowed. This rule will not apply for pins for AMPAC, <u>AMA</u>, 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. General distribution of any pin, button or sticker is disallowed.</p>	<p>ETF2 considered the testimony from the delegates during the I-23 meeting. In order to confine to the security requirements for the meeting badges, no buttons, pins or stickers can be affixed to the badge itself. AMA, AMPAC, AMA-Foundation, specialty society, state or regional delegations pins, buttons, stickers, etc. are not directly connected to the election campaign and thus can be worn on one's self except on the badge. This proposal is intended to avoid uneven general exposure to a particular candidate and will provide an even playing field for all candidates.</p>
<p><i>New language referred at I-23 with proposed changes.</i></p> <p>Only a<u>A</u>n announced candidate in a currently contested election may discuss their candidacy on an individual basis in private conversations from announcement of candidacy until the active campaigning period begins. Prior to the active campaigning period, no other individual may discuss the candidacy including members of campaign teams, delegations or caucuses, and "friends." <u>This rule does not prohibit any candidate from discussions for the purpose of forming a campaign team nor from a campaign team discussing a candidate or campaign strategy. This rule also does not prohibit persons not associated with a campaign from discussing candidates in private conversations.</u></p>	<p>The intent here is to minimize campaign discussions prior to active campaigning. However, the ETF2 was aware of concerns that this rule would prohibit candidates from asking others to join their campaign team as well as prohibiting a designated campaign team from discussing campaign strategy. This clarifies that both are expected and permitted.</p>

ETF 2 Proposed Language <i>(Proposed changes to current policy or items from ETF 2 I-23 report shown in red)</i>	Rationale
<p><i>Proposed changes to current policy:</i></p> <p><u>Printed and digital</u> Ccampaign materials may not be distributed <u>to members of the House other than by the HOD office candidate email and on the Candidate Web Pages, by postal mail or its equivalent.</u> The AMA Office of House of Delegates Affairs will not longer furnish a file containing the names and mailing addresses of members of the AMA-HOD. Printed campaign materials will not be included in the "Not for Official Business" bag and may not be distributed in the House of Delegates. Candidates are encouraged to eliminate printed campaign materials.</p>	<p>In order for candidates to have equal access to HOD members, the route of access to them is limited to the official AMA channels noted here. This will discourage additional printed mailings and digital communications and disallow distribution at the HOD meetings.</p>
<p><i>Proposed changes to current policy:</i></p> <p><u>Active campaigning via mass outreach to delegates by candidates or on behalf of a candidate by any method is prohibited.</u> A reduction in the volume of campaign-related telephone calls and <u>personal</u> electronic communication from candidates and on behalf of candidates is encouraged. <u>No part of this rule shall be interpreted to limit communication among members of a campaign team. The Office of House of Delegates Affairs does not provide email addresses for any purpose. The use of e</u>Electronic messages to contact electors should be minimized, and if used must include a simple mechanism to allow recipients to opt out of receiving future messages.</p>	<p>The ETF2 seeks to clarify guidelines for communication by candidates to other delegates. New language has been added to specifically prohibit mass outreach to candidates. However, this recommendation also clarifies that personal communication is allowed, while simultaneously honoring the desire of many delegates to reduce overall volume of communication. A clarification was added to ensure freedom of communication amongst campaign teams. Language was also revised to reflect the frequency of electronic communication while still maintaining the option to opt out.</p>

ETF 2 Proposed Language <i>(Proposed changes to current policy or items from ETF 2 I-23 report shown in red)</i>	Rationale
<p><i>Proposed changes to current policy:</i></p> <p>Groups conducting interviews with <u>announced</u> candidates for a given office must offer an interview to all individuals that have officially announced their candidacy at the time the group's interview schedule is finalized <u>announced candidates</u> at the time the group's interview schedule is finalized.</p> <p>a. A group may meet with an <u>announced</u> candidate who is a member of their group <u>during the active campaign window</u> without interviewing other candidates for the same office.</p> <p>b. Interviewing groups may, but are not required to, interview late announcing candidates persons who become announced candidates during the active campaign window. Should an interview be offered to a late candidate, all other announced candidates for the same office (even those previously interviewed) must be afforded the same opportunity and medium.</p> <p>c. Any appearance by a candidate before an organized meeting of a caucus or delegation, other than their own, will be considered an interview and fall under the rules for interviews. Any <u>appearance campaign-related presentation</u> to an assembly by an announced candidate, with or without being followed by a discussion, question and answer session, or a vote of the assembly regarding the candidate, is an interview and subject to the rules on in-person interviews. No portion of this rule shall be interpreted to mean that a candidate acting in a formal capacity would be unable to present or discuss matters pertaining to that formal capacity with any group.</p>	<p>The Election Task Force heard concerns about definitions of timelines, candidacy, and potential election violations that would be incurred by delegations meeting with their own members who happened to be candidates. The proposed language here seeks to clarify that there is no restriction on a delegation's ability to hold meetings where all of their members may be in attendance. Further, the Election Task Force wanted to clarify the mechanism for candidates that do not announce until after the active campaign window opens may be offered interviews, and what this means for all other candidates for that same office. Finally, there were questions about what constitutes an interview and how candidates holding an official AMA position while running for office could execute their duties without being considered participating in an interview. This section provides clarity about this definition and the separation of a candidate campaigning and a member performing in their official capacity.</p>
<p><i>New language referred at I-23 with proposed changes.</i></p> <p>Candidates may not produce a personal <u>campaign-related</u> website <u>or other digital campaign-related content</u> or direct to personal or professional websites <u>that contain campaign materials</u> other than the AMA Candidates' Page.</p>	<p>The language in this section provides clarity that explicitly defines that the only authorized campaign or digitally related websites, pages, or other campaign related materials for candidates is a web page provided by the AMA. This allows all candidates to be on equal footing during the election process.</p>

ETF 2 Proposed Language <i>(Proposed changes to current policy or items from ETF 2 I-23 report shown in red)</i>	Rationale
<p><i>Proposed changes to current policy:</i></p> <p>Active campaigning for AMA elective office an elected position may not begin until the <u>active campaign window opens as announced by the Speaker Board of Trustees, after its April meeting, announces the candidates for council seats. Active campaigning includes mass outreach activities directed to all or a significant portion of the members of the House of Delegates and communicated by or on behalf of the candidate. If in the judgment of the Speaker of the House of Delegates circumstances warrant an earlier date by which campaigns may formally begin, the Speaker shall communicate the earlier date to all known candidates.</u></p>	<p>The Election Task Force heard questions concerning timelines for active campaigning in the course of an Election cycle. Active Campaigning is defined as outreach by candidates or their surrogate(s), including but not limited to members of their campaign team, to members of the House of Delegates, with the goal of being elected by the AMA House of Delegates. Active Campaigning activities typically may not occur until after the April meeting of the Board of Trustees, when candidates for Council Seats are announced. The specific dates of the Active Campaigning Window will be announced by the Speaker. The Active Campaigning Window is defined as the period of time after the Speaker's notice of the opening of active campaigning until the Election Session during the House of Delegates meeting at which elections are being held.</p>
<p><i>New language referred at I-23 with proposed changes.</i></p> <p>Candidates and their identified members of campaign teams will be provided a copy of the current election rules and will be required to attest to abiding by them. <u>Candidates are responsible for any and all action or inaction undertaken on their behalf that is campaign related. Campaign managers will also be provided a copy of the current election rules and will be required to attest to abiding by them.</u></p>	<p>While all HOD members should be aware of the current election rules, candidates are ultimately responsible for abiding by these rules and for all campaign related actions taken on their behalf. Therefore, candidates and their campaign managers will be asked to attest to abiding by these rules.</p>
<p><i>New item referred at I-23 (shown below) with proposed new language:</i></p> <p>All meeting attendees will agree to be interviewed by the Speakers or members of the Election Committee for the purpose of investigating a submitted, formal complaint of election rule infractions. Members of the Election Committee, including the Speakers, will identify themselves and the reason for the interview request.</p> <p><i>[Referred language: Candidates, members of their campaign teams, including Federation staff, and HOD members will agree to be interviewed by the Speakers or members of the Election Committee who will identify themselves and the reason for the request.]</i></p>	<p>As part of any investigation, including a simple inquiry as to whether a formally filed complaint has merit to warrant a more complete evaluation, it is important that all attendees (including delegation leadership and staff) assist by complying with a request for an interview with the Speakers or member(s) of the Election Committee, as well as that interviewers clearly identify themselves and the reason for any interview. Cooperation of all attendees would be expected and beneficial to our HOD. This recommendation arises out of prior experience by the Election Committee in trying to evaluate complaints.</p>

REPORT OF THE SPEAKERS

Speakers' Report 03-A-24

Subject: Updated Parliamentary Authority

Presented by: Lisa Bohman Egbert, MD, Speaker, and John H. Armstrong, MD, Vice Speaker

1 Recently, the American Institute of Parliamentarians Standard Code of Parliamentary Procedure,
2 was updated and is now referenced as AIPSC (2nd ed.), with changes taking effect in January of
3 2024. AMA Bylaw 11.1, Parliamentary Procedures, last amended in 2015, states that “In the
4 absence of any provisions to the contrary in the Constitution and these Bylaws, all general
5 meetings of the AMA and all meetings of the House of Delegates, of the Board of Trustees, of
6 Sections and of councils and committees shall be governed by the parliamentary rules and usages
7 contained in the then current edition of The American Institute of Parliamentarians Standard Code
8 of Parliamentary Procedure.”
9

10 When the AMA House of Delegates (HOD) adopted AIPSC as its parliamentary authority in 2015,
11 there were only minor differences between it and AMA’s past parliamentary practices and
12 traditions as embodied in the *HOD Reference Manual*. These were discussed in detail in Speakers
13 Report 1-A-16, which was adopted by the HOD. Adoption allowed the HOD to retain some
14 historical parliamentary practices and traditions, including requiring debate on both sides prior to
15 closing debate on a subject, separate motions of refer for report and refer for decision (AIPSC uses
16 a single motion of refer), the motion to table, and AMA’s historical practice of considering all
17 matters acted upon at a meeting to be final, meaning that items from one meeting are not subject to
18 a motion to recall from committees, a motion to reconsider or any other motion at a subsequent
19 meeting. Adoption also created the motion to Object to Consideration requiring a 3/4 majority vote.
20 Specific AMA bylaws focusing on withdrawal of resolutions, also remained in place: 2.11.3.1.5
21 allows a sponsor to withdraw a resolution at any time prior to its acceptance as business by the
22 HOD, and 2.13.1.7.4, which provides that if, in the judgment of the sponsor and of the reference
23 committee, it appears that withdrawal is preferable to presentation for action, the reference
24 committee may recommend withdrawal to the HOD in its report, with the Proceedings noting only
25 that the resolution was withdrawn. Adoption of Speakers Report 1-A-16 also led to subsequently
26 amended and adopted bylaws related to late and emergency resolutions.
27

28 The Speakers, in concert with the Council on Constitution and Bylaws, have reviewed the AIPSC
29 (2nd ed.) and compared the rules therein to usual practice in the House of Delegates and in the
30 *House of Delegates Reference Manual: Procedures, Policies and Practices*. The *HOD Reference*
31 *Manual* delineates the HOD’s Standing Rules, and is presented in a Rules Report that is adopted
32 by the HOD at each meeting by majority vote, with the Rules Report stating that the *HOD*
33 *Reference Manual* shall be the official method of procedure in handling and conducting the
34 business of the AMA House of Delegates. [The AIPSC (2nd ed.) is available for purchase on
35 Amazon in Kindle and print versions.]

1 AIPSC (2nd ed.) identified the following as among the substantive changes:
2

- 3 • Replacing the concept of restricted debate with a requirement that debate be germane to the
4 motion at hand. (No change required as this is current AMA practice. Note, this would also
5 be inclusive of motions to refer, reconsider and postpone debate.);
6
- 7 • Making Close Debate and Vote Immediately amendable as to the motions to which it
8 applies. **(Rather than making the motion amendable, your Speakers have elected to
9 continue our current AMA practice in which the maker of the motion may specify to
10 which items they wish to apply the motion with the caveat that both sides must have
11 been heard on each item);**
12
- 13 • Removing the debatability of motions that limit debate. **(The motions Object to
14 Consideration* and Limit or Extend Debate will no longer be debatable);**
15
**The motion Object to Consideration requires a 3/4 vote and is unique to the AMA. This was adopted
16 by the HOD at A-16. However, as it limits debate, it will no longer be debatable.*
17
18
- 19 • Removing the concept of a substitute amendment. (No change required as current AMA
20 practice treats substitute amendments as motions to adopt in lieu of);
21
- 22 • Establishing that after debate has been closed, Factual Inquiries are not permitted, although
23 a Parliamentary Inquiry may be. **(This rule will be implemented);**
24
- 25 • Clarifying the methodology and motions used to create a continued meeting. (No change
26 required as AMA items of business are not held over for future meeting);
27
- 28 • Some Main Motions have been retitled as Specific-Purpose Main Motions. (Retitled
29 appropriately on the HOD Reference Manual's Parliamentary Quick Tips Chart, which is
30 appended to this report);
31
- 32 • Special Orders were renamed Scheduled Orders. (Not applicable);
33
- 34 • Standing Rules are now designated as "Standing Rules of Order" or "Temporary Rules.
35 **(The House of Delegates Reference Manual constitutes our Standing Rules of Order.
36 These are highlighted in the Rules Report along with any Temporary Rules for that
37 meeting.);**
38
- 39 • Clarifying rules related to the Credentials Committees, whereby the initial Credentials
40 Committee lists the names of members entitled to vote. (Not applicable as the current
41 AMA practice is to identify credentialed delegates in "The Official Call" with the
42 Committee on Rules and Credentials reporting each day only the number of credentialed
43 delegates in attendance and whether a quorum has been met. The HOD Proceedings reflect
44 the final listing of members of the HOD.)
45

46 The nuances of these changes are addressed in the *HOD Reference Manual* and incorporated into
47 the "Parliamentary Quick Tips" chart that appears as an appendix in the HOD Reference Manual
48 and which is attached to this report also. The Rules Report, to be presented at A-24, will once again
49 ask the HOD to adopt the *HOD Reference Manual* as the official method of procedure in handling
50 and conducting the business of the AMA House of Delegates.

1 There also are several other changes that require additional action: AIPSC (2nd ed.) establishes
2 electronic notice (of a meeting) as the default notification and there are several bylaw provisions
3 (2.12.2, 2.12.3.1, 5.2.4, 5.2.4.1 and 12.3) that specify notification by mail or in writing. The
4 Council has submitted amended bylaw language via CCB Report 4-A-24, AMA Bylaw
5 Amendments Pursuant to AIPSC (2nd ed.).

RELEVANT AMA BYLAWS

2.12.2 Special Meetings of the House of Delegates. Special Meetings of the House of Delegates shall be called by the Speaker on written or electronic request by one third of the members of the House of Delegates, or on request of a majority of the Board of Trustees. When a special meeting is called, the Executive Vice President of the AMA shall mail a notice to the last known address of each member of the House of Delegates at least 20 days before the special meeting is to be held. The notice shall specify the time and place of meeting and the purpose for which it is called, and the House of Delegates shall consider no business except that for which the meeting is called.

2.12.3.1 Invitation from Constituent Association. A constituent association desiring a meeting within its borders shall submit an invitation in writing, together with significant data, to the Board of Trustees. The dates and the city selected may be changed by action of the Board of Trustees at any time, but not later than 60 days prior to the dates selected for that meeting.

5.2.4 Notice of Meeting. Notice is given if delivered in person, by telephone, mail, or any means of electronic communication approved by the Board of Trustees. Notice shall be deemed to be received upon delivery to the Trustee's contact information then appearing on the records of the AMA.

5.2.4.1 Waiver of Notice. Notice of any meeting need not be given if waived in writing before, during or after such meeting. Attendance at any meeting shall constitute a waiver of notice of such meeting, except where such attendance is for the express purpose of objecting to the transacting of any business because of a question as to the legality of the calling or convening of the meeting.

12.3 Articles of Incorporation. The Articles of Incorporation of the AMA may be amended at any regular or special meeting of the House of Delegates by the approval of two-thirds of the voting members of the House of Delegates registered at the meeting, provided that the Board of Trustees shall have approved the amendment and submitted it in writing to each member of the House of Delegates at least 5 days, but not more than 60 days, prior to the meeting of the House of Delegates at which the amendment is to be considered.

Procedures

Types of motions are listed in order of precedence from highest to lowest. A second motion cannot be accepted unless it has a higher precedence than the motion already before the group.

Type of Motion		May Interrupt Speaker?	Requires a Second?	Is motion debatable?	May be Amended?	Vote Needed?
Privileged	Adjourn the meeting	No	Yes	No	Yes	Majority
	Recess the meeting	No	Yes	No	Yes	Majority
	Question of privilege ¹	Yes	No	No	No	None
Subsidiary	Object to consideration ²	No	Yes	No	No	Three-fourths
	Table**	No	Yes	No	No	Two-thirds
	Close debate and vote immediately	No	Yes	No	No	Two-thirds
	Limit or extend debate	No	Yes	No	Yes	Two-thirds
	Postpone to a certain time	No	Yes	Yes	Yes	Majority
	Referred for decision ³	No	Yes	Yes	Yes	Majority
	Referred for report	No	Yes	Yes	Yes	Majority
	Amend	No	Yes	Yes	Yes	Majority
Main	a. The main motion (introduce)	No	Yes	Yes	Yes	Majority
	b. Specific-purpose main motions:					
	Adopt in lieu of	No	Yes	Yes	Yes	***
	Reconsider	Yes*	Yes	Yes	No	Majority
Incidental	Motions					
	Appeal a decision by the Speaker	Yes	Yes	Yes	No	Majority
	Suspend the Rules	No	Yes	No	No	Two-thirds
	Requests					
	Point of order ⁴	Yes	No	No	No	None
	Inquiries ⁵	Yes	No	No	No	None
	Division of question	No	No	No	No	None
	Division of House	Yes	No	No	No	None

Definitions:

- ¹ Question of privilege: Raising a question of privilege allows a single member to request immediate action affecting safety, health, security, comfort, or integrity, including the rights and privileges of a member or members or of the HOD generally.
- ² Object to consideration: Per HOD action at A-16, this motion is unique to the AMA and is used when a delegate objects to HOD consideration of an item. It cannot interrupt a speaker, requires a second, cannot be amended and takes precedence over all subsidiary motions and cannot be renewed. It requires a ¾ vote. However, per AIPSC (2nd ed.) as it limits debate, it will no longer be debatable.
- ³ Refer for decision: Per HOD action at A-16, this motion is used when a delegate wants the Board to determine the appropriate course of action and proceed, and report back on its decision and the action taken. It is one step higher in precedence than the Motion to Refer.
- ⁴ Point of order: A point of order calls to the attention of the Speaker and the HOD an alleged violation of the rules, an omission, a mistake, or an error in procedure and secures a ruling on the question raised.
- ⁵ Inquiries: An inquiry allows a member (1) to ask the Speaker a question relating to procedure in connection with the pending motion or with a motion the delegate may wish to bring immediately before the HOD (Parliamentary Inquiry); or (2) to request substantive information or facts about the pending motion or for information on the meaning or effect of the pending question from the Speaker or a delegate (Factual Inquiry)

* May interrupt the proceedings but not another speaker

** In order only after item is referred to reference committee and until the House takes final action on the item

***Same vote as required for original item. For example, if the motion related to a bylaw change that required a two-thirds vote, the motion to adopt in lieu of would require the same.