

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

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

Date: October 25, 2022

Subject: Handbook Addendum - Supplemental Business and Information

We are pleased to provide the following resolutions received in addition to those included in the advance Delegate's Handbook.

Resolutions Recommended for Consideration

- 009 Medical Decision-Making Autonomy of the Attending Physician
- 011 Advocating for the Informed Consent for Access to Transgender Health Care
- 012 Guidelines on Chaperones for Sensitive Exams
- 013 Hospital Bans on Trial of Labor After Cesarean
- 015 Restricting Derogatory and Stigmatizing Language of ICD-10 Codes
- 216 Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care in Medicare
- 217 Restrictions on the Ownership of Hospitals by Physicians
- 218 Screening and Approval Process for the Over-the-Counter Sale of Substances with Potential for Recreational Use and Abuse
- 219 Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners
- 220 Extend Telemedicine to Out of State Enrolled College Students to Avoid Emergency Room and Inpatient Psychiatric Hospitalizations when in Crisis
- 222 Allocate Opioid Funds to Train More Addiction Treatment Physicians
- 223 Criminalization of Pregnancy Loss as the Result of Cancer Treatment
- 224 Fertility Preservation
- 227 Access to Methotrexate Based on Clinical Decisions
- 310 Enforce AMA Principles on Continuing Board Certification
- 311 Supporting a Hybrid Residency and Fellowship Interview Process
- 313 Request a two-year delay in ACCME Changes to State Medical Society Recognition Program
- 314 Balancing Supply and Demand for Physicians by 2030
- 315 Bedside Nursing and Health Care Staff Shortages
- 606 Patient-Centered Health Equity Strategic Plan and Sustainable Funding
- 607 Accountability for Election Rules Violations
- 815 Opposition to Debt Litigation Against Patients
- 816 Medicaid and CHIP Coverage for Glucose Monitoring Devices for Patients with Diabetes
- 817 Promoting Oral Anticancer Drug Parity
- 818 Pediatric Obesity Treatment Insurance Coverage

Resolutions Recommended for Consideration (cont'd.)

- 819 Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA
- 820 Third-Party Pharmacy Benefit Administrators
- 912 Reevaluating the Food and Drug Administration's Citizen Petition Process
- 913 Supporting and Funding Sobering Centers
- 915 Pulse Oximetry in Patients with Pigmented Skin
- 916 Non-Cervical HPV Associated Cancer Prevention
- 917 Care for Children with Obesity
- 918 Opposition to Alcohol Industry Marketing Self-Regulation
- 919 Decreasing Youth Access to E-cigarettes
- 920 Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings
- 921 Firearm Injury and Death Research and Prevention
- 922 Firearm Safety and Technology
- 923 Physician Education and Intervention to Improve Patient Firearm Safety
- 924 Domestic Production of Personal Protective Equipment
- 926 Limit the Pornography Viewing by Minors Over the Internet
- 927 Off-Label Policy
- 928 Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements
- 929 Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive Populations
- 930 Addressing Longitudinal Health Care Needs of Children in Foster Care
- 931 Amending H-160.903 Eradicating Homelessness to Include Support for Street Medicine Programs
- 933 Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV
- 935 Government Manufacturing of Generic Drugs to Address Market Failures
- 936 Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room

Resolutions Not for Consideration

- 010 Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates
- 014 Gender-Neutral Language in AMA Policy
- 221 Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses
- 225 Drug Policy Reform
- 226 Support for Mental Health Courts
- 312 Reporting of Residency Demographic Data
- 605 Decreasing Political Advantage Within AMA Elections
- 608 Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development
- 914 Greenhouse Gas Emissions from Health Care
- 925 Incorporation of Social Determinants of Health Concepts into Climate Change Work of the AMA
- 932 Increase Employment Services Funding for People with Disabilities
- 934 Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers

Finally, your Speakers wish to inform you that the charts listing actions taken in follow-up to resolutions and report recommendations from the November 2021 Special Meeting and the 2022 Annual Meeting will be posted on the Interim Meeting website (www.ama-assn.org/interim-meeting).

Sincerely,

A handwritten signature in black ink, appearing to read "Bruce A. Scott MD". The signature is fluid and cursive, with the letters "B", "S", and "M" being particularly prominent.

Bruce A. Scott, MD
Speaker, House of Delegates

A handwritten signature in black ink, appearing to read "Lisa Bohman Egbert MD". The signature is fluid and cursive, with the letters "L", "B", and "M" being particularly prominent.

Lisa Bohman Egbert, MD
Vice Speaker, House of Delegates

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 009
(I-22)

Introduced by: Mississippi

Subject: Medical Decision-Making Autonomy of the Attending Physician

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The majority of physicians are now employed in the United States, and many times
2 this is by hospitals; and
3

4 Whereas, Many physician employers have independently created titles for their physician
5 leaders such as Chief Executive Officer, Chief Medical Officer, Chief Medical Information
6 Officer, Chief Operating Officer, Chief Clinical Officer, Chief of Staff, etc.; and
7

8 Whereas, Many times, even though they may sometimes overlap, the stated goals of a hospital
9 administrator and an attending physician are generally not the same; and
10

11 Whereas, There can be questions of loyalties to an institution's financial bottom line or to the
12 health and wellbeing of a patient in certain situations; and
13

14 Whereas, The oath of a physician is first to do no harm; and
15

16 Whereas, Listed within the American Hospital Association's "Patient's Bill of Rights" is the
17 patient's right to be treated fairly, to know the identities of all of their healthcare providers and to
18 make decisions about their own care before and during treatment along with a long list of other
19 pertinent patient rights; and
20

21 Whereas, The autonomy of the medical decisions made about a patient rest with the attending
22 physician who is attending their care directly per our regulatory board as well as a host of other
23 governing boards and agencies; therefore be it
24

25 RESOLVED, That our American Medical Association advocate that no matter what may change
26 in regard to a physician's employment or job status, that there is a sacred relationship between
27 an attending physician and his/her patient that leads the patient's attending physician to hold the
28 ultimate authority in the medical decision-making that affects that patient (Directive to Take
29 Action); and be it further
30

31 RESOLVED, That our AMA advocate strongly that if there is a unique circumstance that puts
32 the attending physician's care into question by a hospital administrator of any sort such as listed
33 above but certainly not limited to that list— physician or not- in the event of a disagreement
34 between an administrator and the attending physician regarding a decision one would call a
35 mere judgment call, the onus would be on the administrator to prove to an ethics committee
36 why the attending physician is wrong prior to anyone having the authority to overturn or overrule
37 the order of the physician attending the patient directly (Directive to Take Action); and be it
38 further

1 RESOLVED, That our AMA reaffirm that the responsibility for the care of the individual patient
2 lies with a prudent and responsible attending physician, and that his/her decisions should not
3 easily be overturned unless there has been an egregious and dangerous judgment error made,
4 and this would still call for an ethics committee consult in that instance (Reaffirm HOD Policy);
5 and be it further
6

7 RESOLVED, That our AMA aggressively pursue any encroachment of administrators upon the
8 medical decision making of attending physicians that is not in the best interest of patients as
9 strongly as possible, for there is no more sacred relationship than that of a doctor and his/her
10 patient, and as listed above, first, we do no harm. (Directive to Take Action)

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

Received: 10/06/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(I-22)

Introduced by: Medical Student Section

Subject: Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, During the ongoing COVID-19 pandemic, our American Medical Association has
2 conducted three meetings of the House of Delegates as Special Meetings, and the November
3 2021 meeting is also a Special Meeting; and
4

5 Whereas, These Special Meetings have played a critical role in allowing for our House to adopt
6 policy on key issues such as health equity, telemedicine, and health system reform even under
7 the extenuating circumstances of the pandemic¹⁻³; and
8

9 Whereas, Each of the four recent Special Meetings has involved the introduction of new
10 procedures or alterations of procedures for that meeting; and
11

12 Whereas, Though tremendous efforts have been made at each Special Meeting to ensure the
13 meetings are useful to our organization, Delegates have concerns about the procedures
14 employed, including but not limited to: (1) procedures used in the Special Meeting were not
15 described fully prior to the meetings, (2) some procedures were kept confidential from
16 Delegates, (3) the House was not made aware of any formally established mechanisms by
17 which concerns could be relayed to leadership, (4) there was no independent oversight of these
18 concerns; and
19

20 Whereas, New procedures regulating consideration of items of business have resulted in an
21 unprecedented backlog of policies awaiting consideration by the House of Delegates; and
22

23 Whereas, Our AMA had never held a virtual House of Delegates prior to June 2020, and our
24 Bylaws on Special Meetings were most recently amended at the Interim Meeting in 2009^{4,5}; and
25

26 Whereas, The uncertain course of the COVID-19 pandemic and other natural disasters and
27 national events raise the likelihood that Special Meetings may be imminently necessary in our
28 AMA's future proceedings; and
29

30 Whereas, Our AMA supports individual member participation (G-625.011) and feedback to
31 leadership by members (G-635.011) and Delegates (G-600.031); and
32

33 Whereas, Our AMA has precedent for the creation and release of as-needed reports
34 (G-635.125, G-605.051); therefore be it

1 RESOLVED, That our American Medical Association update its Special Meeting procedures by
2 updating the Special Meetings Bylaws as follows:

- 3
- 4 1. Specification that the processes used to determine which items of business meet
5 or do not meet the purpose for which the Special Meeting is called shall be
6 published online and electronically sent to all members of the House of
7 Delegates prior to the initiation of the Special Meeting.
- 8 2. Specification concerning the processes for how formal feedback may be
9 submitted and reviewed prior to, during, and after the conclusion of the Special
10 Meeting.
- 11 3. Description of how a Special Meeting report, detailing the processes that were
12 used in the meeting, along with a summary of the concerns and suggestions
13 submitted by the formal feedback mechanism, shall be produced by the
14 Speakers and Board of Trustees following each Special Meeting that occurs.
- 15 4. Description of how, after each Special Meeting, a committee that is
16 representative of House membership shall be formed for the purpose of (a)
17 reviewing the Special Meeting and (b) proposing any improvements to the
18 processes for future Special Meetings. (Modify Bylaws)

Fiscal Note: Bylaws amendment less than \$1,000, ensuing steps up to \$10,000 depending on implementation.

Received: 10/05/22

REFERENCES:

1. O'Reilly KB. Highlights from the November 2020 AMA Special Meeting. Published November 18, 2020. Accessed September 14, 2021. Online: <https://www.ama-assn.org/house-delegates/special-meeting/highlights-november-2020-ama-special-meeting>
2. O'Reilly KB. Highlights from the June 2021 AMA Special Meeting. Published June 17, 2021. Accessed September 14, 2021. Online: <https://www.ama-assn.org/house-delegates/special-meeting/highlights-june-2021-ama-special-meeting>
3. O'Reilly KB. AMA: Racism is a threat to public health. Published November 16, 2020. Accessed September 14, 2021. Online: <https://www.ama-assn.org/delivering-care/health-equity/ama-racism-threat-public-health>
4. American Medical Association. June 2020 Special Meeting of the House of Delegates (HOD). Website. Accessed September 14, 2021. Online: <https://www.ama-assn.org/house-delegates/special-meeting/june-2020-special-meeting-house-delegates-hod>
5. American Medical Association. House of Delegates Proceedings, Interim Meeting v.2009 i.0002. Published November 10, 2009. Accessed September 14, 2021. Online: https://ama.nmtvault.com/jsp/PSImageViewer.jsp?doc_id=1ee24daa-2768-4bff-b792-e4859988fe94%2Fama_arch%2FHOD00006%2F00000001&pg_seq=6

RELEVANT AMA POLICY

Meetings of the House of Delegates. B-2.12

2.12.1 Regular Meetings of the House of Delegates. The House of Delegates shall meet twice annually, at an Annual Meeting and an Interim Meeting.

2.12.1.1 Business of Interim Meeting. The business of an Interim Meeting shall be focused on advocacy and legislation. Resolutions pertaining to ethics, and opinions and reports of the Council on Ethical and Judicial Affairs, may also be considered at an Interim Meeting. Other business requiring action prior to the following Annual Meeting may also be considered at an Interim Meeting. In addition, any other business may be considered at an Interim Meeting by majority vote of delegates present and voting.

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 Locations. The House of Delegates shall meet in cities selected by the Board of Trustees.

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.

2.12.4 Meetings.

2.12.4.1 Open. The House of Delegates may meet in an open meeting to which any person may be admitted. By majority vote of delegates present and voting, an open meeting may be moved into either a closed or an executive meeting.

2.12.4.2 Closed. A closed meeting shall be restricted to members of the AMA, and to employees of the AMA and of organizations represented in the House of Delegates.

2.12.4.3 Executive. An executive meeting shall be limited to the members of the House of Delegates and to such employees of the AMA necessary for its functioning.

Membership and Governance G-635.005

The House affirms that the AMA shall remain an association of voluntary, individual medical student and physician members and that the Association shall continue to be individually funded and organizationally governed through representation in the HOD.

Citation: Report of the Committee on Organization of Organizations, A-03; Reaffirmed: CCB/CLRPD Rep. 3, A-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22

Statement of Collaborative Intent G-620.030

(1) The AMA House of Delegates endorses the following preamble of a Statement of Collaborative Intent: The Federation of Medicine is a collaborative partnership in medicine. This partnership is comprised of the independent and autonomous medical associations in the AMA House of Delegates and their component and related societies. As the assemblage of the Federation of Medicine, the AMA House of Delegates is the framework for this partnership. The goals of the Federation of Medicine are to: (a) achieve a unified voice for organized medicine;

(b) work for the common good of all patients and physicians;

(c) promote trust and cooperation among members of the Federation; and

(d) advance the image of the medical profession; and (e) increase overall efficiency of organized medicine for the benefit of our member physicians.

(2) The AMA House of Delegates endorses the following principles of a Statement of Collaborative Intent:

(a) Organizations in the Federation will collaborate in the development of joint programs and services that benefit patients and member physicians.

(b) Organizations in the Federation will be supportive of membership at all levels of the Federation.

(c) Organizations in the Federation will seek ways to enhance communications among physicians, between physicians and medical associations, and among organizations in the Federation.

(d) Each organization in the Federation of Medicine will actively participate in the policy development process of the House of Delegates.

(e) Organizations in the Federation have a right to express their policy positions.

- (f) Organizations in the Federation will support, whenever possible, the policies, advocacy positions, and strategies established by the Federation of Medicine.
- (g) Organizations in the Federation will support an environment of mutual trust and respect.
- (h) Organizations in the Federation will inform other organizations in the Federation in a timely manner whenever their major policies, positions, strategies, or public statements may be in conflict.
- (i) Organizations in the Federation will support the development and use of a mechanism to resolve disputes among member organizations.
- (j) Organizations in the Federation will actively work toward identification of ways in which participation in the Federation could benefit them.

Citation: CLRPD/CEJA/C&B Report, A-97; Consolidated: CLRPD Rep. 3, I-01; Modified: BOT Rep. 23, A-02; Modified: CCB/CLRPD Rep. 3, A-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22

Function, Role and Procedures of the House of Delegates G-600.011

The function and role of the House of Delegates includes setting policy on health, medical, professional, and governance matters, as well as the broad principles within which AMA's business activities are conducted. The Board of Trustees is vested with the responsibility for the AMA's business strategy and the conduct of AMA affairs. Our AMA adopts the *AMA House of Delegates Reference Manual: Procedures, Policies and Practices* as the official method of procedure in handling and conducting the business before the AMA House of Delegates.

Citation: CCB/CLRPD Rep. 3, A-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22

Participation of Individual Members in our AMA G-635.011

Our AMA supports individual member, two-way electronic communications that promote active grassroots discussion of timely issues; regular feedback for AMA leadership; and a needed voice for diverse ideas and initiatives from throughout the Federation. AMA members are encouraged to participate in the activities of the AMA, particularly in the following ways: (1) Though the AMA website or other communications conduits, provide comments and suggestions to the AMA Board and the AMA Councils? on their policy development projects and on other AMA products and services; (2) Participate in the on-line discussion groups on the items of business included in the Handbook of the House of Delegates; (3) Communicate their views on the items of business in the Houses Handbook to their AMA delegates and alternate delegates; (4) Inform the AMA, directly or through their AMA delegates, of situations that may represent opportunities to implement the Associations policy positions; (5) Help the AMA promote its policy positions; (6) When opportunities present themselves, explain the value of the AMA and the importance of belonging to the AMA to physicians; and (7) Work to help the AMA increase its membership level.

Citation: CCB/CLRPD Rep. 3, A-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22

AMA Goals, Roles, and Obligations G-625.011

Our AMA: (1) reaffirms its goal to be the unified voice of the medical profession speaking for all physicians, and, (2) above all, affirms its role and obligations as a steward of our professional values, as well as the right and obligation of individual physicians to participate in the process.

Citation: Consolidated: CLRPD Rep. 3, I-01; Reaffirmed: BOT Rep. 35, A-08; Reaffirmed: CCB/CLRPD Rep. 3, A-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22

Roles and Responsibilities of AMA Delegates and Alternate Delegates G-600.031

- (1) 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 email addresses so that the AMA can make the information accessible to individual members through the AMA Web site and through other communication mechanisms.
- (2) The roles and responsibilities of delegates and alternate delegates are as follows: (a) regularly communicate AMA policy, information, activities, and programs to constituents so he/she will be

recognized as the representative of the AMA; (b) relate constituent views and suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff; (c) advocate constituent views within the House of Delegates or other governance unit, including the executive staff; (d) attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings; (e) serve as an advocate for patients to improve the health of the public and the health care system; (f) cultivate promising leaders for all levels of organized medicine and help them gain leadership positions; and (g) actively recruit new AMA members and help retain current members.

Citation: Special Advisory Committee to the Speaker of the House of Delegates, I-99; Consolidated: CLRPD Rep. 3, I-01; Modified: Jt. Rep. of the BOT and CLRPD, A-02; Reaffirmed: CCB/CLRPD Rep. 3, A-12; Modified: Speakers Rep., I-18

Ancillary Meetings and Conferences of the House G-600.090

The Speakers of our AMA House must be notified prior to any planning for ancillary meetings and conferences to be scheduled in conjunction with the Annual or Interim Meetings of the House of Delegates in sufficient time to assess the impact of the timing and purpose on the deliberations of the House of Delegates. Prior approval of the Speaker and Vice Speaker is required before any meeting other than regular meetings of AMA Councils, Committees, Sections, and other groups that are part of the formal structure of our AMA can be scheduled in conjunction with Meetings of the House of Delegates.

Citation: Rep. on Rules and Credentials, A-93; Consolidated: CLRPD Rep. 3, I-01; Reaffirmed: CC&B Rep. 2, A-11; Reaffirmed: Joint CCB/CLRPD Rep. 1, A-21

AMA Membership Demographics G-635.125

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.

Citation: BOT Rep. 26, A-10; Reaffirmed: CCB/CLRPD Rep. 3, A-12; Appended: Res. 603, A-17

Greater Involvement of Medical Students in Federation Organizations G-620.050

Our AMA encourages medical societies to provide mechanisms for more direct involvement of students at the state and local levels, and to implement membership options for their state's medical students who are enrolled in medical school for longer than four years. Our AMA will work with the Association of American Medical Colleges to promote medical student engagement in professional medical societies, including attendance at local, state, and national professional organization meetings, during the pre-clinical and clinical years.

Citation: CCB/CLRPD Rep. 3, A-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22

Data Used to Apportion Delegates G-600.016

1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each state medical society and each national medical specialty society that is in the process of its 5-year review of its current AMA membership count.

2. "Pending members" (defined as individuals who at the time they apply for membership are not current in their dues and who pay dues for the following calendar year) will be added to the number of active AMA members in the December 31 count for the purposes of AMA delegate allocations to state medical societies for the following year and this total will be used to determine the number of national medical specialty delegates to maintain parity.

3. Our AMA will track "pending members" from a given year who are counted towards delegate allocation for the following year and these members will not be counted again for delegate allocation unless they renew their membership before the end of the following year.

4. Our AMA Board of Trustees will issue a report to the House of Delegates at the 2022 Annual Meeting on the impact of Policy G-600.016 and recommendations regarding continuation of this policy.

Citation: BOT Rep. 01, I-18; Modified: BOT Rep. 12, A-19; Modified: CCB Rep. 3, I-19

Situational Reporting Responsibilities of the AMA Board of Trustees G-605.051

The Board of Trustees provides reports to the House when the following situations occur:

- (1) the Board submits a report to the House when the Board takes actions that differ from current AMA policy;
 - (2) consistent with AMA Bylaws, the Board submits a report to the House when the Board determines that the expenditures associated with recommendations and resolves that were adopted by the House would be inadvisable;
 - (3) consistent with AMA Bylaws, the Board transmits reports of the SSS to the House and informs the House of important developments with regard to Federation organizations; and
 - (4) consistent with Policy G-630.040, the Board reports to the House when the Board's review of the AMA's Principles on Corporate Relationships results in recommendations for changes in the Principles.
- In fulfilling its responsibilities to report to the House when certain specified situations develop, the Board should provide succinct reports to the House and, if additional detail is needed, use the AMA web site to provide the additional information to interested members of the House.

Citation: CLRPD Rep. 1, A-03; Modified: CCB/CLRPD Rep. 3, A-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22;

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.

Citation: Res. 608, A-17; Appended: Res. 617, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 011
(I-22)

Introduced by: Washington

Subject: Advocating for the Informed Consent for Access to Transgender Health Care

Referred to: Reference Committee on Amendments to Constitution and Bylaws

Whereas, Transgender and gender-diverse individuals experience several challenges in accessing appropriate health care, including gatekeeping and difficulty with insurance coverage; and

Whereas, Providing gender-affirming care is a medical necessity as determined by the World Professional Association for Transgender Health and supported by the American Medical Association, the American Academy of Family Physicians, the American Academy of Pediatrics, and several other medical organizations; and

Whereas, Gender-affirming health care improves quality of life, mental health, and overall well-being in gender-diverse people; and

Whereas, Currently, under the mainstream diagnostic model for transgender health, to be deemed eligible for gender transition services, transgender clients must meet criteria for a diagnosis of “gender dysphoria” as described in the DSM-5; and

Whereas, An alternative to that diagnostic model for transgender health is the informed consent model, which allows for clients who are transgender to access hormone treatments and surgical interventions without undergoing mental health evaluation or referral from a mental health specialist; therefore be it

RESOLVED, That our American Medical Association advocate and encourage the adoption of an informed consent model when determining coverage for transgender health care services.
(Directive to Take Action)

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

Received: 10/10/22

REFERENCES:

1. Reisner, S. L., Poteat, T., Keatley, J., Cabral, M., Mothopeng, T., Dunham, E., ... & Baral, S. D. (2016). Global health burden and needs of transgender populations: a review. *The Lancet*, 388(10042), 412-436.
2. Grant, Jaime M., Lisa A. Mottet, Justin Tanis, Jack Harrison, Jody L. Herman, and Mara Keisling. Injustice at Every Turn: A Report of the National Transgender Discrimination Survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011.
3. Position Statement on Medical Necessity of Treatment, Sex Reassignment, and Insurance Coverage in the U.S.A. - World Professional Association for Transgender Health. Accessed December 29, 2021. <https://www.wpath.org/newsroom/medical-necessity-statement>
4. Jellestad, L., Jäggi, T., Corbisiero, S., Schaefer, D. J., Jenewein, J., Schneeberger, A., Kuhn, A., & Garcia Nuñez, D. (2018). Quality of Life in Transitioned Trans Persons: A Retrospective Cross-Sectional Cohort Study. *BioMed research international*, 2018, 8684625. <https://doi.org/10.1155/2018/8684625>
5. Schulz, S. L. (2018). The Informed Consent Model of Transgender Care: An Alternative to the Diagnosis of Gender Dysphoria. *Journal of Humanistic Psychology*, 58(1), 72–92. <https://doi.org/10.1177/0022167817745217>

RELEVANT AMA POLICY

Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population H-140.824

Our AMA supports: (1) shared decision making between gender diverse individuals, their health care team, and, where applicable, their families and caregivers; and (2) treatment models for gender diverse people that promotes informed consent, personal autonomy, increased access for gender affirming treatments and eliminates unnecessary third-party involvement outside of the physician-patient relationship in the decision making process.

Citation: Res. 014, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 012
(I-22)

Introduced by: Medical Student Section

Subject: Guidelines on Chaperones for Sensitive Exams

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Estimates indicate that almost 11 percent of provider misconduct reports are sexual in
2 nature¹; and
3

4 Whereas, Rigorous published studies conclude that we lack sufficient information on
5 malpractice to accurately establish the rates and types of physician misconduct²; and
6

7 Whereas, Medical chaperones are third parties who accompany patients during medical
8 examinations³; and
9

10 Whereas, The presence of medical chaperones is a common practice during sensitive exams
11 for patients^{3,4}; and
12

13 Whereas, Physicians can be reported for alleged misconduct that never occurred, but is difficult
14 to disprove without witnesses⁵; and
15

16 Whereas, University of Michigan policy states that “A chaperone’s presence may also provide
17 protection to health professionals against unfounded allegations of improper behavior, and a
18 health professional should be able request a chaperone for any examination or procedure”⁶; and
19

20 Whereas, A study investigating whether medical chaperones affect patient satisfaction found
21 that 61% of adolescent patients preferred to be offered a chaperone^{3,4}; and
22

23 Whereas, American College of Obstetricians and Gynecologists (ACOG) recommends, in part,
24 accommodating patient requests for a chaperone, regardless of the physician's gender⁷; and
25

26 Whereas, The American College of Physicians Ethics Manual states that “in general, the more
27 intimate the examination, the more the physician is encouraged to offer the presence of a
28 chaperone”⁸; and
29

30 Whereas, Pediatric patients, disabled patients, patients with judgement-altering health
31 conditions, patients who lack the capacity to give informed consent, and patients who are
32 otherwise unable to protect themselves from abuse, neglect or exploitation are vulnerable to
33 potential misconduct and may be unable to request a chaperone; and
34

35 Whereas, Some institutions require formally trained chaperones, including in 7 states which
36 have implemented legal mandates for the presence of medical chaperones during sensitive
37 physical exams⁹⁻¹³; and

1 Whereas, Patients may not want an extra person present for sensitive examinations due to the
2 private nature of such examinations, and thus an opt-in/opt-out policy is preferable to a fully
3 mandated policy¹⁴; and
4

5 Whereas, Documentation of patient interactions has been shown to decrease rates of litigation
6 ruled against providers¹⁵; and
7

8 Whereas, Patients may be uncomfortable requesting a chaperone when the provider asks
9 themselves due to intimidation or fear of undermining the trust in the patient-provider
10 relationship, and a study found that 54% of patients preferred to have the nurse ask about
11 chaperone preference rather than the physician⁵; and
12

13 Whereas, Chaperones may feel uncertain or concerned about intervening during an
14 inappropriate exam or reporting potential misconduct, especially if they are hierarchically inferior
15 to the provider, demonstrating the need to educate chaperones on proper conduct¹³; and
16

17 Whereas, AMA policy states says any authorized member of the health care team can serve as
18 a medical chaperone as long as there are clear expectations to uphold professional standards
19 of privacy and confidentiality, failing to address potential discomfort a chaperone may have in
20 reporting egregious behavior during exams; and
21

22 Whereas, There have been instances of litigation when patient declined a chaperone during an
23 exam¹⁶; and
24

25 Whereas, Physicians may feel uncomfortable performing sensitive exams on patients without a
26 chaperone due to fear of litigation or discomfort with patient conduct during an exam; and
27

28 Whereas, American Association of Family Physicians Policy suggests that providers should not
29 allow the process of ensuring that an exam is chaperoned to interfere with appropriate and
30 timely patient care and clinical judgment; and
31

32 Whereas, AMA and ACOG policy have extensive protection guidelines for patients, but do not
33 include guidelines to protect physicians¹⁷; therefore be it
34

35 RESOLVED, That our American Medical Association ask the Council on Ethical and Judicial
36 Affairs to consider amending E-1.2.4, "Use of Chaperones in Code of Medical Ethics," to ensure
37 that it is most in line with the current best practices and potentially considers the following
38 topics: a) opt-out chaperones for breast, genital, and rectal exams; b) documentation
39 surrounding the use or not-use of chaperones; c) use of chaperones for patients without
40 capacity; d) asking patients' consent regarding the gender of the chaperons and attempting to
41 accommodate that preference as able. (Directive to Take Action)

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

Received: 10/12/22

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RELEVANT AMA POLICY

1.2.4 Use of Chaperones

Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients' dignity. These efforts may include providing appropriate gowns, private facilities for undressing, sensitive use of draping, and clearly explaining various components of the physical examination. They also include having chaperones available. Having chaperones present can also help prevent misunderstandings between patient and physician.

Physicians should:

- (a) Adopt a policy that patients are free to request a chaperone and ensure that the policy is communicated to patients.
- (b) Always honor a patient's request to have a chaperone.
- (c) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold professional standards of privacy and confidentiality.
- (d) In general, use a chaperone even when a patient's trusted companion is present.
- (e) Provide opportunity for private conversation with the patient without the chaperone present. Physicians should minimize inquiries or history taking of a sensitive nature during a chaperoned examination.

AMA Principles of Medical Ethics: I,IV

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: 013
(I-22)

Introduced by: Medical Student Section

Subject: Hospital Bans on Trial of Labor After Cesarean

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Trial of labor after cesarean (TOLAC) is a procedure where women who have
2 undergone a previous cesarean section undergo trial of vaginal birth; and
3

4 Whereas, Many hospitals ban the practice of TOLAC¹⁻³; and
5

6 Whereas, Hospital bans on TOLAC increase the number of unnecessary cesarean sections
7 because women eligible for vaginal birth are not given the opportunity for TOLAC⁴; and
8

9 Whereas, Women may have to travel far distances to find a hospital or provider that is willing to
10 let them attempt TOLAC⁵; and
11

12 Whereas, Cesarean section rates are at a medically unjustifiable level, reaching 32% of all
13 United States births in 2017⁶⁻⁸; and
14

15 Whereas, Cesarean sections are major surgeries that have inherent risks for the mother not
16 associated with vaginal birth, such as increased risk of blood loss, hysterectomy, and preterm
17 delivery for future pregnancies⁹; and
18

19 Whereas, Vaginal births result in decreased rates of respiratory distress and other complications
20 for newborns as compared to cesarean section births^{10,11}; and
21

22 Whereas, While relative risk of uterine rupture is higher for women undergoing TOLAC than
23 elective repeat cesarean deliveries (ERCD), the absolute risk remains low at 0.47%¹²; and
24

25 Whereas, There are no significantly different rates of hemorrhage, hysterectomy, or infection
26 between women undergoing TOLAC versus ERCD¹²; and
27

28 Whereas, TOLAC is associated with lower risk of maternal mortality at 3.8 deaths per 100,000
29 deliveries than ERCD at 13.4 deaths per 100,000 deliveries, showing it to be a safe option for
30 women with no contraindications¹³; and
31

32 Whereas, The American College of Obstetrics and Gynecology recommends TOLAC at
33 hospitals that provide at least basic maternal care^{14,15}; and
34

35 Whereas, TOLAC is a viable alternative to cesarean section that should be considered during
36 the antepartum course of care and be part of the physician-patient decision process¹⁶; and
37

38 Whereas, Opinion 1.1.3 in the AMA Code of Medical Ethics states that choice in treatment
39 allows patients control and autonomy over their healthcare decisions; and

Whereas, Hospital bans on TOLAC infringe on patient autonomy by preventing providers from respecting patient choice; and

Whereas, Hospital policies regarding TOLAC are not always easily accessible to patients^{3,17}; and

Whereas, Opinion 1.1.1 in the AMA Code of Medical Ethics supports shared decision making between patient and physician in order to help patients make informed decisions about their health care; therefore be it

RESOLVED, That our American Medical Association encourage hospitals that can provide basic maternal care as defined by the American College of Obstetrics and Gynecology not to prohibit trial of labor after cesarean (TOLAC) (New HOD Policy); and be it further

RESOLVED, That our AMA encourage hospitals that do not have resources to perform TOLAC to assist in the transfer of care of patients who desire TOLAC to a hospital that is equipped to perform TOLAC. (New HOD Policy)

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

Received: 10/12/22

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RELEVANT AMA POLICY

Code of Medical Ethics Opinion 1.1.1 Patient-Physician Relationships

The practice of medicine, and its embodiment in the clinical encounter between a patient and a physician, is fundamentally a moral activity that arises from the imperative to care for patients and to alleviate suffering. The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare.

A patient-physician relationship exists when a physician serves a patient's medical needs. Generally, the relationship is entered into by mutual consent between physician and patient (or surrogate).

However, in certain circumstances a limited patient-physician relationship may be created without the patient's (or surrogate's) explicit agreement. Such circumstances include:

- (a) When a physician provides emergency care or provides care at the request of the patient's treating physician. In these circumstances, the patient's (or surrogate's) agreement to the relationship is implicit.
- (b) When a physician provides medically appropriate care for a prisoner under court order, in keeping with ethics guidance on court-initiated treatment.
- (c) When a physician examines a patient in the context of an independent medical examination, in keeping with ethics guidance. In such situations, a limited patient-physician relationship exists.

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

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

Code of Medical Ethics Opinion 1.1.3 Patient Rights

The health and well-being of patients depends on a collaborative effort between patient and physician in a mutually respectful alliance. Patients contribute to this alliance when they fulfill responsibilities they have, to seek care and to be candid with their physicians, for example. Physicians can best contribute to a mutually respectful alliance with patients by serving as their patients' advocates and by respecting patients' rights. These include the right:

- (a) To courtesy, respect, dignity, and timely, responsive attention to his or her needs.
- (b) To receive information from their physicians and to have opportunity to discuss the benefits, risks, and costs of appropriate treatment alternatives, including the risks, benefits and costs of forgoing treatment. Patients should be able to expect that their physicians will provide guidance about what they consider the optimal course of action for the patient based on the physician's objective professional judgment.
- (c) To ask questions about their health status or recommended treatment when they do not fully understand what has been described and to have their questions answered.
- (d) To make decisions about the care the physician recommends and to have those decisions respected. A patient who has decision-making capacity may accept or refuse any recommended medical intervention.
- (e) To have the physician and other staff respect the patient's privacy and confidentiality.
- (f) To obtain copies or summaries of their medical records.
- (g) To obtain a second opinion.
- (h) To be advised of any conflicts of interest their physician may have in respect to their care.
- (i) To continuity of care. Patients should be able to expect that their physician will cooperate in coordinating medically indicated care with other health care professionals, and that the physician will not discontinue treating them when further treatment is medically indicated without

giving them sufficient notice and reasonable assistance in making alternative arrangements for care.

[AMA Principles of Medical Ethics: I,IV,V,VIII,IX](#)

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Issued: 2016

Obstetrical Delivery in the Home or Outpatient Facility H-420.998

Our AMA (1) believes that obstetrical deliveries should be performed in properly licensed, accredited, equipped and staffed obstetrical units; (2) believes that obstetrical care should be provided by qualified and licensed personnel who function in an environment conducive to peer review; (3) believes that obstetrical facilities and their staff should recognize the wishes of women and their families within the bounds of sound obstetrical practice; and (4) encourages public education concerning the risks and benefits of various birth alternatives. Res. 23, A-78 Reaffirmed: CLRPD Rep. C, A-89 Reaffirmed: Sunset Report, A-00 Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Shared Decision-Making H-373.997

Our AMA:

1. recognizes the formal shared decision-making process as having three core elements to help patients become active partners in their health care: (a) clinical information about health conditions, treatment options, and potential outcomes; (b) tools to help patients identify and articulate their values and priorities when choosing medical treatment options; and (c) structured guidance to help patients integrate clinical and values information to make an informed treatment choice;
2. supports the concept of voluntary use of shared decision-making processes and patient decision aids as a way to strengthen the patient-physician relationship and facilitate informed patient engagement in health care decisions;
3. opposes any efforts to require the use of patient decision aids or shared decision-making processes as a condition of health insurance coverage or provider participation;
4. supports the development of demonstration and pilot projects to help increase knowledge about integrating shared decision-making tools and processes into clinical practice;
5. supports efforts to establish and promote quality standards for the development and use of patient decision aids, including standards for physician involvement in development and evaluation processes, clinical accuracy, and conflict of interest disclosures; and
6. will continue to study the concept of shared decision-making and report back to the House of Delegates regarding developments in this area.

CMS Rep. 7, A-10. Reaffirmed in lieu of Res. 5, A-12 Reaffirmation I-14 Reaffirmed: CMS Rep. 06, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014
(I-22)

Introduced by: Medical Student Section

Subject: Gender-Neutral Language in AMA Policy

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Existing American Medical Association policy inconsistently uses gendered language-
2 in particular, gender pronouns- when referring to physicians, medical students, patients, and
3 others, most often referencing generic individuals with traditionally male and sometimes female
4 pronouns (“he/him/his”, “he or she”, “his or hers”); and
5

6 Whereas, One of many examples of gendered language is AMA Policy H-140.951, which states
7 “Our AMA believes that the primary mission of the physician is to use his best efforts and skill in
8 the care of his patients...”; and
9

10 Whereas, The American medical profession is increasingly gender diverse: 50.5% of all current
11 U.S. medical students are women, and there many medical students and physicians who have
12 other genders that are not male or female, including gender-expansive, gender-fluid, gender-
13 nonconforming, genderqueer, nonbinary, and others^{1,2,7}; and
14

15 Whereas, The frequent default use of male pronouns to describe generic physicians in AMA
16 policy (for example, using “him” and “his” as pronouns for “the physician”) may reinforce
17 patriarchal (pro-male) bias in medicine and disadvantage physicians who do not use such
18 pronouns³⁻⁶; and
19

20 Whereas, The AMA should aspire to use gender-neutral language where feasible, recognizing
21 that American physicians and the patients we serve have diverse gender identities and may use
22 similarly diverse personal pronouns; and
23

24 Whereas, One solution for correcting the bias established by using traditionally male pronouns
25 as default in AMA policy is to replace them with gender-neutral pronouns such as “they”, “them”,
26 “their”, and “theirs”, which are pronouns used by many gender non-binary individuals and may
27 also be used to collectively describe people of all genders⁷; and
28

29 Whereas, The pronouns “they”, “them”, “their”, and “theirs” have long been widely accepted as
30 both singular and plural pronouns, allowing them to be incorporated into AMA policy with great
31 flexibility⁸⁻¹⁰; and
32

33 Whereas, Adopting consistent gender-neutral pronouns and other non-gendered language into
34 AMA policy would be an efficient and adequate way to collectively reference medical students,
35 physicians, patients, and others of all genders; and
36

37 Whereas, Updating the language in our AMA’s policies to be maximally inclusive is a simple act
38 that aligns with our organization’s work to document and appreciate the diversity in sexual
39 orientation and gender identity (SOGI) of our members as well as to champion gender equity
40 and non-discrimination in medicine and society¹¹⁻¹⁶; and

Whereas, AMA policy D-65.990, which calls on the AMA to standardize existing and future language relating to LGBTQ people, establishes precedent for this timely action; therefore be it

RESOLVED, That our American Medical Association (1) revise all relevant policies to utilize gender-neutral pronouns and other non-gendered language in place of gendered language where such text inappropriately appears, and (2) utilize gender-neutral pronouns and other non-gendered language in future policies where gendered language does not specifically need to be used. (Directive to Take Action)

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

Received: 10/13/22

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16. Advocating for the LGBTQ Community. AMA-assn.org. <https://www.ama-assn.org/delivering-care/population-care/advocating-lgbtq-community>. Accessed March 30, 2020.

RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce," and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students,

residents, and fellows underrepresented in medicine and in specific specialties; (4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.

Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13;

Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21

Principles for Advancing Gender Equity in Medicine H-65.961

Our AMA:

1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one's career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.

Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur. Citation: BOT Rep. 27, A-19

Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms D-315.974

Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues and appropriate medical and community based organizations to distribute and promote the adoption of the recommendations pertaining to medical documentation and related forms in AMA policy H-315.967, Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, to our membership.

Citation: Res. 014, A-18

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

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

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

Utilization of "LGBTQ" in Relevant Past and Future AMA Policies D-65.990

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

Citation: Res. 016, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 015
(I-22)

Introduced by: Washington

Subject: Restricting Derogatory and Stigmatizing Language of ICD-10 Codes

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, LGBTQI+ individuals, particularly our transgender patients, face high levels of stigma
2 and discrimination; and
3

4 Whereas, Transgender individuals experience several challenges in accessing appropriate
5 health care and encounter difficulties with insurance coverage; and
6

7 Whereas, Requiring a diagnosis with stigmatizing language may further restrict and harm
8 LGBTQI+ patients attempting to access inclusive health care, such as gender-affirming
9 hormonal therapy and preexposure prophylaxis, to lower the risk of acquiring HIV; and
10

11 Whereas, There are few if any diagnosis codes without stigmatizing language in ICD-10
12 accepted by insurance companies to cover certain services, such as gender-affirming health
13 care and preexposure prophylaxis for human immunodeficiency syndrome; therefore be it
14

15 RESOLVED, That our American Medical Association collaborate with the World Health
16 Organization to implement destigmatizing terminology in ICD-10 that will cover gender-affirming
17 health care services as well as human immunodeficiency virus pre-exposure prophylaxis
18 services and medications. (Directive to Take Action)

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

Received: 10/10/22

RELEVANT AMA POLICY

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(I-22)

Introduced by: American Society of Addiction Medicine, American Psychiatric Association,
American Academy of Psychiatry and the Law, American Association for
Geriatric Psychiatry, American Academy of Child and Adolescent Psychiatry

Subject: Expanding Parity Protections and Coverage of Mental Health and Substance
Use Disorder Care in Medicare

Referred to: Reference Committee B

1 Whereas, The Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity
2 Act of 2008 (MHPAEA) requires that coverage of mental health (MH) and substance use
3 disorder (SUD) benefits in health benefit plans be comparable to and no more restrictive than
4 medical and surgical benefits;ⁱ and

5
6 Whereas, The Affordable Care Act of 2010 (ACA) provides that coverage of MH/SUD is an
7 “essential health benefit;”ⁱⁱ requires that non-grandfathered individual and small group market
8 plans cover MH/SUD services, and extends MHPAEA parity protections to plans sold through
9 state health insurance exchanges;ⁱⁱⁱ and

10
11 Whereas, A 2016 final rule of the Centers for Medicare & Medicaid Services applies MHPAEA
12 to Medicaid and the State Children’s Health Insurance Program (CHIP) and requires states and
13 their managed care organizations to analyze limits placed on MH/SUD benefits in Medicaid and
14 CHIP;^{iv} and

15
16 Whereas, Medicare is now the single largest payer not subject to the mandated parity between
17 benefits for the treatment of MH/SUD and benefits for the treatment of other medical
18 conditions;^v and

19
20 Whereas, The Medicare program imposes varying treatment limitations to MH/SUD services to
21 a greater degree than those applied to medical/surgical services;^{vi} and

22
23 Whereas, Some Medicare Advantage and Part D plans impose burdensome and treatment-
24 delaying utilization management controls on MH/SUD care;^{vii} and

25
26 Whereas, Medicare places a 190-day lifetime limit on inpatient psychiatric care and burdensome
27 documentation requirements for psychiatric hospitals that are far more stringent than
28 documentation requirements for all other hospitals; and

29
30 Whereas, Medicare may provide coverage and payment for the least and most intensive levels
31 of MH/SUD care, but does not cover all intermediate levels of such care, such as intensive
32 outpatient services;^{viii} and

33
34 Whereas, Medicare does not cover freestanding community-based SUD treatment facilities,
35 except for opioid treatment programs (OTPs);^{ix} and

Whereas, The aforementioned coverage gaps, limitations, and restrictions result in a denial of the full continuum of MH/SUD benefits available to Medicare beneficiaries; and

Whereas, There has been an observed increase in the number of people seeking MH/SUD services related to the COVID-19 pandemic;^x and

Whereas, Almost 2 million Medicare beneficiaries report having a SUD, yet only 11% received any SUD treatment in 2021,^{xi} and opioid overdose deaths and hospitalizations continue to increase among older adults;^{xii} and

Whereas, Black and Hispanic Medicare beneficiaries with SUD have more difficulty accessing care and have worse outcomes than White beneficiaries,^{xiii} and Black and Indigenous Medicare beneficiaries have experienced a significant increase in opioid-related overdoses and have the highest rate of opioid-related fatalities; therefore be it^{xiv}

RESOLVED, That our American Medical Association amend policy H-185.974, "Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs," by addition and deletion to read as follows:

Parity for Mental Illness Health, Alcoholism, and Related Substance Use Disorders in Health Insurance Medical Benefits Programs H-185.974

1. Our AMA supports parity of coverage for mental illness, alcoholism, health, and substance use, and eating disorders.

2. Our AMA supports federal legislation, standards, policies, and funding that 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. (Modify Current HOD Policy)

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

Received: 10/07/22

REFERENCES:

ⁱ Wellstone, P., & Domenici, P. (2008). Mental Health Parity and Addiction Equity Act of 2008. Pub. L. 110-343 (2008). 122 Stat. 3881. Codified as 42 USC 300gg, 26.

ⁱⁱ Act, Affordable Care. "Patient protection and affordable care act." Public law 111 (2010): 148.

ⁱⁱⁱ Ibid

^{iv} <https://www.macpac.gov/wp-content/uploads/2021/07/Implementation-of-the-Mental-Health-Parity-and-Addiction-Equity-Act-in-Medicaid-and-CHIP.pdf>

^v Steinberg D, Weber E, Medicare Coverage of Substance Use Disorder Care: A Landscape Review of Benefit Coverage, Service Gaps and a Path to Reform, Legal Action Center, 2021. Available at: <https://www.lac.org/resource/medicare-coverage-of-substance-use-disorder-care-a-landscape-review-of-benefit-coverage-service-gaps-and-a-path-to-reform>

^{vi} Steinberg D, Weber E, Medicare Coverage of Substance Use Disorder Care: A Landscape Review of Benefit Coverage, Service Gaps and a Path to Reform, Legal Action Center, 2021. Available at: <https://www.lac.org/resource/medicare-coverage-of-substance-use-disorder-care-a-landscape-review-of-benefit-coverage-service-gaps-and-a-path-to-reform>

^{vii} Ibid

^{viii} Ibid

^{ix} Ibid

^x Ibid

^{xi} Parish, W. J., Mark, T. L., Weber, E., & Steinberg, D. (2021). Substance use disorders among Medicare beneficiaries: Insights from analysis of the National Survey of Drug Use and Health. Working paper.

^{xii} Steinberg D, Weber E, Medicare Coverage of Substance Use Disorder Care: A Landscape Review of Benefit Coverage, Service Gaps and a Path to Reform, Legal Action Center, 2021. Available at: <https://www.lac.org/resource/medicare-coverage-of-substance-use-disorder-care-a-landscape-review-of-benefit-coverage-service-gaps-and-a-path-to-reform>

^{xiii} Ibid

^{xiv} Ibid

RELEVANT AMA POLICY

Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs H-185.974

Our AMA supports parity of coverage for mental illness, alcoholism, substance use, and eating disorders. Citation: Res. 212, A-96; Reaffirmation A-97; Reaffirmed: Res. 215, I-98; Reaffirmation A-99; Reaffirmed: BOT Action in response to referred for decision Res. 612, I-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 9, A-01; Reaffirmation A-02; Reaffirmation I-03; Modified: CMS Rep. 2, A-08; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed in lieu of Res. 804, I-13; Reaffirmation A-15; Modified: Res. 113, A-16

Maintaining Mental Health Services by States H-345.975

Our AMA:

1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.

Citation: Res. 116, A-12; Reaffirmation A-15; Reaffirmed: Res. 414, A-22

Opioid Mitigation H-95.914

Our AMA urges state and federal policymakers to enforce applicable mental health and substance use disorder parity laws.

Citation: BOT Rep. 09, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(I-22)

Introduced by: Mississippi

Subject: Restrictions on the Ownership of Hospitals by Physicians

Referred to: Reference Committee B

1 Whereas, Physician-owned hospitals (POHs) are known for providing some of the highest
2 quality and lowest cost medical care in the nation; and
3

4 Whereas, Medicine has drastically changed over the past two decades with physician
5 stakeholders losing more and more autonomy over patient care; and
6

7 Whereas, Many of the rules and regulations prohibiting physician ownership of hospitals were
8 written years ago when physicians were largely in private practice, and self-referral was of
9 limited though potentially more relevant concern; and
10

11 Whereas, CMS imposes significant requirements upon POHs that make the status difficult to
12 attain and then generally prohibits expansion capability even if a POH is established; and
13

14 Whereas, In the early 2000s there was a concerted lobbying effort by some in the hospital
15 industry who erroneously and some would say intentionally claimed that physicians owning
16 hospitals was a conflict of interest; and
17

18 Whereas, In 2003 Congress imposed an 18-month moratorium on new POH construction, and
19 then upon further persistent lobbying by many in the hospital industry, in 2010, based on
20 specialty hospital data and other confounding and external factors, POHs were banned from
21 participating in the Medicare program; and
22

23 Whereas, The historic and deadly COVID-19 pandemic exposed bare the dangerous practices
24 of allowing business-minded colleagues to run hospitals and not physicians who selflessly
25 served patients on the frontlines of the pandemic, many times with woefully inadequate personal
26 protective equipment (PPE) as drastic as bandanas and garbage bags, and many lost their lives
27 or suffered serious detriment in nobly doing so; and
28

29 Whereas, These “healthcare heroes” hereby decry that physician ownership of hospitals is an
30 innate conflict of interest, and furthermore proclaim that these institutions are in reality known for
31 providing higher quality of medical care at a lower cost as referenced in this resolution above;
32 therefore be it
33

34 RESOLVED, That our American Medical Association advocate to alleviate any restriction upon
35 physicians from owning, constructing and/or expanding any hospital facility type - in the name of
36 patient safety, fiscal responsibility, transparency and in acknowledgment of physicians
37 everywhere who have given of themselves valiantly in the name of patient care. (Directive to
38 Take Action)

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

Received: 10/06/22

References:

<https://www.statnews.com/2021/09/30/covid-19-reveals-blocking-physician-owned-hospitals/>

https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Physician_Owned_Hospitals

RELEVANT AMA POLICY

Hospital Consolidation H-215.960

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

Citation: CMS Rep. 07, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(I-22)

Introduced by: Mississippi

Subject: Screening and Approval Process for the Over-the-Counter Sale of
Substances with Potential for Recreational Use and Abuse

Referred to: Reference Committee B

1 Whereas, In recent years there has been an influx of substances legally into convenience and
2 grocery stores for the retail sale of these products intended for recreational use and abuse by
3 the public but not regulated in any formal fashion regarding this use; and
4

5 Whereas, We are living in a time deemed an opioid crisis; and
6

7 Whereas, Just in recent years significant time and financial resources have been spent trying to
8 combat the over-the-counter sales of bath salts, kratom and most recently tianeptine; therefore
9 be it
10

11 RESOLVED, That our American Medical Association advocate for the implementation of a
12 national impact on substance abuse by working on model state legislation for state level
13 screening and approval programs to fall under the authority of the State Health Officer which
14 would bestow the authority on his/her office to approve or deny the over-the-counter availability
15 and/or sales of any substance with the potential to be recreationally used and/or abused based
16 on anecdotal, scientific or any other relevant and available evidence to help determine such
17 approval or denial. An appeals process, should one be necessary, would be available by way of
18 appeal to the Board of Health directly by the manufacturer or distributor of such substance that
19 was denied by the State Health Officer initially (Directive to Take Action); and be it further
20

21 RESOLVED, That our AMA work with stakeholders to create a public education campaign
22 regarding these unregulated substances. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 10/06/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(I-22)

Introduced by: Mississippi

Subject: Hold Accountable the Regulatory Bodies, Hospital Systems, Staffing Organizations, Medical Staff Groups, and Individual Physicians Supporting Systems of Care Promoting Direct Supervision of Emergency Departments by Nurse Practitioners

Referred to: Reference Committee B

Whereas, “Direct supervision of emergency services” refers to an individual actively practicing clinical medicine in the emergency department and overseeing all medical decisions in the emergency department at the point of care¹; and

Whereas, Direct supervision of emergency care is distinct from medical direction; and

Whereas, Only 10% of nurse practitioners nationwide are trained in emergency care²; and

Whereas, Nursing and medical leaders strongly recommend that, because of variations in training, licensure, and certification, nurse practitioners should not work alone in emergency departments²⁻⁴; and

Whereas, CMS provides clear regulations on the direct supervision of emergency care in hospitals¹; and

Whereas, In the conditions of participation, CMS requires that for a hospital to provide emergency care, all emergency departments must have direct supervision by a qualified member of medical staff present in the hospital at all hours emergency services are provided; and

Whereas, “Direct supervision for emergency services” is defined as being physically in the hospital and not telemedicine; and

Whereas, The word “must” indicates without exception; and

Whereas, The words “qualified member” are clearly proscribed by the American College of Emergency Physicians (ACEP) and American Association of Emergency Medicine (AAEM)^{2,3}; and

Whereas, While the words “medical staff,” according to CMS, may include physicians, nurse practitioners, and physicians assistants¹, there is a clear requirement for additional specialized training; and

Whereas, It is the responsibility of the national organizations of emergency medicine physicians ACEP and AAEM to set standards for the practice of emergency medicine^{3,4}; and

1 Whereas, ACEP and AAEM determine standards for the practice of emergency medicine and
2 explicitly set the standard that nurse practitioners are unqualified to directly supervise medical
3 care (i.e. work alone) in emergency departments^{2,3}; and
4

5 Whereas, When a nurse practitioner directly supervises the emergency department (i.e. works
6 alone), the are in violation of CMS regulations; and
7

8 Whereas, The risk of nurse practitioners directly supervising emergency care in emergency
9 departments puts patients at risk of misdiagnosis, incorrect treatment, delay in care, or
10 inadequate in care when time sensitive diseases present²⁻⁴; and
11

12 Whereas, A waiver for telemedicine can mitigate staffing shortages, but it remains a temporary
13 solution and does not change the CMS regulation or standards defined by AAEM or ACEP⁵;
14 therefore be it
15

16 RESOLVED, That, in accordance with Centers for Medicare & Medical Services regulations and
17 standards of practice for emergency medicine as defined by ACEP and AAEM, our American
18 Medical Association hold accountable the regulatory bodies, hospital systems, staffing
19 organizations, medical staff groups, and individual physicians supporting systems of care that
20 promote direct supervision of emergency departments by nurse practitioners. (New HOD Policy)

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

Received: 10/06/22

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2. Lavin RP, Veenema TG, Sasnett L, Schneider-Firestone S, Thornton CP, Saenz D, Cobb S, Shahid M, Peacock MN, Couig MP. Analysis of Nurse Practitioners' Educational Preparation, Credentialing, and Scope of Practice in U.S. Emergency Departments. Journal of Nursing Regulation 12(4): 50-62.
3. American College of Emergency Physicians. Providers of Unsupervised Emergency Department Care. 2019. <https://www.acep.org/patient-care/policy-statements/providers-of-unsupervised-emergency-department-care/?fbclid=IwAR2utWVu9H9ky400IaC75piNfNw-zVHh0tiaGSL34SfQWmsWjaJBIGVwlfrc>. Accessed June 21, 2022.
4. American Association of Emergency Physicians. Updated Position Statement on Non-physician Practitioners. 2020. <https://www.aaem.org/resources/statements/position/updated-advanced-practice-providers>. Accessed June 21, 2022.
5. Galli R, Keith JC, McKenzie K, Hall GS, Henderson K. TelEmergency: a novel system for delivering emergency care to rural hospitals. Ann Emerg Med. 2008 Mar;51(3):275-84

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(I-22)

Introduced by: Mississippi

Subject: Extend Telemedicine to Out of State Enrolled College Students to Avoid
Emergency Room and Inpatient Psychiatric Hospitalizations when in Crisis

Referred to: Reference Committee B

1 Whereas, Telemedicine has and continues to be a very helpful tool in the ongoing management
2 of a patient's healthcare; and
3

4 Whereas, The prevalence of mental illness is increasing worldwide; and
5

6 Whereas, In America, one out of five people have some type of mental health condition, and this
7 number seems to be on the rise; and
8

9 Whereas, Among college students specifically, between 25 and 50% of students "meet the
10 criteria" for [at least one mental disorder](#) in a given yearⁱ; and
11

12 Whereas, College student populations are [prone to stress, anxiety, and depression](#). The strain
13 of living away from home for the first time, forming new relationships with peers and teachers,
14 and academic concerns can feel overwhelmingⁱⁱ; and
15

16 Whereas, Additionally, the [mental health crisis at colleges and universities](#) has gone from bad to
17 worse due to COVID-19ⁱⁱⁱ; and
18

19 Whereas, The [Centers for Disease Control and Prevention \(CDC\) reports](#) 1 in 4 people ages 18
20 to 24 "seriously considered suicide" in the last 30 days^{iv}; and
21

22 Whereas, While college students are at a lower risk of experiencing serious symptoms caused
23 by COVID-19, they are at disproportionately high risk for suicide; and
24

25 Whereas, During the COVID-19 pandemic, the utilization of telemedicine particularly in the
26 space of mental health has benefited many patients who have been able to seek ongoing
27 treatment; and
28

29 Whereas, College students from out of state who are enrolled in universities and colleges in
30 Mississippi often establish a patient physician relationship while pursuing academic studies; and
31

32 Whereas, When those college students return home during recess from university studies, it is
33 very difficult when in crisis to seek and establish treatment with a psychiatrist in their local
34 community; and
35

36 Whereas, The utilization of telemedicine for those needed treatment encounters would
37 strengthen the continuity of care for those out of state college student patients and reduce
38 emergency room visits and inpatient psychiatric hospitalization for care; therefore be it

1 RESOLVED, That our American Medical Association work with state medical associations, the
2 American Psychiatric Association, the American Osteopathic Association, and the Federation of
3 State Medical Boards to advocate to Congress that legislation be introduced and passed to
4 extend telemedicine coverage for out of state enrolled college and graduate-level students with
5 an established physician-patient relationship to avoid emergency room and inpatient psychiatric
6 hospitalizations. (Directive to Take Action)

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

Received: 10/06/22

ⁱ <https://www.healthrecoveryolutions.com/blog/stress-control-for-college-students-with-telemedicine>

ⁱⁱ <https://mhealthintelligence.com/news/telehealth-gives-college-students-a-discreet-path-to-counseling>

ⁱⁱⁱ <https://www.bestcolleges.com/blog/coronavirus-survey/>

^{iv} <https://stateofreform.com/news/2020/08/cdc-reports-one-in-four-young-adults-contemplated-suicide-during-covid-19-pandemic/>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(I-22)

Introduced by: Medical Student Section

Subject: Development and Implementation of Recommendations for Responsible
Media Coverage of Opioid Overdoses

Referred to: Reference Committee B

1 Whereas, The number of opioid-related overdose deaths in the United States has been steadily
2 increasing since 1999, reaching 80,816 deaths in 2021¹⁻³; and
3

4 Whereas, The media has the capacity to condition people's perceptions of and attitudes towards
5 disease severity⁴; and
6

7 Whereas, By selectively including or excluding content, perspectives, and material, media
8 platforms have a powerful capacity to frame issues, shape community attitudes, and impact
9 political decision making⁵; and
10

11 Whereas, Media coverage of the opioid overdose crisis has impacted public attitudes regarding
12 the crisis and the subsequent response⁵⁻⁷; and
13

14 Whereas, The *Herald Sun* newspaper in Australia effectively put heroin at the forefront of the
15 public agenda by consistently highlighting heroin-related overdose deaths in the 1990s⁵; and
16

17 Whereas, In the United States from 2008-2013, the news media used an increasing amount of
18 stigmatizing language, such as referring to victims of addiction as "substance abusers" or
19 "addicts" (appeared in 49% of stories) in lieu of less stigmatizing substitutes such as "person
20 with a substance use disorder" (appeared in 2% of stories), potentially leading to increased
21 stigma regarding opioid addiction among the American public⁶; and
22

23 Whereas, In the United States from 1998-2012, coverage of the opioid epidemic focused on
24 criminal justice solutions for the opioid epidemic; this coverage shifted to increasingly
25 emphasize treatment, harm reduction, and prevention from 2013-2017, largely mirroring
26 increased public acceptance that the War on Drugs had failed⁷; and
27

28 Whereas, Despite increased coverage of the opioid epidemic in the United States occurring
29 through the framework of prevention and treatment from 2013-2017, many evidence-based
30 solutions were rarely mentioned, including the use of medication for treatment (9% of stories),
31 syringe service programs (5% of stories), and safe injection sites (2% of stories)⁷; and
32

33 Whereas, The lack of mention of these evidence-based interventions in the news media is
34 correlated with reduced public acceptance of these approaches for treatment of the opioid
35 epidemic⁷⁻⁹; and
36

37 Whereas, The stigma surrounding opioid addiction and strategies for harm reduction have
38 significantly hindered the public health response to the opioid epidemic in the United States¹⁰;
39 and

1 Whereas, Increased stigma associated with media coverage of the opioid epidemic adversely
2 impacts the ability of patients to seek and receive treatment for opioid addiction, as 25% of
3 individuals report negative impacts on their job or fear of a negative opinion of community
4 members as reasons for not seeking treatment¹¹; and
5

6 Whereas, News media framing of the opioid epidemic in the context of race has contributed to
7 the differentiation of “white from black (and brown) suffering, white from black culpability, and
8 white from black deservingness” in the public discourse¹²; and
9

10 Whereas, Coded language used by the media can also contribute to the framing of issues, for
11 example by establishing “urban” as code for Black or Latino and “suburban”/“rural” as code for
12 White, effectively creating perceived separate spaces for White and Black drug users¹²; and
13

14 Whereas, This difference in framing leads to a system where Black and Brown people who use
15 drugs are more likely to be incarcerated and less likely to be offered access to healthcare
16 providers, addiction treatment, and tools to prevent overdose and infection¹²; and
17

18 Whereas, News media framing of White victims of the opioid epidemic as innocent and their
19 deaths as shocking or out of the ordinary contrasts with persistent framing of the opioid
20 epidemic in Black or Brown communities as normal, contributing to increased stigma¹³; and
21

22 Whereas, Stigmatization and marginalization of victims of opioid addiction are associated with
23 greater support for punitive policies instead of investment in prevention and treatment
24 programs¹⁴; and
25

26 Whereas, Ecological studies have shown a significant tendency for increases in fatal overdoses
27 to follow increased media coverage of opioid-related deaths¹⁵; and
28

29 Whereas, Our AMA supports the development of standards for media coverage of mass
30 shootings to help address the gun violence public health crisis in Policy H-145.971, showing that
31 the precedent exists for the AMA to encourage more thoughtful public engagement with health-
32 related issues; therefore be it
33

34 RESOLVED, That our American Medical Association encourage the Centers for Disease
35 Control and Prevention, in collaboration with other public and private organizations, to develop
36 recommendations or best practices for media coverage and portrayal of opioid overdoses. (New
37 HOD Policy)

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

Received: 10/05/22

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RELEVANT AMA POLICY

Development and Implementation of Recommendations for Responsible Media Coverage of Mass Shootings H-145.971

Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations and/or best practices for media coverage of mass shootings, including informed discussion of the limited data on the relationship between mental illness and gun violence, recognizing the potential for exacerbating stigma against individuals with mental illness. Citation: Res. 212, I-18; Modified: Res. 934, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(I-22)

Introduced by: Washington

Subject: Allocate Opioid Funds to Train More Addiction Treatment Physicians

Referred to: Reference Committee B

Whereas, There are not enough medical physicians in the U.S. actively prescribing medications for opioid use disorder, especially in rural areas; and

Whereas, \$26 billion in opioid settlement funds are available nationally from the “Big Three” drug distributors AmerisourceBergen, Cardinal Health, and McKesson, and opioid manufacturer Johnson & Johnson; therefore be it

RESOLVED, That our American Medical Association amend Policy H-95.918, “Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs,” by addition to read as follows:

Our AMA will advocate that any monies paid to the states, received as a result of a settlement or judgment, or other financial arrangement or agreement as a result of litigation against pharmaceutical manufacturers, distributors, or other entities alleged to have engaged in unethical and deceptive misbranding, marketing, and advocacy of opioids, be used exclusively for research, education, prevention, and treatment of overdose, opioid use disorder, and pain, as well as expanding physician training opportunities to provide clinical experience in the treatment of opioid use disorders.
(Modify Current HOD Policy)

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

Received: 10/10/22

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3. Press Release. “Thousands of U.S. communities to receive opioid recovery funds from \$26 billion global settlements as soon as May 2022.” National Opioid Settlement, https://nationalopioidsettlement.com/wp-content/uploads/2022/02/Opioids_release_20220225.pdf

RELEVANT AMA POLICY

Holding the Pharmaceutical Industry Accountable for Opioid-Related Costs H-95.918

Our AMA will advocate that any monies paid to the states, received as a result of a settlement or judgment, or other financial arrangement or agreement as a result of litigation against pharmaceutical manufacturers, distributors, or other entities alleged to have engaged in unethical and deceptive misbranding, marketing, and advocacy of opioids, be used exclusively for research, education, prevention, and treatment of overdose, opioid use disorder, and pain.

Citation: Res. 204, A-19;

Improving Residency Training in the Treatment of Opioid Dependence H-310.906

Our AMA: (1) encourages the expansion of residency and fellowship training opportunities to provide clinical experience in the treatment of opioid use disorders, under the supervision of an appropriately trained physician; and (2) supports additional funding to overcome the financial barriers that exist for trainees seeking clinical experience in the treatment of opioid use disorders.

Citation: Res. 301, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(I-22)

Introduced by: Association for Clinical Oncology, American Society for Radiation Oncology,
American Society of Hematology

Subject: Criminalization of Pregnancy Loss as the Result of Cancer Treatment

Referred to: Reference Committee B

Whereas, The Supreme Court ruling in *Dobbs vs. Jackson* overruled *Roe vs. Wade*, returning an individual's right to access abortion to state law¹; and

Whereas, Each year, one in 1,000 pregnant people will be diagnosed with cancer, and there are patients who become pregnant after having been diagnosed with cancer²; and

Whereas, The most common cancers diagnosed during pregnancy are breast, lymphoma, and cervical cancer³; and

Whereas, Cancer diagnoses during pregnancy can be delayed, since symptoms like fatigue, anemia, and nausea, can be similar for both conditions⁴; and

Whereas, Some cancer treatments and diagnostic services can harm a fetus or cause serious birth defects and for that reason, experts recommend avoiding radiation therapy during the entire pregnancy and most chemotherapies during the first trimester; and

Whereas, Some cancer therapies should not be used during any stage of pregnancy; and

Whereas, Pregnant individuals diagnosed with cancer, or who become pregnant during cancer treatment, face difficult choices about whether to initiate, delay, or continue life-saving cancer treatment, or whether to terminate their pregnancy; and

Whereas, These medical decisions are complex because timely cancer treatment improves a person's likelihood of survival; and

Whereas, Every patient with cancer should receive evidence-based information about all treatment options, including known side effects of those options; and

Whereas, Every patient should be able to maximize their chance for survival by receiving recommended care promptly; and

Whereas, A growing number of current and pending laws insert government into the patient-physician relationships by dictating limits or bans on reproductive health services while also

¹ Dobbs v. Jackson Women's Health Organization, No. 19-1392, 597 U.S. (2022)

² Hepner A, et al. Cancer During Pregnancy: The Oncologist Overview. World J Oncol. 2019 Feb 10

³ Maggen C, et al. International Network on Cancer, Infertility and Pregnancy (INCIP). Pregnancy and Cancer: the INCIP Project. Curr Oncol Rep. 2020 Feb 5

⁴ Silverstein J, et al. Multidisciplinary Management of Cancer During Pregnancy. JCO Oncol. Practice 2020

1 aiming to criminally punish physicians who provide services that result in the loss of a
2 pregnancy⁵; therefore be it

3
4 RESOLVED, That our American Medical Association advocate that pregnancy loss as a result
5 of medically necessary treatment for cancer shall not be criminalized for physicians or patients
6 (Directive to Take Action); and

7
8 RESOLVED, That our AMA advocate that physicians should not be held civilly liable for
9 pregnancy loss as a result of treatment for cancer. (Directive to Take Action)

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

Received: 10/13/22

RELEVANT AMA POLICY

Criminalization of Medical Judgment H-160.954

(1) Our AMA continues to take all reasonable and necessary steps to insure that errors in medical decision-making and medical records documentation, exercised in good faith, do 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.

Citation: 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; Reaffirmation: I-12; Modified: Sub. Res. 716, A-13; Reaffirmed in lieu of Res. 605, I-13; Reaffirmed: Res. 250, A-22; Reaffirmed: Res. 252, A-22

Preserving Access to Reproductive Health Services D-5.999

Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive health services, including fertility treatments, contraception, and abortion; (3) will work with interested state medical societies and medical specialty societies to vigorously advocate for broad, equitable access to reproductive health services, including fertility treatments, contraception, and abortion; (4) supports shared decision-making between patients and their physicians regarding reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing reproductive health services; (7) will advocate for legal protections for patients who cross state lines to receive reproductive health services, including contraception and abortion, or who receive medications for contraception and abortion from across state lines, and legal protections for those that provide, support, or refer patients to these services; and (8) will review the AMA policy compendium and recommend policies which should be amended or rescinded to reflect these core values, with report back at the 2022 Interim Meeting.

Citation: Res. 028, A-22

⁵ Guttmacher Institute. State Legislation Tracker. <https://www.guttmacher.org/state-policy>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(I-22)

Introduced by: Association for Clinical Oncology, American Society for Radiation Oncology,
American Society of Hematology

Subject: Fertility Preservation

Referred to: Reference Committee B

1 Whereas, Individuals of child-bearing age face unique challenges related to their treatment
2 because of the effects many anti-cancer treatments can have on the reproductive system; and
3

4 Whereas, Chemotherapy can damage reproductive cells, resulting in infertility related to
5 damaged sperm, ovaries, and eggs; and
6

7 Whereas, Radiation therapy to the pelvis and abdomen can damage reproductive organs, and
8 radiation for brain malignancies can have negative impact on fertility if there is damage to the
9 pituitary gland; and
10

11 Whereas, Surgery for cancers of the reproductive system also carries risk, including scarring or
12 other harm to organs that affect fertility; and
13

14 Whereas, Patients receiving bone marrow or stem cell transplants often are exposed to high
15 doses of radiation and chemotherapy, which can cause infertility¹; and
16

17 Whereas, Despite clear risk to fertility posed by cancer treatment, many payers deem fertility
18 care as not medically necessary and either limit or exclude coverage of this benefit; and
19

20 Whereas, Due to coverage gaps and high cost, fertility care in the United States remain
21 inaccessible for many patients with cancer; and
22

23 Whereas, Cost and coverage issues for fertility preservation are particularly acute in populations
24 already facing access to care issues, including Medicaid beneficiaries; and
25

26 Whereas, New findings show that more than 32,000 newly diagnosed adolescent and young
27 adult patients may lose or face compromised fertility preservation care each year due to
28 legislation that has been enacted or is expected to be enacted in in some states following the
29 Supreme Court's recent ruling in *Dobbs vs. Jackson Women's Health*²; and
30

31 Whereas, The *Dobbs vs. Jackson Women's Health* ruling could interfere with fertility
32 preservation for adolescent and young adult patients with cancer due to new restrictions on
33 genetic testing, storage, and disposal of embryos; and
34

35 Whereas, Potential fertility preservation restrictions could widen geographical and
36 socioeconomic disparities in access to fertility preservation; therefore be it

¹ ASCO. Fertility Preservation and Cancer Policy Brief. <https://www.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2022-Fertility-Preservation-Brief.pdf>

² American Cancer Society. Continued Access to Fertility Preservation Critical for Adolescent and Young Adult Cancer Patients Following SCOTUS Decision. <http://pressroom.cancer.org/FertilityPreservation>

1 RESOLVED, That our American Medical Association advocate for state legislation requiring
2 payment for fertility preservation therapy services by all payers when iatrogenic infertility may be
3 caused directly or indirectly by necessary medical treatments as determined by a licensed
4 treating physician (Directive to Take Action); and be it further

5
6 RESOLVED, That our AMA advocate that “fertility preservation therapy services” should include
7 cryopreservation of embryos, sperm, and oocytes (Directive to Take Action); and be it further

8
9 RESOLVED, That our AMA advocate against the prosecution of physicians for eliminating or
10 transporting unused embryos created during and subsequent to the fertility preservation
11 process. (Directive to Take Action)

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

Received: 10/13/22

RELEVANT AMA POLICY

Infertility and Fertility Preservation Insurance Coverage H-185.990

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.
3. Our AMA encourages the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility, and supports access to fertility preservation services for those affected.

Citation: Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14; Appended: Res. 012, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(I-22)

Introduced by: Medical Student Section

Subject: Drug Policy Reform

Referred to: Reference Committee B

Drug Use in the US

Whereas, In 2019, 197.5 million Americans (71.8%) aged 12 and over used a substance in the past year, with 179 million using alcohol, 72 million using tobacco, and 57.2 million using an illicit drug, including 9.7 million using prescription opioids, 6 million using hallucinogens, 5.9 million using prescription tranquilizers or stimulants, 5.5 million using cocaine, 2 million using methamphetamine, and 745,000 using heroin¹; and

Whereas, In 2019, 20.4 million Americans (9.7% of those who used a substance in the past year) aged 12 and over met substance use disorder (SUD) criteria, including 14.5 million Americans with alcohol use disorder and 8.3 million with an SUD involving an illicit drug¹; and

Incarceration for Drug Possession in the US

Whereas, The US classifies controlled substances into five schedules, but significant controversy exists over the schedules of certain drugs deemed to have “no medical use,” despite research showing that these drugs may have therapeutic potential²⁻⁵; and

Whereas, Sentences and penalties for federal and state drug offenses vary depending on the drug’s schedule, amount of drug, circumstances of arrest, and previous drug convictions and criminal record⁶⁻⁸; and

Whereas, Drug possession is defined as being found with an amount of a drug small enough for personal use (as determined by the government) without legal justification⁶⁻⁸; and

Whereas, Under federal statute, drug possession is classified as a criminal misdemeanor and can be punishable by up to 1 year imprisonment and/or at least \$1,000 in fines for a first-time offense and up to 3 years imprisonment and/or \$5,000 in fines for repeat offenses, with greater sentences and penalties depending on amount of drug, previous drug convictions, and criminal record⁷⁻⁸; and

Whereas, State statutes are most commonly used to charge people with drug possession and these statutes vary significantly, with many states (including Indiana, Kentucky, and Oklahoma) reclassifying possession from felonies to misdemeanors over the last decade, lowering mandatory minimums, and using savings from reduced incarceration to fund social services, while many other states (such as Idaho, Missouri, and Nebraska) continue to charge possession as felonies often punished with multiple years of imprisonment⁹⁻¹³; and

1 Whereas, In some states, multiple drug felony convictions can result in being charged with a
2 “violent offense,” despite no physical violence being committed against any person, which can
3 further increase sentences and penalties and limit eligibility for parole¹⁴; and
4

5 Whereas, Drug possession arrests comprise 10% of all arrests in the US and make up over
6 80% of all drug offense arrests, and possession arrests drastically increased alongside
7 changing policies of the War on Drugs from 538,100 in 1982 to over 1.4 million in 2018, even as
8 arrests for drug distribution and manufacture remained relatively stable since 1990¹⁵⁻¹⁶; and
9

10 Whereas, Of the 2.3 million people incarcerated in the US, 450,000 (20%) are incarcerated for
11 “nonviolent drug offenses,” including 120,000 unconvicted awaiting trial¹⁶; and
12

13 Whereas, Defelonization refers to the reclassification of an offense from a felony to a
14 misdemeanor, reduces the probability and potential length of imprisonment and decreasing the
15 long-term harms associated with incarceration¹⁷⁻¹⁹; and
16

17 Whereas, “Decriminalization” is distinct from legalization and only refers to the removal of
18 criminal charges associated with drug possession and its reclassification as a civil infraction,
19 which is a prohibited action that results in civil penalties and sanctions against a person¹⁷⁻²⁰; and
20

21 Whereas, “Legalization” would move beyond decriminalization by eliminating civil infractions for
22 drug possession and creating a regulatory system to control legal production and sale of drugs
23 to adults without a prescription, as with alcohol and tobacco¹⁷⁻²⁰; and
24

25 Whereas, AMA Policy H-95.924, “Cannabis Legalization for Adult Use,” states that our AMA
26 “supports public health based strategies, rather than incarceration,” and the AMA Council on
27 Science and Public Health’s Interim 2020 report on cannabis states that “AMA policy supports
28 decriminalization of cannabis (i.e., reduction in the penalty associated with possession of a
29 small amount of cannabis from a criminal offense subject to arrest to a civil infraction)”²¹; and
30

31 Whereas, Various states are considering policies to expunge (destroy) certain offenses (such as
32 drug offenses, especially those due to cannabis) from a person’s criminal record after
33 completion of sentences and penalties, but expungement processes can still be costly and
34 complicated, hindering eligible people from applying (for example, expungement in Missouri
35 costs \$250)²²⁻²⁶; and
36

37 Whereas, The Marijuana Opportunity Reinvestment & Expungement Act, which was passed by
38 the US House of Representatives in December 2020 but has not yet been considered in the
39 Senate, contains language to “create an automatic process, at no cost to the individual, for the
40 expungement, destruction, or sealing of criminal records for cannabis offenses; and...eliminate
41 violations or other penalties for persons under parole, probation, pre-trial, or other State or local
42 criminal supervision for a cannabis offense”²⁷⁻²⁸; and
43

44 Detrimental Health Impacts of Drug Criminalization

45

46 Whereas, The US Department of Health & Human Services’ Healthy People 2020 initiative
47 considers incarceration a key issue within the broad category of social determinants of health,
48 due to poor physical and mental health outcomes and cross-generational effects on the children
49 of those incarcerated, with evidence demonstrating the disproportionate impact of the “War on
50 Drugs” on minoritized communities²⁹⁻³¹; and

Whereas, While only 5% of people who use drugs are Black, arrests of Black people comprise nearly 30% of all drug arrests, and Black people are nearly six times more likely to be arrested for a drug offense than a white person, even when controlling for differences in drug use, exacerbating racial injustice³²⁻³³; and

Whereas, Research shows that incarceration is ineffective and does not significantly reduce recidivism, drug use, drug overdose deaths, or drug arrests, with a 2013 Washington state study finding that overdose was the leading cause of death for people previously incarcerated³⁴⁻³⁶; and

Whereas, Drug criminalization is associated with increased stigma and discrimination against people who use drugs, impairing their mental and physical health and hindering treatment efforts; has fueled the growth of illegal markets, organized crime, and violent injuries; and detrimentally affected public health by increasing overdose deaths due to drug contamination and spreading HIV and hepatitis C³⁷⁻⁴¹; and

Whereas, Previous incarceration of people who use drugs is associated with lack of access to health insurance, even after the implementation of the Affordable Care Act, while possession arrests, regardless of conviction, can negatively impact employment, housing, and student loan eligibility, leading to widespread and multifactorial health consequences⁴²⁻⁴⁴; and

Whereas, Drug felony convictions can lead to lifelong bans from receiving government assistance (such as SNAP and TANF), employment and housing discrimination, and loss of the right to vote or serve on a jury^{7,45-48}; and

Whereas, People who are incarcerated are at higher risk of chronic conditions such as cardiovascular disease, hypertension, and cancer compared to the general population, with an important 2013 New York state study finding that each year spent in prison corresponded with a two-year decline in life expectancy⁴⁹⁻⁵⁰; and

Outcomes of Drug Decriminalization

Whereas, Drug criminalization is costly, ineffective, and stigmatizing, exposing people to incarceration, encouraging more dangerous drug consumption methods, and discouraging people from receiving health services⁵¹⁻⁵³; and

Whereas, 83% of Americans believe that the “War on Drugs” has failed, 66% support “eliminating criminal penalties for drug possession,” and 61% of voters support reducing sentences of people currently incarcerated for drug offenses, with similar findings replicated across multiple states⁵⁴⁻⁵⁸; and

Whereas, California reclassified drug possession from a felony to misdemeanor in 2014 by passing ballot initiative Proposition 47, “The Safe Neighborhoods and Schools Act,” leading to the release or resentencing of 3,000 people and saving the state \$156 million, with a later study finding no associated increase in crime⁵⁹⁻⁶³; and

Whereas, A 2018 study on cannabis decriminalization in five U.S. states did not find an increase in the prevalence of youth cannabis use as a result of decriminalization⁶⁴; and

Whereas, In 2010 the Czech Republic decriminalized personal drug possession after a comprehensive policy review determined that criminal penalties did not reduce use or harm and were instead costly and unjustifiable, with later studies demonstrating net societal benefits without increased rates of drug use⁶⁵⁻⁶⁶; and

Whereas, Drug decriminalization in Portugal resulted in a decrease in heroin- and cocaine-related seizures, HIV and drug-related deaths, and decreased societal costs related to drug use⁶⁷⁻⁶⁸; and

Whereas, In 2019 the United Nations Chief Executives Board for Coordination issued a statement calling for the “promot[ion of] alternatives to conviction and punishment in appropriate cases, including the decriminalization of drug possession for personal use”^{18,69}; and

Whereas, Decriminalization of personal use and possession of drugs is supported by the World Health Organization, American Public Health Association, Human Rights Watch, Global Commission on Drug Policy, International Federation of Red Cross and Red Crescent Societies, NAACP, and National Latino Congreso⁷⁰⁻⁷⁶; therefore be it

RESOLVED, That our American Medical Association advocate for federal and state reclassification of drug possession offenses as civil infractions and the corresponding reduction of sentences and penalties for individuals currently incarcerated, monitored, or penalized for previous drug-related felonies (Directive to Take Action); and be it further

RESOLVED, That our AMA support federal and state efforts to expunge criminal records for drug possession upon completion of a sentence or penalty at no cost to the individual (New HOD Policy); and be it further

RESOLVED, That our AMA support federal and state efforts to eliminate incarceration-based penalties for persons under parole, probation, pre-trial, or other criminal supervision for drug possession. (New HOD Policy)

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

Received: 10/12/22

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RELEVANT AMA POLICY

Federal Drug Policy in the United States H-95.981

The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) acknowledge that federal efforts to address illicit drug use via supply reduction and enforcement have been ineffective (2) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction; (3) lead a coordinated approach to adolescent drug education; (4) develop community-based prevention programs for youth at risk; (5) continue to fund the Office of National Drug Control Policy to coordinate federal drug policy; (6) extend greater protection against discrimination in the employment and provision of services to drug abusers; (7) make a long-term commitment to expanded research and data collection; (8) broaden the focus of national and local policy from drug abuse to substance abuse; and (9) recognize the complexity of the problem of substance abuse and oppose drug legalization.

Citation: BOT Rep. NNN, A-88; Reaffirmed: CLRPD 1, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 2, I-13; Reaffirmed: BOT Rep. 14, I-20

Cannabis Legalization for Adult Use (commonly referred to as recreational use) H-95.924

Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for adult use should not be legalized (with adult defined for these purposes as age 21 and older); (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (4) believes states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety including but not limited to: regulating retail sales, marketing, and promotion intended to encourage use; limiting the potency of cannabis extracts and concentrates; requiring packaging to convey meaningful and easily understood units of consumption, and requiring that for commercially available edibles, packaging must be child-resistant and come with messaging about the hazards about unintentional ingestion in children and youth; (5) laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (6) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis, especially emergency department visits and hospitalizations, impaired driving, workplace impairment and worker-related injury and safety, and prevalence of psychiatric and addictive disorders, including cannabis use disorder; (7) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use; (8) encourages research on the impact of legalization and decriminalization of cannabis in an effort to promote public health and public safety; (9) encourages dissemination of information on the public health impact of legalization and decriminalization of cannabis; (10) will advocate for stronger public health messaging on the health effects of cannabis and cannabinoid inhalation and ingestion, with an emphasis on reducing initiation and frequency of cannabis use among adolescents, especially high potency products; use among women who are pregnant or contemplating pregnancy; and avoiding cannabis-impaired driving; (11) supports social equity programs to address the impacts of cannabis prohibition and enforcement

policies that have disproportionately impacted marginalized and minoritized communities; and (12) will coordinate with other health organizations to develop resources on the impact of cannabis on human health and on methods for counseling and educating patients on the use cannabis and cannabinoids. Citation: CSAPH Rep. 05, I-17; Appended: Res. 913, I-19; Modified: CSAPH Rep. 4, I-20

Support for Drug Courts H-100.955

Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; (2) encourages legislators to establish drug courts at the state and local level in the United States; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.

Citation: Res. 201, A-12; Appended: BOT Rep. 09, I-19

Youth Incarceration in Adult Facilities H-60.916

1. Our AMA supports, with respect to juveniles (under 18 years of age) detained or incarcerated in any criminal justice facility: (a) early intervention and rehabilitation services, (b) appropriate guidelines for parole, and (c) fairness in the expungement and sealing of records.

2. Our AMA opposes the detention and incarceration of juveniles (under 18 years of age) in adult criminal justice facilities.

Citation: Alt. Res. 917, I-16

Ending Money Bail to Decrease Burden on Lower Income Communities H-80.993

Our AMA: (1) recognizes the adverse health effects of pretrial detention; and (2) will support legislation that promotes the use of non-financial release options for individuals charged with nonviolent crimes.

Citation: Res. 408, A-18; Reaffirmed: Res. 234, A-22

The Reduction of Medical and Public Health Consequences of Drug Abuse H-95.954

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

Citation: (CSA Rep. 8, A-97; Reaffirmed: CSA Rep. 12, A-99; Appended: Res. 416, A-00; Reaffirmation I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 2, I-13

Syringe and Needle Exchange Programs H-95.958

Our AMA: (1) encourages all communities to establish needle exchange programs and physicians to refer their patients to such programs; (2) will initiate and support legislation providing funding for needle exchange programs for injecting drug users; and (3) strongly encourages state medical associations to initiate state legislation modifying drug paraphernalia laws so that injection drug users can purchase and

possess needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.

Citation: Res. 231, I-94; Reaffirmed Ref. Cmt. D, I-96; Modified by CSA Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Modified: Res. 203, A-13; Modified: Res. 914, I-16

Pilot Implementation of Supervised Injection Facilities H-95.925

Our AMA supports the development and implementation of pilot supervised injection facilities (SIFs) in the United States that are designed, monitored, and evaluated to generate data to inform policymakers on the feasibility, effectiveness, and legal aspects of SIFs in reducing harms and health care costs related to injection drug use.

Citation: Res. 513, A-17

Drug Paraphernalia H-95.989

The AMA opposes the manufacture, sale and use of drug paraphernalia.

Citation: (BOT Rep. N, A-82; Reaffirmed: Sub. Res. 108, A-87; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: CSAPH Rep. 1, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(I-22)

Introduced by: Medical Student Section

Subject: Support for Mental Health Courts

Referred to: Reference Committee B

1 Whereas, “Mental health courts” are correctional diversion and rehabilitation programs used by
2 state and local courts to support individuals with mental illness in the justice system¹⁻⁷; and
3

4 Whereas, Mental health courts connect individuals with mental illness to mental health
5 treatment, as an alternative to incarceration or other legal sentences and penalties¹⁻⁷; and
6

7 Whereas, Two pieces of federal Congressional legislation, the America’s Law Enforcement and
8 Mental Health Project of 2000 and the Mentally Ill Offender Treatment and Crime Reduction Act
9 of 2004 (MIOTCRA), were enacted to improve the use of mental health personnel and
10 resources in the justice system and to establish grants to fund mental health court programs⁸⁻⁹;
11 and
12

13 Whereas, The continued funding of MIOTCRA programs over the last two decades has been
14 dependent on Congressional appropriations¹⁰; and
15

16 Whereas, The US Substance Abuse and Mental Health Services Administration (SAMHSA) in
17 the Department of Health and Human Services and the US Bureau of Justice Assistance (BJA)
18 in the Department of Justice administer grants to fund state and local mental health courts^{11,12};
19 and
20

21 Whereas, Research demonstrates that mental health courts appear to be associated with
22 reductions in recidivism, length of incarceration, severity of charges, risk of violence, and
23 rehospitalization among individuals with mental illness in the justice system^{3,13-26}; and
24

25 Whereas, SAMHSA published a 2015 report noting that because “the vast majority of individuals
26 who come into contact with the criminal justice system appear” before municipal courts and
27 “many of these individuals have mental illness and co-occurring substance use disorders,”
28 municipal courts may be an especially effective “and often overlooked” method of diversion of
29 individuals with mental illness from the justice system²⁶; and
30

31 Whereas, In addition to SAMHSA and BJA, several nonprofit advocacy organizations, including
32 Mental Health America, the National Alliance on Mental Illness, the Treatment Advocacy Center,
33 the National Sheriffs’ Association, the Council on State Governments, and the National Center
34 for State Courts, support the use of mental health courts^{2,27-32}; and
35

36 Whereas, While several hundred mental health courts exist across all 50 states, mental health
37 courts do not exist in all counties and localities, indicating that these programs may not be
38 accessible or available to all individuals who could benefit from them⁴; and

Whereas, Because mental health courts are dependent on participation from national, state, and local governmental agencies, justice systems, and mental health service organizations and on the appropriation of public funds, including federal monies for MIOTCRA programs and grants administered by SAMHSA and BJA¹⁰⁻¹², the American Medical Association can play a role in advocating for the continued support and funding of mental health courts by policymakers; and

Whereas, Courts that connect individuals with mental illness to treatment as an alternative to incarceration exist under many different names, with each focused on different types of mental illness, including “mental health courts” (for mental illness in general), “drug courts” (for substance use disorders), and “sobriety” or “sober courts” (for alcohol use disorder and sometimes certain other substance use disorders)³²⁻³⁵; and AMA policy should be inclusive of all these different types; and

Whereas, Existing AMA Policy H-100.955 (passed at A-12) established support for drug courts, which are similar in function to mental health courts but narrower in scope, “for individuals with addictive disease who are convicted of nonviolent crimes”; and

Whereas, Existing AMA Policy H-510.979 (passed at I-19) established support for veteran courts, which are similar in function to mental health courts but narrower in scope, “for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder”; and

Whereas, At I-19, House of Delegates Reference Committee B originally recommended amending Resolution 202 on veteran courts to limit their use to only nonviolent offenses, to be consistent with previous Policy H-100.955 on drug courts³⁶⁻³⁷; and

Whereas, At I-19, despite the Reference Committee B recommendation, Resolution 202 was extracted in our HOD to remove the restriction on only using veteran courts for nonviolent offenses, and our HOD ultimately passed Policy H-510.979 such that veteran courts could potentially be used for criminal offenses in general and not only for nonviolent offenses³⁶; and

Whereas, To be consistent with our HOD’s most recent debate on this matter, Policy H-100.955 on drug courts and any future AMA policy on alternatives to incarceration for individuals with mental illness should not be limited to only nonviolent offenses; therefore be it

RESOLVED, That AMA Policy H-100.955, Support for Drug Courts, be amended by addition and deletion to read as follows:

Support for Mental Health Drug Courts, H-100.955

Our AMA: (1) supports the establishment and use of mental health drug courts, including drug courts and sobriety courts, as an effective method of intervention for individuals with mental illness involved in the justice system within a comprehensive system of community-based services and supports ~~addictive disease who are convicted of nonviolent crimes~~; (2) encourages legislators to establish mental health drug courts at the state and local level in the United States; and (3) encourages mental health drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration. (Modify Current HOD Policy)

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

Received: 10/13/22

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RELEVANT AMA POLICY

Support for Drug Courts H-100.955

Our AMA: (1) supports the establishment of drug courts as an effective method of intervention for individuals with addictive disease who are convicted of nonviolent crimes; (2) encourages legislators to establish drug courts at the state and local level in the United States; and (3) encourages drug courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.

Citation: Res. 201, A-12; Appended: BOT Rep. 09, I-19

Support for Veterans Courts H-510.979

Our AMA supports the use of Veterans Courts as a method of intervention for veterans who commit criminal offenses that may be related to a neurological or psychiatric disorder.

Citation: Res. 202, I-19

Maintaining Mental Health Services by States H-345.975

Our AMA:

1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.

Citation: Res. 116, A-12; Reaffirmation A-15; Reaffirmed: Res. 414, A-22

AMA Support for Justice Reinvestment Initiatives H-95.931

Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.

Citation: Res. 205, A-16

Prevention of Impaired Driving H-30.936

Our AMA: (1) acknowledges that all alcohol consumption, even at low levels, has a negative impact on driver skills, perceptions, abilities, and performance and poses significant health and safety risks; (2)

supports 0.04 percent blood-alcohol level as per se illegal for driving, and urges incorporation of that provision in all state drunk driving laws; and (3) supports 21 as the legal drinking age, strong penalties for providing alcohol to persons younger than 21, and stronger penalties for providing alcohol to drivers younger than 21.

Education: Our AMA: (1) favors public information and education against any drinking by drivers; (2) supports efforts to educate physicians, the public, and policy makers about this issue and urges national, state, and local medical associations and societies, together with public health, transportation safety, insurance, and alcohol beverage industry professionals to renew and strengthen their commitment to preventing alcohol-impaired driving; (3) encourages physicians to participate in educating patients and the public about the hazards of chemically impaired driving; (4) urges public education messages that now use the phrase "drunk driving," or make reference to the amount one might drink without fear of arrest, be replaced with messages that indicate that "all alcohol use, even at low levels, impairs driving performance and poses significant health and safety risks;" (5) encourages state medical associations to participate in educational activities related to eliminating alcohol use by adolescents; and (6) supports and encourages programs in elementary, middle, and secondary schools, which provide information on the dangers of driving while under the influence of alcohol, and which emphasize that teenagers who drive should drink no alcoholic beverages whatsoever; and will continue to work with private and civic groups such as Mothers Against Drunk Driving (MADD) to achieve those goals.

Legislation: Our AMA: (1) supports the development of model legislation which would provide for school education programs to teach adolescents about the dangers of drinking and driving and which would mandate the following penalties when a driver under age 21 drives with any blood alcohol level (except for minimal blood alcohol levels, such as less than .02 percent, only from medications or religious practices): (a) for the first offense - mandatory revocation of the driver's license for one year and (b) for the second offense - mandatory revocation of the driver's license for two years or until age 21, whichever is greater; (2) urges state medical associations to seek enactment of the legislation in their legislatures; (3) urges all states to pass legislation mandating all drivers convicted of first and multiple DUI offenses be screened for alcoholism and provided with referral and treatment when indicated; (4) urges adoption by all states of legislation calling for administrative suspension or revocation of driver licenses after conviction for driving under the influence, and mandatory revocation after a specified number of repeat offenses; and (5) encourages passage of state traffic safety legislation that mandates screening for substance use disorder for all DUI offenders, with those who are identified with substance use disorder being strongly encouraged and assisted in obtaining treatment from qualified physicians and through state and medically certified facilities.

Treatment: Our AMA: (1) encourages that treatment of all convicted DUI offenders, when medically indicated, be mandated and provided but in the case of first-time DUI convictions, should not replace other sanctions which courts may levy in such a way as to remove from the record the occurrence of that offense; and (2) encourages that treatment of repeat DUI offenders, when medically indicated, be mandated and provided but should not replace other sanctions which courts may levy. In all cases where treatment is provided to a DUI offender, it is also recommended that appropriate adjunct services should be provided to or encouraged among the family members actively involved in the offender's life;

Repeat Offenders: Our AMA: (1) recommends the following measures be taken to reduce repeat DUI offenses: (a) aggressive measures be applied to first-time DUI offenders (e.g., license suspension and administrative license revocation), (b) stronger penalties be leveled against repeat offenders, including second-time offenders, (c) such legal sanctions must be linked, for all offenders, to substance abuse assessment and treatment services, to prevent future deaths in alcohol-related crashes and multiple DUI offenses; and (2) calls upon the states to coordinate law enforcement, court system, and motor vehicle departments to implement forceful and swift penalties for second-time DUI convictions to send the message that those who drink and drive might receive a second chance but not a third.

On-board devices: Our AMA: (1) supports further testing of on-board devices to prevent the use of motor vehicles by intoxicated drivers; this testing should take place among the general population of drivers, as well as among drivers having alcohol-related problems; (2) encourages motor vehicle manufacturers and the U.S. Department of Transportation to monitor the development of ignition interlock technology, and plan for use of such systems by the general population, when a consensus of informed persons and studies in the scientific literature indicate the systems are effective, acceptable, reasonable in cost, and safe; and (3) supports continued research and testing of devices which may incapacitate vehicles owned or operated by DUI offenders without needlessly penalizing the offender's family members.

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

9.7.2 Court-Initiated Medical Treatment in Criminal Cases

Court-initiated medical treatments raise important questions as to the rights of prisoners, the powers of judges, and the ethical obligations of physicians. Although convicted criminals have fewer rights and protections than other citizens, being convicted of a crime does not deprive an offender of all protections under the law. Court-ordered medical treatments raise the question whether professional ethics permits physicians to cooperate in administering and overseeing such treatment. Physicians have civic duties, but medical ethics do not require a physician to carry out civic duties that contradict fundamental principles of medical ethics, such as the duty to avoid doing harm.

In limited circumstances physicians can ethically participate in court-initiated medical treatments.

Individual physicians who provide care under court order should:

- (a) Participate only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control.
- (b) Treat patients based on sound medical diagnoses, not court-defined behaviors. While a court has the authority to identify criminal behavior, a court does not have the ability to make a medical diagnosis or to determine the type of treatment that will be administered. When the treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, the physicians diagnosis must be confirmed by an independent physician or a panel of physicians not responsible to the state. A second opinion is not necessary in cases of court-ordered counseling or referrals for psychiatric evaluations.
- (c) Decline to provide treatment that is not scientifically validated and consistent with nationally accepted guidelines for clinical practice.
- (d) Be able to conclude, in good conscience and to the best of his or her professional judgment, that to the extent possible the patient voluntarily gave his or her informed consent, recognizing that an element of coercion that is inevitably present. When treatment involves in-patient therapy, surgical intervention, or pharmacological treatment, an independent physician or a panel of physicians not responsible to the state should confirm that voluntary consent was given.

AMA Principles of Medical Ethics: I.III

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.

Citation: Issued: 2016

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 patients decision-making capacity. Even when a medical condition or disorder impairs a patients 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 patients 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 patients preferences (if any) as expressed in an advance directive or as documented in the medical record;
 - (ii) the patients views about life and how it should be lived;
 - (iii) how the patient constructed his or her life story; and
 - (iv) the patients attitudes toward sickness, suffering, and certain medical procedures.
- (e) Assist the surrogate to make decisions in keeping with the best interest standard when the patients 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

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.

Citation: Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(I-22)

Introduced by: Women Physicians Section

Subject: Access to Methotrexate Based on Clinical Decisions

Referred to: Reference Committee B

1 Whereas, Methotrexate is a medication used to treat many medical conditions including, but not
2 limited to, cancer, psoriasis, myasthenia gravis, and various autoimmune diseases;^{1,2,3} and
3

4 Whereas, Methotrexate has remained a cornerstone in treatment specifically for rheumatoid
5 arthritis (RA) and common rheumatic disorders with 90% of RA patients using methotrexate
6 alone or in combination with other medications at some point in their treatment;⁴ and
7

8 Whereas, Autoimmune disorders are twice as prevalent in women, and RA rates are typically
9 two-to-three times higher in women than men;^{5,6} and
10

11 Whereas, Methotrexate may also be used off-label, alone or in combination with mifepristone as
12 a non-invasive alternative method for early medical pregnancy terminations and treatment of
13 ectopic pregnancies;^{7,8} and
14

15 Whereas, The Supreme Court ruling in Dobbs v. Jackson Women's Health Organization
16 revoked the constitutional right to abortion;⁹ and
17

18 Whereas, Because methotrexate "can cause a pregnancy to terminate, some pharmacists in
19 states that have added further restrictions that limit or ban abortions may hesitate to fill
20 methotrexate prescriptions for women of childbearing age because of legal concerns";^{10,11} and
21

22 Whereas, Two large United States pharmacy chains have "instructed their pharmacists to
23 confirm methotrexate will not be used to terminate a pregnancy before dispensing it to people in
24 states that ban abortion in many circumstances,"¹² and
25

26 Whereas, As an example of numerous accounts of refusal of methotrexate, in interviews with
27 CNN, a Maryland woman with Crohn's disease said her health insurance plan informed her they
28 would no longer cover her methotrexate prescription, and a Virginia woman with lupus said her
29 rheumatologist told her she would need to be weaned off methotrexate and switched to another
30 drug due to legal concerns;^{11,14} and
31

32 Whereas, Restricting access to methotrexate based on non-clinical decisions can lead to
33 unintended consequences, including worsening health conditions, suffering, and death for
34 patients that cannot safely access methotrexate; and
35

36 Whereas, Restricting access to methotrexate may impact the health and safety of female
37 patients, who are disproportionately affected by health conditions that could be treated using
38 methotrexate; and

Whereas, Methotrexate is on the World Health Organization's list of essential medicines for a basic health-care system due to efficacy, safety, and cost-effectiveness;¹³ and

Whereas, Our American Medical Association issued a statement regarding state laws that limit patient access to medically necessary treatment and impede use of professional judgment by physicians;¹⁵ therefore be it

RESOLVED, That our American Medical Association work to create a formal process to review pharmaceutical practices related to refusal of methotrexate and other drugs on the basis that it could be used off-label for pregnancy termination (Directive to Take Action); and be it further

RESOLVED, That our AMA work to provide educational guidance on state-specific laws that have impacted the distribution of methotrexate given post Dobbs vs. Jackson Women's Health Organization restrictions. (Directive to Take Action)

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

Received: 10/12/22

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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.

Citation: Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified by CSA Rep. 3, A-97; Reaffirmed and Modified by Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04; Reaffirmation I-07; Reaffirmed: Res. 819, I-07; Reaffirmation A-09; Reaffirmation I-10; Modified: BOT Rep. 5, I-14; Reaffirmed: Res. 505, A-15; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: Res. 509, I-20

Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted G-605.009

1. Our AMA will convene a task force of appropriate AMA councils and interested state and medical specialty societies, in conjunction with the AMA Center for Health Equity, and in consultation with relevant organizations, practices, government bodies, and impacted communities for the purpose of preserving the patient-physician relationship.

2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to:

a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;

b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;

c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;

d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;

e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;

f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and

g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

Citation: Res. 621, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 310
(I-22)

Introduced by: Michigan

Subject: Enforce AMA Principles on Continuing Board Certification

Referred to: Reference Committee C

1 Whereas, The AMA Principles on Continuing Board Certification have been developed through
2 the democratic process of various states' Houses of Delegates and the AMA House of
3 Delegates, reflecting the collective will of state and national medical societies and their
4 physician members; and

5
6 Whereas, These longstanding principles clearly demand a continuing board certification process
7 that is low cost, evidence-based, untied to insurance and hospital credentialing, and free of
8 harm to the physician workforce; and

9
10 Whereas, The proprietary American Board of Medical Specialties (ABMS) and American
11 Osteopathic Association (AOA) continuing board certification product continues to be high cost,
12 high stress, without evidence over other forms of continuing medical education, required for
13 insurance and hospital credentialing, and harmful to the physician workforce; and

14
15 Whereas, ABMS and AOA boards are still not fully aligned with the AMA's policy on continuing
16 board certification; and

17
18 Whereas, A failure to protect physicians from recertification harm has significant effects upon
19 cost of care, physician burnout, and access to qualified physicians; and

20
21 Whereas, Organized medicine has been called upon to advocate successfully for these
22 principles in order to defend physicians and our right to care for patients; therefore be it

23
24 RESOLVED, That our American Medical Association continue to actively work to enforce
25 current AMA Principles on Continuing Board Certification (Directive to Take Action); and be it
26 further

27
28 RESOLVED, That our AMA publicly report their work on enforcing AMA Principles on
29 Continuing Board Certification at the Annual and Interim meetings of the AMA House of
30 Delegates. (Directive to Take Action)

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

Received: 10/13/22

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.

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;

Continuing Board Certification H-275.924

Continuing Board Certification

AMA Principles on Continuing Board Certification

1. Changes in specialty-board certification requirements for CBC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in CBC must be reasonable and take into consideration the time needed to develop the proper CBC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the CBC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for CBC.
4. Any changes in the CBC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. CBC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of CBC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for CBC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of CBC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with CBC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for CBC Part II. The content of CME and self-assessment programs receiving credit for CBC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit", American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to CBC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to

standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. CBC is but one component to promote patient safety and quality. Health care is a team effort, and changes to CBC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. CBC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The CBC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. CBC should be used as a tool for continuous improvement.

15. The CBC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards developing CBC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. CBC activities and measurement should be relevant to clinical practice.

19. The CBC process should be reflective of and consistent with the cost of development and administration of the CBC components, ensure a fair fee structure, and not present a barrier to patient care.

20. Any assessment should be used to guide physicians' self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in CBC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards websites or physician certification databases even if the diplomate chooses not to participate in CBC.

27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Continuing Board Certification from their specialty boards. Value in CBC should include cost effectiveness with full financial transparency, respect for physicians' time and their patient care commitments, alignment of CBC requirements with other regulator and payer requirements, and adherence to an evidence basis for both CBC content and processes.

Citation: CME Rep. 16, A-09; Reaffirmed: CME Rep. 11, A-12; Reaffirmed: CME Rep. 10, A-12; Reaffirmed in lieu of Res. 313, A-12; Reaffirmed: CME Rep. 4, A-13; Reaffirmed in lieu of Res. 919, I-13; Appended: Sub. Res. 920, I-14; Reaffirmed: CME Rep. 2, A-15; Appended: Res. 314, A-15; Modified: CME Rep. 2, I-15; Reaffirmation A-16; Reaffirmed: Res. 309, A-16; Modified: Res. 307, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 319, A-17; Reaffirmed in lieu of: Res. 322, A-17; Modified: Res. 953, I-17; Reaffirmation: A-19; Modified: CME Rep. 02, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 311
(I-22)

Introduced by: Medical Student Section

Subject: Supporting a Hybrid Residency and Fellowship Interview Process

Referred to: Reference Committee C

1 Whereas, The Association of American Medical Colleges released data suggesting residency
2 interviews cost medical students between \$1,000 to \$11,580, with a median cost of \$4,000 and
3 an average cost of \$200-499 per interview¹; and
4

5 Whereas, Studies suggest 71% of medical students borrow money for residency interviews and
6 four out of ten students decline interviews for financial reasons²; and
7

8 Whereas, Interviews costs residency programs a significant amount of money, with one plastic
9 surgery program reporting a cost of \$2763 per applicant interviewed, which includes applicant
10 receptions, food and beverage costs, and losses of clinical productivity³; and
11

12 Whereas, It is estimated virtual interviews would allow residency programs to reduce the
13 amount of time needed to conduct interviews by approximately 7 days, reducing faculty's time
14 away from clinical and teaching responsibilities⁴; and
15

16 Whereas, The standard model of in-person residency interviews takes time away from medical
17 student educational and clinical work, given that applicants devote an average of 20 days
18 towards residency interviews^{5,6}; and
19

20 Whereas, In a 2014 study of GI fellowship applicants with four in-person interviews and a single
21 video interview, 87% of applicants thought that video interviews should continue and 81%
22 reported that the video interview met or exceeded their expectations, which suggests web-
23 based video interviews has the potential to either be an effective screening tool or an
24 acceptable alternative to in-person interviews⁷; and
25

26 Whereas, In a survey of the 46 applicants and 36 program directors after the 2020
27 cardiothoracic fellowship match, the majority of the applicants and program directors thought
28 virtual interviews should be continued in the future; however, most do not think that virtual
29 interviews should completely replace in-person interviews⁸; and
30

31 Whereas, In the same 2020 cardiothoracic fellowship study, most applicants and program
32 directors did not believe virtual interviews negatively impacted applicants' chances of matching
33 into programs at the top of their rank list⁸; and
34

35 Whereas, An observational study of an anesthesiology residency program with options for in-
36 person or virtual interviews demonstrated a higher proportion of non-local applicants and the
37 preference for virtual format was driven by travel concerns and interview date conflicts⁷; and

Whereas, A 2020 survey of 1711 medical students and 113 residents in Texas medical programs indicated majority of respondents believed virtual interviews were less stressful than in-person interviews, and residency programs should offer both options for interviewing⁹; and

Whereas, In May 2020, the American Association of Medical Colleges released resources and protocols for residency interviewees and program directors to use in preparing for virtual interviews^{10,11}; and

Whereas, Several studies from August 2020-June 2021 showed that although residency interviewees expressed concerns about the limitations of virtual interviews such as ability to assess the program, ability to fully demonstrate their personality, and increased emphasis on exam scores and class rank, residency programs may be able to improve the virtual interview experience, by developing comprehensive marketing materials, hosting a resident panel for interviewees, and creating an informal virtual gathering for interviewees and residents¹²⁻¹⁴; and

Whereas, The 2020-2021 MATCH success rate for applicants was 94.9 percent and 99.6 percent at the conclusion of the Supplemental Offer and Acceptance Program (SOAP), which were comparable to that of years before the COVID-19 pandemic¹⁵; and

Whereas, The National Resident Matching Program reported that 60% of surveyed program directors from the 2021 MATCH intended to use virtual platforms for future recruitment seasons, including two-thirds of these respondents intending to use these platforms for the interview¹⁶; and

Whereas, Incorporating video conferencing into residency interviews as an adjunct to in-person interviews is proposed as a means to increase efficiency and lower costs, given its perceived feasibility from the 2021 MATCH¹⁷; and

Whereas, Most existing American Medical Association policy supports studying methods to reduce residency interviewing cost (H-310.966, D-310.949), but does not take a stance to support the incorporation of technologies, such as videoconferencing, as a method to increase interview efficiency; therefore be it

RESOLVED, That our American Medical Association support incorporating virtual interviews as a component to the residency and fellowship interview process as a means to increase interviewing efficiency (New HOD Policy); and be it further

RESOLVED, That our AMA work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, to study interviewee and program perspectives on incorporating videoconferencing as an adjunct to residency and fellowship interviews, in order to guide the development of protocols for expansion of hybrid residency and fellowship interviews. (Directive to Take Action)

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

Received: 10/12/22

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RELEVANT AMA POLICY

Residency Interview Costs H-310.966

1. It is the policy of the AMA to pursue changes to federal legislation or regulation, specifically to the Higher Education Act, to include an allowance for residency interview costs for fourth-year medical students in the cost of attendance definition for medical education.

2. Our AMA will work with appropriate stakeholders, such as the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, in consideration of the following strategies to address the high cost of interviewing for residency/fellowship: a) establish a method of collecting data on interviewing costs for medical students and resident physicians of all specialties for study, and b) support further study of residency/fellowship interview strategies aimed at mitigating costs associated with such interviews.

Citation: (Res. 265, A-90; Reaffirmed: Sunset Report, I-00; Modified: CME Rep. 2, A-10; Appended: Res. 308, A-15)

Medical Student Involvement and Validation of the Standardized Video Interview Implementation D-310.949

Our AMA: (1) will work with the Association of American Medical Colleges and its partners to advocate for medical students and residents to be recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; (2) will advocate for delaying expansion of the Standardized Video Interview until data demonstrates the Association of American Medical Colleges stated goal of predicting resident performance, and make timely recommendations regarding the efficacy and implications of the Standardized Video Interview as a mandatory residency application requirement; and (3) will, in collaboration with the Association of American Medical Colleges, study the potential implications and repercussions of expanding the Standardized Video Interview to all residency applicants.

Citation: Res. 960, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(I-22)

Introduced by: Medical Student Section

Subject: Reporting of Residency Demographic Data

Referred to: Reference Committee C

1 Whereas, While organizations, including the American Medical Association, Association of
2 American Medical Colleges (AAMC), National Resident Matching Program (NRMP), and
3 Accreditation Council for Graduate Medical Education (ACGME), have gathered data on current
4 residents and residency applicants, this information typically captures very little demographic
5 information and no family planning or parental leave data; and
6

7 Whereas, The AMA's Fellowship and Residency Electronic Interactive Database (FREIDA)
8 offers information on academic background of residents (United States MD, United States DO,
9 International Medical Graduate) and the Male to Female ratio, but largely focuses on the
10 academic and professional experiences of residents¹; and
11

12 Whereas, FREIDA's data is derived from the ACGME's annual survey of all residents, which
13 captures little additional demographic and familial data²; and
14

15 Whereas, AAMC gathers this information, as well as a residency applicant's self-identification,
16 via its Electronic Residency Application Service (ERAS)³; and
17

18 Whereas, ERAS makes it possible for the AAMC to sort this data by specialty, which is of
19 particular importance because of the limited number of professional medical societies that have
20 developed surveys to capture this information^{3,4,5}; and
21

22 Whereas, The National Resident Matching Program (NRMP) stated their intention to capture
23 demographic data following the 2022 Main Residency Match, but has primarily gathered
24 information on residents' attitudes towards the graduate medical education experience to
25 date^{6,7}; and
26

27 Whereas, Studies on diversity and inclusion in graduate medical education have largely relied
28 upon the little demographic data published by these national surveys^{8,9}; and
29

30 Whereas, To date, endeavors to gather information on trends in pregnancy, childbirth, and
31 parenthood among residents have been restricted to academic studies, which typically maintain
32 a limited regional focus^{10,11}; and
33

34 Whereas, A recent study of the residency programs affiliated with *US News & World Report's*
35 top 50 medical schools made some information on national family leave policies available¹²; and
36

37 Whereas, Forty-two percent of the study's residency programs offered unpaid leave in
38 accordance with the Family Medical Leave Act (FMLA), which ensures employees of a company
39 or institution for at least 1 year, with 1250 hours of service, qualify for up to 12 weeks of unpaid
40 job protection for family and medical reasons^{12,13}; and

Whereas, Forty-two percent of the studied residency programs offered paid parental leave in some capacity, and twenty-two percent of the study's programs referred residents to state-funded paid family leave programs¹²; and

Whereas, No mention was made of adherence to the additional parental leave guidelines imposed by professional specialty societies¹⁴; and

Whereas, It is of note that these family leave policies were not necessarily published on each program's website, and the authors of this study conducted a web search to find publicly available information, then contacted schools directly for this data¹²; and

Whereas, Even after these efforts, there was one school that did not publish family leave information on their website and did not respond to inquiries, indicating this information may not be readily accessible to prospective residency applicants and current residents¹²; and

Whereas, In addition to gathering and publishing information on the items identified in FREIDA, ACGME surveys, and internal residency program surveys should consider collecting information on ability, religion, and immigration status to identify additional resources necessary to support current residents¹⁵; and

Whereas, To date, there is a scarcity of information on the demographic and parenthood of residents, and existing surveys from FREIDA, ACGME, and internal residency programs could be used to gather this information, as well as data on factors such as incoming and current residents' ability, religion, and immigration status; and

Whereas, Gathering this robust array of data on the background of residents has the potential to elucidate the path to equity, diversity, and inclusion in medicine; therefore be it

RESOLVED, That our American Medical Association work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, (a) demographic data, including but not limited to the composition of their program over the last 5 years by age, gender identity, URM status, and LGBTQIA+ status; (b) parental and family leave policies; and (c) the number and/or proportion of residents who have utilized parental or family leave in the past 5 years (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on pregnancy, childbirth, and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty. (New HOD Policy)

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

Received: 10/13/22

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RELEVANT AMA POLICY

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 use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.
 10. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).
 11. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.
 12. Our AMA opposes legislation that would undermine institutions' ability to properly employ affirmative action to promote a diverse student population.
 13. Our AMA will work with the AAMC and other stakeholders to create a question for the AAMC electronic medical school application to identify previous pipeline program (also known as pathway program) participation and create a plan to analyze the data in order to determine the effectiveness of pipeline programs.
- Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 313
(I-22)

Introduced by: Oklahoma, Arizona, District of Columbia, Hawaii, Iowa, Kansas, Kentucky, Maine, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Carolina, North Dakota, Utah, Virginia, Alabama

Subject: Request a two-year delay in ACCME Changes to State Medical Society Recognition Program

Referred to: Reference Committee C

1 Whereas, The American Medical Association awards the *AMA PRA Category 1 Credit*™ for
2 continuing medical education credit; and
3

4 Whereas, The Accreditation Council for Continuing Medical Education (ACCME) is the
5 organization the AMA has given authority to accredit providers of *AMA PRA Category 1*
6 *Credit*™; and
7

8 Whereas, ACCME recognizes state medical societies to accredit local hospitals and
9 organizations to provide CME credit in their state; and
10

11 Whereas, In August 2022, the ACCME announced it would no longer allow state medical
12 societies with fewer than 20 accredited providers to be recognized accreditors. This change
13 directly affects 19 state medical societies and indirectly affects the rest. Those directly affected
14 include AL, AZ, HI, IA, IL, KY, ME, MN, MS, MO, NE, NH, NM, NC, OK, UT, VA, WV, and WI;
15 and
16

17 Whereas, The state medical societies with fewer than 20 CME providers have until March of
18 2023 to notify ACCME whether they will: (a) Expand their accreditation program through
19 recruitment of new providers to serve at least 20 eligible organizations; (b) Combine their
20 program with one or more state medical societies (within regions defined by the ACCME) so
21 that the merged/combined program has 20 or more accredited providers, or (c) Withdraw from
22 recognition; and
23

24 Whereas, The ACCME requires state medical societies to implement the changes by
25 January 1, 2024; and
26

27 Whereas, Most impacted state medical societies were not included in formal discussions about
28 this proposal and did not find out about this decision until receiving letters on August 1, 2022
29 from ACCME announcing their CME programs would no longer be included in the state medical
30 society accreditor program; and
31

32 Whereas, Several state medical societies dispute the ACCME rationale for the change that
33 reliability and accuracy of accreditation decisions are linked to the number of providers a state
34 medical society accredits; and

1 Whereas, This proposed change will negatively affect hospitals and CME providers in rural and
2 other underserved areas; therefore be it
3

4 RESOLVED, That our American Medical Association collaborate with Accreditation Council for
5 Continuing Medical Education (ACCME) with a goal to secure a two-year delay in the
6 implementation of any changes to the state medical society accreditor program. During that
7 time, AMA, ACCME and state medical societies will work collaboratively to study the impact and
8 unintended consequences of the proposed action and to create a plan that is in the best
9 interests of all parties, including the continuing medical education providers currently accredited
10 by state medical societies. (Directive to Take Action)

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

Received: 10/13/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 314
(I-22)

Introduced by: Michigan

Subject: Balancing Supply and Demand for Physicians by 2030

Referred to: Reference Committee C

1 Whereas, Current demographics predict growth of an aging population of people over age 65 by
2 55 percent;; and
3

4 Whereas, Projected shortfalls in primary care physicians ranges between 7,300 and 43,000 by
5 2030; and
6

7 Whereas, If current underserved populations utilize health care at the same rate as other patient
8 populations, even higher demand is projected for primary care physicians; and
9

10 Whereas, Current proportion of internal medicine residents completing training and going into
11 primary care practice has fallen below 10 percent; and
12

13 Whereas, Lifestyle, medical student debt, complex patient care demands, silos of care,
14 electronic health record overload, and burnout all work against primary care physician
15 recruitment; therefore be it
16

17 RESOLVED, That our American Medical Association take action on all fronts to advocate for
18 and implement remedies that will rebalance the supply and demand equation for primary care
19 physicians by 2030 (Directive to Take Action); and be it further
20

21 RESOLVED, That our AMA reaffirm AMA Policies H-200.954, H-200.955, H-200.972,
22 H-465.988, and D-305.958. (Reaffirm HOD Policy)

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

Received: 10/13/22

RELEVANT AMA POLICY

US Physician Shortage H-200.954

Our AMA:

- (1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
- (2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
- (3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
- (4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
- (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
- (6) encourages medical schools to include criteria and processes in admission of medical students that

are predictive of graduates' eventual practice in underserved areas and with underserved populations;

(7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;

(8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;

(9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;

(10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and

(11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.

(12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.

(13) will work to augment the impact of initiatives to address rural physician workforce shortages.

Citation: Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08; Appended: CME Rep. 4, A-10; Appended: CME Rep. 16, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 922, I-13; Modified: CME Rep. 7, A-14; Reaffirmed: CME Rep. 03, A-16; Appended: Res. 323, A-19; Appended: CME Rep. 3, I-21;

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.
- Citation: CME Rep. 2, I-03; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CME Rep. 15, A-10; Reaffirmation: I-12;

Primary Care Physicians in Underserved Areas H-200.972

1. Our AMA should pursue the following plan to improve the recruitment and retention of physicians in underserved areas:

- (a) Encourage the creation and pilot-testing of school-based, faith-based, and community-based urban/rural family health clinics, with an emphasis on health education, prevention, primary care, and prenatal care.
 - (b) Encourage the affiliation of these family health clinics with local medical schools and teaching hospitals.
 - (c) Advocate for the implementation of AMA policy that supports extension of the rural health clinic concept to urban areas with appropriate federal agencies.
 - (d) Encourage the AMA Senior Physicians Section to consider the involvement of retired physicians in underserved settings, with appropriate mechanisms to ensure their competence.
 - (e) Urge hospitals and medical societies to develop opportunities for physicians to work part-time to staff health clinics that help meet the needs of underserved patient populations.
 - (f) Encourage the AMA and state medical associations to incorporate into state and federal health system reform legislative relief or immunity from professional liability for senior, part-time, or other physicians who help meet the needs of underserved patient populations.
 - (g) Urge hospitals and medical centers to seek out the use of available military health care resources and personnel, which can be used to help meet the needs of underserved patient populations.
2. Our AMA supports efforts to: (a) expand opportunities to retain international medical graduates after the expiration of allocated periods under current law; and (b) increase the recruitment and retention of physicians practicing in federally designated health professional shortage areas.
- Citation: CMS Rep. I-93-2; Reaffirmation A-01; Reaffirmation I-03; Modified: CME Rep. 13, A-06; Reaffirmed: CMS Rep. 01, A-16; Modified: CME Rep. 04, I-18; Appended: Res. 206, I-19;

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.

Citation: 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;

Increasing Graduate Medical Education Positions as a Component to any Federal Health Care Reform Policy D-305.958

1. Our AMA will ensure that actions to bolster the physician workforce must be part of any comprehensive federal health care reform.

2. Our AMA will work with the Centers for Medicare and Medicaid Services to explore ways to increase graduate medical education slots to accommodate the need for more physicians in the US.

3. Our AMA will work actively and in collaboration with the Association of American Medical Colleges and other interested stakeholders to rescind funding caps for GME imposed by the Balanced Budget Act of 1997.

4. Our AMA will actively advocate for expanded funding for entry and continued training positions in specialties and geographic regions with documented medical workforce shortages.

5. Our AMA will lobby Congress to find ways to increase graduate medical education funding to accommodate the projected need for more physicians.

6. Our AMA will work with key organizations, such as the US Health Resources and Services Administration, the Robert Graham Center, and the Cecil G. Sheps Center for Health Services Research, to: (A) support development of reports on the economic multiplier effect of each residency slot by geographic region and specialty; and (B) investigate the impact of GME funding on each state and its impact on that state's health care workforce and health outcomes.

Citation: (Sub. Res. 314, A-09; Appended: Res. 316, A-12; Reaffirmed: Res. 921, I-12; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13)

Sources:

1. Complexities of Physician supply and Demand 2017 Association of American Medical Colleges; IHS Markit report 2019 update
2. Trends in Career Paths of Internal Medicine Residents. Internal Medicine In-Training Exam Survey of interest to disclose.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 315
(I-22)

Introduced by: Michigan

Subject: Bedside Nursing and Health Care Staff Shortages

Referred to: Reference Committee C

1 Whereas, There is a national shortage of bedside nurses; and

2
3 Whereas, It has been reported that nurses working for travel nurse agencies receive higher
4 compensation than nurses employed directly by hospitals; and

5
6 Whereas, There is competition amongst hospitals, travel nurse agencies, and other
7 organizations for nurses; and

8
9 Whereas, Experienced nurses are leaving bedside nursing jobs and choosing nonclinical
10 careers; and

11
12 Whereas, Nursing students often wait to finish their education due to a lack of clinical sites or
13 nursing educator availability; and

14
15 Whereas, Hospitals have reduced numbers of ancillary staff; and

16
17 Whereas, There is a shortage of emergency medical services providers; and

18
19 Whereas, Working in a hospital is physically demanding, requires working long shifts, and may
20 require mandatory overtime; and

21
22 Whereas, Working in a hospital and other health care jobs pay lower wages than less
23 demanding occupations; and

24
25 Whereas, Many nurses, physicians, ancillary staff, and physician assistants are suffering from
26 moral injury and burnout related to the COVID-19 pandemic; and

27
28 Whereas, Hospitals had nursing and staff shortages before the COVID-19 pandemic and
29 hospitals have been receiving federal financial assistance during the pandemic; and

30
31 Whereas, There is a need for systematic long-term strategies to address bedside nursing and
32 other health care worker shortages including, but not limited to, improved staffing models and
33 employee wellness programming to improve career longevity; therefore be it

1 RESOLVED, That our AMA amend AMA policy D-360.998, "The Growing Nursing Shortage in
2 the United States" by addition to read as follows:

3
4 Our AMA: (1) recognizes the important role nurses and other allied health
5 professionals play in providing quality care to patients, and participate in activities with
6 state medical associations, county medical societies, and other local health care
7 agencies to enhance the recruitment and retention of qualified individuals to the
8 nursing profession and the allied health fields;

9 (2) encourages physicians to be aware of and work to improve workplace conditions
10 that impair the professional relationship between physicians and nurses in the
11 collaborative care of patients;

12 (3) encourages hospitals and other health care facilities to collect and analyze data on
13 the relationship between staffing levels, nursing interventions, and patient outcomes,
14 and to use this data in the quality assurance process;

15 (4) will work with nursing, hospital, and other appropriate organizations to enhance
16 the recruitment and retention of qualified individuals to the nursing and other allied
17 health professions;

18 (5) will work with nursing, hospital, and other appropriate organizations to seek to
19 remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in
20 nursing and promote better patient care-;

21 (6) will approach appropriate stakeholders such as the American Hospital Association
22 to collaborate on the identification of and advocacy for short- and long-term strategies
23 and solutions to address nursing and other health care staff shortages in order to
24 promote a stable work force and career longevity. (Modify Current HOD Policy)

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

Received: 10/13/22

RELEVANT AMA POLICY

The Growing Nursing Shortage in the United States D-360.998

Our AMA: (1) recognizes the important role nurses and other allied health professionals play in providing quality care to patients, and participate in activities with state medical associations, county medical societies, and other local health care agencies to enhance the recruitment and retention of qualified individuals to the nursing profession and the allied health fields;

(2) encourages physicians to be aware of and work to improve workplace conditions that impair the professional relationship between physicians and nurses in the collaborative care of patients;

(3) encourages hospitals and other health care facilities to collect and analyze data on the relationship between staffing levels, nursing interventions, and patient outcomes, and to use this data in the quality assurance process;

(4) will work with nursing, hospital, and other appropriate organizations to enhance the recruitment and retention of qualified individuals to the nursing and other allied health professions;

(5) will work with nursing, hospital, and other appropriate organizations to seek to remove administrative burdens, e.g., excessive paperwork, to improve efficiencies in nursing and promote better patient care.

Citation: (CMS Rep. 7, A-01; Modified: Res. 708, A-03; Reaffirmed: CME Rep. 2, A-13)

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.
- Citation: 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;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(I-22)

Introduced by: Melissa Garretson, MD, Delegate

Subject: Decreasing Political Advantage Within AMA Elections

Referred to: Reference Committee F

1 Whereas, Delegate votes on American Medical Association elections should be based upon
2 each delegate's belief of which candidate is most qualified for the elected office; and
3

4 Whereas, Our AMA election reforms which were adopted in 2021 are scheduled to be reviewed
5 for report back to the HOD after June 2023; and
6

7 Whereas, Currently seated board and council members who seek election to a higher office
8 while in the middle of said member's current term provides an unfair advantage to said member
9 in elections by opening up an "additional" seat of said council/board; and
10

11 Whereas, If a currently seated council or board member is considered to be resigning from the
12 currently held position upon completion of the upcoming Annual HOD meeting at which they
13 would be elected to or appointed to a new office, then the advantage is negated as the opening
14 of the candidate's current position will occur regardless of the election outcome for the currently
15 seated board or council member; and
16

17 Whereas, The work of our AMA councils and Board of Trustees remains critical for the
18 improvement of the practice of medicine and our patients' health outcomes; and
19

20 Whereas, Our AMA and our patients deserve the most qualified candidates who have fully
21 participated in the election process in order to help achieve the best outcomes for both;
22 therefore be it
23

24 RESOLVED, That our American Medical Association amend operating procedures and bylaws
25 as needed to assure that any currently seated member of an appointed or elected council who
26 announces and seeks another elected or appointed office prior to completion of said member's
27 current term shall be deemed to have resigned from the member's current council/board term
28 effective upon completion of the Annual Meeting of the House of Delegates at which the
29 member has run for another office. (Directive to Take Action)

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

Received: 10/12/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(I-22)

Introduced by: Oklahoma, South Carolina, Mississippi

Subject: Patient-Centered Health Equity Strategic Plan and Sustainable Funding

Referred to: Reference Committee F

1 Whereas, AMA policy H-180.944, “Plan for Continued Progress Toward Health Equity” states:
2 Health equity, defined as optimal health for all, is a goal toward which our AMA will work by
3 advocating for health care access, research, and data collection; promoting equity in care;
4 increasing health workforce diversity; influencing determinants of health; and voicing and
5 modeling commitment to health equity; and
6

7 Whereas, AMA policy D-180.981, “Plan for Continued Progress Toward Health Equity,” states:
8 1. Our AMA will develop an organizational unit, e.g., a Center or its equivalent, to facilitate,
9 coordinate, initiate, and track AMA health equity activities; and 2. The Board will provide an
10 annual report to the House of Delegates regarding AMA’s health equity activities and
11 achievements; and
12

13 Whereas, AMA policy H-180.944 is focused on better healthcare for all and is patient centered;
14 and
15

16 Whereas, Our AMA HOD established policy H-65.952, “Racism as a Public Health Threat,” and
17 H-350.974, “Racism and Ethnic Disparities in Health Care”; and
18

19 Whereas, In April of 2019, the AMA launched the AMA Center for Health Equity with the hiring
20 of its first Chief Health Equity Officer (1); and
21

22 Whereas, On May 11, 2021, our AMA senior staff released the “Organizational Strategic Plan to
23 Embed Racial Justice and Advance Health Equity” (2) (Strategic Plan) to the press prior to
24 releasing the document to our HOD; and
25

26 Whereas, The “Strategic Plan” is a 65-page document with an additional 21 pages of charts and
27 additional information; and
28

29 Whereas, The “strategic plan” serves as a three-year roadmap to plant the initial seeds for
30 action and accountability to embed racial justice and advance health equity for years to come
31 (1); and
32

33 Whereas, The release date of the “Strategic Plan” on May 11, 2021 was one day before the “on
34 time” resolution deadline date of May 12, 2021 for the AMA June 2021 special-called meeting,
35 therefore making submission of an “on-time” resolution to address this plan practically
36 impossible; and
37

38 Whereas, Review of the AMA Board of Trustee minutes from 9/2018 to 8/2021, there are
39 references to health equity throughout, in a variety of contexts; most were directly relevant to
40 the development of the health equity strategic plan (3); and

1 Whereas, Other than a mention at the April 2021 meeting that a report would be coming soon,
2 no specific reference can be found that the Board took any kind of official action related to the
3 “Strategic Plan” (3); and
4

5 Whereas, Bylaws of the American Medical Association (January 2022) state
6 “Board of Trustees shall: (5.3.2). Serve as the principal planning agent for the AMA;
7 and (5.3.2.1) Planning focuses on the AMA’s goals and objectives and involves decision-
8 making over allocation of resources and strategy development. Planning is a collaborative
9 process involving all of the AMA’s Councils, Sections, and other appropriate AMA components;”
10 (4) and
11

12 Whereas, Our AMA cannot achieve our goal of optimal health for all without collaborative
13 organizations with like goals and proper funding for enhancements to community health centers
14 including their infrastructures; and
15

16 Whereas, The Health Resources and Services Administration mission is to improve health
17 outcomes and achieve health equity through access to quality services, a skilled health
18 workforce, and innovative, high-value programs; (5) and
19

20 Whereas, In April 2022 Health Resources and Services Administration announced the
21 availability of nearly \$90 million in one-time American Rescue Plan funding to support new data-
22 driven efforts at health centers to identify and reduce health disparities;(6) and
23

24 Whereas, Our AMA House of Delegates recognizes the Board of Trustees is responsible for the
25 development and oversight of any organizational strategic plan for any of our AMA pillars;
26 therefore be it
27

28 RESOLVED, Our American Medical Association HOD reaffirm policy H-180.944, “Plan for
29 Continued Progress Toward Health Equity,” and aggressively advocate for Health Equity as
30 defined as optimal health for all which should be the goal toward which our AMA will work by
31 advocating for health care access, promoting equity in care, increasing health workforce
32 diversity, influencing determinants of health, and voicing and modeling commitment to health
33 equity (Reaffirm HOD Policy); and be it further
34

35 RESOLVED, That our AMA Center for Health Equity’s future strategic plan should include
36 advocacy planning and be presented to the AMA HOD for consideration with the opportunity for
37 it to be more widely understood, strengthened, and supported by the HOD (Directive to Take
38 Action); and be it further
39

40 RESOLVED, As the AMA Center for Health Equity develops its next strategic plan, it shall
41 actively engage our AMA Board of Trustees in the strategic planning process, and ensure a
42 more patient-centered strategic plan for health equity advocacy that is consistent with the intent
43 of AMA policies, including H-180.944, “ Plan for Continued Progress Toward Health Equity,”
44 and D-180.981, “Plan for Continued Progress Toward Health Equity,” and report the strategic
45 plan to the HOD at the 2024 Annual Meeting prior to publicly releasing the plan to the press
46 (Directive to Take Action); and be it further
47

48 RESOLVED, That our AMA, in a collaboration with interested stakeholders, actively advocate
49 for sustainable funding from Congress to increase health equity efforts of identifying and
50 reducing health disparities including but not limited to funding of the Health Resources and
51 Services Administration through U.S. Department of Health and Human Services and our AMA
52 Health Equity Center. (Directive to Take Action)

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

Received: 10/13/22

References

- (1) <https://www.ama-assn.org/about/leadership/ama-s-strategic-plan-embed-racial-justice-and-advance-health-equity>
- (2) <https://www.ama-assn.org/about/leadership/ama-s-strategic-plan-embed-racial-justice-and-advance-health-equity>
- (3) <https://www.ama-assn.org/about/board-trustees/board-trustees-actions-official-record>
- (4) <https://www.ama-assn.org/system/files/ama-constitution-and-bylaws.pdf>
- (5) <https://www.hrsa.gov/about/index.html>
- (6) <https://www.hhs.gov/about/news/2022/04/21/hhs-announces-90-million-support-new-data-driven-approaches-health-centers-identify-reduce-health-disparities.html>

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.

Citation: BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, I-21

Plan for Continued Progress Toward Health Equity D-180.981

1. Our AMA will develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities.
2. The Board will provide an annual report to the House of Delegates regarding AMAs health equity activities and achievements.

Citation: BOT Rep. 33, A-18

Racism as a Public Health Threat H-65.952

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

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

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 is an issue of highest priority for the American Medical Association.
2. The AMA emphasizes three approaches that it believes should be given high priority:
 - A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.
 - B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their

own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

Plan for Continued Progress Toward Health Equity D-180.981

1. Our AMA will develop an organizational unit, e.g., a Center or its equivalent, to facilitate, coordinate, initiate, and track AMA health equity activities.

2. The Board will provide an annual report to the House of Delegates regarding AMAs health equity activities and achievements.

Citation: BOT Rep. 33, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 607
(I-22)

Introduced by: Texas

Subject: Accountability for Election Rules Violations

Referred to: Reference Committee F

1 Whereas, Our American Medical Association has a strong code of ethics; and

2
3 Whereas, Our AMA requires honesty and good citizenship of all its physician members; and

4
5 Whereas, Our AMA has election rules adjudicated by an Election Committee; and

6
7 Whereas, Accountability for violations of such rules is ill-defined; and

8
9 Whereas, The Election Committee's current structure has not been effective in discouraging
10 violations of the election rules; and

11
12 Whereas, The current penalty for a serious elections rules violation is limited to an
13 announcement of such violation to the House of Delegates; therefore be it

14
15 RESOLVED, That our American Medical Association empower the Election Committee to
16 develop a list of appropriate penalties for candidates and caucus/delegation/section leadership
17 who violate election rules (Directive to Take Action); and be it further

18
19 RESOLVED, That the Election Committee define potential election rule violations as minor
20 (oversight or misinterpretation of rules), moderate (more serious and more likely to affect the
21 outcome of an election), and severe (intentional violation with high likelihood of affecting the
22 outcome of an election) and assign appropriate penalties or actions to remedy the situation
23 and/or report the violation to the House of Delegates (Directive to Take Action); and be it further

24
25 RESOLVED, That any candidate who is deemed to have violated the vote trading election rule
26 be disqualified from the current race as well as any future races at the AMA for a period not less
27 than 2 years, upon the recommendation of the Election Committee and approval of the full
28 House of Delegates (Directive to Take Action); and be it further

29
30 RESOLVED, That any caucus/delegation/section leadership that is found to have engaged in
31 vote trading shall not be allowed to sponsor any candidates for a period not less than 2 years
32 (Directive to Take Action); and be it further

33
34 RESOLVED, That anyone who is deemed by the Election Committee to have knowingly and
35 egregiously violated the vote trading rule be referred to the Council on Ethical and Judicial
36 Affairs for potential ethics violations. (Directive to Take Action)

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

Received: 10/13/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608
(I-22)

Introduced by: Medical Student Section

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

Referred to: Reference Committee F

1 Whereas, Our American Medical Association supports augmented intelligence (AI) systems that
2 advance the quadruple aim (H-480.939), specifically:

- 3 (1) To enhance the patient experience of care and outcomes,
- 4 (2) To improve population health,
- 5 (3) To reduce overall costs for the healthcare system while increasing value, and
- 6 (4) To support the professional satisfaction of physicians and the healthcare team; and

7
8 Whereas, Our AMA seeks to identify opportunities to integrate practicing physicians'
9 perspectives into the development, design, validation, and implementation of health care AI (H-
10 480.940); and

11
12 Whereas, Research from the medical device industry has provided evidence that physicians
13 substantially contribute to medical device innovation, specifically that:

- 14 (1) Physicians contributed to a fifth of medical device patents and generated a
15 significant number of citations, demonstrating the importance of physician
16 involvement in medical device innovation¹,
- 17 (2) Physician patents were cited more times by subsequent patents than those without
18 physician involvement, suggesting that physician-led innovation sparks more
19 subsequent follow-on innovation¹,
- 20 (3) Physician patents generated more follow-on innovations from a more diverse set of
21 disciplines, emphasizing the broad impact of physician involvement in research¹;
22 and

23
24 Whereas, Research on the implementation of electronic health records (EHRs) has indicated
25 that technology developed with physician involvement is associated with improved perceived
26 ease of use and acceptance by physicians²; and

27
28 Whereas, Current research on AI has indicated that:

- 29 (1) Physicians assisted by AI models can outperform physicians or AI alone, specifically
30 in diagnosing metastatic breast cancer and diabetic retinopathy^{3,4},
- 31 (2) Physicians can use interactive AI-based technologies in medical image
32 segmentation and identification, providing evidence that physicians and AI
33 technologies can work together to better fulfill the quadruple aim⁵; and

34
35 Whereas, Our AMA has launched pathways for healthcare innovation, but these pathways are
36 greatly targeted to physicians currently involved in AI, such as Health 2047, a business that
37 connects our AMA to leading experts in AI and machine learning to produce healthcare
38 solutions⁶; and

Whereas, Our AMA has supported physician innovation, especially in the field of AI, through the Physician Innovation Network (PIN), an online forum board for entrepreneurs to seek medical specialists to “connect the health care innovation ecosystems to improve the development of emerging healthcare technology solutions”⁷; and

Whereas, Early analysis of the PIN has identified that early engagement of physicians and respecting a physician’s time and expertise contribute to more meaningful connections between physicians and entrepreneurs⁸; and

Whereas, The PIN currently experiences limited physician utilization, as evidenced by:

- (1) Interviews with current physicians on the PIN suggest that the PIN only appeals to a small subset of physicians who have already realized early in their careers that they wish to pursue a nontraditional path in medicine and innovation⁹,
- (2) As of 2018, only 2,600 physicians were reported to be on the network, or about 1% of our AMA’s physician membership base¹⁰; and

Whereas, Our AMA advocates that our organization, national, and medical specialty societies and state medical associations (H-480.939):

- (1) Leverage medical expertise to ensure clinical validation and assessment of clinical applications of AI systems by practicing physicians,
- (2) Outline a new professional role to aid and guide health care AI systems; therefore be it

RESOLVED, That our American Medical Association augment the existing Physician Innovation Network (PIN) through the creation of advisors to specifically link physician members of AMA and its associated specialty societies with companies or individuals working on augmented intelligence (AI) research and development, focusing on:

- (1) Expanding recruitment among AMA physician members,
- (2) Advising AMA physician members who are interested in healthcare innovation/AI without knowledge of proper channels to pursue their ideas,
- (3) Increasing outreach from AMA to industry leaders and companies to both further promote the PIN and to understand the needs of specific companies,
- (4) Facilitating communication between companies and physicians with similar interests,
- (5) Matching physicians to projects early in their design and testing stages,
- (6) Decreasing the time and workload spent by individual physicians on finding projects themselves,
- (7) Above all, boosting physician-centered innovation in the field of AI research and development (Directive to Take Action); and be it further

RESOLVED, That our AMA support selection of PIN advisors through an application process where candidates are screened by PIN leadership for interpersonal skills, problem solving, networking abilities, objective decision making, and familiarity with industry. (Directive to Take Action)

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

Received: 10/11/22

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5. Cai CJ, Stumpe MC, Terry M, et al. Human-Centered Tools for Coping with Imperfect Algorithms During Medical Decision-Making. *Proceedings of the 2019 CHI Conference on Human Factors in Computing Systems - CHI 19*. 2019;(4):1-14. doi:10.1145/3290605.3300234.
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8. Hodgkins, M, Barron, M, Lloyd, S. How to engage physicians in innovative health care efforts. *Harvard Business Review*. 2019 Nov 11.
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RELEVANT AMA POLICY

Augmented Intelligence in Health Care H-480.940

As a leader in American medicine, our AMA has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community. To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
 - a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
 - b. is transparent;
 - c. conforms to leading standards for reproducibility;
 - d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
 - e. safeguards patients and other individuals privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.

Citation: BOT Rep. 41, A-18

Augmented Intelligence in Health Care H-480.939

Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team. To that end our AMA will advocate that:

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient

safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.

3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.

4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.

5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.

6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:

a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.

b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.

7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:

a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.

b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.

c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.

8. Our AMA, national medical specialty societies, and state medical associations—

a. Identify areas of medical practice where AI systems would advance the quadruple aim;

b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts;

c. Outline new professional roles and capacities required to aid and guide health care AI systems; and

d. Develop practice guidelines for clinical applications of AI systems.

9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)

10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

Citation: BOT Rep. 21, A-19; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 815
(I-22)

Introduced by: Medical Student Section

Subject: Opposition to Debt Litigation Against Patients

Referred to: Reference Committee J

1 Whereas, In 2020, medical debt was \$429 million across the United States, exceeding
2 nonmedical debt by \$39 million¹; and
3

4 Whereas, Medical debt affects a significant portion of the population, with 19% of U.S. families
5 unable to afford paying up-front for medical care in 2017²; and
6

7 Whereas, 26.7% of households with a Black family member had medical debt compared to
8 17.2% of households with a White family member and 9.7% of households with an Asian family
9 member²; and
10

11 Whereas, 31% of households with a family member in poor health had medical debt compared
12 to 14.4% of those with family members in adequate health²; and
13

14 Whereas, 64% of Americans in 2018 delayed or avoided treatment due to cost of medical care³;
15 and
16

17 Whereas, Medical debt is a risk factor for prolonging a period of homelessness, and in a study
18 of 1,600 low income individuals, 27% stated they had housing problems including difficulty
19 qualifying for a mortgage and inability to pay rent or mortgage as a result of their medical
20 debt⁴⁻⁵; and
21

22 Whereas, Individual medical debt is often an insignificant portion of hospital's overall revenue,
23 despite the devastating impacts it has on individuals and families⁶; According to ProPublica this
24 portion can be as little as 0.03%, and the Healthcare Financial Management Association found
25 that in 2018, bad debt (debt unlikely to be paid) consisted of 1-3% of total hospital revenue⁷;
26 and
27

28 Whereas, There is a growing national recognition of the problems associated with medical
29 billing, reflected in the introduced Medical Debt Relief Act of 2021, which primarily aims for
30 increased forgiveness regarding the reporting of medical debt on patient credit, but does not
31 address hospital billing practices⁸; and
32

33 Whereas, An August 2021 study published in JAMA Network Open found that after media
34 coverage of debt litigation against patients in Virginia, Virginia hospitals filed 59% fewer medical
35 debt lawsuits compared to the previous year and 11 hospitals banned the practice altogether,
36 demonstrating that public accountability can reduce this predatory practice⁹; and

Whereas, The American Hospital Association (AHA) Patient Billing Guidelines state that health care organizations have a responsibility to communicate effectively with patients and provide resources for patients wishing to discuss their payments; in the event of a nonpayment, the AHA guidelines recommend giving patients 30 days prior notice of any actions a hospital will take as a result¹⁰; and

Whereas, The AHA Patient Billing Guidelines state that health care organizations working with third-party debt collectors should ensure that the collectors adhere to the Fair Debt Collection Practices Act (FDCPA), which establishes guidelines meant to prevent abusive debt practice against consumers¹⁰; and

Whereas, AMA Policy H-385.963 encourages physicians to ensure no debt collection is sent to a patient without the physician's knowledge and to practice compassion and discretion when sending collection; and

Whereas, Our AMA currently lacks policy addressing the practice of debt litigation directly conducted by health care organizations; therefore be it

RESOLVED, That our American Medical Association oppose the practice of health care organizations pursuing litigation against patients due to medical debt, and encourages health care organizations to consider the relative financial benefit of collecting medical debt to their revenue, against the detrimental cost to a patient's well-being (New HOD Policy); and be it further

RESOLVED, That our AMA encourage health care organizations to manage medical debt with patients directly and consider several options, including discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before resorting to third-party debt collectors or any punitive actions (New HOD Policy); and be it further

RESOLVED, That our AMA encourage health care organizations to consider the American Hospital Association Patient Billing Guidelines when faced with patients struggling to finance their medical bills. (New HOD Policy)

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

Received: 10/05/22

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RELEVANT AMA POLICY

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.

Citation: CMS Rep. 8, A-05; Reaffirmation A-07; Modified: CMS Rep. 01, A-17

Exclusion of Medical Debt That Has Been Fully Paid or Settled H-373.996

Our AMA supports the principles contained in The Medical Debt Relief Act as drafted and passed by the US House of Representatives to provide relief to the American consumer from a complicated collections process and supports medical debt resolution being portrayed in a positive and productive manner.

Citation: Res. 226, I-10; Reaffirmed: BOT Rep. 04, A-20

Health Plan Payment of Patient Cost-Sharing D-180.979

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

Citation: CMS Rep. 09, A-19;

Physician Review of Accounts Sent for Collection H-385.963

(1) The AMA encourages all physicians and employers of physicians who treat patients to review their accounting/collection policies to ensure that no patient's account is sent to collection without the physician's knowledge. (2) The AMA urges physicians to use compassion and discretion in sending accounts of their patients to collection, especially accounts of patients who are terminally ill, homeless, disabled, impoverished, or have marginal access to medical care.

Citation: (Res. 127, I-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 816
(I-22)

Introduced by: Medical Student Section

Subject: Medicaid and CHIP Coverage for Glucose Monitoring Devices for Patients
with Diabetes

Referred to: Reference Committee J

1 Whereas, Type 1 diabetes mellitus (T1DM) and type 2 diabetes mellitus (T2DM) pose large and
2 steadily increasing health threats for both adults and youth in the United States, with
3 approximately 26.8 million adults and 210,000 youth under the age of 20 currently diagnosed
4 with either disease¹⁻⁶; and
5

6 Whereas, There is increasing evidence for the role of glycemic variability in the development of
7 diabetic complications and mortality, particularly cardiovascular disease, stroke, and kidney
8 disease, which alongside diabetes are four of the top 10 leading causes of death in the U.S.⁷⁻¹²;
9 and
10

11 Whereas, Glycemic variability for both T1DM and T2DM patients overall has been shown to
12 reduce quality of life and increase the burden of diabetes to healthcare systems, which currently
13 stands at over \$1 billion annually¹²⁻¹⁵; and
14

15 Whereas, National trends in U.S. hospitalizations show an increasing number of admissions for
16 hypoglycemia among those with T2DM in recent years, with highest rates among Black
17 Medicare beneficiaries and those older than 75 years old¹⁶; and
18

19 Whereas, Investigators found that frequency of hypoglycemic events can be markedly reduced
20 in individuals with impaired hypoglycemia awareness through use of continuous glucose
21 monitors (CGM) for patients with T1DM, T2DM and gestational diabetes mellitus^{17,18}; and
22

23 Whereas, CGM use has been demonstrated to improve patients' quality of life, reduce fear of
24 hypoglycemia, and provide a sense of empowerment to patients and their caregivers¹⁹⁻²⁷; and
25

26 Whereas, Data show that restrictive access to CGMs in the Medicare and Medicaid populations
27 may have deleterious health, economic, and quality of life consequences^{17,26}; and
28

29 Whereas, Many Medicare beneficiaries are subject to restrictive criteria for eligibility of CGMs,
30 such as documenting four fingerstick glucose tests per day for coverage of CGMs, despite only
31 100 test strips per 3 months being covered for non-insulin dependent diabetics^{17,28,29}; and
32

33 Whereas, As of February 2020, 11 of 36 state Medicaid programs have required similar
34 stringent criteria of individuals needing to document four fingerstick glucose tests per day for
35 coverage of CGMs, and only four states have openly committed to Medicaid covering CGMs in
36 patients with T2DM regardless of durable medical equipment (DME) classification¹⁷; and
37

38 Whereas, CGMs offer a cost-effective alternative to traditional self-monitoring via finger prick at
39 an additional \$653 over a patient's lifetime, translating to \$8898 per quality-adjusted life year

(QALY) gained that is well below the \$100,000 per QALY cost-effectiveness threshold often cited in healthcare economics studies^{30,31}; and

Whereas, Approximately 14% of adults under 65 covered by Medicaid have a form of diabetes³²; and

Whereas, Retrospective analysis of patients prescribed to a professional CGM for T2DM showed no statistically significant increase in total annual costs compared to those who were not prescribed a professional CGM, but did see an improvement in hemoglobin A1c (HbA1c) without intensification of the current treatment regimen^{19,33}; and

Whereas, While long-term cost effectiveness studies have demonstrated CGMs' potential to decrease overall costs for patients with T2DM through elimination of test strips and lancets, a majority of financial benefit is due to lower HbA1c readings and mitigation of direct diabetes related complications such as hospitalizations, emergency room visits, non-diabetes prescription medications, and indirect costs such as hampered productivity, which collectively account for 73.1% of total diabetes care cost^{17,33}; and

Whereas, The lowest-cost option among CGMs, with an out-of-pocket price of less than \$100 for uninsured individuals, are an alternative non-invasive glucose monitor called flash glucose monitoring which provides glucose readings on demand and allows for downloadable glucose data, and use has been found to decrease acute diabetes-related events and all-cause inpatient hospitalizations in patients with T2DM treated with short or rapid acting insulin³⁴⁻³⁶; and

Whereas, Patients with T2DM treated with oral agents are often placed on a basal-bolus regimen of insulin while admitted to the hospital for glucose control, and use of flash glucose monitoring in these patients during admission demonstrated lower average daily glucose and increased detection of hypoglycemia^{37,38}; and

Whereas, CGMs have been able to provide increased insight into nocturnal glucose levels, glucose metabolism during exercise and feeding, and relative impact of medications on ambient glucose than any form of episodic self-monitoring of blood glucose for all patients with diabetes, and CGM users spent significantly less time in hypoglycemic ranges compared to their self-monitoring of blood glucose counterparts^{17,39}; and

Whereas, AMA Directive D-185.983 asks our AMA Board of Trustees to consider a legal challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services (CMS) and other health care insurers placing onerous barriers on diabetic patients to procure medically necessary "durable medical equipment and supplies"; and

Whereas, Certain CGMs which require adjunctive therapy are deemed "non-therapeutic" and thus are ineligible to be classified as durable medical equipment (DME) and supplies, despite their ability to influence medical decision making⁴⁰; and

Whereas, CMS Proposal CMS-1739-P includes a section on reclassifying "therapeutic" and "non-therapeutic" CGMs as DME, as access to DME has been associated with better outcomes and significantly lower healthcare spending due to patients' ability to receive care at home, and variations in Medicaid definitions of DME have been linked to variations in geographic healthcare expenditure^{40,41}; and

Whereas, Increased eligibility and access to all glucose monitors, including CGM and flash glucose monitoring, would provide improved, cost-effective health care outcomes for low-income patients with diabetes on Medicaid and Medicare^{19,33-35,37,38}, and

Whereas, Medicaid and public state medical insurance expansions that include CGM devices have been demonstrated to improve glycemic control and reduce disparities in pediatric patients with type 1 diabetes^{42,43}, and

Whereas, Current AMA policy H-330.885 supports coverage of CGM for Medicare patients with insulin-dependent diabetes but does not address Medicaid or CHIP; therefore be it

RESOLVED, That our American Medical Association advocate for broadening the classification criteria of Durable Medical Equipment to include all clinically effective and cost-saving diabetic glucose monitors (Directive to Take Action); and be it further

RESOLVED, That our AMA amend AMA Policy H-330.885, "Medicare Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes," by addition and deletion to read as follows:

Medicare Public Insurance Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes H-330.885

Our AMA supports efforts to achieve Medicare coverage of continuous and flash glucose monitoring systems for all patients with insulin-dependent diabetes by all public insurance programs. (Modify Current HOD Policy)

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

Received: 10/12/22

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RELEVANT AMA POLICY

Diabetic Documentation Requirements D-185.983

1. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services (CMS) and other health care insurers placing onerous barriers on diabetic patients to procure medically necessary durable medical equipment and supplies. 2. Our AMA Board of Trustees will consider a legal challenge, if appropriate, to the authority and policy of CMS and other insurers to practice medicine through their diabetes guidelines, and place excessive time and financial burdens without reimbursement on a physician assisting patients seeking reimbursement for supplies needed to treat their diabetes. Res. 730, A-13

Medicare Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes H-330.885

Our AMA supports efforts to achieve Medicare coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes. Res. 126, A-14

CMS Required Diabetic Supply Forms H-330.908

Our AMA requests that CMS change its requirement so that physicians need only re-write prescriptions for glucose monitors every twelve months, instead of a six month requirement, for Medicare covered diabetic patients and make the appropriate diagnosis code sufficient for the determination of medical necessity.

Sub Res. 102, A-00; Reaffirmation and Amended: Res. 520, A-02; Modified: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 1, A-22

Physician Ordering of Durable Medical Equipment and Home Health Services H-330.936

The AMA urges CMS and other payers to require that durable medical equipment and home health and other outpatient medical services be ordered by the physician responsible for the patient's care, with appropriate documentation of medical necessity, before such services are offered to the patient or family; and that suppliers provide to the physician the charge for all durable medical equipment and home health and other outpatient services prior to the time the physician signs the order.

Res. 112, I-96; Reaffirmed by Res. 122, A-97; Amended: CMS Rep. 4, I-97; Reaffirmation: A-99; Reaffirmation: A-04; Reaffirmation: A-08; Reaffirmed: CMS Rep. 01, A-18

Access to Medical Care D-480.991

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

Res. 130, A-02; Reaffirmation: A-04; Reaffirmed: CMS Rep. 1, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 817
(I-22)

Introduced by: Medical Student Section

Subject: Promoting Oral Anticancer Drug Parity

Referred to: Reference Committee J

1 Whereas, Chemotherapy drugs have been traditionally administered intravenously, although the
2 FDA has increasingly approved oral anticancer drugs to reflect not only medical advancement
3 but a growing patient preference^{1,2}; and
4

5 Whereas, Oral drug disparity is found in the disparity between insurance policy medical benefits
6 versus pharmacy benefits, with the former requiring little to no copay for IV chemotherapy and
7 the latter frequently requiring heavy out-of-pocket costs for oral anti-cancer medications^{3,4}; and
8

9 Whereas, For many oral chemotherapeutics, their classification as prescription drug benefits as
10 opposed to medical benefits allows private insurers to impose more expensive monthly copays,
11 sometimes as high as \$2500 compared to \$50 for the IV-administered form of the same drug¹;
12 and
13

14 Whereas, Many oral chemotherapeutics present the only viable option in cancer treatment and
15 have no IV-counterpart⁵; and
16

17 Whereas, Upwards of 40% of all new chemotherapeutics are available solely as oral
18 treatments⁶; and
19

20 Whereas, A portion of patients who cannot afford these oral chemotherapeutics forego taking
21 them, resulting in higher rates of hospitalizations, complications, and increased costs to both the
22 patient and health care system^{2,3,7,8}; and
23

24 Whereas, Despite the inaccessibility of oral chemotherapeutics, studies demonstrate patient-
25 reported preferences for oral administration over intravenous due to convenience, perceived
26 improvement of quality of life, and comfort⁹; and
27

28 Whereas, Higher monthly payments can be associated with a statistically significant higher risk
29 of medication non-adherence²; and
30

31 Whereas, Nonadherence to therapy is the strongest risk factor for cancer recurrence, after
32 which total cost of cancer-related treatment for the patient increases significantly^{2,10}; and
33

34 Whereas, "Oral parity" refers to ensuring equitable costs to patients for orally-administered
35 anticancer drugs as compared to IV-administered anticancer drugs¹¹; and
36

37 Whereas, While some form of oral parity legislation exists in 43 states, many states' policies are
38 unevenly applied such that large, private-sector, multi-state health plans are often excluded^{2,5};
39 and

Whereas, The Cancer Drug Parity Act (originally introduced in the House of Representatives and Senate in 2019, and later re-introduced in 2021) promotes equal coverage of intravenous and oral medications and prohibits insurance companies from making an inequitable distinction between oral and intravenous forms of chemotherapy drugs but has still not been passed in the US Congress⁵; and

Whereas, Coverage requirements for private health insurance companies are regulated by the federal government through the Public Health Service Act (PHSA), the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code (IRC)¹²; and

Whereas, There has been little evidence of increased premiums amongst the 43 states that have enacted oral parity legislation, relative to states without such legislation^{9,13}; and

Whereas, Oral parity is supported by numerous organizations including the American Society of Clinical Oncology (ASCO), the Leukemia and Lymphoma Society, and Susan G. Komen Breast Cancer Foundation^{11,14,15}; and

Whereas, Existing AMA policy H-55.986 supports financial reimbursement of chemotherapy and antibiotic drugs at home via infusion or injection, but does not extend coverage to oral therapies; therefore be it

RESOLVED, That our American Medical Association amend policy H-55.986, "Home Chemotherapy and Antibiotic Infusions," by addition to read as follows:

H-55.986 - HOME CHEMOTHERAPY AND ANTIBIOTIC INFUSIONS

Our AMA: (1) endorses the use of home medications to include those orally-administered, injections and/or infusions of FDA approved drugs and group C drugs (including chemotherapy and/or antibiotic therapy) for appropriate patients under physicians' recommendation and supervision; (2) only considers extension of the use of home infusions for biologic agents, immune modulating therapy, and anti-cancer therapy as allowed under the public health emergency when circumstances are present such that the benefits to the patient outweigh the potential risks; (3) encourages CMS and/or other insurers to provide adequate reimbursement and liability protections for such treatment; (4) supports educating legislators and administrators about the risks and benefits of such home infused antibiotics and supportive care treatments in terms of cost saving, increased quality of life and decreased morbidity, and about the need to ensure patient and provider safety when considering home infusions for such treatment as biologic, immune modulating, and anti-cancer therapy; (5) advocates for appropriate reimbursement policies for home infusions; and (6) opposes any requirement by insurers for home administration of drugs, if in the treating physician's clinical judgment it is not appropriate, or the precautions necessary to protect medical staff, patients and caregivers from adverse events associated with drug infusion and disposal are not in place; this includes withholding of payment or prior authorization requirements for other settings; and (7) advocates for patient cost-sharing parity between office- and home-administered anticancer drugs. (Modify Current HOD Policy)

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

Received: 10/12/22

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RELEVANT AMA POLICY

Health Plan Coverage Policies for Anti-Nausea Regimens H-55.975

Our AMA advocates: (1) that ethical, cost effective, and compassionate cancer therapy requires the best possible anti-nausea treatment; (2) that no health plan should require a less expensive initial anti-nausea regimen that has been shown to be less than optimally effective compared to other available and approved regimens, thereby preventing patients from receiving the best possible anti-nausea therapy; (3) that all health plans should collaborate with the oncology physician community before changing coverage for anti-nausea therapy; and (4) that clinical coverage decisions for anti-nausea therapy should base considerations of cost effectiveness on the entire cost to the system, including patient co-pays and deductibles for oral anti-nausea agents, the use of oncologists' on-call time for fielding calls late at night when anti-nausea therapy fails, as well as the cost of office visits, emergency room visits, and hospitalizations.

Res. 826, I-10; Reaffirmed: CMS Rep. 01, A-20

Symptomatic and Supportive Care for Patients with Cancer H-55.999

Our AMA recognizes the need to ensure the highest standards of symptomatic, rehabilitative, and supportive care for patients with both cured and advanced cancer. The Association supports clinical research in evaluation of rehabilitative and palliative care procedures for the cancer patient, this to include such areas as pain control, relief of nausea and vomiting, management of complications of surgery, radiation and chemotherapy, appropriate hemotherapy, nutritional support, emotional support, rehabilitation, and the hospice concept. Our AMA actively encourages the implementation of continuing education of the practicing American physician regarding the most effective methodology for meeting the symptomatic, rehabilitative, supportive, and other human needs of the cancer patient.

CSA Rep. H, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 514, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Home Chemotherapy and Antibiotic Infusions H-55.986

Our AMA: (1) endorses the use of home injections and/or infusions of FDA approved drugs and group C drugs (including chemotherapy and/or antibiotic therapy) for appropriate patients under physicians' recommendation and supervision; (2) only considers extension of the use of home infusions for biologic agents, immune modulating therapy, and anti-cancer therapy as allowed under the public health emergency when circumstances are present such that the benefits to the patient outweigh the potential risks; (3) encourages CMS and/or other insurers to provide adequate reimbursement and liability protections for such treatment; (4) supports educating legislators and administrators about the risks and benefits of such home infused antibiotics and supportive care treatments in terms of cost saving, increased quality of life and decreased morbidity, and about the need to ensure patient and provider safety when considering home infusions for such treatment as biologic, immune modulating, and anti-cancer therapy; (5) advocates for appropriate reimbursement policies for home infusions; and (6) opposes any requirement by insurers for home administration of drugs, if in the treating physician's clinical judgment it is not appropriate, or the precautions necessary to protect medical staff, patients and caregivers from adverse events associated with drug infusion and disposal are not in place; this includes withholding of payment or prior authorization requirements for other settings..

Citation: Res. 186, I-89; Reaffirmed: Sunset Report and Reaffirmation A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20; Modified: Res. 508, I-20;

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.

CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation A-14; Reaffirmed in lieu of Res. 229, I-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 818
(I-22)

Introduced by: American Academy of Pediatrics, Obesity Medicine Association

Subject: Pediatric Obesity Treatment Insurance Coverage

Referred to: Reference Committee J

1 Whereas, Obesity is the most common chronic disease in childhood; and

2
3 Whereas, Untreated pediatric obesity leads to significant morbidity, premature mortality, and an
4 enormous financial burden to society from health care costs and lost productivity; and

5
6 Whereas, Obesity in the pediatric population increases the risk of obesity in adulthood; and

7
8 Whereas, Effective treatment of pediatric obesity requires a comprehensive multi-pronged
9 approach delivered chronically including lifestyle therapy, anti-obesity medications, and
10 metabolic and bariatric surgery; and

11
12 Whereas, Several anti-obesity medications have now been approved by the FDA for use in the
13 pediatric population, thus substantially expanding the options for safe and effective
14 pharmacological options for pediatric obesity treatment; and

15
16 Whereas, Many health insurance plans, public and private, do not adequately cover lifestyle
17 therapy, anti-obesity medications, and metabolic and bariatric surgery, resulting in progressive
18 weight gain, worsening obesity, and weight-related co-morbidities; and

19
20 Whereas, Recent AMA policy D-440.954, Addressing Obesity, establishes the AMA as working
21 to improve national understanding of the obesity epidemic and address gaps in medical obesity
22 education and health disparities, and the lack of insurance coverage for obesity treatment; and

23
24 Whereas, Currently 38% of children in the US are insured by Medicaid and other public health
25 insurance plans; therefore be it

26
27 RESOLVED, That our American Medical Association immediately call for full public health
28 insurance coverage of pediatric evidence-based anti-obesity treatment, including
29 comprehensive life-style therapy, anti-obesity medications and metabolic and bariatric surgery
30 (Directive to Take Action); and be it further

31
32 RESOLVED, That our AMA work with all interested parties to lobby the legislative and executive
33 branches of government to affect public health insurance coverage and payment for the full
34 spectrum of evidence-based pediatric anti-obesity therapy. (Directive to Take Action)

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

Received: 10/13/22

RELEVANT AMA POLICY

Addressing Obesity D-440.954

1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.

2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).

3. Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.

Citation: BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 819
(I-22)

Introduced by: American College of Preventive Medicine

Subject: Advocating for the Implementation of Updated U.S. Preventive Services Task Force Recommendations for Colorectal Cancer Screening Among Primary Care Physicians and Major Payors by the AMA

Referred to: Reference Committee J

Whereas, Colorectal cancer is the third leading cause of cancer death for both men and women, with an estimated 52,980 persons in the US projected to die of colorectal cancer in 2021¹; and

Whereas, There is sufficient evidence to suggest early detection and screening of colorectal cancer can reduce mortality²³⁴⁵; and

Whereas, The incidence of colorectal cancer in adults aged 40 to 49 years has increased by almost 15% from 2000-2002 to 2014-2016; and

Whereas, In 2016, 25.6% of eligible adults in the US had never been screened for colorectal cancer⁶; and

Whereas, The primary barriers to patients not receiving the recommended screenings at age 45-49: lack of physician follow-up, mistrust of medical institutions, and lack of insurance coverage⁷⁸⁹¹⁰; are risk factors modifiable by way of advocacy from Our AMA; and

Whereas, Our AMA supports physician engagement with patients to share decision-making on screening efforts (H-55.981, last modified 2018) and improving prevention via insurance coverage for screening tests (H-330.877, last modified 2018) and encourages appropriate screening (D-55.998, last modified 2013); and

¹ Siegel RL, Miller KD, Fuchs HE, Jemal A. Cancer statistics, 2021. *CA Cancer J Clin*. 2021;71(1):7-33. doi:10.3322/caac.21654

² Etzioni R, Urban N, Ramsey S, et al The case for early detection. *Nat Rev Cancer* 2003;3:243–52.

³ Lin JS, Perdue LA, Henrikson NB, Bean SI, Blasi PR. Screening for Colorectal Cancer: An Evidence Update for the US Preventive Services Task Force. Evidence Synthesis No. 202. Agency for Healthcare Research and Quality; 2021. AHRQ publication 20-05271-EF-1.

⁴ Lin JS, Perdue LA, Henrikson NB, Bean SI, Blasi PR. Screening for colorectal cancer: updated evidence report and systematic review for the US Preventive Services Task Force. *JAMA*. Published May 18, 2021. doi:10.1001/jama.2021.4417

⁵ Chiu HM, Chen SL, Yen AM, et al. Effectiveness of fecal immunochemical testing in reducing colorectal cancer mortality from the One Million Taiwanese Screening Program. *Cancer*. 2015;121 (18):3221-3229. doi:10.1002/cncr.29462

⁶ Montminy EM, Zhou M, Maniscalco L, et al. Contributions of adenocarcinoma and carcinoid tumors to early-onset colorectal cancer incidence rates in the United States. *Ann Intern Med*. 2021;174 (2):157-166. doi:10.7326/M20-0068

⁷ Azulay R, Valinsky L, Hershkowitz F, Elran E, Lederman N, Kariv R, Braunstein B, Heymann A. Barriers to completing colonoscopy after a positive fecal occult blood test. *Isr J Health Policy Res*. 2021 Feb 11;10(1):11. doi: 10.1186/s13584-021-00444-2. PMID: 33573698; PMCID: PMC7879608.

⁸ Cole H, Thompson HS, White M, Browne R, Trinh-Shevrin C, Braithwaite S, Fiscella K, Boutin-Foster C, Ravenell J. Community-Based, Preclinical Patient Navigation for Colorectal Cancer Screening Among Older Black Men Recruited From Barbershops: The MISTER B Trial. *Am J Public Health*. 2017 Sep;107(9):1433-1440. doi: 10.2105/AJPH.2017.303885. Epub 2017 Jul 20. PMID: 28727540; PMCID: PMC5551599.

⁹ Ho, I. K., Sheldon, T. A., & Botelho, E. (2021). Medical mistrust among women with intersecting marginalized identities: a scoping review. *Ethnicity & health*, 1–19. Advance online publication. <https://doi.org/10.1080/13557858.2021.1990220>

¹⁰ White, P. M., & Itzkowitz, S. H. (2020). Barriers driving racial disparities in colorectal cancer screening in African Americans. *Current Gastroenterology Reports*, 22(8). <https://doi.org/10.1007/s11894-020-00776-0>

1 Whereas, Members of historically excluded and marginalized populations experience worse
2 overall survival for colorectal cancer when controlling for factors such as income and
3 education¹¹, and our AMA Has resolved to support (H-180.994, last modified 2021) efforts to
4 engender health equity; and

5
6 Whereas, No recent policy explicitly supports our AMA engaging with payors, health systems,
7 and other clinician organizations to advocate for the adoption of routine screening for Colorectal
8 Cancer among patients⁴⁵⁻⁴⁹; therefore be it

9
10 RESOLVED, That our American Medical Association advocate that payors, health systems, and
11 clinicians adopt the updated U.S. Preventive Services Task Force Recommendation to initiate
12 routine preventive screening for colorectal cancer at age 45; and to coordinate with like-minded
13 professional organizations to enhance physician education and awareness of this essential
14 recommendation. (Directive to Take Action)

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

Received: 10/13/22

¹¹ Kamath SD, Torrejon N, Wei W, et al. Racial disparities negatively impact outcomes in early-onset colorectal cancer independent of socioeconomic status. *Cancer Medicine*. 2021 Nov;10(21):7542-7550. DOI: 10.1002/cam4.4276. PMID: 34647438; PMCID: PMC8559495.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 820
(I-22)

Introduced by: American College of Rheumatology, American Academy of Allergy,
Asthma & Immunology, American Academy of Dermatology, American
Academy of Neurology, American Academy of Ophthalmology, American
College of Gastroenterology, American Society of Hematology, Association
for Clinical Oncology, North American Neuro-Ophthalmology Society,
American Gastroenterological Association, American Contact Dermatitis
Society, American Society of Dermatopathology, Florida, Iowa, Arizona,
Utah

Subject: Third-Party Pharmacy Benefit Administrators

Referred to: Reference Committee J

1 Whereas, The operations of third-party companies that manage specialty pharmacy benefits are
2 an emerging national issue with significant negative effects on patients and the practice of
3 medicine; and
4

5 Whereas, These entities contract to manage the specialty pharmacy portion of the drug
6 formulary, generally for self-insured entities, and manage formularies, negotiate rebates,
7 process claims, and pay pharmacies for prescriptions, like pharmacy benefit managers (PBMs);
8 and
9

10 Whereas, Although these entities hold themselves out to be something new and different, the
11 only difference from traditional PBMs is that they operate solely in the specialty pharmacy
12 formulary; and
13

14 Whereas, These third-party administrators use heavy-handed tactics with physicians and
15 patients to force the use of preferred prescriptions, with little transparency and opaque
16 practices; and
17

18 Whereas, These entities generally use “proprietary algorithms” to determine the treatments to
19 which a patient will have access, and are forcing patients to change medications with no clear
20 method to override decisions made by the algorithm-- an affront to personalized medical care
21 and to the physician and patient relationship; and
22

23 Whereas, The practices of these third-party companies amount to the practice of medicine. As
24 an example, a common practice is a biologic taper program, overseen by staff of the entity, in
25 which they and not the treating physician make decisions on the dosing and frequency of
26 medication, with no transparency about who is making treating decisions or any data behind the
27 tapering schedule; and
28

29 Whereas, As a result of the Supreme Court decision in *Rutledge v. PCMA*, states can require
30 licensing, registration, and reporting for PBMs that operate in ERISA plans. Even if these
31 entities are contracted directly with employers to manage specialty formularies, states can
32 require licensing, registration, and transparency reporting; and

1 Whereas, Interest in the practices of PBMs has increased at the federal level as well, including
2 federal legislative hearings and a review of PBM business practices by the Federal Trade
3 Commission; and
4

5 Whereas, Because these organizations are newer to the healthcare landscape, they are not
6 bound to PBM-related regulations or laws; therefore be it
7

8 RESOLVED, That our American Medical Association recommend that third-party pharmacy
9 benefit administrators that contract to manage the specialty pharmacy portion of drug
10 formularies be included in existing pharmacy benefit manager (PBM) regulatory frameworks and
11 statutes, and be subject to the same licensing, registration, and transparency reporting
12 requirements (New HOD Policy); and be it further
13

14 RESOLVED, That our AMA advocate that third-party pharmacy benefit administrators be
15 included in future PBM oversight efforts at the state and federal levels. (Directive to Take
16 Action)

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

Received: 10/13/22

RELEVANT AMA POLICY

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-19Reaffirmed: CMS Rep. 6, I-20

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

Interference in the Practice of Medicine D-125.997

Our AMA shall initiate action by whatever means to bring a halt to the interference in medical practice by pharmacy benefit managers and others.

Res. 529, A-02Reaffirmation A-10Reaffirmed: CMS Rep. 04, A-16Reaffirmed: Res. 250, A-22

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-97Appended: Res. 224, I-98Appended: Res. 529, A-02Reaffirmed: Res. 533A-03Reaffirmation I-08Reaffirmation A-10Reaffirmed: Alt. Res. 806, I-17Modified: Res. 242, A-18Reaffirmed: CMS Rep. 08, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 912
(I-22)

Introduced by: Medical Student Section

Subject: Reevaluating the Food and Drug Administration's Citizen Petition Process

Referred to: Reference Committee K

1 Whereas, Pharmaceutical drug prices in the United States are increasing at an alarming rate
2 and are more expensive than the rest of the industrialized world¹⁻³; and
3

4 Whereas, Although brand name drugs account for about 15% of prescriptions dispensed by
5 Medicaid and Medicare Part D, they account for about 75-80% spending on prescription
6 drugs^{1,4}; and
7

8 Whereas, In many situations, generic and brand name medications have the same clinical
9 efficacy, risks and benefits because they have the same active ingredients and mechanism of
10 action⁵; and
11

12 Whereas, Competition between generic drug companies and brand name manufacturers
13 typically results in an 85% price reduction, and generic drugs saved the U.S. healthcare system
14 \$1.67 trillion from 2007 to 2016^{5,6}; and
15

16 Whereas, The Food and Drug Administration's (FDA) citizen petition process is intended as a
17 method for average individuals, industry or consumer groups to formally request the FDA
18 commissioner to invoke, amend, or revoke directives or pharmaceutical monographs as a
19 democratic and transparent mode of regulation^{7,8}; and
20

21 Whereas, Manufacturers of brand name drugs employ strategies including filing petitions to the
22 FDA that delay and prevent the entry of generic drugs into the market and prevent this loss of
23 profit⁹⁻¹¹; and
24

25 Whereas, An estimated 92% of citizen petitions filed against generic brands are filed by brand-
26 name manufacturers¹²; and
27

28 Whereas, One of every five citizen petitions filed by brand-name manufacturers (including but
29 not limited to pharmaceutical drugs) has had the potential to delay generic entry into the
30 market^{13,14}; and
31

32 Whereas, An analysis of four frivolous citizen petitions filed by brand-name manufacturers in a
33 2-year span found a total market delay time of 521 days (against generic drugs) which cost
34 approximately \$782 million to government-provided insurance programs and \$1.9 billion total¹⁵;
35 and
36

37 Whereas, The Federal Trade Commission (FTC) has filed a formal complaint that these
38 "repetitive, serial, and meritless filings lacked any supporting clinical data" that have
39 "succeeded in delaying generic entry at a cost of hundreds of millions of dollars to patients and
40 other purchasers"¹⁶; and

Whereas, Despite the overwhelming empirical data on the abuse of the FDA citizen petition process, there is minimal official data on the true cost to society¹⁵; and

Whereas, The FDA is not obligated to nor does it actively report to Congress which petitions have been filed fraudulently or the nature of generic entry market delay¹⁷; and

Whereas, Increasing the transparency of the citizen petition process would facilitate more thorough research and analysis of petitions and lower unnecessary resource expenditure by the FDA¹⁷; therefore be it

RESOLVED, That our American Medical Association support the research of anti-competitive practices on the Food and Drug Administration's (FDA) citizen petitions process (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for further public transparency by the FDA in the content of each petition, the relationship between citizen petitions and decisions to delay generic approval, and the time and resources expended on petition reviews. (Directive to Take Action)

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

Received: 10/05/22

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RELEVANT AMA POLICY

Pharmaceutical Costs H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
 2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
 4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
 7. Our AMA supports legislation to shorten the exclusivity period for biologics.
 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
 10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
 11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
 12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
 13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
 14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.
- Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 913
(I-22)

Introduced by: Medical Student Section

Subject: Supporting and Funding Sobering Centers

Referred to: Reference Committee K

1 Whereas, Public intoxication related charges were among the top ten reasons for arrest in the
2 United States (US) in 2019, with over 450,000 arrests¹; and
3

4 Whereas, In the US, Black, American Indian, and Alaska Native people are arrested at greater
5 annual rates per capita for public intoxication charges than those who are White¹; and
6

7 Whereas, Several sobering centers are led by Alaska Native tribal organizations and have led to
8 reduced incarceration rates per capita for public intoxication among Alaska Natives²; and
9

10 Whereas, Specialty and hospital-based treatments for acute alcohol intoxication account for
11 \$24.6 billion in healthcare costs, with most patients seeking care in emergency departments³;
12 and
13

14 Whereas, The number of acute alcohol-related emergency department visits increased from
15 1,801,006 in 2006 to 2,728,313 in 2014, indicating a growing need for substance use disorder
16 resources and interventions⁴; and
17

18 Whereas, The US has the highest incarceration rate in the world and incarceration can result in
19 a series of social sequelae affecting a person's ability to maintain housing, personal health,
20 employment, and other necessities⁵; and
21

22 Whereas, A growing number of local jurisdictions within the US and nations around the globe
23 are shifting towards a health-based response to public intoxication, as opposed to
24 criminalization⁶; and
25

26 Whereas, At least 35 sobering centers across 14 US states currently function to safely lead
27 those acutely intoxicated by various substances to recover under medical observation and to
28 connect them with substance use disorder recovery programs^{7, 8}; and
29

30 Whereas, Sobering centers are able to treat patients with substance use disorders and are well
31 positioned to provide services to those disadvantaged by other social barriers, including persons
32 experiencing homelessness⁹; and
33

34 Whereas, Houston Recovery Center in Houston, Texas is a nationally recognized sobering
35 center model, serving the largest metropolitan population among all sobering centers in the
36 United States⁸; and
37

38 Whereas, Jail admissions for public intoxication in Harris County, Texas decreased by 95
39 percent (from 15,357 to 835) from 2012 to 2017 following the opening of the Houston Recovery
40 Center¹⁰; and

1 Whereas, A jail admission in Harris County was reported to cost \$286 per day while the
2 sobering center at full capacity would cost \$127 per admission, allowing Harris County to view
3 the program as a cost-offset¹⁰; and
4

5 Whereas, The primary workforce of the Houston Recovery Center consists of Texas state-
6 certified peer recovery support specialists who work alongside nurses, licensed chemical
7 dependency counselors, emergency medical technicians, social workers, and civilians with
8 institution-specific training who provide comprehensive services¹¹; and
9

10 Whereas, Sobering centers accept clients through multiple referral sources including ambulatory
11 and vehicular outreach teams, walk-ins, police, emergency medical services, and emergency
12 departments¹¹; and
13

14 Whereas, Forty-eight percent of the 25,282 clients admitted to the Houston Recovery Center
15 over 5 years accepted referral to additional services, requested housing assistance, or enrolled
16 in treatment upon discharge¹⁰; and
17

18 Whereas, In 2014 the Houston Recovery Center launched the Partners in Recovery (PIR)
19 program designed to address substance use among low-income, uninsured clients with complex
20 needs and more than two admissions to the sobering center¹²; and
21

22 Whereas, The PIR Houston Recovery Center is able to practice a proactive intervention strategy
23 by working with individuals with active substance use disorders in criminal justice and street
24 outreach settings¹²; and
25

26 Whereas, A modeling study with a sobering center diversion rate of 50 percent resulted in an
27 estimated annual national savings ranging from \$230 million to \$1.0 billion¹³; and
28

29 Whereas, The City of Houston reported a \$2.9 million positive fiscal impact in the first 20
30 months after sobering center operation¹⁴; and
31

32 Whereas, Estimated national savings range from \$230 million to \$1.0 billion annually based on
33 Monte Carlo modeling with a sobering center diversion rate of 50%¹⁵; and
34

35 Whereas, Cost analysis of the San Francisco Sobering Center comparing direct costs of
36 emergency department to per-encounter costs at the Sobering Center found significantly less
37 cost for care of acute intoxication than in the emergency department, leading to savings of \$243
38 per patient¹⁶; and
39

40 Whereas, A review done by Santa Cruz Recovery Center in 2018 reported a 86% decline in
41 time spent by law enforcement processing public inebriates, with a 53% decline from 2014 to
42 2017 in average monthly jail bookings translating into \$83,290 savings in officer costs¹⁷;
43 therefore be it
44

45 RESOLVED, That our American Medical Association recognize the utility, cost effectiveness,
46 and racial justice impact of sobering centers (New HOD Policy); and be it further
47

48 RESOLVED, That our AMA support the maintenance and expansion of sobering centers (New
49 HOD Policy); and be it further
50

51 RESOLVED, That our AMA support ongoing research of the sobering center public health
52 model (New HOD Policy); and be it further

- 1 RESOLVED, That our AMA support the use of state and national funding for the development
2 and maintenance of sobering centers. (New HOD Policy)

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

Received: 10/05/22

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RELEVANT AMA POLICY

Substance Use and Substance Use Disorders H-95.922

Our AMA:

- (1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;
- (2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to

communicate the fact that substance use disorder is a treatable disease; and
 (3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

Citation: CSAPH Rep. 01, A-18; Reaffirmed: BOT Rep. 14, I-20

Harmful Substance Use H-95.967

Our AMA encourages every physician to make a commitment to join his/her community in attempting to reduce harmful substance use and that said commitment encourage involvement in at least one of the following roles: (1) donation of time to talk to local civic groups, schools, religious institutions, and other appropriate groups about harmful substance use; (2) join or organize local groups dedicated to the prevention of harmful substance use; (3) talk to youth groups about brain damage and other deleterious effects of harmful substance use; and (4) educate and support legislators, office holders and local leaders about ways to end harmful substance use and providing adequate treatment to patients with substance use disorder.

Citation: Sub. Res. 36, I-90; Modified: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20

Increased Funding for Substance Use Disorder Treatment H-95.973

Our AMA (1) urges Congress to substantially increase its funding for substance use disorder treatment programs; (2) urges Congress to increase funding for the expansion and creation of new staff training programs; and (3) urges state medical societies to press for greater commitment of funds by state and local government to expand the quantity and improve the quality of the substance use disorder treatment system.

Citation: Res. 116, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20

Involuntary Civic Commitment for Substance Use Disorder H-95.912

Our AMA opposes civil commitment proceedings for patients with a substance use disorder unless: a) a physician or mental health professional determines that civil commitment is in the patient's best interest consistent with the AMA Code of Medical Ethics; b) judicial oversight is present to ensure that the patient can exercise his or her right to oppose the civil commitment; c) the patient will be treated in a medical or other health care facility that is staffed with medical professionals with training in mental illness and addiction, including medications to help with withdrawal and other symptoms as prescribed by his or her physician; and d) the facility is separate and distinct from a correctional facility.

Citation: BOT Rep. 7, I-20

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.

Citation: BOT Rep. Y, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09; Modified: CSAPH Rep. 01, A-19

Federal Drug Policy in the United States H-95.981

The AMA, in an effort to reduce personal and public health risks of drug abuse, urges the formulation of a comprehensive national policy on drug abuse, specifically advising that the federal government and the nation should: (1) acknowledge that federal efforts to address illicit drug use via supply reduction and enforcement have been ineffective (2) expand the availability and reduce the cost of treatment programs for substance use disorders, including addiction; (3) lead a coordinated approach to adolescent drug education; (4) develop community-based prevention programs for youth at risk; (5) continue to fund the Office of National Drug Control Policy to coordinate federal drug policy; (6) extend greater protection against discrimination in the employment and provision of services to drug abusers; (7) make a long-term commitment to expanded research and data collection; (8) broaden the focus of national and local policy from drug abuse to substance abuse; and (9) recognize the complexity of the problem of substance abuse and oppose drug legalization.

Citation: BOT Rep. NNN, A-88; Reaffirmed: CLRPD 1, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 2, I-13; Reaffirmed: BOT Rep. 14, I-20

Community-Based Treatment Centers H-160.963

Our AMA supports the use of community-based treatment centers for substance use disorders, mental health disorders and developmental disabilities.

Citation: BOT Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21

Involuntary Civic Commitment for Substance Use Disorder D-95.963

Our AMA will continue its work to advance policy and programmatic efforts to address gaps in voluntary substance use treatment services.

Citation: BOT Rep. 7, I-20

AMA Support for Justice Reinvestment Initiatives H-95.931

Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.

Citation: Res. 205, A-16

Substance Use Disorders as a Public Health Hazard H-95.975

Our AMA: (1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach;

(2) declares substance use disorders are a public health priority;

(3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction;

(4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and

(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances.

Citation: Res. 7, I-89; Appended: Sub. Res. 401, Reaffirmed: Sunset Rep., I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19

Enhanced Funding for and Access to Outpatient Addiction Rehabilitation D-95.962

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.

Citation: BOT Rep.14, I-20

Increasing Detection of Mental Illness and Encouraging Education D-345.994

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 914
(I-22)

Introduced by: Washington

Subject: Greenhouse Gas Emissions from Health Care

Referred to: Reference Committee K

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

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

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

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

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

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

19 RESOLVED, That our American Medical Association advocate for reducing greenhouse gas
20 emissions from health care as well as strategies for increasing the resilience of our health
21 system to the adverse impacts of climate change (Directive to Take Action); and be it further
22

23 RESOLVED, That our AMA study the climate effects of metered-dose inhalers, options for
24 reducing hydrofluorocarbon use in the medical sector, and strategies for encouraging the
25 development of alternative inhalers with equal efficacy and less adverse effect on our climate.
26 (Directive to Take Action)

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

Received: 10/10/22

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RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.

Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19;
Modified: Res. 424, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 915
(I-22)

Introduced by: Washington

Subject: Pulse Oximetry in Patients with Pigmented Skin

Referred to: Reference Committee K

1 Whereas, Awareness of concerns on the accuracy of pulse oximetry in pigmented skin has
2 been noted since the 1970s and the Hewlett Packard Model 47021A Oximeter was designed in
3 that era specifically with the ability to calibrate for various degrees of skin pigmentation⁴; and
4

5 Whereas, The Journal of the American Medical Association (JAMA) has reported an increased
6 incidence of hidden hypoxemia (SaO₂ <88% despite SpO₂ ≥88%) in racial and ethnic minority
7 groups – specifically Black, Hispanic, and Asian groups – with an associated increase in major
8 organ dysfunction at 24 hours in otherwise matched groups and increased in-hospital mortality;
9 and
10

11 Whereas, The British Medical Journal has reported that in general care inpatient settings across
12 the Veterans Health Administration where paired readings of arterial blood gas and pulse
13 oximetry were obtained, black patients had higher odds than white patients of having occult
14 hypoxemia noted on arterial blood gas but not detected by pulse oximetry; and
15

16 Whereas, JAMA Internal Medicine has reported that greater occult hypoxemia in Asian, Black,
17 and non-Black Hispanic patients with COVID-19, which was associated with significantly
18 delayed or unrecognized eligibility for COVID-19 therapies among Black and Hispanic patients;
19 and
20

21 Whereas, The Critical Care Societies Collaborative has urged the FDA to direct pulse oximeter
22 manufacturers to conduct the tests needed to ensure that their devices provide accurate and
23 reliable readings for patients with diverse degrees of skin pigmentation; and
24

25 Whereas, The FDA has acknowledged that skin pigmentation can affect the accuracy of pulse
26 oximetry readings and is planning to convene a public meeting of the Medical Devices Advisory
27 Committee later this year to discuss available evidence about the accuracy of pulse oximeters,
28 recommendations for patients and health care providers, the amount and type of data that
29 should be provided by manufacturers to assess pulse oximeter accuracy, and to guide other
30 regulatory actions as needed; therefore be it
31

32 RESOLVED, That our American Medical Association make recommendations to the US Food
33 and Drug Administration that will ensure pulse oximeters provide accurate and reliable readings
34 for patients with diverse degrees of skin pigmentation. (Directive to Take Action)

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

Received: 10/10/22

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 916
(I-22)

Introduced by: Medical Student Section

Subject: Non-Cervical HPV Associated Cancer Prevention

Referred to: Reference Committee K

1 Whereas, While Human Papillomavirus (HPV) infection with high risk strains is a well-known risk
2 factor for cervical cancer and widespread efforts have been made to educate healthcare
3 providers and the public about screening and vaccination for cervical cancer prevention, HPV
4 infection has also been associated with the development of other cancers such as vulvar,
5 vaginal, head and neck, penile, and anal cancer, among others¹⁻⁵; and
6

7 Whereas, Of the approximately 34,800 new cases of HPV-related cancer diagnoses in the U.S.
8 annually, less than one third are due to cervical cancer and 40% are found in males⁶; and
9

10 Whereas, HPV associated head and neck cancer predominates in males in a ratio of 8:1 and
11 has increased in prevalence by 225% since the 1980s, and the annual number of cases are
12 expected to surpass the annual number of cervical cancers per year by 2020⁷; and
13

14 Whereas, HPV vaccination has been recommended by the U.S. Food and Drug Administration
15 (FDA) for females ages 9 to 26 for cervical, vulvar, and vaginal cancer prevention since 2006,
16 all individuals for the prevention of anal cancer since 2010, individuals up to age 45 that may be
17 at higher risk of infection since 2018, and for head and neck cancer prevention since 2020^{10,11};
18 and
19

20 Whereas, Despite HPV vaccination being recommended for all individuals, vaccination rates are
21 still suboptimal, and significantly lower for males (27.4% - 56%) compared to females (45.7% -
22 65%), with approximately 37% of individuals receiving all three doses¹²⁻¹⁵; and
23

24 Whereas, It has been hypothesized that vaccination rates are suboptimal in part due to a
25 “feminization of HPV” that evolved from a focus on cervical cancer screening and the
26 conception of women bearing the burden of HPV related illness, which suggests that
27 vaccination rates may increase if stakeholders actively work to normalize HPV vaccination as an
28 important gender-neutral component of routine healthcare¹⁶; and
29

30 Whereas, A 2019 meta-analysis showed that healthcare professionals’ knowledge and
31 counseling tendencies regarding HPV infection and vaccination remain low and are crucial to
32 vaccine uptake; notably many providers are unaware that HPV is associated with non-cervical
33 cancers and that the HPV vaccine can prevent non-cervical cancers¹⁷⁻²⁰; and
34

35 Whereas, In a study of pediatric residents and fellows, 68.3% rated their prior education as
36 “none” or “fair” regarding HPV related head and neck cancer and over half reported “never”
37 discussing it with their patients, in contrast to 70.9% who rated their education on cervical
38 cancer as “good” or “excellent”, and 95% indicated a need for increased HPV education²¹; and

1 Whereas Studies have shown adults have a general lack of knowledge about HPV vaccinations
2 and less than a third are aware of the association with non-cervical cancers, which has been
3 associated with lower vaccination rates for themselves and their children^{22,23}; and
4

5 Whereas, While current AMA policies (H-440.872 and H-370.995) address increasing physician
6 and public education about HPV and cervical cancer, these current policies fail to explicitly
7 address other HPV related cancers beyond cervical cancer, thereby potentially perpetuating
8 prevalent misconceptions regarding the scope of HPV related cancers; and
9

10 Whereas, The Advisory Committee on Immunization Practices support removing barriers to
11 vaccination access including offering immunizations in schools increasing access and follow up
12 at appropriate intervals for patients that may have difficulty obtaining their vaccinations^{25,26};
13 and
14

15 Whereas, While School-based HPV vaccination programs utilized in several other countries
16 have resulted in the highest vaccination rates in the world, ranging from 69 to 90%, and large
17 decreases in HPV related cancers, school-based HPV vaccination is rare in the U.S.^{27,28}; and
18

19 Whereas, A Texas HPV vaccination education and administration program increased
20 vaccination rates greater than HPV education alone by providing vaccinations to students and
21 covering the cost by screening for insurance and covering uninsured students²⁹; and
22

23 Whereas, Vaccine mandates to attend school are routine for communicable diseases including
24 Hepatitis B for which 48 states mandate vaccination, while only 3 have HPV mandates^{30,31}; and
25

26 Whereas, Physicians often present HPV vaccination as optional or non-urgent because it is not
27 required for school entry which results in greater vaccination hesitancy among patients³²; and
28

29 Whereas, AMA policy H-60.923 sets a precedent for supporting mandatory vaccination and H-
30 440.970 states that nonmedical exemptions from immunizations endanger the health of the
31 community at large and supports legislation eliminating such nonmedical exemptions; and
32

33 Whereas, Rhode Island mandates HPV vaccination for school attendance without explicitly
34 permitting nonmedical exemptions which led to increased vaccine uptake compared to states
35 that explicitly permit nonmedical exemptions, and funds this program at the state level by
36 directly purchasing vaccines from the Centers for Disease Control at low costs to give to
37 providers for free, thus eliminating financial barriers^{16,33-35}; and
38

39 Whereas, Because screening for signs of non-cervical HPV related cancer is limited,
40 vaccination is the primary method of cancer prevention, however, there has been evidence
41 supporting the use of non-cervical cancer screening in high risk populations³⁶⁻³⁸; therefore be it

1 RESOLVED, That our American Medical Association amend policy H-440.872, "HPV Vaccine
2 and Cervical Cancer Prevention Worldwide," by addition and deletion to read as follows:
3

4 **HPV Vaccine and ~~Cervical~~ Cancer Prevention Worldwide, H-440.872**

- 5 1. Our AMA (a) urges physicians to educate themselves and their patients about HPV
6 and associated diseases, HPV vaccination, as well as routine ~~cervical~~-cancer
7 screening for those at risk; and (b) encourages the development and funding of
8 programs targeted at HPV vaccine introduction and cervical cancer screening in
9 countries without organized cervical cancer screening programs.
- 10 2. Our AMA will intensify efforts to improve awareness and understanding about HPV
11 and associated diseases, in all individuals regardless of sex, such as, but not limited
12 to, cervical cancer, head and neck cancer, anal cancer, and penile cancer, the
13 availability and efficacy of HPV vaccinations, and the need for routine cervical cancer
14 screening in the general public.
- 15 3. Our AMA:
- 16 a. encourages the integration of HPV vaccination and routine cervical cancer screening
17 into all appropriate health care settings and visits ~~for adolescents and young adults~~,
- 18 b. supports the availability of the HPV vaccine and routine cervical cancer screening to
19 appropriate patient groups that benefit most from preventive measures, including but
20 not limited to low-income and pre-sexually active populations,
- 21 c. recommends HPV vaccination for all groups for whom the federal Advisory
22 Committee on Immunization Practices recommends HPV vaccination.
- 23 4. Our AMA encourage appropriate stakeholders to investigate means to increase HPV
24 vaccination rates by:
- 25 a. facilitating administration of HPV vaccinations in community-based settings including
26 school settings, and
- 27 b. supporting state mandates for HPV vaccination for school attendance. (Modify
28 Current HOD Policy); and be it further
29

30 RESOLVED, That our AMA support legislation and funding for research aimed towards
31 discovering screening methodology and early detection methods for other non-cervical HPV
32 associated cancers. (New HOD Policy)

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

Received: 10/12/22

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RELEVANT AMA POLICY

Meningococcal Vaccination for School Children H-60.923

Our AMA supports efforts to require that school children receive meningococcal vaccine per the Advisory Committee on Immunization Practices guidelines. Res. 414, A-14

Childhood Immunizations H-60.969

1. Our AMA will lobby Congress to provide both the resources and the programs necessary, using the recommendations of the National Vaccine Advisory Committee and in accordance with the provision set forth in the National Vaccine Injury Compensation Act, to ensure that children nationwide are immunized on schedule, thus representing progress in preventive medicine.
2. Our AMA endorses the recommendations on adolescent immunizations developed by the Advisory Committee for Immunization Practices and approved by both the American Academy of Family Physicians and the American Academy of Pediatrics.
3. Our AMA will develop model state legislation to require that students entering middle or junior high school be adequately immunized according to current national standards.
4. Our AMA encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation.
5. Our AMA will continue to work with managed care groups and state and specialty medical societies to support a dedicated preventive health care visit at 11-12 years of age.
6. Our AMA will work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage the Centers for Medicare & Medicaid Services to deactivate coding edits that cause a decrease in immunization rates for children, and to make these edit deactivations retroactive to January 1, 2013.

Res. 542, A-92; CSA Rep. 4, I-95; Reaffirmed by BOT Rep. 24, A-97; Reaffirmation A-05; Appended: Res. 121, A-13

Human Papillomavirus (HPV) Inclusion in School Education Curricula D-170.995

Our AMA will:

1. strongly urge existing school health education programs to emphasize the high prevalence of human papillomavirus in all genders, the causal relationship of HPV to cancer and genital lesions, and the importance of routine pap tests in the early detection of cancer;
2. urge that students and parents be educated about HPV and the availability of the HPV vaccine; and
3. support appropriate stakeholders to increase public awareness of HPV vaccine effectiveness for all genders against HPV-related cancers.

Res. 418, A-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: Res. 404, A-18

HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.
3. Our AMA: (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (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, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

Res. 503, A-07; Appended: Res. 6, A-12; Reaffirmed: CSAPH Rep. 1, A-22; Reaffirmation: A-22

Insurance Coverage for HPV Vaccine D-440.955

Our AMA: (1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices;

(2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and

(3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.

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

Nonmedical Exemptions from Immunizations H-440.970

1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large.

Therefore, our AMA (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.

2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to (a) eliminate non-medical exemptions from mandated immunizations and (b) limit medical vaccine exemption authority to only licensed physicians.

CSA Rep. B, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 10, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 416, A-19; Modified: Res. 207, I-21

Organ Donor Recruitment H-370.995

Our AMA supports development of "state of the art" educational materials for the medical community and the public at large, demonstrating at least the following:

- (1) the need for organ donors;
- (2) the success rate for organ transplantation;
- (3) the medico-legal aspects of organ transplantation;
- (4) the integration of organ recruitment, preservation and transplantation;
- (5) cost/reimbursement mechanisms for organ transplantation; and
- (6) the ethical considerations of organ donor recruitment.

Citation: Res. 32, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12; Reaffirmed: CEJA Rep. 4, A-22;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 917
(I-22)

Introduced by: Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)

Subject: Care for Children with Obesity

Referred to: Reference Committee K

1 Whereas, Childhood obesity is a major public health problem, and the United States faces a
2 childhood obesity epidemic that disproportionately affects minority groups; and
3

4 Whereas, Obesity is now recognized as a disease of the metabolism whereby the body stores
5 excess fat and can develop metabolic health problems including resistance to insulin; and
6

7 Whereas, Obesity in children leads to severe health complications, including but not limited to
8 type 2 diabetes, hypertension, hepatic steatosis, obstructive sleep apnea, gastroesophageal
9 reflux disease, various orthopedic disorders, and polycystic ovarian syndrome; and
10

11 Whereas, Many of these comorbidities can be prevented, alleviated, or resolved by a
12 combination of behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions
13 to treat obesity; and
14

15 Whereas, Mild obesity of class I may be preventable and treatable with lifestyle and medical
16 interventions and the treatment of higher classes of obesity includes bariatric surgery; and
17

18 Whereas, Current evidence shows bariatric surgery to be the most effective and the only
19 durable treatment for severe obesity of class II and III in adults and in children; and
20

21 Whereas, The American Academy of Pediatrics, in a position statement that is co-endorsed by
22 several surgical organizations, including the Society of American Gastrointestinal and
23 Endoscopic Surgeons, states that bariatric surgery should be used in the treatment of children
24 with obesity meeting specific, objective criteria, including body mass index (BMI) at 140% of the
25 95th percentile of the growth curve or at 120% of the 95th percentile of the growth curve in the
26 presence of a comorbidity such as hypertension; and
27

28 Whereas, Significant barriers to the treatment of childhood obesity persist, such as insurance
29 coverage denials and the use of outdated eligibility criteria to access care; and
30

31 Whereas, these barriers delay treatment of obesity and prevention of further comorbidity
32 development, which results in worse patient outcomes; and
33

34 Whereas, The negative consequences of delayed treatment extend to adulthood for patients,
35 families, communities, and impact our health as a nation; therefore be it

36 RESOLVED, That our American Medical Association actively support the education of
37 physicians on the morbidity of childhood obesity, the existence of effective treatment for this
38 condition, and the importance of patients obtaining bariatric care as early as possible (Directive
39 to Take Action); and be it further

1 RESOLVED, That our AMA support the development of multidisciplinary care programs for
 2 children with obesity, inclusive of bariatric surgery care, access to medications, nutrition, and
 3 mental health support (Directive to Take Action); and be it further

4
 5 RESOLVED, That our AMA actively work to remove barriers to bariatric surgery, access to
 6 medications, nutrition, and mental health support for the treatment of obesity in children.
 7 (Directive to Take Action)

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

Received: 10/13/22

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RELEVANT AMA POLICY

Addressing Obesity D-440.954

1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the

study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.

2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).

3. Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.

Citation: BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18

Obesity as a Major Health Concern H-440.902

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of patients with obesity; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat patients affected by obesity.

Citation: Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04; Reaffirmation A-10; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Modified: Res. 402, A-17

Obesity as a Major Public Health Problem H-150.953

Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;

(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;

(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;

(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;

(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;

(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;

(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and

(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.

Citation: CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 3, A-13; Reaffirmation: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 918
(I-22)

Introduced by: Medical Student Section

Subject: Opposition to Alcohol Industry Marketing Self-Regulation

Referred to: Reference Committee K

1 Whereas, The American alcohol industry's political activity in opposition to federal regulation of
2 its marketing venues is based on claims that its advertising practices are responsible and do not
3 target youth, though there is a strong body of contradictory evidence to suggest that they
4 consistently violate their own marketing guidelines with respect to youth-targeting behavior^{1,9,10};
5 and
6

7 Whereas, The onset of binge drinking and hazardous drinking behaviors has been shown to
8 have a stronger association with alcohol marketing exposure than with parental drinking status²;
9 and
10

11 Whereas, Multiple studies have demonstrated that the alcohol industry's advertising practices
12 disproportionately targets youth and has contributory effect toward the initiation and progression
13 of youth drinking behaviors³⁻⁵; and
14

15 Whereas, The International Center for Alcohol Policies, an alcohol industry-sponsored
16 organization whose role is to set standards of practice for alcohol marketing, states in its
17 "Guiding Principles" that alcohol marketing communications should only be placed in media in
18 which the audience composition is, at minimum, of 70% legal drinking age⁶; and
19

20 Whereas, Of the top 100 box office-grossing movies of each year from 1996-2009, alcohol
21 brand placement increased in prevalence approximately 5% each year and was featured in 41%
22 of top movies rated G, PG, PG-13 for children/adolescents, in direct violation of self-imposed
23 industry standards^{6,7}; and
24

25 Whereas, Alcohol brand appearances in youth-rated movies trended upward from 1996 to 2009,
26 increasing from 80 to 145 per year, an increase of 5.2 appearances per year, indicating
27 increased alcohol industry expenditure on brand placement in these movies⁷; and
28

29 Whereas, According to a 2015 report put forward by The Beer Institute, an American trade
30 association which represents the alcohol industry's interests before Congress, the Institute
31 alleges that the industry's marketing efforts direct consumer attention toward particular brands
32 but do not encourage drinking in any segment of the population⁸; and
33

34 Whereas, A 2016 review of recent studies showed evidence of a dose-dependent relationship
35 between youth alcohol marketing exposure and subsequent initiation of drinking/progression to
36 binge drinking behaviors⁴; and
37

38 Whereas, A 2020 study demonstrated that global alcohol sales totaled over \$1.5 trillion, with the
39 most spending focused in countries with limited industry marketing regulation and high youth
40 alcohol marketing exposure levels¹¹; and

Whereas, In regions of the world where the alcohol industry has self-regulated marketing codes, youth have consistently higher exposure to alcohol marketing¹⁰; and

Whereas, The youth population is considered a cohort particularly susceptible to socialization-based advertising techniques frequently employed by the alcohol industry, wherein products are intentionally paired with agents of socialization in order to create favorable associations between the two in consumers' minds, including through product placement near to or usage by popular television characters, social media campaigns, and the sponsorship of sporting teams, events, and celebrities¹¹⁻¹³; and

Whereas, The Master Settlement Agreement (MSA) was reached in 1999 between 46 state attorneys general and 4 tobacco manufacturers to resolve the largest class action lawsuit in American history; among its provisions, the MSA: forced the tobacco industry to make concessions/admissions of guilt regarding the ways in which their advertising practices disproportionately targeted the youth population, placed restrictions on advertising venues for the tobacco industry, and mandated that the industry pay out 206 billion dollars in reparations^{14,15}; and

Whereas, Prior to the MSA, the tobacco industry had self-regulatory standards for advertising practices, identical in nature to the current status of the alcohol industry^{14,15}; and

Whereas, Following the MSA, youth cigarette usage has now dropped to the lowest levels seen in decades¹⁶; and

Whereas, A WHO Global Status Report on international alcohol policy demonstrated that up to 56% of countries worldwide have alcohol marketing regulations to protect youth and other vulnerable populations from the harmful effects of alcohol marketing¹⁷; and

Whereas, The United Nations Convention on the Rights of the Child declares it the responsibility of sovereign nations to create appropriate guidelines to protect children from information and material injurious to their wellbeing¹⁸; and

Whereas, A 2017 study demonstrated that there is no effective system currently in place to remove- or enforce punitive measures for production of- advertisements deemed "non-compliant" to the American alcohol industry's self-imposed 'youth-protective' advertising regulations^{9,10}; therefore be it

RESOLVED, That our American Medical Association amend policy H-30.940, "Labeling Advertising, and Promotion of Alcoholic Beverages," by addition and deletion to read as follows:

H-30.940, Labeling, Advertising, and Promotion of Alcoholic Beverages

(1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of

1 federal legislation to require nutritional labels on alcoholic beverages in accordance
2 with the Nutritional Labeling and Education Act.

3 (2.) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by
4 persons under 21 years of age, which creates an image of drinking alcoholic
5 beverages and thereby may encourage the illegal underaged use of alcohol; (b)
6 recommends that health education labels be used on all alcoholic beverage containers
7 and in all alcoholic beverage advertising (with the messages focusing on the hazards
8 of alcohol consumption by specific population groups especially at risk, such as
9 pregnant women, as well as the dangers of irresponsible use to all sectors of the
10 populace); and (c) recommends that the alcohol beverage industry be encouraged to
11 accurately label all product containers as to ingredients, preservatives, and ethanol
12 content (by percent, rather than by proof).

13 (3.) Actively supports and will work for a total statutory prohibition of advertising of all
14 alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal,
15 our AMA (a) supports federal and/or state oversight for all forms of alcohol advertising
16 in lieu of the alcohol industry's current practice of self-regulated advertising and
17 marketing; ~~(a)~~(b) supports continued research, educational, and promotional activities
18 dealing with issues of alcohol advertising and health education to provide more
19 definitive evidence on whether, and in what manner, advertising contributes to alcohol
20 abuse; ~~(b)~~(c) opposes the use of the radio and television any form of advertising which
21 links alcoholic products to agents of socialization in order to promote drinking; ~~(e)~~(d)
22 will work with state and local medical societies to support the elimination of advertising
23 of alcoholic beverages from all mass transit systems; ~~(d)~~(e) urges college and
24 university authorities to bar alcoholic beverage companies from sponsoring athletic
25 events, music concerts, cultural events, and parties on school campuses, and from
26 advertising their products or their logo in school publications; and ~~(e)~~(f) urges its
27 constituent state associations to support state legislation to bar the promotion of
28 alcoholic beverage consumption on school campuses and in advertising in school
29 publications.

30 (4.) (a) Urges producers and distributors of alcoholic beverages to discontinue all
31 advertising directed toward youth, including ~~such as~~ promotions on high school and
32 college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating
33 television program content that depicts the irresponsible use of alcohol without
34 showing its adverse consequences (examples of such use include driving after
35 drinking, drinking while pregnant, or drinking to enhance performance or win social
36 acceptance); (e) supports continued warnings against the irresponsible use of alcohol
37 and challenges the liquor, beer, and wine trade groups to include in their advertising
38 specific warnings against driving after drinking; and (f) commends those automobile
39 and alcoholic beverage companies that have advertised against driving while under
40 the influence of alcohol. (Modify Current HOD Policy)

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

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RELEVANT AMA POLICY

AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages H-30.940 Our AMA:

- (1) (a) supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.
- (2) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underage use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace); (c) recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof); and (d) advocates that the alcohol beverage industry be required to include pictorial health warnings on alcoholic beverages.
- (3) actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; (b) opposes the use of the radio and television to promote drinking; (c) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; (d) urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and (e) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on

school campuses and in advertising in school publications.

(4) (a) urges producers and distributors of alcoholic beverages to discontinue advertising directed toward youth, such as promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (c) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking; and (d) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol.

(5) will advocate for the implementation of pictorial health warnings on alcoholic beverages.

Citation: CSA Rep. 1, A-04; Reaffirmation A-08; Reaffirmed: CSAPH Rep. 01, A-18; Modified: Res. 427, A-22

Prevention of Underage Drinking: A Call to Stop Alcoholic Beverages with Special Appeal to Youths D-60.973

1. Our AMA will advocate for a ban on the marketing of products such as flavored malt liquor beverages, gelatin-based alcohol products, food-based alcohol products, alcohol mists, and beverages that contain alcohol and caffeine and other additives to produce alcohol energy drinks that have special appeal to youths under the age of 21 years of age.
2. Our AMA supports state and federal regulations that would reclassify flavored malt liquor beverages as a distilled spirit so that it can be taxed at a higher rate and cannot be advertised or sold in certain locations.

Citation: Res. 435, A-07; BOT Action in response to referred for decision Res. 411, A-08; Reaffirmed in lieu of Res. 902, I-09; Modified: CSAPH Rep. 01, A-19

Alcohol and Youth D-170.998

Our AMA will work with the appropriate medical societies and agencies to draft legislation minimizing alcohol promotions, advertising, and other marketing strategies by the alcohol industry aimed at adolescents.

Citation: Res. 415, I-01; Reaffirmation A-08; Reaffirmed: CSAPH Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 919
(I-22)

Introduced by: Medical Student Section

Subject: Decreasing Youth Access to E-cigarettes

Referred to: Reference Committee K

1 Whereas, The Centers for Disease Control and Prevention (CDC) defines an “e-cigarette” (also
2 known as “e-cig,” “e-hookah,” “mod,” “vape pen,” “vape,” “tank system,” and “electronic nicotine
3 delivery system”) as a device that produces an aerosol by heating a liquid that usually contains
4 nicotine, flavorings, and other chemicals, such as diacetyl, volatile organic compounds, and
5 heavy metals, that help to make the aerosol¹; and
6

7 Whereas, Per the CDC, the act of using this device is termed as “vaping,” which allows for
8 ultrafine particles to be inhaled deeply into the lungs¹; and
9

10 Whereas, Youth use of electronic cigarettes is widespread in the US, with 10.5% of middle
11 school students and 27.5% of high school students reporting in 2019 that they used electronic
12 cigarettes in the past 30 days²⁻⁵; and
13

14 Whereas, From July 2019 through February 2020, electronic cigarette, or vaping, product use-
15 associated lung injury (EVALI) resulted in the hospitalization of 2,807 people across the United
16 States and at least 68 deaths, with a majority of affected patients being under 25 years of age⁶;
17 and
18

19 Whereas, A single cartridge of the e-cigarettes used by the majority of US youth has a nicotine
20 content equivalent to roughly 20 combustible cigarettes, and nicotine has been determined to be
21 a highly addictive substance that can adversely harm the developing adolescent brain^{4,7}; and
22

23 Whereas, The safety and health effects of long-term inhalation of the volatile organic
24 compounds, heavy metals, and known cancer-causing agents contained in e-cigarettes are
25 currently unknown⁸; and
26

27 Whereas, The Food and Drug Administration (FDA)’s restrictions on flavored e-cigarettes
28 passed in February 2020 narrowly targeted pre-filled cartridge-based vaping devices and do not
29 apply to disposable or refillable tank-based products based on the FDA’s “interest in balancing
30 between preventing youth usage and preserving options for adults trying to transition away from
31 combustible products”^{9,10}; and
32

33 Whereas, Existing AMA-MSS policy 490.025MSS “acknowledges the known harms of electronic
34 nicotine delivery systems, particularly their ineffectiveness of smoking cessation devices” and
35 existing AMA policy D-495.992 acknowledges the insufficiency of data on the safety and
36 effectiveness of e-cigarettes products for tobacco cessation purposes; and
37

38 Whereas, Recent news reports suggest an immediate increase in youth use of flavored
39 disposable e-cigarettes in response the FDA’s restrictions on cartridge-based e-cigarettes^{11,12};
40 and

1 Whereas, Prior to the recent popularity of cartridge-based devices, refillable tank-based devices
2 were the most popular e-cigarette type among youth, with 51.8% of youth using tank-based e-
3 cigarettes as compared to 47.1% using cartridge-based e-cigarettes in 2017^{10,13}; and
4

5 Whereas, Disposable e-cigarettes and tank-based devices contain the same ingredients as
6 cartridge-based devices and are considered by the CDC to be in the same overarching category
7 as cartridge-based devices¹; and
8

9 Whereas, Despite use of e-liquids with the same nicotine concentration, modifiable tank-based
10 e-cigarette products are thought to deliver higher levels of nicotine as compared to other e-
11 cigarette products¹⁴; and
12

13 Whereas, High tobacco retailer density increases access to tobacco products and the likelihood
14 of smoking initiation, particularly among youth because identification is requested less often,
15 prices decrease due to increased competition, and there are more advertisements that
16 incentivize purchase in high-density tobacco retail areas¹⁵⁻¹⁸; and
17

18 Whereas, Experimental smoking among high school-aged minors increases when tobacco
19 retailers are closer to schools and densely populate those locations^{19,20}; and
20

21 Whereas, Higher tobacco retailer densities proximal to schools and homes are
22 disproportionately prevalent in low-income communities and communities of color, posing a
23 significant public health injustice, and policies banning tobacco product sales near schools have
24 been projected to reduce or eliminate existing disparities in tobacco retailer density by income
25 level and by proportion of African American residents^{17,21,22}; and
26

27 Whereas, Proximity-based point of sale laws that restrict sale of tobacco or opening of new
28 tobacco retailers within a certain distance of schools, playgrounds, parks, libraries, and existing
29 retailers have been successfully implemented in California, Illinois, Louisiana, and Rhode
30 Island²³⁻²⁸; and
31

32 Whereas, E-cigarette marketing in the US contains features that are particularly more appealing
33 to youth, and youth exposed to e-cigarette advertisements are significantly more likely to initiate
34 vaping^{29,30}; and
35

36 Whereas, E-cigarette package warning labels that communicate the health risks of e-cigarettes
37 can reduce students' intention to use e-cigarettes and increase perceived risks of e-cigarette
38 use³¹; and
39

40 Whereas, Adolescents who vape e-cigarettes in nontraditional flavors are more likely to continue
41 vaping and take more puffs per vaping occasion, compared with those who exclusively vaped
42 tobacco-flavored, mint- or menthol-flavored, or flavorless e-cigarettes³²; therefore be it
43

44 RESOLVED, That our American Medical Association support the inclusion of disposable and
45 tank-based e-cigarettes in the language and implementation of any restrictions that are applied
46 by the Food and Drug Administration or other bodies to cartridge-based e-cigarettes (New HOD
47 Policy); and be it further

1 RESOLVED, That AMA policy H-495.986, "Tobacco Product Sales and Distribution," be
2 amended by addition to read as follows:

3
4 **Tobacco Product Sales and Distribution, H-495.986**

5 Our AMA:

6 (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and
7 will actively work with the Food and Drug Administration and other relevant stakeholders
8 to counteract the marketing and use of addictive e-cigarette and vaping devices, including
9 but not limited to bans and strict restrictions on marketing to minors under the age of 21;

10 (2) encourages the passage of laws, ordinances and regulations that would set the
11 minimum age for purchasing tobacco products, including electronic nicotine delivery
12 systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws
13 prohibiting the sale of tobacco products to minors;

14 (3) supports the development of model legislation regarding enforcement of laws
15 restricting children's access to tobacco, including but not limited to attention to the
16 following issues: (a) provision for licensure to sell tobacco and for the revocation thereof;
17 (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to
18 deter violation of laws restricting children's access to and possession of tobacco; (c)
19 requirements for merchants to post notices warning minors against attempting to
20 purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to
21 facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f)
22 requiring tobacco purchasers and vendors to be of legal smoking age;

23 (4) requests that states adequately fund the enforcement of the laws related to tobacco
24 sales to minors;

25 (5) opposes the use of vending machines to distribute tobacco products and supports
26 ordinances and legislation to ban the use of vending machines for distribution of tobacco
27 products;

28 (6) seeks a ban on the production, distribution, and sale of candy products that depict or
29 resemble tobacco products;

30 (7) opposes the distribution of free tobacco products by any means and supports the
31 enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco
32 products by mail;

33 (8) (a) publicly commends (and so urges local medical societies) pharmacies and
34 pharmacy owners who have chosen not to sell tobacco products, and asks its members
35 to encourage patients to seek out and patronize pharmacies that do not sell tobacco
36 products; (b) encourages other pharmacists and pharmacy owners individually and
37 through their professional associations to remove such products from their stores; (c)
38 urges the American Pharmacists Association, the National Association of Retail
39 Druggists, and other pharmaceutical associations to adopt a position calling for their
40 members to remove tobacco products from their stores; and (d) encourages state medical
41 associations to develop lists of pharmacies that have voluntarily banned the sale of
42 tobacco for distribution to their members; and

43 (9) opposes the sale of tobacco at any facility where health services are provided; and

44 (10) supports that the sale of tobacco products be restricted to tobacco specialty stores.

45 (11) supports measures that prevent retailers from opening new tobacco specialty stores
46 in proximity to elementary schools, middle schools, and high schools; and

47 (12) support measures that decrease the overall density of tobacco specialty stores,
48 including but not limited to, preventing retailers from opening new tobacco specialty
49 stores in proximity to existing tobacco specialty stores. (Modify Current HOD Policy)

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

Received: 10/11/22

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RELEVANT AMA POLICY

Tobacco Prevention and Youth H-490.914

Our AMA:

- (1) (a) urges the medical community, related groups, educational institutions, and government agencies to demonstrate more effectively the health hazards inherent in the use of tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco); (b) encourages state and local medical societies to actively advise municipalities and school districts against use of health education material sponsored or distributed by the tobacco industry; and (c) publicly rejects the tobacco industry as a credible source of health education material;
- (2) opposes the use of tobacco products of any kind in day care centers or other establishments where pre-school children attend for educational or child care purposes;
- (3) advises public and private schools about the very early smoking habits observed in children and encourages appropriate school authorities to prohibit the use of all tobacco products in elementary through senior high school by anyone during the school day and during other school-related activities;
- (4) (a) supports the concept that a comprehensive health education program stressing health maintenance be part of the required curriculum through 12th grade to: (i) help pre-teens, adolescents, and young adults avoid the use of tobacco products, including smokeless tobacco; and (ii) emphasize the benefits of remaining free of the use of tobacco products; (b) will work with other public and private parties to actively identify and promote tobacco prevention programs for minors and encourages the development, evaluation, and incorporation of appropriate intervention programs, including smoking cessation programs, that are tailored to the needs of children; and (c) recommends that student councils and student leaders be encouraged to join in an anti-smoking campaign.
- (5) urges state medical societies to promote the use of appropriate educational films and educational programs that reduce tobacco use by young people;
- (6) (a) favors providing financial support to promising behavioral research into why people, especially youth, begin smoking, why they continue, and why and how they quit; (b) encourages research into further reducing the risks of cigarette smoking; and (c) continues to support research and education programs, funded through general revenues and private sources, that are concerned with health problems associated with tobacco and alcohol use;
- (7) opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products, as youth are particularly susceptible;
- (8) supports working with appropriate organizations to develop a list of physicians and others recommended as speakers for local radio and television to discuss the harmful effects of tobacco usage and to advocate a tobacco-free society; and
- (9) commends the following entities for their exemplary efforts to inform the Congress, state legislatures, education officials and the public of the health hazards of tobacco use: American Cancer Society, American Lung Association, American Heart Association, Action on Smoking and Health, Inc., Groups Against Smoker's Pollution, National Congress of Parents and Teachers, National Cancer Institute, and National Clearinghouse on Smoking (HEW).

Citation: (CSA Rep. 3, A-04; Modified: Res. 402, A-13

FDA Regulation of Tobacco Products H-495.988

1. Our AMA: (A) acknowledges that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health, and that there is no such thing as a safe cigarette; (B) recognizes that currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless and increases youth risk of using combustible tobacco cigarettes; (C) encourages long-term studies of vaping (the use of electronic nicotine delivery systems) and recognizes that complete cessation of the use of tobacco and nicotine-related products is the goal; (D) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (E) reaffirms its position that the Food and Drug Administration (FDA) does, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (F) strongly supports the substance of the August 1996 FDA regulations

intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (G) urges Congress to pass legislation to phase in the production of reduced nicotine content tobacco products and to authorize the FDA have broad-based powers to regulate tobacco products; (H) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; and (I) strongly opposes legislation which would undermine the FDA's authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA's authority to regulate tobacco products.

2. Our AMA: (A) supports the US Food and Drug Administration (FDA) as it takes an important first step in establishing basic regulations of all tobacco products; (B) strongly opposes any FDA rule that exempts any tobacco or nicotine-containing product, including all cigars, from FDA regulation; and (C) will join with physician and public health organizations in submitting comments on FDA proposed rule to regulate all tobacco products.

3. Our AMA: (A) will continue to monitor the FDA's progress towards establishing a low nicotine product standard for tobacco products and will submit comments on the proposed rule that are in line with the current scientific evidence and (B) recognizes that rigorous and comprehensive post-market surveillance and product testing to monitor for unintended tobacco use patterns will be critical to the success of a nicotine reduction policy.

Citation: CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Appended: Res. 234, A-12; Reaffirmation A-13; Modified: Res. 402, A-13; Modified: Speakers Rep., A-14; Appended: Res. 420, A-14; Reaffirmation A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed in lieu of: Res. 412, A-19; Modified: CSAPH Rep. 03, A-19;

Opposition to Addition of Flavors to Tobacco Products H-495.971

Our AMA: (1) supports state and local legislation to prohibit the sale or distribution of all flavored tobacco products, including menthol, mint and wintergreen flavors; (2) urges local and state medical societies and federation members to support state and local legislation to prohibit the sale or distribution of all flavored tobacco products; and (3) encourages the FDA to prohibit the use of all flavoring agents in tobacco products, which includes electronic nicotine delivery systems as well as combustible cigarettes, cigars and smokeless tobacco.

Citation: CSAPH Rep. 01, A-18; Modified: Res. 916, I-18; Modified: Res. 918, I-19

Electronic Cigarettes, Vaping, and Health H-495.972

1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly.

2. Our AMA: (a) encourages further clinical and epidemiological research on e-cigarettes; (b) supports education of the public on the health effects, including toxins and carcinogens of electronic nicotine delivery systems (ENDS) including e-cigarettes; and (c) recognizes that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction.

3. Our AMA supports legislation and associated initiatives and will work in coordination with the Surgeon General to prevent e-cigarettes from reaching youth and young adults through various means, including, but not limited to, CDC research, education and a campaign for preventing and reducing use by youth, young adults and others of e-cigarettes, and combustible and emerging tobacco products.

Citation: CSAPH Rep. 2, I-14; Modified in lieu of Res. 412, A-15; Modified in lieu of Res. 419, A-15; Reaffirmed: Res. 421, A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed: CSAPH Rep. 03, A-19; Appended: Res. 428, A-19

FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973

Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 21; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth; and (3) urges federal officials, including but not limited to the U.S. Food and Drug Administration to: (a) prohibit the sale of any e-cigarette cartridges and e-liquid refills that do not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling); and (b) require that an accurate nicotine content of e-cigarettes, e-cigarette cartridges, and e-liquid refills be prominently displayed on the product alongside a warning of the addictive quality of nicotine.

Citation: Res. 206, I-13; Modified in lieu of Res. 511, A-14; Modified in lieu of Res. 518, A-14; Modified in lieu of Res. 519, A-14; Modified in lieu of Res. 521, A-14; Modified: CSAPH Rep. 2, I-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 412, A-15; Reaffirmed in lieu of Res. 419, A-15; Reaffirmed: Res. 421, A-15; Reaffirmation A-16; Appended: Res. 429, A-18; Modified: CSAPH Rep. 05, A-18; Reaffirmation: I-19

Tobacco Advertising and Media H-495.984

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 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;
- (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;
- (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;

- (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;
- (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;
- (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;
- (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
- (14) encourages the motion picture industry to apply an "R" rating to all new films depicting cigarette smoking and other tobacco use.
- Citation: (CSA Rep. 3, A-04; Appended: Res. 427, A-04; Reaffirmation A-05; Reaffirmation A-14

Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986

H-495.986 Tobacco Product Sales and Distribution

Our AMA:

- (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;
- (2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
- (3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;
- (4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;
- (5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;
- (6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;
- (7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;
- (8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and

- (9) opposes the sale of tobacco at any facility where health services are provided; and
- (10) supports that the sale of tobacco products be restricted to tobacco specialty stores.

Citation: CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 817, I-07; Reaffirmation A-08; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Modified in lieu of Res. 421, A-15; Modified in lieu of Res. 424, A-15; Reaffirmation I-16; Appended: Res. 926, I-18; Reaffirmation: I-19

Tobacco Product Labeling H-495.989

Our AMA: (1) supports requiring more explicit and effective health warnings, such as graphic warning labels, regarding the use of tobacco (and alcohol) products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco, and ingredients of tobacco products sold in the United States); (2) encourages the Food and Drug Administration, as required under Federal law, to revise its rules to require color graphic warning labels on all cigarette packages depicting the negative health consequences of smoking; (3) supports legislation or regulations that require (a) tobacco companies to accurately label their products, including electronic nicotine delivery systems (ENDS), indicating nicotine content in easily understandable and meaningful terms that have plausible biological significance; (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the United States; (c) an increase in the size of warning labels to include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack of cigarettes to carry a legible, boxed warning such as: "Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;" (4) urges the Congress to require that: (a) warning labels on cigarette packs should appear on the front and the back and occupy twenty-five percent of the total surface area on each side and be set out in black-and-white block; (b) in the case of cigarette advertisements, warning labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (c) warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets; and (5) supports requiring warning labels on all ENDS products, starting with the warning that nicotine is addictive.

Citation: CSA Rep. 3, A-04; Modified: Res. 402, A-13; Modified: Res. 925, I-16; Modified: Res. 428, A-19

Legal Action to Compel FDA to Regulate E-Cigarettes D-495.992

1. Our AMA will consider joining other medical organizations in an amicus brief supporting the American Academy of Pediatrics legal action to compel the U.S. Food and Drug Administration to take timely action to establish effective regulation of e-cigarettes, cigars and other nicotine tobacco products.

2. Our AMA will: (a) urgently advocate for regulatory, legislative, and/or legal action at the federal and/or state levels to ban the sale and distribution of all e-cigarette and vaping products, with the exception of those which may be approved by the FDA for tobacco cessation purposes and made available by prescription only; and (b) will advocate for research funding to sufficiently study the safety and effectiveness of e-cigarette and vaping products for tobacco cessation purposes.

Citation: Res. 432, A-18; Appended: Res. 910, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 920
(I-22)

Introduced by: Medical Student Section

Subject: Mitigating Environmental Contributors to Disease and Sustainability of AMA
National Meetings

Referred to: Reference Committee K

1 Whereas, Environmental health is defined as the science and practice of preventing the direct
2 and indirect adverse effects of hazardous agents on health and wellbeing^{1,2}; and
3

4 Whereas, A 2018 report by the World Health Organization (WHO) on the burden of disease
5 from environmental risks estimated that approximately thirteen million deaths worldwide could
6 be attributed to preventable environmental factors and 24% of global deaths were due to
7 modifiable environmental factors³; and
8

9 Whereas, Environmental justice is defined as the principle that all people and communities
10 regardless of race, color, national origin, or income, are entitled to equal protection by
11 environmental and public health laws and regulations, while environmental injustice describes
12 environmental laws, regulations and policies that overly affect a group of people resulting in
13 greater exposure to environmental hazards⁴; and
14

15 Whereas, Environmental racism refers to a type of environmental injustice in which the racial
16 and ethnic contexts of environmental regulations and policies, exposures, support structures,
17 and health outcomes cause inequitable environmental hazards for some racial groups^{5,6}; and
18

19 Whereas, Low-income and minoritized communities are burdened by environmental injustice in
20 that they reside in areas with higher environmental exposures, reduced preventive measures,
21 and limited medical intervention, further exacerbating health outcome disparities⁷⁻¹¹; and
22

23 Whereas, The enactment of exclusionary housing policies, including zoning ordinances,
24 restrictive covenants, blockbusting, steering, and redlining, purposefully created racial
25 segregation, exposed Black communities to environmental pollutants and targeting for
26 construction of toxin-releasing facilities, isolated them from essential health resources such as
27 healthy food options, hospitals, and green spaces, and permitted health inequities to
28 concentrate in disadvantaged low-income neighborhoods¹²⁻¹⁶; and
29

30 Whereas, The environmental justice and fair housing collaboration between the Environmental
31 Protection Agency (EPA) and U.S. Department of Housing and Urban Development (HUD)
32 remains inadequate due to insufficient action to provide non-discriminatory and affordable
33 housing units in locations without risk of environmental health exposures¹⁷; and
34

35 Whereas, A combination of inequitable land-use policies, lack of environmental regulation and
36 enforcement, and market forces in petrochemical and heavy metal industries have contributed
37 to the perpetuation of poverty and worse health outcomes in minoritized populations¹⁸; and

Whereas, Proximity to and exposure to hazards from the oil and gas, plastics, animal production, chemical manufacturing, endocrine-disrupting chemicals, and metal industries have been strongly linked to at least one of the following: neural tube defects, preterm birth, low-birth weight, diffuse interstitial lung fibrosis, chronic bronchitis, asthma exacerbation, diabetes, hypertension secondary to chronic inflammation, pneumonia, reduced child cognition from heavy metal exposure, neurologic diseases, cancers, hyperlipidemia, and thyroid disease¹⁹⁻²⁸; and

Whereas, Closures of industrial sites and reductions in pollution have been linked to improved fertility and reduced preterm births and respiratory hospitalizations²⁹⁻³¹; and

Whereas, Recent natural disasters such as hurricanes, the over 1,500 oil spills from the Dakota Access Pipeline and the Keystone Pipeline in the last decade alone, the Texas freeze, and states' responses to these natural disasters perpetuate environmental injustice by disproportionately affecting predominantly minoritized and low-income communities³²⁻³⁷; and

Whereas, The health of American Indian tribes depends on essential natural resources that have either been depleted and/or contaminated by mining and oil corporations, leading to adverse health outcomes³⁸⁻⁴¹; and

Whereas, Government agencies have failed to act on current policy and integrate current environmental science research or expertise into ongoing environmental regulations and public health initiatives, resulting in continued and amplified environmental hazards and failing to protect people, especially in Black and American Indian communities, from known and predictable environmental health dangers⁴²⁻⁴⁹; and

Whereas, Climate change represents an important tenet of environmental health that can significantly impact public and community health⁵⁰; and

Whereas, The United States healthcare system alone is responsible for 10% of national greenhouse gas emissions and, if it were its own country, it would be the 13th largest producer of greenhouse gas emissions in the world^{50,51}; and

Whereas, Extreme weather and climate events have significantly increased healthcare spending in the United States, with \$14 billion in additional spending through 760,000 additional patient encounters and 1,689 premature deaths between 2000 and 2009⁵²⁻⁵³; and

Whereas, The Intergovernmental Panel on Climate Change (IPCC) has determined it is possible to avoid warming past 1.5°C above pre-industrial levels by 2100 if extreme measures are taken to curtail anthropogenic emissions⁵⁴; and

Whereas, If global warming exceeds 1.5°C, the estimated global effects include 92,207 additional heat-related deaths per year by 2030, 350 million more humans exposed to severe heat by 2050, and 31 to 69 million humans exposed to flooding from sea level rise by 2100⁵⁴; and

Whereas, Compared to no action, limiting global warming to less than 1.5°C would result in ~50% lower annual health-related costs and prevention of ~50% of infectious disease cases in the United States by 2100^{52,53}; and

1 Whereas, The IPCC has estimated that limiting global warming to 1.5°C would require “global
2 net human-caused emissions of carbon dioxide to fall by about 45 percent from 2010 levels by
3 2030, and reach net zero by approximately 2050”⁵⁴; and
4

5 Whereas, IPCC defines net zero emissions as a state where anthropogenic emissions of
6 greenhouse gasses (GHG) are balanced by anthropogenic removals of GHG over a specific
7 time period⁵²; and
8

9 Whereas, Setting emissions targets is an essential part of carbon abatement, and many non-
10 profit organizations, large corporations, and countries have committed to carbon neutrality for
11 their business operations by a date certain in order to improve their business efficiencies and to
12 foster the development of carbon neutral practices⁵⁵⁻⁵⁷; and
13

14 Whereas, Multiple organizations in the healthcare industry have committed to becoming carbon
15 neutral on or before 2030, including Harvard Medical School and its affiliated hospitals, all
16 University of California campus and medical centers, the Cleveland Clinic, and Kaiser-
17 Permanente⁵⁸⁻⁶¹; and
18

19 Whereas, Other professional organizations, including the Association of Energy Services
20 Professionals, and International Federation of Medical Students’ Associations have committed
21 to making their conferences carbon neutral^{62,63}; and
22

23 Whereas, Our AMA has set discrete benchmark dates for achieving goals in other settings,
24 including child blood lead levels (H-60.924), accreditation of health care service providers in jails
25 (D-430.997), and disaggregation of demographic data (H-350.954); and
26

27 Whereas, Our AMA recognizes that racism, in all its forms, is an urgent public health threat, and
28 has pledged to work to combat the adverse health effects of racism (H-65.952); and
29

30 Whereas, Our AMA has substantial policy recognizing the impacts of climate change,
31 committing to sustainable business operations, emphasizing the importance of physician
32 leadership regarding climate change, encouraging the study of environmental causes of
33 disease, and encouraging other stakeholders in healthcare to practice environmental
34 responsibility, but has no explicit emissions goal and no way to account for progress towards
35 environmental sustainability (H-135.938, H-135.923, G-630.100, D-135.997, H-135.973);
36 therefore be it

1 RESOLVED, That our American Medical Association amend Policy D-135.997, "Research into
2 the Environmental Contributors to Disease," by addition and deletion to read as follows:

3
4 **Research into the Environmental Contributors to Disease and Advocating for**
5 **Environmental Justice D-135.997**

6 Our AMA will (1) advocate for greater public and private funding for research into
7 the environmental causes of disease, and urge the National Academy of Sciences
8 to undertake an authoritative analysis of environmental causes of disease; (2) ask
9 the steering committee of the Medicine and Public Health Initiative Coalition to
10 consider environmental contributors to disease and environmental racism as a
11 priority public health issues; (3) encourage federal, state, and local agencies to
12 address and remediate environmental injustice, environmental racism, and all other
13 environmental conditions that are adversely impacting health, especially in
14 marginalized communities; and (4) lobby Congress to support ongoing initiatives
15 that include reproductive health outcomes and development particularly in minority
16 populations in Environmental Protection Agency Environmental Justice policies
17 (Modify Current HOD Policy); and be it further

18
19 RESOLVED, That our AMA commit to reaching net zero emissions for its business operations
20 by 2030, and remain net zero or net negative, as defined by a carbon neutral certifying
21 organization (Directive to Take Action); and be it further

22
23 RESOLVED, That our AMA create educational programs for and encourage the United States
24 healthcare system, including but not limited to hospitals, clinics, ambulatory care centers, and
25 healthcare professionals, to decrease emissions to half of 2010 levels by 2030 and become net
26 zero by 2050, and remain net zero or negative, as defined by a carbon neutral certifying
27 organization (Directive to Take Action); and be it further

28
29 RESOLVED, That our AMA report the progress on implementing this resolution at each Annual
30 Meeting hereafter. (Directive to Take Action)

Fiscal Note: Estimated cost of \$125K to implement resolution.

Received: 10/11/22

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RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health

infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

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

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

Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22

Global Climate Change - The "Greenhouse Effect" H-135.977

Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting;

(2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;

(3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity;

(4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and

(5) encourages humanitarian measures to limit the burgeoning increase in world population.

Citation: (CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14)

AMA Advocacy for Environmental Sustainability and Climate H-135.923

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.

Citation: Res. 924, I-16; Reaffirmation: I-19

Stewardship of the Environment H-135.973

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation; (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921

1. Our AMA will: (a) choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and (b) support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.
2. Our AMA: (a) declares that climate change is an urgent public health emergency, and calls upon all governments, organizations, and individuals to work to avert catastrophe; (b) urges all health and life insurance companies, including those that provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; and (c) will send letters to the nineteen largest health or life insurance companies in the United States to inform them of AMA policies concerned with climate change and with fossil fuel divestments, and urging these companies to divest.

Citation: BOT Rep. 34, A-18; Appended: Res. 607, A-22

Support of Clean Air and Reduction in Power Plant Emissions H-135.949

1. Our AMA supports (a) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (b) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.
2. Our AMA will: (a) support the Environmental Protection Agency's proposal, under the Clean Air Act, to regulate air quality for heavy metals and other air toxins emitted from smokestacks. The risk of dispersion through air and soil should be considered, particularly for people living downwind of smokestacks; and (b) urge the EPA to finalize updated mercury, cadmium, and air toxic regulations for monitoring air quality emitted from power plants and other industrial sources, ensuring that recommendations to protect the public's health are enforceable.

Citation: Res. 429, A-03; Reaffirmation I-07; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Modified: Res. 506, A-15; Modified: Res. 908, I-17; Appended: Res. 401, A-22

EPA and Green House Gas Regulation H-135.934

1. Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house gas emissions in the United States.
2. Our AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification.

Citation: Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Appended: Res. 523, A-17

Conservation, Recycling and Other "Green" Initiatives G-630.100

AMA policy on conservation and recycling include the following: (1) Our AMA directs its offices to implement conservation-minded practices whenever feasible and to continue to participate in "green" initiatives. (2) It is the policy of our AMA to use recycled paper whenever reasonable for its in-house printed matter and publications, including JAMA, and materials used by the House of Delegates, and that AMA printed material using recycled paper should be labeled as such. (3) During meetings of the American Medical Association House of Delegates, our AMA Sections, and all other AMA meetings, recycling bins, where and when feasible, for white (and where possible colored) paper will be made prominently available to participants. Citation: CCB/CLRPD Rep. 3, A-12; Modified: Speakers Rep., A-15; Reaffirmed: CCB/CLRPD Rep. 1, A-22

Disaggregation of Demographic Data Within Ethnic Groups H-350.954

1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.

2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.

Citation: Res. 001, I-17; Appended: Res. 403, A-19

Reducing Lead Poisoning H-60.924

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

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

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

4. Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply.

Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 926, I-16; Appended: Res. 412, A-17

Pollution Control and Environmental Health H-135.996

Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.

Citation: Sub. Res. 40, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00;
Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Research into the Environmental Contributors to Disease D-135.997

Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

Citation: Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of: Res. 505, A-19

Environmental Health Programs H-135.969

Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees.

Citation: Res. 124, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Federal Programs H-135.999

The AMA believes that the problem of air pollution is best minimized through the cooperative and coordinated efforts of government, industry and the public. Current progress in the control of air pollution can be attributed primarily to such cooperative undertakings. The Association further believes that the federal government should play a significant role in these continuing efforts. This may be done by federal grants for (1) the development of research activity and (2) the encouragement of local programs for the prevention and control of air pollutants.

Citation: BOT Rep. M, A-63; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98;
Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17

Racism as a Public Health Threat H-65.952

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 921
(I-22)

Introduced by: American Academy of Pediatrics

Subject: Firearm Injury and Death Research and Prevention

Referred to: Reference Committee K

1 Whereas, The 1996 Dickey Amendment led to a near 25 year prohibition on federal funding for
2 research into gun violence and prevention; and

3
4 Whereas, Congressional funding for research into firearm injury prevention has remained flat at
5 \$25 million annually despite federal budget requests for increased dollars; and

6
7 Whereas, This lack of funding and research has impeded our ability to apply evidence-based
8 approaches to decrease firearm injuries and deaths in US children and youth; and

9
10 Whereas, The National Highway Transportation and Safety Administration has detailed
11 databases on motor vehicle crash deaths and injuries, which have been vitally important in
12 implementing interventions and ultimately decreasing motor vehicle-related death; and

13
14 Whereas, As of 2020 funding has been appropriated in all 50 states to provide data for the
15 National Violent Death Reporting System (NVDRS); and

16
17 Whereas, While the NVDRS is an important first step, a real-time surveillance system for
18 injuries, including those involving firearms, is necessary to truly understand the changing
19 dynamic of firearm injuries and death; and

20
21 Whereas, The use of state firearm registration files, including hand guns, rifles, and semi-
22 automatic weapons for research is prohibited by the 2003 Tiahrt amendment; therefore be it

23
24 RESOLVED, That our American Medical Association and all interested medical societies
25 advocate for a comprehensive national-level data system for firearm injuries and deaths
26 including real-time surveillance and continued improvements to the quality and comparability of
27 currently collected data (Directive to Take Action); and be it further

28
29 RESOLVED, That our AMA advocate for repeal of the 2003 Tiahrt amendment which prohibits
30 the release of firearm tracing data for research (Directive to Take Action); and be it further

31
32 RESOLVED, That our AMA advocate for additional federal budgetary funding for expanded
33 firearm injury and death prevention research at all appropriate federal agencies in order to
34 better understand the risk and protective factors for firearm injuries and to develop evidence-
35 based interventions at the individual, house-hold, community, state, and federal levels to
36 decrease firearm injuries and deaths. (Directive to Take Action)

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

Received: 10/13/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 922
(I-22)

Introduced by: American Academy of Pediatrics

Subject: Firearm Safety and Technology

Referred to: Reference Committee K

1 Whereas, Firearms have the highest fatality rate(>90%) compared with other methods of
2 suicide; and
3

4 Whereas, Technology advancements currently allow safety locks on cell phones ensuring only
5 authorized users can access personal cellphone data; and
6

7 Whereas, Firearms are the leading cause of death in children and youth ages 0-24 years,
8 surpassing deaths from motor vehicle crashes, since 2017; therefore be it
9

10 RESOLVED, That our American Medical Association solicit technology company interest in and
11 advocate for the design of affordable personalized “smart” gun and safety technology which
12 allow only authorized users to pull the trigger on the firearm. (Directive to Take Action)

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

Received: 10/13/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 923
(I-22)

Introduced by: American Academy of Pediatrics

Subject: Physician Education and Intervention to Improve Patient Firearm Safety

Referred to: Reference Committee K

1 Whereas, The majority of deaths from firearms (85%) in younger children ages 0-12 years occur
2 in the home; and

3
4 Whereas, Older children (13-18 years) are equally likely to be killed at home (39%) or on the
5 sidewalk/street; and

6
7 Whereas, Providing barriers to access to firearms in the home is a crucial mechanism to
8 decrease the risks of unintentional firearm shooting as well as suicide and homicide; and

9
10 Whereas, Safer storage of guns in homes includes storing the firearm unloaded, storing the
11 firearm locked, storing the ammunition separately from the firearm, and storing the ammunition
12 locked; and

13
14 Whereas, Studies have demonstrated that parents underestimate their child's response to
15 encountering an unsecured gun; and

16
17 Whereas, Studies have also demonstrated that patients and families will accept safe storage
18 devices for guns when provided by their physician; and

19
20 Whereas, In the context of suicide prevention, "lethal means counseling" means 1) assessing
21 whether a person at risk for suicide has access to a firearm or other lethal means, and 2)
22 working with them and their family and support system to limit their access to said lethal means
23 until they are no longer at elevated risk; and

24
25 Whereas, Permanent or even temporary removal of a firearm from a home with a person at risk
26 of lethal intent can prevent the injury or death from occurring; and

27
28 Whereas, In many instances firearms can be temporarily transferred to other people, stored at
29 gun clubs or shooting ranges, or stored with the local police in many localities; therefore be it

30
31 RESOLVED, That our American Medical Association and all interested medical societies
32 educate physicians about firearm epidemiology, anticipatory guidance, and lethal means
33 screening for and exploring potential restrictions to access to high-lethality means of suicide
34 such as firearms. Health care clinicians, including trainees, should be provided training on the
35 importance of anticipatory guidance and lethal means counseling to decrease firearm injuries
36 and deaths and be provided training introducing evidence-based techniques, skills and
37 strategies for having these discussions with patients and families (Directive to Take Action); and
38 be it further

1 RESOLVED, That our AMA and all interested medical societies educate physicians about lethal
2 means counseling in health care settings and intervention options to remove lethal means,
3 either permanently or temporarily from the home (Directive to Take Action); and be it further
4

5 RESOLVED, That our AMA and all interested medical societies advocate for policies that
6 support the provision of funding for physicians to provide affordable rapid-access safe storage
7 devices to patients with firearms in the home (Directive to Take Action); and be it further
8

9 RESOLVED, That our AMA and all interested medical societies educate the public about: (1)
10 best practices for firearm storage safety; (2) misconceptions families have regarding child
11 response to encountering a gun in the home; and (3) the need to ask other families with whom
12 the child interacts regarding the presence and storage of guns in other homes the child may
13 enter. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 10/13/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 924
(I-22)

Introduced by: Association for Clinical Oncology

Subject: Domestic Production of Personal Protective Equipment

Referred to: Reference Committee K

Whereas, The Biden Administration on January 21, 2021, issued an Executive Order on a Sustainable Public Health Supply Chain, directing the development of a strategy to design, build, and sustain a long-term capability in the United States to manufacture supplies for future pandemics and biological threats¹; and

Whereas, This strategy shall include an approach to develop a multi-year implementation plan for domestic production of pandemic supplies; and

Whereas, The Biden Administration on February 24, 2021, issued an Executive Order² on America's Supply Chains, ordering an examination of several critical supply chains and the issuance within 100 days of a report³ with recommendations to the White House; and

Whereas, The Centers for Medicare and Medicaid Services in July, 2022, proposed policy⁴ to enable and encourage hospitals to purchase and utilize domestically-produced N95 respirators via a payment adjustment to compensate hospitals for the additional resource costs of acquiring domestically-made NIOSH-approved surgical N95 respirators for cost reporting periods beginning on or after January 1, 2023; and

Whereas, The Association for Clinical Oncology has previously recommended⁵ that the Executive Branch identify raw materials, components, parts or accessories of critical devices that should have domestic manufacturing capacity to improve the resilience of the U.S. device supply chain and incentivize their production without limiting access to foreign sources of devices; therefore be it

RESOLVED, That our American Medical Association support state and federal incentives to locate the manufacturing of goods used in healthcare and healthcare facilities in the United States (New HOD Policy); and be it further

¹ White House. Executive Order on a Sustainable Public Health Supply Chain. 2021 Jan 21. <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/21/executive-order-a-sustainable-public-health-supply-chain/>

² White House. Executive Order on America's Supply Chains. 2021 Feb 24. <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/02/24/executive-order-on-americas-supply-chains/>

³ White House. Building Resilient Supply Chains, Revitalizing American Manufacturing, and Fostering Broad-Based Growth. 2021 June. <https://www.whitehouse.gov/wp-content/uploads/2021/06/100-day-supply-chain-review-report.pdf>

⁴ Federal Register. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating. 2022 July 26. <https://www.federalregister.gov/documents/2022/07/26/2022-15372/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment>

⁵ American Medical Association, American Society of Anesthesiologists, American Society of Health-System Pharmacists, Association for Clinical Oncology, and the United States Pharmacopeia. Improving the Quality and Resilience of the United States Healthcare Supply Chain. <https://www.ashp.org/-/media/assets/news-and-media/docs/Healthcare-Supply-Chain-Recommendations>

1 RESOLVED, That our AMA support the efforts of the Administration and CMS to encourage the
2 purchase of domestically produced personal protective equipment (New HOD Policy); and be it
3 further

4
5 RESOLVED, That our AMA reaffirm policy H-440.847, "Pandemic Preparedness." (Reaffirm
6 HOD Policy)

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

Received: 10/13/22

RELEVANT AMA POLICY

Pandemic Preparedness H-440.847

In order to prepare for a pandemic, our AMA:

- (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to a pandemic or other serious public health emergency;
- (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, anti- microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people, without overreliance on unreliable international sources of production; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to a pandemic or other serious public health emergency;
- (3) encourages states to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency;
- (4) urges the federal government to meet treaty and trust obligations by adequately sourcing medical and personal protective equipment directly to tribal communities and the Indian Health Service for effective preparedness and to respond to a pandemic or other major public emergency;
- (5) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of health care personnel in direct patient care settings;
- (6) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) continue to plan and test distribution activities in advance of a public health emergency, to assure that physicians, nurses, other health care personnel, and first responders having direct patient contact, receive any appropriate vaccination or medical countermeasure in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care provider;
- (7) will monitor progress in developing a contingency plan that addresses future vaccine production or distribution problems and in developing a plan to respond to a pandemic in the United States.

Citation: CSAPH Rep. 5, I-12; Reaffirmation A-15; Modified: Res. 415, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 925
(I-22)

Introduced by: American College of Preventive Medicine

Subject: Incorporation of Social Determinants of Health Concepts into Climate Change Work of the AMA

Referred to: Reference Committee K

1 Whereas, The World Health Organization has asserted that climate change is the single biggest
2 health threat facing humanity;¹ and
3

4 Whereas, Climate change plays a role in the more than 700 Americans dying from heat related
5 illness each year and over 11 million Americans living in counties with unhealthy levels of air
6 pollution (PM2.5);² and
7

8 Whereas, Climate change plays a role in death and illness from increasingly frequent extreme
9 weather events, such as heatwaves, storms and floods, the disruption of food systems,
10 increases in zoonoses and food-, water- and vector-borne diseases, and mental health
11 issues;^{1,3} and
12

13 Whereas, Climate change also plays a role in undermining many of the social determinants for
14 good health, such as livelihoods, equality and access to health care and social support
15 structures.¹ These climate-sensitive health risks are disproportionately suffered by the most
16 vulnerable and disadvantaged;^{1,4,5} and
17

18 Whereas, Like many other social determinants of health, the environmental impacts of climate
19 change are often affected by historical, economic, and sociopolitical factors;⁴ and
20

21 Whereas, The relationship between climate change and social inequality can be characterized
22 by a vicious cycle, whereby initial inequality makes disadvantaged groups suffer
23 disproportionately from the adverse effects of climate change, resulting in greater subsequent
24 inequality;⁶ and
25

26 Whereas, Our AMA has recently prioritized action on climate change by requesting
27 development of a strategic plan (D-135.966, last modified 2022). Furthermore, our AMA policy
28 aims to support “efforts to search for novel, comprehensive, and economically sensitive
29 approaches to mitigating climate change” (H-135.938, last modified 2022); and
30

31 Whereas, While recent policy supports incorporating upstream determinants of health into
32 individual patient care (H-135.938, last modified 2022), no policy exists to explicitly support
33 incorporating social determinants of health considerations into systems level, “novel,
34 comprehensive, and economically sensitive approaches to mitigating climate change”;
35 therefore be it

- 1 RESOLVED, That our American Medical Association consider climate change, and the
- 2 environmental impacts thereof, as social determinants of health and modifiers of other social
- 3 determinants of health in its work on systems level, “novel, comprehensive, and economically
- 4 sensitive approaches to mitigating climate change”. (New HOD Policy)

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

Received: 10/13/22

1. World Health Organization. Climate change and health. 30 October 2021. <https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health>
2. CDC. Environmental Justice Dashboard. Accessed October 2022. <https://ephrtracking.cdc.gov/Applications/ejdashboard/>
3. USGCRP, 2016: The Impacts of Climate Change on Human Health in the United States: A Scientific Assessment. Crimmins, A., J. Balbus, J.L. Gamble, C.B. Beard, J.E. Bell, D. Dodgen, R.J. Eisen, N. Fann, M.D. Hawkins, S.C. Herring, L. Jantarasami, D.M. Mills, S. Saha, M.C. Sarofim, J. Trtanj, and L. Ziska, Eds. U.S. Global Change Research Program, Washington, DC, 312 pp.
4. HHS: Office of Disease Prevention and Health Promotion. Healthy People 2030: Environmental Conditions. <https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/environmental-conditions>.
5. U.S. Global Change Research Program. FOURTH NATIONAL CLIMATE ASSESSMENT CHAPTER 14: HUMAN HEALTH. <https://nca2018.globalchange.gov/chapter/14/>
6. UNITED NATIONS: Department of Economic and Social Affairs. Climate Change and Social Inequality: DESA Working Paper No. 152. October 2017. https://www.un.org/esa/desa/papers/2017/wp152_2017.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 926
(I-22)

Introduced by: Michigan

Subject: Limit the Pornography Viewing by Minors Over the Internet

Referred to: Reference Committee K

1 Whereas, The pornography industry has developed at a fast-pace secondary to Internet
2 accessibility; and
3

4 Whereas, Explicit material is readily available on the internet; and
5

6 Whereas, The number of pornography consumers is steadily increasing, mostly represented by
7 men and young adults below the age of 34; and
8

9 Whereas, 70 percent of adult U.S. citizens aged 18-30 admit to watching online pornography at
10 least once per month; and
11

12 Whereas, 60 percent of college students admit to viewing pornography once per week; and
13

14 Whereas, 59-96 percent of adolescents in countries such as Taiwan and Sweden view
15 pornography; and
16

17 Whereas, While pornography has a long history, new technology offers unlimited sexual
18 diversity via free-of-charge online websites; and
19

20 Whereas, Long term use of pornography correlates with erectile dysfunction, decreased libido,
21 and lower sexual and relationship satisfaction, and has a negative effect on the quality of social
22 relationships; and
23

24 Whereas, While the incidence of pornographic use is mostly in the male population, the
25 incidence of women using pornography is increasing; and
26

27 Whereas, Frequent use of pornography leads to increased incidence of buying sex; therefore be
28 it

1 RESOLVED, That our American Medical Association amend existing policy H-60.934,
2 "Internet Pornography Protecting Children and Youth Who Use the Internet and Social Media,"
3 by addition to read as follows:

4
5 Our AMA:

- 6 (1) Recognizes the positive role of the Internet in providing health information to
7 children and youth.
8 (2) Recognizes the negative role of the Internet in connecting children and youth to
9 predators and exposing them to pornography.
10 (3) Supports federal legislation that restricts Internet access to pornographic materials
11 in designated public institutions where children and youth may use the Internet.
12 (4) Encourages physicians to continue efforts to raise parent/guardian awareness
13 about the importance of educating their children about safe Internet and social media
14 use.
15 (5) Supports school-based media literacy programs that teach effective thinking,
16 learning, and safety skills related to Internet and social media use.
17 6) Actively support legislation that would strengthen child-centric content protection by
18 internet service providers and/or search engines in order to limit the access of
19 pornography to minors on the internet and mobile applications. (Modify Existing
20 Policy)

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

Received: 10/13/22

RELEVANT AMA POLICY

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

Our AMA:

- (1) Recognizes the positive role of the Internet in providing health information to children and youth.
(2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.
(3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.
(4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.
(5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.

Citation: BOT Rep. 10, I-06; Modified: CSAPH Rep. 01, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 927
(I-22)

Introduced by: Michigan

Subject: Off-Label Policy

Referred to: Reference Committee K

1 Whereas, "One size does not fit all" and physicians are uniquely positioned to discuss and
2 evaluate the risks and benefits of specific medications and dosage for each individual; and
3

4 Whereas, Physicians have the best interests of the individual at the forefront, education to
5 evaluate studies, and the ability to move more quickly than official channels especially when
6 profits are a determinant of such approval; and
7

8 Whereas, New data is continuously emerging that may affect new treatments, dosage,
9 conditions, and situations; and
10

11 Whereas, AMA policy, Patient Access to Treatments Prescribed by Their Physicians H-120.988,
12 affirms the autonomous clinical decision-making authority of a physician and the ability of that a
13 physician to lawfully use an FDA approved drug product or medical device for an off-label
14 indication when such use is based upon sound scientific evidence or sound medical opinion;
15 supports the need for physicians to have access to accurate and unbiased information about
16 off-label uses of drugs and devices; supports the dissemination of generally available, unedited,
17 independently derived, peer reviewed, scientifically sound, and truthful information about off-
18 label uses by manufacturers to physicians; recognizes the obligations of physicians to interpret
19 and put into context information received from any source, including pharmaceutical
20 manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use);
21 supports the addition to FDA-approved labeling those uses of drugs for which safety and
22 efficacy have been demonstrated; and, supports the continued authorization, implementation,
23 and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research
24 Equity Act; therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-120.988, "Patient Access
2 to Treatments Prescribed by Their Physicians," by addition to read as follows:

3
4 1. Our AMA confirms its strong support for the autonomous clinical decision-making
5 authority of a physician and that a physician may lawfully use an FDA approved drug
6 product or medical device for an off-label indication when such use is based upon sound
7 scientific evidence or sound medical opinion; and affirms the position that, when the
8 prescription of a drug or use of a device represents safe and effective therapy, third
9 party payers, including Medicare, should consider the intervention as clinically
10 appropriate medical care, irrespective of labeling, should fulfill their obligation to their
11 beneficiaries by covering such therapy, and be required to cover appropriate 'off-label'
12 uses of drugs on their formulary.

13 2. Our AMA strongly supports the important need for physicians to have access to
14 accurate and unbiased information about off-label uses of drugs and devices, while
15 ensuring that manufacturer-sponsored promotions remain under FDA regulation.

16 3. Our AMA supports the dissemination of generally available information about off-label
17 uses by manufacturers to physicians. Such information should be independently derived,
18 peer reviewed, scientifically sound, and truthful and not misleading. The information
19 should be provided in its entirety, not be edited or altered by the manufacturer, and be
20 clearly distinguished and not appended to manufacturer-sponsored materials. Such
21 information may comprise journal articles, books, book chapters, or clinical practice
22 guidelines. Books or book chapters should not focus on any particular drug.

23 Dissemination of information by manufacturers to physicians about off-label uses should
24 be accompanied by the approved product labeling and disclosures regarding the lack of
25 FDA approval for such uses, and disclosure of the source of any financial support or
26 author financial conflicts.

27 4. Physicians have the responsibility to interpret and put into context information
28 received from any source, including pharmaceutical manufacturers, before making
29 clinical decisions (e.g., prescribing a drug for an off-label use).

30 5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs
31 for which safety and efficacy have been demonstrated.

32 6. Our AMA supports the continued authorization, implementation, and coordination of
33 the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.

34 7. Our AMA supports physician autonomy with regard to deciding appropriate dosing.
35 (Modify Current Policy)

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

Received: 10/13/22

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.
- Citation: Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified by CSA Rep. 3, A-97; Reaffirmed and Modified by Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04; Reaffirmation I-07; Reaffirmed: Res. 819, I-07; Reaffirmation A-09; Reaffirmation I-10; Modified: BOT Rep. 5, I-14; Reaffirmed: Res. 505, A-15; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: Res. 509, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 928
(I-22)

Introduced by: Medical Student Section

Subject: Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements

Referred to: Reference Committee K

1 Whereas, In 2017, liver cirrhosis was the 11th leading cause of death in the United States (over
2 44,000 deaths), and among all cirrhosis deaths, 50% were alcohol associated¹; and
3

4 Whereas, From 2010 to 2016, alcohol-associated liver disease was the primary cause of nearly
5 1 in 3 liver transplants in the United States, replacing hepatitis C virus infection as the leading
6 cause of liver transplantation due to chronic liver disease²⁻³; and
7

8 Whereas, Liver transplants in patients presenting with life-threatening severe alcoholic hepatitis
9 due to alcohol-associated liver dysfunction without 6-month sobriety have major improvements
10 in mortality (1 year survival of 94% compared with a 6-month predicted survival of less than
11 20%) with low post-transplant alcohol relapse rates⁴; and
12

13 Whereas, Patients suffering from either severe acute alcoholic hepatitis or acute-on-chronic liver
14 failure and not responding to medical therapy have high 3-month mortality rates ranging from
15 60%-70%, even reaching as high as 90% within the first year⁶; and
16

17 Whereas, The justification for the 6-month rule in 1997 at the conference of the American
18 Association for the Study of Liver Diseases and American Society of Transplantation cited three
19 studies that were confounded by small sample sizes and methodological flaws⁷; and
20

21 Whereas, Subsequent studies have failed to show the 6-month rule affects patient survival after
22 liver transplant and instead can be lethal⁸; and
23

24 Whereas, Studies have shown that alcohol relapse rates among liver transplant recipients are
25 identical whether or not there is a 6-month wait before transplant if there is careful selection of
26 patients with factors such as a strong social support, awareness of the role of alcohol in their
27 condition, free of severe comorbid psychiatric or comorbid disease⁹; and
28

29 Whereas, Transplant centers such as Johns Hopkins University¹⁰ regularly transplant livers into
30 patients with alcohol-related liver disease whose sobriety does not reach the six-month
31 threshold¹⁰ and transplant centers such as the University of California, Los Angeles¹¹, University
32 of Chicago¹², and others consider listing patients without 6-month sobriety after careful
33 selection¹³; and
34

35 Whereas, Reluctance to perform liver transplantation in patients with alcohol use disorder is
36 based on the fact that alcoholism is frequently considered to be self-inflicted and due to fears of
37 harmful post-transplant alcoholism recurrence¹⁴; and

1 Whereas, Alcohol use disorder is a recognized disease and not a mental failure, diagnosed
2 based on the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, and is due to
3 complex interactions between environmental factors, genetics, psychiatric conditions¹⁵; and
4

5 Whereas, The utilization of abstinence periods unfairly discriminates against a patient
6 population with a specific medical condition¹⁶; and
7

8 Whereas, Despite the widespread adoption of a 6-month rule requiring abstinence prior to liver
9 transplant, this has never been a formal recommendation from the International Liver
10 Transplantation Society¹⁷, the Organ Transplant Procurement Network or European consensus
11 groups⁹ likely due the fact that it is an indefensible position from a legal standpoint¹⁸; and
12

13 Whereas, Failure to create national policy on abstinence periods may exacerbate existing
14 inequities and disparities in access to liver transplantation²; and
15

16 Whereas, The American Academy of Addiction Psychiatry has a policy (Re: Organ
17 Transplantation) in support of the evaluation of a patient's candidacy for organ transplantation
18 based on clinical grounds alone, without an arbitrary length of time for a sobriety period, and
19 substance use and the possibility of future substance use being just one clinical factor in
20 evaluation¹⁹; and
21

22 Whereas, The American Medical Association-Medical Student Section (AMA-MSS) has a policy
23 (370.014MSS) in support of removing cannabis as a contraindication for potential organ
24 transplant; and
25

26 Whereas, The AMA-MSS has a policy transmittal (440.101MSS) in support of opposing sobriety
27 requirements for hepatitis C treatment; and
28

29 Whereas, The AMA has a policy (H- 370.973) in support of the removal of transplant center
30 policy excluding patients maintained on methadone from liver transplant waiting lists and
31 encouraging transplant centers to assess patients maintained on methadone on a case-by-case
32 basis; and
33

34 Whereas, The AMA has a policy (H-370.982) in support of ethical considerations in the
35 allocation of organs among patients, stating allocation decisions should respect the individuality
36 of patients and the particulars of individual cases as much as possible; therefore be it
37

38 RESOLVED, That our American Medical Association encourage transplant centers to expand
39 potential recipient evaluation criteria to include patients that may not satisfy center-specific
40 alcohol sobriety requirements on a case-by-case basis, using medically appropriate criteria
41 supportable by peer-reviewed and published research. (New HOD Policy)

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

Received: 10/12/22

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RELEVANT AMA POLICY

Methadone Maintenance and Transplantation H-370.973

Our AMA: (1) urges transplant centers across the nation to abrogate any policies that automatically exclude patients maintained on methadone from liver transplant recipient waiting lists; and (2) encourages transplant centers to assess patients maintained on methadone on a case-by-case basis using medically appropriate criteria supportable by peer-reviewed and published research.

Citation: Res. 405, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Medical, Surgical, and Psychiatric Service Integration and Reimbursement H-345.983

Our AMA advocates for: (1) health care policies that insure access to and reimbursement for integrated and concurrent medical, surgical, and psychiatric care regardless of the clinical setting; and (2) standards that encourage medically appropriate treatment of medical and surgical disorders in psychiatric patients and of psychiatric disorders in medical and surgical patients.

Citation: Res. 135, A-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 6, A-15; Reaffirmation: I-18

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

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

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

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

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

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 929
(I-22)

Introduced by: Medical Student Section

Subject: Opposing the Marketing of Pharmaceuticals to Parties Responsible for
Captive Populations

Referred to: Reference Committee K

1 Whereas, The United States has over 2 million individuals in its prisons or jails at any given
2 time¹; and
3

4 Whereas, An estimated 41% of incarcerated individuals have a chronic medical condition such
5 as hypertension, diabetes, or asthma, equating to almost 820,000 incarcerated individuals with
6 a chronic medical condition²; and
7

8 Whereas, Mental illness specifically is increasingly prevalent in the incarceration system, with
9 20% of individuals in jails and 15% of individuals in prisons estimated to have serious mental
10 illness³; and
11

12 Whereas, There are significant racial disparities in incarceration rates, with Black people having
13 a per capita imprisonment rate nearly six times that of Whites and nearly double that of Hispanic
14 individuals⁴; and
15

16 Whereas, Incarceration generally constrains individuals and restricts their ability to make truly
17 voluntary and unforced decisions, establishing incarcerated individuals as a vulnerable
18 population for which special protections are warranted⁵; and
19

20 Whereas, Incarcerated individuals have specific sets of protections with respect to human
21 subjects research under 45 CFR 46 Subpart C, indicating the same acknowledgement by the
22 U.S. government⁶; and
23

24 Whereas, The loss of autonomy is even more pronounced for detainees of Immigration and
25 Customs Enforcement (ICE); since non-citizens are not entitled to a lawyer, detainees have very
26 few avenues to ensure complaints they submit are adequately reviewed, and therefore this
27 population is even more captive than even a "standard" prison population composed of
28 citizens^{7,8}; and
29

30 Whereas, Despite the constitutional guarantee of healthcare access to incarcerated individuals,
31 the autonomy of incarcerated individuals with respect to their own healthcare is restricted for a
32 variety of reasons, including financial interests of management, the safety of other incarcerated
33 individuals, and discrimination by their providers, all of which can lead to long-term
34 consequences that follow former inmates years after release^{9,10}; and
35

36 Whereas, While persons being detained by ICE are entitled to receive medical care and
37 treatment as needed, drug procurement and formulary management differs based on the type of
38 facility an individual is detained at^{11,12}; and

1 Whereas, ICE manages three types of facilities: service processing centers (SPCs) that are run
2 entirely by ICE, contract detention facilities (CDFs) where third parties contract with ICE to
3 provide detention services, and local, state, and federal jails that ICE may reimburse to house
4 inmates¹²; and

5
6 Whereas, The ICE Health Service Corps (IHSC) is the division of ICE responsible for providing
7 medical care to SPCs and for financial reimbursement for medical care, including
8 pharmaceuticals, provided by CDFs and ICE-contracted jails¹³; and

9
10 Whereas, IHSC operates a formulary consisting of approved medications that applies to
11 pharmaceuticals prescribed and dispensed at non-IHSC staffed facilities¹⁴; and

12
13 Whereas, Non-formulary prescriptions require prior authorization by IHSC¹⁵; and

14
15 Whereas, The pharmacy benefits provided by IHSC, including the formulary used to determine
16 which medications are pre-approved for inmates, appear to be managed by the pharmacy
17 benefit manager ScriptCare, but there is no public information about how the formulary is set or
18 what factors are used to set the formulary, raising a concerning set of questions about whether
19 decisions made on the basis of financial incentives for ScriptCare or IHSC are impacting the
20 quality of healthcare available to ICE detainees¹⁵; and

21
22 Whereas, There are no universally applies standards for the procurement or availability of
23 medications in jails and prisons^{16,17}; and

24
25 Whereas, The Federal Bureau of Prisons maintains its own formulary, but this formulary is not
26 used by state prisons and jails^{16,17}; and

27
28 Whereas, The Office of Justice Program only requires that for jail health services a formulary be
29 created, contributing to the lack of formulary standardization across the country^{16,17}; and

30
31 Whereas, The National Commission on Correctional Health Care (NCCH) stipulates that
32 departments of correction must have a method for approving off-formulary medications, but
33 these are only recommendations and may not consistently be applied¹⁸; and

34
35 Whereas, This notable lack of standardization has created an opaque situation where the exact
36 criteria used to set formularies for prisons and jails across the nation is unclear and different
37 from institution to institution, leading the American Society of Health-System Pharmacists
38 (ASHP) recently releasing updated guidance that formulary decisions should include
39 representative medical staff from the facility including practicing physicians and other providers,
40 as well as other facility leaders, and patient or family stakeholders¹⁹; and

41
42 Whereas, Because state prison systems have to dedicate 15-23% of their health benefit
43 expenditures to pharmaceuticals, the primary driver of formulary creation tends to be cost
44 reduction²⁰; and

45
46 Whereas, There are multiple methods that jails and prisons use to procure medications,
47 including direct purchase by Department of Corrections (DOC) physicians, bulk purchases via
48 contracts with private groups, purchase through state universities/academic medical centers
49 when these institutions provide care to inmates, or centralized ordering and distribution as seen
50 in Massachusetts²⁰; and

Whereas, Though the Federal Bureau of Prisons has released guidance for securing the lowest-cost medications ethically, these guidelines are not followed universally²¹; and

Whereas, Pharmaceutical companies may exert influence over these decision makers and even offer free samples or rebates to incentivize their products being preferred on formulary²²; and

Whereas, While some may advocate for accepting these reduced-cost drugs as a cost-saving measure, it can be a source of bias and compromises medical necessity being a driver of formulary creation, particularly for inmates who have no choice or agency in where they access their healthcare²³; and

Whereas, While existing American Medical Association policy expresses strong support for the ethical provision of medical care to incarcerated individuals (see: D-430.997, Item 9.7.2 of the AMA Code of Medical Ethics), opposes direct-to-consumer (H-105.988) and EHR-facilitated direct-to-provider (D-478.961) prescription drug advertising, and endorses principles for sound formulary design (H-125.985), but has no policy explicitly recognizing the unique protections that must be afforded to vulnerable, captive populations like incarcerated individuals with respect to formulary design and medication procurement; therefore be it

RESOLVED, That our American Medical Association oppose the practice of pharmaceutical marketing towards those who make decisions for captive populations, including, but not limited to, doctors working in a correctional capacity, judges, wardens, sheriffs, correctional officers, Immigration and Customs Enforcement, and other detention administrators (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the inclusion of physicians in the selection of medications available to vulnerable populations such as incarcerated individuals (Directive to Take Action); and be it further

RESOLVED, That our AMA support and work with state medical societies to support measures to increase transparency in medication procurement, including but not limited to: (1) requiring those responsible for medical procurement to report gifts from pharmaceutical companies over a minimum amount; and (2) centralizing formulary choices in a physician-led office, agency, or commission following the principles of a sound formulary. (New HOD Policy)

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

Received: 10/12/22

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RELEVANT AMA POLICY

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:

- (1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
- (2) encourage all correctional systems to support NCCHC accreditation;
- (3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;
- (4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
- (5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
- (6) support an incarcerated person's right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.

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

Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988

1. To support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices.
2. That until such a ban is in place, our AMA opposes product-claim DTCA that does not satisfy the following guidelines:

- (a) The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.
 - (b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.
 - (c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products.
 - (d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.
 - (e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.
 - (f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.
 - (g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.
 - (h) In general, product-claim DTCA should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTCA, a disclaimer should be prominently displayed.
 - (i) The use of actual health care professionals, either practicing or retired, in DTCA to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.
 - (j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.
 - (k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.
3. That the FDA review and pre-approve all DTCA for prescription drugs or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.
4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTCA.
5. That DTCA for newly approved prescription drug or implantable medical device products not be run until sufficient post-marketing experience has been obtained to determine product risks in the general population and until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTCA for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it.
6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTCA.
7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTCA, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.

8. That our AMA supports the concept that when companies engage in DTCA, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.
 9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-claim DTCA and with the Council on Ethical and Judicial Affairs Ethical Opinion E-9.6.7 and to adhere to the ethical guidance provided in that Opinion.
 10. That the Congress should request the Agency for Healthcare Research and Quality or other appropriate entity to perform periodic evidence-based reviews of DTCA in the United States to determine the impact of DTCA on health outcomes and the public health. If DTCA is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTCA regulation or, if necessary, to prohibit DTCA in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.
 11. That our AMA supports eliminating the costs for DTCA of prescription drugs as a deductible business expense for tax purposes.
 12. That our AMA continues to monitor DTCA, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTCA, as necessary.
 13. That our AMA supports "help-seeking" or "disease awareness" advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA).
 14. Our AMA will advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer's suggested retail price of those drugs.
- Citation: BOT Rep. 38 and Sub. Res. 513, A-99; Reaffirmed: CMS Rep. 9, Amended: Res. 509, and Reaffirmation I-99; Appended & Reaffirmed: Sub. Res. 503, A-01; Reaffirmed: Res. 522, A-02; Reaffirmed: Res. 914, I-02; Reaffirmed: Sub. Res. 504, A-03; Reaffirmation A-04; Reaffirmation A-05; Modified: BOT Rep. 9, A-06; Reaffirmed in lieu of Res. 514, A-07; BOT Action in response to referred for decision: Res. 927, I-15; Modified: BOT Rep. 09, I-16; Appended: Res. 236, A-17; Reaffirmed in lieu of: Res. 223, A-17; Reaffirmed in lieu of: Res. 112, A-19

Pharmaceutical Advertising in Electronic Health Record Systems D-478.961

Our AMA: (1) opposes direct-to-prescriber pharmaceutical and promotional content in electronic health records (EHR); (2) opposes direct-to-prescriber pharmaceutical and promotional content in medical reference and e-prescribing software, unless such content complies with all provisions in Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices (H-105.988); (3) encourages study of the effects of direct-to-prescriber advertising at the point of care, including advertising in EHRs, on physician prescribing, patient safety, data privacy, health care costs, and EHR access for physician practices; (4) opposes the preferential placement of brand name medications in e-prescription search results or listings; and (5) encourages e-prescribing and EHR companies to ensure that the generic medication name will appear first in e-prescription search results and listings.

Citation: Res. 207, I-19; Modified: BOT Rep. 14, A-21;

Expanded Use of the AMA's Principles of a Sound Drug Formulary H-125.985

Our AMA urges managed care organizations, pharmacy benefit managers, and others who design benefit packages and/or make pharmacy benefit decisions, to utilize the Principles of a Sound Drug Formulary System (as described in BOT Rep. 28, I-00) as they develop their pharmaceutical benefit plan(s) and that the Principles of a Sound Drug Formulary System be readily available on the AMA web site.

Citation: Res. 520, A-01; Amended: Res. 514, A-02; Reaffirmed: CSA Rep. 2, A-04; Reaffirmation I-04; Reaffirmed: Sub. Res. 529, A-05; Reaffirmed in lieu of Res. 535, A-05; Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05; Reaffirmation A-06; Reaffirmed: CSAPH Rep. 01, A-

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 930
(I-22)

Introduced by: Medical Student Section

Subject: Addressing Longitudinal Health Care Needs of Children in Foster Care

Referred to: Reference Committee K

1 Whereas, The most recent estimation showed 424,000 children in foster care in the U.S. in
2 2019, which has stayed consistent since 2009^{1,2}; and
3

4 Whereas, American Indian/Alaska Native (AI/AN) children were disproportionately
5 overrepresented in the foster care system by double their share of the U.S. population in 2020,
6 are twice as likely as their White counterparts to be removed from their family, and more likely to
7 have special health care needs^{3, 4, 5}; and
8

9 Whereas, Upon entering foster care, 30% to 80% of children have at least one physical health
10 problem, 33% have a chronic health condition, 40% have significant dental issues, and up to
11 80% have a significant mental health need^{6,7}; and
12

13 Whereas, During foster care, 50% of children have healthcare needs which remain chronic or
14 unmet and 30% of children with potential mental health needs went 12 months without
15 intervention^{8,9}; and
16

17 Whereas, While in foster care, 50% of children are subject to at least one change of placement,
18 and 20% move at least three times in one year¹⁰; and
19

20 Whereas, Poor communication between caregivers, Child welfare services, and medical
21 personnel results in 50% of children having discrepancies in identifying data that prevents their
22 electronic medical record from being matched with their child welfare files, and more than 40%
23 of those children lack a basic social history in their health record such as why they entered
24 foster care^{6,11,12}; and
25

26 Whereas, Incomplete medical histories and frequent changes in physical custody lead to
27 decreased continuity of care, causing the health needs of children in foster care to often go
28 undiagnosed and untreated^{1,6,8,13,14,15,16}; and
29

30 Whereas, A “pediatric medical home” is a primary care model which provides a single home for
31 medical records, maintains provider continuity throughout the childhood of a patient, and
32 coordinates specialty care^{17,18,19}; and
33

34 Whereas, In 2016, only 40% to 50% of all children in the U.S. were reported to have access to a
35 medical home¹⁸; and
36

37 Whereas, Pediatric medical homes are associated with increased primary care utilization and
38 improved health outcomes, making them ideal for children in foster care^{19, 20, 21, 22}; and

1 Whereas, Computerized intersystem health information exchange platforms are associated with
2 increased immunization and health record completeness, reduced care disparities, and
3 increased overall quality of care²³; and
4

5 Whereas, Interagency information exchange results in more than a threefold increase in the
6 likelihood of receiving needed behavioral health services for a child managed by child welfare
7 agencies²⁴; and
8

9 Whereas, Several states have implemented computerized health systems to improve
10 information exchange between child welfare agencies and health care services including The
11 Texas Health Passport, Ohio IDENTITY, Pennsylvania UPMC for You, and California Foster
12 Health Link²⁵; and
13

14 Whereas, Health case management services and designation of accountability for the health
15 services of a child in foster care are associated with positive health outcomes and more than a
16 threefold increase in likelihood of a child receiving needed health services^{24,26}; and
17

18 Whereas, Some states have implemented medical case management programs to longitudinally
19 follow children in foster care including California and North Carolina^{8,27,28}; and
20

21 Whereas, The variability in infrastructure to address health needs of children in foster care
22 between and within states suggests a need for standardization of care quality through state-
23 level supervision^{6,25,27,28}; and
24

25 Whereas, The Indian Child Welfare Act (ICWA), enacted in 1978 to address the disparities in
26 Native child foster placement, provides placements for AI/AN children that are conducive to
27 longitudinal health care by requiring minimal Federal standards for their removal and placement
28 of such children in long-lasting, culturally appropriate homes^{5,29}; and
29

30 Whereas, The American Academy of Pediatrics (AAP) recognizes that the ICWA protects AI/AN
31 children and adolescents from disproportionate rates of child removal and negative health
32 outcomes, and supports increased engagement with the Indian Health Service which provides
33 medical care to AI/AN children⁵; and
34

35 Whereas, The AAP recommends the use of pediatric medical homes, increased information
36 exchange between child welfare and medical providers, and the appointment of a pediatrician to
37 supervise state-level medical case management of children in foster care⁶; and
38

39 Whereas, Our American Medical Association MSS policies support the health coverage of all
40 children in foster care and the entire transferability of electronic health records data between
41 independent healthcare systems (Enabling Contiguous, National Electronic Health Record
42 Network 315.003MSS, Addressing Healthcare Accessibility for Current and Aged-Out Youth in
43 the Foster Care System 60.037MSS); and
44

45 Whereas, Existing AMA policy encourages the use of medical homes, supports the use of
46 health information technology in conjunction with medical homes, and advocates for
47 comprehensive and evidence-based care that addresses the specific health care needs of
48 children in foster care (The Patient-Centered Medical Home H-160.918, Principles of the
49 Patient-Centered Medical Home H-160.919, Addressing Healthcare Needs of Children in Foster
50 Care H-60.910); and

Whereas, No existing AMA policy addresses longitudinal continuity of care needs of children in foster care which remain unaddressed in spite of legal access to medical care for foster children^{30,31}; therefore be it

RESOLVED, That our American Medical Association support the construction of computerized health information systems to enhance information exchange between both tribal and non-tribal child welfare agencies and healthcare professionals (New HOD Policy); and be it further

RESOLVED, That our AMA promote existing pediatric medical homes which provide continuity of care to children in foster care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the designation of medical providers, teams, and/or committees to longitudinally follow children in foster care (Directive to Take Action); and be it further

RESOLVED, That our AMA support the appointment of a pediatrician in each state with experience in child welfare to the position of state medical director of foster care health case management in accordance with AAP guidelines to ensure standards of care are met (New HOD Policy); and be it further

RESOLVED, That the AMA support the longitudinal stability and care of American Indian and Alaska Native children in foster care by promoting the Indian Child Welfare Act. (New HOD Policy)

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

Received: 10/12/22

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30. Fostering Connections to Success and Increasing Adoptions Act of 2008, 42 U.S.C. § 1305 (2008).
31. Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010)

RELEVANT AMA POLICY

The Patient-Centered Medical Home H-160.918

Our AMA:

1. will urge the Centers for Medicare and Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;
2. will urge CMS to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources;
3. will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule;
4. will advocate that all payers support and assist PCMH transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care recognizing that payer support is crucial to the long-term sustainability of delivery reform; and
5. encourages health agencies, health systems, and other stakeholders to support and assist patient-centered medical home transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care.

Citation: CMS Rep. 8, A-09; Modified: CMS Rep. 03, I-18;

Principles of the Patient-Centered Medical Home H-160.919

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:

Principles

Personal Physician - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician Directed Medical Practice - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

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.

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.

Quality and safety are hallmarks of the medical home:

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.

Evidence-based medicine and clinical decision-support tools guide decision making.

Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

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.

Patients and families participate in quality improvement activities at the practice level.

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.

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:

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.

It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

It should support adoption and use of health information technology for quality improvement.

It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

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).

It should recognize case mix differences in the patient population being treated within the practice.

It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

It should allow for additional payments for achieving measurable and continuous quality improvements.

2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care.

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.

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.

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.

Citation: Res. 804, I-08; CMS Rep. 8, A-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmed: Res. 723, A-11; Appended: Res. 723, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed in lieu of Res. 706, A-12; Reaffirmed: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 03, I-18

Addressing Healthcare Needs of Children in Foster Care H-60.910

Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.

Citation: Res. 907, I-17;

Medicaid Coverage for American Indian and Alaska Native Children D-350.992

Our AMA will advocate for immediate changes in Medicaid regulations to allow American Indian/Alaska Native (AI/AN) children who are eligible for Medicaid in their home state to be automatically eligible for Medicaid in the state in which the Bureau of Indian Affairs boarding school is located.

Citation: BOT Action in response to referred for decision Res. 102, A-06; Reaffirmed: Res. 221, A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 931
(I-22)

Introduced by: Medical Student Section

Subject: Amending H-160.903 Eradicating Homelessness to Include Support for Street Medicine Programs

Referred to: Reference Committee K

Whereas, "Street medicine" is the practice of providing medical care to unsheltered people experiencing homelessness in locations like encampments, parks, and under bridges¹; and

Whereas, Street medicine is an evidence-based health provision model that effectively bridges the unique barriers and gaps in care seen in populations experiencing unsheltered homelessness by bringing medicine to the streets and connecting individuals to the existing resources they need and have difficulty accessing^{2,3}; and

Whereas, Approximately one third of the estimated 580,466 persons experiencing homelessness in 2020 were unsheltered according to reports from the United States Department of Housing and Development and the Urban Institute⁴; and

Whereas, The National Healthcare for the Homeless Council reports up to 46,500 persons experiencing homelessness die each year in the United States, and this number is climbing⁵; and

Whereas, Life expectancy for people living on the streets is estimated to be twelve years shorter than the national average, and chronic diseases and disabilities are abundant and exacerbated by life on the street^{5,6}; and

Whereas, The COVID-19 pandemic resulted in an increased rate of persons experiencing homelessness, increased criminalization of homelessness, and increased death rates amongst people experiencing homelessness^{5,7,8}; and

Whereas, 1.4 million unsheltered people access emergency shelter or transitional housing each year, placing them in congregative settings which pose tremendous risk for the spread of communicable diseases like COVID-19, with the New York City Department of Emergency Services reporting that COVID-19 mortality rates are 49 percent higher for sheltered homeless individuals⁹; and

Whereas, Lack of access to health care services, limited autopsies, and the absence of housing status on death certificates and hospital records leads to a severe undercount of COVID-related cases and deaths among unsheltered individuals^{10,11}; and

Whereas, Rent prices have risen dramatically in recent years, placing undue burden upon lower income households¹²; and

1 Whereas, Communities criminalize homelessness and make it illegal for people to sit, sleep, or
2 eat in public places, thus creating arrest records that further prevent unsheltered people from
3 obtaining jobs or housing¹³; and
4

5 Whereas, A report from the American Hospital Association showed that those experiencing
6 homelessness are five times more likely to be admitted as inpatients into a hospital and
7 experience longer hospital stays after admission, and further showed that investing in the care
8 of these patients will reduce this cost burden¹⁴; and
9

10 Whereas, Unsheltered individuals have health care costs on average five times higher than the
11 national average, largely due to their overreliance on Emergency Rooms; the majority do not
12 have health insurance or a primary care doctor, and up to 80% of these Emergency Room visits
13 are for ailments that could have been addressed preventatively^{2,15-18}; and
14

15 Whereas, Individuals experiencing homelessness who were treated by a Street Medicine team
16 were more likely to subsequently engage with a primary care provider as compared to
17 individuals experiencing homelessness who were not seen by a Street Medicine team, and
18 therefore did not receive referral to crucial healthcare services^{19,20}; and
19

20 Whereas, Street Medicine has been shown to decrease hospital admissions, hospital length-of-
21 stay, emergency department visits, and saved one health system 3.7 million dollars in
22 Emergency Department visits^{21,22}; and
23

24 Whereas, Institutions such as the Street Medicine Institute, a non-profit organization that aims to
25 cultivate and improve Street Medicine programs both nationally and globally, have successfully
26 maintained 85 programs along with their student coalition, which contains 30 student-run
27 programs across 17 states²³; and
28

29 Whereas, There are multiple ways to implement a street medicine program based on the
30 geographical regions of people experiencing homelessness or through follow up discharge visits
31 after hospitalization²⁴; and
32

33 Whereas, Street medicine program creation involves education, funding, partnering with local
34 agencies, establishing supplies, implementing protocols, and the formation of a medical team²⁵;
35 and
36

37 Whereas, There may be challenges to starting a Street medicine program such as maintaining
38 connection in a population with a migratory culture, building interpersonal relationships, and
39 establishing institutional partnerships that can be overcome through joint efforts such as
40 partnerships between institutions knowledgeable in this area as well as recruiting professionals
41 that are experienced with this population²⁶; and
42

43 Whereas, There is growing legislative awareness around the impact of such programs, with the
44 California State legislature having recently passed AB 369, which will now require Medi-Cal,
45 California's Medicaid program, to reimburse street medicine¹⁹; and
46

47 Whereas, There are several existing AMA policies (H-160.903, H-160.978, H-160.894, H-
48 20.903, H-345.975, H-440.938) that advocate for and support measures that improve access to
49 adequate health care for people experiencing homelessness through methods such as waiving
50 co-pays, or providing care through free clinics; and

Whereas, H-160.903 specifically asks that the AMA “recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address [homelessness] on a long-term basis”, and as such has set precedence for feasibly supporting such measures; therefore be it

RESOLVED, That our American Medical Association encourage medical schools to implement Street Medicine programs and/or promote student-led Street Medicine programs (New HOD Policy); and be it further

RESOLVED, That our AMA recognizes and supports the use of Street Medicine programs by amending policy H-160.903 Eradicating Homelessness by addition and deletion to read as follows:

Eradicating Homelessness, H-160.903

Our AMA:

- (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
- (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
- (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
- (4) supports the use of street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;
- ~~(45)~~ recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
- ~~(56)~~ encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
- ~~(67)~~ will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians’ role therein, in addressing these needs;
- ~~(78)~~ encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
- ~~(89)~~ encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
- ~~(910)~~ (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
- ~~(1011)~~ recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods; ~~and~~

(4412) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals; and
(13) supports federal and state efforts to enact just cause eviction statutes and examine and restructure punitive eviction practices; instate inflation-based rent control; guarantee tenants' right to counsel in housing disputes and improve affordability of legal fees; and create national, state, and/or local rental registries. (Modify Current HOD Policy)

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

Received: 10/12/22

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RELEVANT AMA POLICY

Eradicating Homelessness H-160.903

Our AMA:

- (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
- (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
- (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
- (4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
- (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
- (6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
- (7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
- (8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
- (9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available;
- (10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods; and
- (11) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.

Citation: Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19; Appended: Res. 414, A-22;

Housing Insecure Individuals with Mental Illness H-160.978

- (1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws

that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population. Citation: BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: BOT Rep. 16, A-19; Reaffirmed: Res. 414, A-22

Maintaining Mental Health Services by States H-345.975

Our AMA:

1. supports maintaining essential mental health services at the state level, to include maintaining state inpatient and outpatient mental hospitals, community mental health centers, addiction treatment centers, and other state-supported psychiatric services;
2. supports state responsibility to develop programs that rapidly identify and refer individuals with significant mental illness for treatment, to avoid repeated psychiatric hospitalizations and repeated interactions with the law, primarily as a result of untreated mental conditions;
3. supports increased funding for state Mobile Crisis Teams to locate and treat homeless individuals with mental illness;
4. supports enforcement of the Mental Health Parity Act at the federal and state level; and
5. will take these resolves into consideration when developing policy on essential benefit services.

Citation: Res. 116, A-12; Reaffirmation A-15; Reaffirmed: Res. 414, A-22

11.1.4 Financial Barriers to Health Care Access

Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means.

In view of this obligation,

(a) Individual physicians should:

(i) take steps to promote access to care for individual patients, such as providing pro bono care in their office or through freestanding facilities or government programs that provide health care for the poor, or, when permissible, waiving insurance copayments in individual cases of hardship. Physicians in the poorest communities should be able to turn for assistance to colleagues in more prosperous communities.

(ii) help patients obtain needed care through public or charitable programs when patients cannot do so themselves.

(b) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.

(c) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services.

(d) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure sufficient access to appropriate health care for all people.

AMA Principles of Medical Ethics: I,II,VI,VII,IX

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Citation: Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 932
(I-22)

Introduced by: Medical Student Section

Subject: Increase Employment Services Funding for People with Disabilities

Referred to: Reference Committee K

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

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

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

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

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

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

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

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

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

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

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

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

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

Whereas, Our AMA Policy H-90.967 and MSS Policy 25.002 encourage government agencies and other organizations to provide psychosocial support for people with disabilities, but do not include employment benefits; and

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

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

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

Received: 10/13/22

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RELEVANT AMA POLICY

Support for Persons with Intellectual Disabilities H-90.967

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

Citation: Res. 01, A-16;

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

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

Citation: Res. 220, I-17

Enhancing Accommodations for People with Disabilities H-90.971

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

Citation: (Res. 705, A-13)

Early Intervention for Individuals with Developmental Delay H-90.969

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

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

SSI Benefits for Children with Disabilities H-90.986

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

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

Support for Housing Modification Policies H-160.890

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

Citation: Res. 806, I-19;

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 933
(I-22)

Introduced by: Medical Student Section

Subject: Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV

Referred to: Reference Committee K

Whereas, Sexual identity is fluid and can be defined on a spectrum, ranging from exclusively homosexual behavior to exclusively heterosexual behavior¹; and

Whereas, According to the U.S. National Survey of Family Growth, 17.4% of women and 6.2% of men aged 18-44 report any same-sex sexual behavior at any time in their life, despite only 6.8% of women and 3.9% of men aged 18-44 report being homosexual, gay, lesbian, or bisexual²; and

Whereas, Patients' reported sexual behavior and orientation is not always consistent with actual sexual behavior as patients may not be willing to report their sexual histories accurately²; and

Whereas, In 2017, 30% of new HIV diagnoses in the United States were not attributed to the men who have sex with men (MSM) demographic³; and

Whereas, From 2010-2016, African American heterosexual women accounted for the second highest incidence of HIV infection after MSM⁴; and

Whereas, Black men who have sex with men and women (MSMW) have been hypothesized to be the "bridge" through which HIV has been transmitted to black heterosexual men and women⁵⁻⁶; and

Whereas, Several studies have shown that African American MSMW may challenge targeted HIV prevention approaches that focus explicitly on sexual orientation since this population may not identify as gay or bisexual and is therefore unlikely to participate in programs that prioritize gay community affiliation as foundations for HIV prevention⁵⁻⁶; and

Whereas, In 2017, the African American population and Hispanic population collectively accounted for 69% of HIV diagnoses, despite comprising only 31% of the U.S. population³; and

Whereas, A report from the CDC concluded that increasing HIV prevention services among heterosexuals at increased risk is important, especially among racial and ethnic groups disproportionately affected by HIV infection, such as blacks and Hispanics/Latinos⁷; and

Whereas, In 2019, the United States Preventive Services Task Force (USPSTF) recommended with an "A" rating that clinicians offer HIV pre-exposure prophylaxis (PrEP) to persons who are at high risk of HIV acquisition as an evidence-based primary prevention because PrEP reduces the risk of sexual transmission of HIV by about 99% when taken daily⁸⁻⁹; and

1 Whereas, While there are over 77,000 PrEP users in the United States, over 1.1 million
2 additional individuals would benefit from being on it¹⁰⁻¹³; and

3
4 Whereas, Sixty-nine percent of the individuals that could benefit from PrEP are Black or
5 Hispanic, yet these individuals comprise only 4% of the individuals who are prescribed it¹¹⁻¹²;
6 and

7
8 Whereas, PrEP uptake does not reflect the general distribution of the HIV epidemic in the
9 United States, as people of color and women bear a high HIV burden, but have a
10 disproportionately limited uptake¹⁴; and

11
12 Whereas, Only 28% of primary care physicians are comfortable with prescribing PrEP, with the
13 most frequently cited barrier to prescribing it being lack of knowledge¹⁵⁻¹⁶; and

14
15 Whereas, A 2018 study showed that medical students were unable to identify individuals at
16 highest risk of HIV acquisition and recommend PrEP accordingly¹⁷; and

17
18 Whereas, Educational interventions targeted at primary care physicians that focus on HIV
19 epidemiology, an introduction to PrEP and appropriate candidates, an overview of how to
20 prescribe PrEP, as well as recommendations on sexual-history taking have all been shown to
21 increase rates of PrEP prescribing when clinically indicated¹⁶; and

22
23 Whereas, Regardless of the patient's current stated sexual behavior, routine primary care office
24 visits are comprised of a comprehensive discussion of sexual health, sexual activity, sexuality,
25 contraception, and prevention of sexually transmitted infections/diseases (STIs), beginning as
26 early as age 11¹⁸⁻¹⁹; and

27
28 Whereas, It is considered a best practice in primary care settings to educate patients about all
29 the available options for preventing STIs, especially in sexually active adolescents and in adults
30 at increased risk for STIs¹⁸⁻¹⁹; and

31
32 Whereas, PrEP is considered to be an option for the prevention of HIV infection in seronegative
33 individuals at high risk of HIV acquisition, yet it is not routinely discussed with patients^{8,15}; and

34
35 Whereas, A study found that the strongest factor influencing PrEP uptake among majority non-
36 white heterosexual individuals at high risk of HIV, a group with disproportionately low PrEP
37 uptake, was suggestion to initiate PrEP by a healthcare provider¹⁴; and

38
39 Whereas, AMA policies H-180.944 "Plan for Continued Progress Toward Health Equity" and H-
40 350.974 "Racial and Ethnic Disparities in Health Care" has named the elimination of racial and
41 ethnic disparities in health care "an issue of highest priority" as they are a "barrier to effective
42 medical diagnosis and treatment"; and

43
44 Whereas, H-350.974 calls on the importance of "evidence-based guidelines to promote the
45 consistency and equity of care for all persons" and "supports research to identify the most
46 effective strategies for educating physicians on how to eliminate disparities in health outcomes
47 in all at-risk populations"; and

48
49 Whereas, No existing AMA policy explicitly acknowledges the disparities that exist in HIV
50 prevention and treatment nor proposes a specific intervention to reduce such disparities;
51 therefore be it

RESOLVED, That our American Medical Association amend Policy H-20.895 “Pre-Exposure Prophylaxis (PrEP) for HIV” by addition to read as follows:

Pre-Exposure Prophylaxis (PrEP) for HIV, H-20.895

1. Our AMA will educate physicians, physicians-in-training, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
5. Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling, regardless of a patient’s current reported sexual behaviors. (Modify Current HOD Policy)

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

Received: 10/13/22

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RELEVANT AMA POLICY

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

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
 2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
 3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
 4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
- Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

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

- Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education.
- Citation: Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16; Modified: Res. 16, A-18; Modified: Res. 302, I-19

Improving the Health 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.

Citation: CLRPD Rep. 3, I-98; Reaffirmation A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 1, A-21

Plan for Continued Progress Toward Health Equity H-180.944

Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

Citation: BOT Rep. 33, A-18; Reaffirmed: CMS Rep. 5, I-21

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895

1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.

Citation: Res. 106, A-16; Modified: Res. 916, I-16; Appended: Res. 101, A-17

Support of a National HIV/AIDS Strategy H-20.896

1. Our AMA supports the creation of a National HIV/AIDS strategy, and will work with relevant stakeholders to update and implement the National HIV/AIDS strategy.
2. Our AMA supports and will strongly advocate for the funding of plans to end the HIV epidemic that focus on: (a) diagnosing individuals with HIV infection as early as possible; (b) treating HIV infection to achieve sustained viral suppression; (c) preventing at-risk individuals from acquiring HIV infection, including through the use of pre-exposure prophylaxis; and (d) rapidly detecting and responding to emerging clusters of HIV infection to prevent transmission.

Citation: Sub Res. 425, A-09; Modified: CSAPH Rep. 01, A-19; Appended: Res. 413, A-19

HIV/AIDS Education and Training H-20.904**(1) Public Information and Awareness Campaigns**

Our AMA:

- a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.
- b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;
- c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;
- d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;
- e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.

(2) HIV/AIDS Education in Schools

Our AMA:

- a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;
- b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools.

(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers

Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies. Citation: CSA Rep. 4, A-03; Appended: Res. 516, A-06; Modified: CSAPH 01, A-16; Reaffirmed: Res. 916, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 934
(I-22)

Introduced by: Medical Student Section

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

Referred to: Reference Committee K

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

27 Whereas, Solitary confinement increases the risk of recidivism, with some studies finding that
28 spending any amount of time in solitary confinement is associated with two times the risk of
29 being reincarcerated within two weeks of release, and other studies finding a 10-25% increased
30 overall risk of recidivism^{14,18-20}; and
31

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

36 Whereas, Transitioning prisoners from solitary confinement to the general prison population
37 prior to release reduces recidivism rates²⁰; and
38

39 Whereas, A 2018 nationwide survey of correctional facilities found that, in most jurisdictions,
40 certain racial minorities are disproportionately more likely to be placed in solitary confinement
41 while white prisoners are 14% less likely to be placed in solitary confinement⁸; and
42

43 Whereas, A study of over 100,000 prisoners found that the odds that gay and bisexual men will
44 be placed in solitary confinement are 80% greater than heterosexual men, and the odds are
45 190% greater that lesbian and bisexual women will be placed in solitary confinement than
46 heterosexual women²¹; and
47

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

1 Whereas, In 2015 the United Nations General Assembly adopted “The Standard Minimum
2 Rules for the Treatment of Prisoners,” also known as the “Mandela Rules,” which condemn the
3 use of solitary confinement for prisoners with mental or physical disabilities when their
4 conditions would be exacerbated by such measures²³; and
5

6 Whereas, The same rules call for the prohibition of prolonged solitary confinement, longer than
7 15 days, because it is a “cruel, inhuman or degrading treatment or punishment”²³; and
8

9 Whereas, The Mandela Rules further state that “solitary confinement shall be used only in
10 exceptional cases as a last resort, for as short a time as possible and subject to independent
11 review”²³; and
12

13 Whereas, Solitary confinement is a risk for self-harm and predisposes to a multitude of physical
14 and psychological health issues, and could be considered a cruel and unusual punishment and
15 a human rights violation²⁴; and
16

17 Whereas, At least some United States correctional facilities have managed to reform and
18 reduce their use of solitary confinement in order to better respect the dignity and human rights
19 of inmates while still maintaining the safety of correctional officers and inmates in jails and
20 prisons¹⁸; and
21

22 Whereas, In Colorado, state prisons have reduced their use of solitary confinement by 85%
23 without any other interventions and have seen a concurrent drop in the rate of prisoner on staff
24 violence¹⁸; and
25

26 Whereas, In Mississippi, when correctional facilities reduced their solitary confinement
27 population, violent incidents also dropped by nearly 70%¹⁹; and
28

29 Whereas, A 2015 study found that placing male inmates who were violent in solitary
30 confinement did not effectively deter or alter the probability, timing, or development of future
31 misconduct or violence²⁵; and
32

33 Whereas, Some correctional facilities have created special units to protect vulnerable groups
34 together with similar access to privileges and programs available to the general population
35 without using solitary confinement as a means of protection¹⁸; and
36

37 Whereas, Alternatives to solitary confinement exist for individuals with mental illness and for
38 sexual minorities, such as the Clinical Alternative to Punitive Segregation (CAPS) unit in New
39 York City²⁶; and
40

41 Whereas, AMA policy H-60.922 opposes the use of solitary confinement of juveniles for
42 disciplinary purposes in correctional facilities; therefore be it

RESOLVED, That our American Medical Association policy H-430.983, "Reducing the Use of Restrictive Housing in Prisoners with Mental Illness," be amended by addition and deletion to read as follows:

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

Our AMA will: (1) support limiting oppose the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities and detention centers, except for medical isolation or to protect individuals who are actively being harmed or will be immediately harmed by a physically violent individual, in which cases confinement may be used for as short a time as possible; and (2) while solitary confinement practices are still in place, support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement safe, humane, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities; and (3) ~~encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~ (Modify Current HOD Policy)

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

Received: 10/13/22

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RELEVANT AMA POLICY

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

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

Citation: Res. 412, A-18

Solitary Confinement of Juveniles in Legal Custody H-60.922

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

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

Discriminatory Policies that Create Inequities in Health Care H-65.963

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

Citation: Res. 001, A-18

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes

pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

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

Human Rights and Health Professionals H-65.981

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

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

Human Rights H-65.997

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

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

Appropriate Placement of Transgender Prisoners H-430.982

1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner's genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.
2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.

Citation: BOT Rep. 24, A-18;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 935
(I-22)

Introduced by: Medical Student Section

Subject: Government Manufacturing of Generic Drugs to Address Market Failures

Referred to: Reference Committee K

1 Whereas, Among United States adults, 24% indicate that it is difficult to afford the cost of their
2 prescription medication(s) and 29% state that they have been unable to take their medications
3 as prescribed within the past year (either not filling a prescription, substituting an over-the-
4 counter drug, cutting pills in half, skipping doses, or some combination thereof) due to inability
5 to afford them¹; and
6

7 Whereas, In 2019, 1.49 million Medicare Part D enrollees exceeded the out-of-pocket
8 catastrophic coverage threshold of \$6,550, such that they had to pay out of pocket for 5% of
9 total drug costs with no hard cap on total spending by enrollees, resulting in \$1.8 billion in out-
10 of-pocket spending by these enrollees for drug costs over the threshold²; and
11

12 Whereas, Spending on prescription pharmaceuticals constitutes 10% of national health
13 spending, 18% of large employer health benefit expenses, 19% of out-of-pocket spending for
14 Medicare beneficiaries, and 17% of out-of-pocket spending for employees³; and
15

16 Whereas, One analysis of the economic impact of medication non-adherence among fourteen
17 disease groups estimated the all-causes cost of non-adherence at between \$5,271 and \$52,341
18 per patient⁴; and
19

20 Whereas, A 2017 study published in *Cancer* determined that 23.8% of adolescent and young
21 adult cancer survivors (aged 15 to 39 years) experience cost-related medication non-
22 adherence, with Black survivors, uninsured survivors, and survivors with multiple comorbidities
23 suffering the highest rates of medication non-adherence⁵; and
24

25 Whereas, Research on patients with hypertension demonstrated that patients with cost-related
26 non-adherence are less likely to have self-reported normal blood pressure (59.5% versus 69.8%
27 for patients without nonadherence)⁶; and
28

29 Whereas, An analysis by the Kaiser Family Foundation found that 50% of drugs covered by
30 Medicare Part D had list price increases that were greater than the rate of inflation between July
31 2018 and 2019, with 14% of Part D-covered drugs having list price increases of 10% or more
32 over that year-long timeframe⁷; and
33

34 Whereas, Approximately 60% of total Medicare Part D spending (\$87 billion) results from the
35 purchase of the 250 top-selling drugs covered by Part D that have one manufacturer and no
36 generic or biosimilar competition⁸; and
37

38 Whereas, The number of generic suppliers per market decreased over time from 2004 to 2016,
39 due to both increased exit from markets and decreased market entry⁹; and

1 Whereas, The median number of drug manufacturers per market in 2016 was two, with 40% of
2 pharmaceutical markets supplied by a sole manufacturer as of 2016⁹; and
3

4 Whereas, There is evidence that the price of generic drugs is undergoing a statistically
5 significant increase over time, and the price increases are associated with decreasing numbers
6 of manufacturers for each generic drug, as well as alternative measures of increased supplier
7 concentration⁹; and
8

9 Whereas, According to a 2016 United States Government Accountability Office report, between
10 2010 and 2015, 315 of the 1,441 generic pharmaceuticals that were available for the duration of
11 the study period (22%) underwent at least one “extraordinary” price increase in Medicare Part
12 D, defined as a price increase of 100% or more¹⁰; and
13

14 Whereas, Generic drug shortages in the United States quadrupled between 2005 and 2011,
15 increasing from 61 drugs to 250 drugs¹¹; and
16

17 Whereas, The entry of additional generic manufacturers to a pharmaceutical market frequently
18 results in rapidly decreasing prices, as generic drugs entering the market between 2002 and
19 2014 lowered drug prices by 51% in the first year¹¹; and
20

21 Whereas, An antitrust investigation into generic manufacturers in 2018 uncovered evidence of a
22 generic “cartel” implicating at least 16 companies, in which anti-competitive price-fixing
23 agreements involving 300 pharmaceuticals resulted in price increases of up to 2,000
24 percent^{12,13}; and
25

26 Whereas, A *National Bureau of Economic Research* paper noted that “for products targeting
27 exceptionally small patient populations, the fixed costs of entry and the likelihood of intense
28 post-entry price competition mean that a new entrant is unlikely to earn profits”- in other words,
29 a generic manufacturer is highly unlikely to ever enter the market for some drugs targeted at
30 small patient populations¹⁴; and
31

32 Whereas, In 2018, a group of major hospital systems, including the Mayo Clinic and HCA
33 Healthcare, and philanthropies launched a non-profit generic drug manufacturer to produce
34 generic drugs experiencing shortages or dramatic price increases^{15,16}; and
35

36 Whereas, A recent *New England Journal of Medicine* perspective proposed the creation of a
37 non-profit generic pharmaceutical manufacturer to mitigate generic market failures and sell
38 generic drugs directly to hospitals and other institutional partners, with predetermined contracts
39 to ensure low prices and a minimum volume, which would protect the non-profit manufacturer
40 from being forced out of the market because of price changes¹⁷; and
41

42 Whereas, There is federal legislation most recently re-introduced in January 2020 that seeks to
43 establish an Office of Drug Manufacturing within the Department of Health and Human Services
44 to facilitate public manufacturing of generic drugs¹⁸⁻²⁰; and
45

46 Whereas, In recent testimony before the House of Representatives Subcommittee on
47 Regulatory Reform, Commercial and Antitrust Law, economist Craig Garthwaite characterized
48 the proposal to establish a government generic manufacturer for small market drugs as “a
49 potentially viable policy option” to mitigate the market failure resulting from the dearth of
50 competition in markets for generic drugs with insufficient market size to support more than one
51 manufacturer, which creates a natural monopoly²¹; and

Whereas, A federal non-profit government manufacturer would be able to focus production of generic version of prescription drugs on circumstances in which market failures occur, as in scenarios where there are no generic manufacturers within a market or there are two or fewer manufacturers and a significant price increase or a drug shortage^{18,22,23}; therefore be it

RESOLVED, That our American Medical Association support the formation of a non-profit government manufacturer of pharmaceuticals to produce small-market generic drugs. (New HOD Policy)

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

Received: 10/13/22

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RELEVANT AMA POLICY

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980

1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
 - a. The arbitration process should be overseen by objective, independent entities;
 - b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
 - c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
 - d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
 - e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
 - f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
 - g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
 - h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
 - i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
 2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
 - a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
 - b. The use of any international drug price index or average should preserve patient access to necessary medications;
 - c. The use of any international drug price index or average should limit burdens on physician practices; and
 - d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.
 3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.
- Citation: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Modified: CMS Rep. 4, A-22

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.

Citation: 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

Pharmaceutical Costs H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
 2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
 4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
 7. Our AMA supports legislation to shorten the exclusivity period for biologics.
 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
 10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
 11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
 12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
 13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
 14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.
- Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21;

Pay for Delay Arrangements by Pharmaceutical Companies H-110.989

Our AMA supports: (1) the Federal Trade Commission in its efforts to stop "pay for delay" arrangements by pharmaceutical companies and (2) federal legislation that makes tactics delaying conversion of medications to generic status, also known as "pay for delay," illegal in the United States.

Citation: Res. 520, A-08; Appended: Res. 222, I-12; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 817, I-16

Price of Medicine H-110.991

Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health

plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "clawbacks"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard.

Citation: CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Reaffirmation: A-19; Appended: Res. 126, A-19

Incorporating Value into Pharmaceutical Pricing H-110.986

1. Our AMA supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.

2. Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research.

3. Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.

Citation: CMS Rep. 05, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS-CSAPH Rep. 01, A-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: CSAPH Rep. 2, I-19; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 6, I-20

Cost of Prescription Drugs H-110.997

Our AMA:

(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;

(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;

(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;

(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;

(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;

(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA

A-rated generic); and

(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

Citation: BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep.3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

Opposition to Medicare Part B to Part D Changes H-110.982

Our AMA will advocate against Medicare changes which would recategorize Medicare Part B drugs into Part D.

Citation: Res. 217, I-18

Insulin Affordability H-110.984

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

Citation: CMS Rep. 07, A-18; Modified: Res. 118, A-22

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.

Citation: (CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation A-14; Reaffirmed in lieu of Res. 229, I-14)

Co-Pay Accumulators D-110.986

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

Citation: Res. 205, I-19; Appended: Res. 212, I-20

Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers H-100.950

1. Our AMA will advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek Food and Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system.

2. Our AMA supports requiring pharmaceutical companies to allow for reasonable access to and purchase of appropriate quantities of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays.

3. Our AMA will advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs.

Citation: Res. 809, I-16

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. Citation: Alt. Res. 806, I-17

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988

1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.
2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.
3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.
4. Our AMA supports measures that increase price transparency for generic prescription drugs.

Citation: Sub. Res. 106, A-15; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

Cost Sharing Arrangements for Prescription Drugs H-110.990

Our AMA:

1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes;
3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition; and
4. supports public and private prescription drug plans in offering patient-friendly tools and technology that allow patients to directly and securely access their individualized prescription benefit and prescription drug cost information.

Citation: CMS Rep. 1, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed in lieu of Res. 105, A-13; Reaffirmed in lieu of: Res. 205, A-17; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS Rep. 07, A-18; Appended: CMS Rep. 2, I-21

Study of Actions to Control Pharmaceutical Costs H-110.992

Our AMA will monitor the relationships between pharmaceutical benefits managers and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs.

Citation: Sub. Res. 114, A-01; Reaffirmed: Res. 533, A-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmed in lieu of Res. 229, I-14; Reaffirmed: CMS 2, I-15; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: CMS Rep. 08, A-19

Cost of New Prescription Drugs H-110.998

Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs.

Citation: (Res. 112, I-89; Reaffirmed: Res. 520, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 229, I-14)

Public Reporting of PBM Rebates H-110.981

Our AMA will advocate for: (1) Pharmacy Benefit Managers (PBMs) and state regulatory bodies to make rebate and discount reports and disclosures available to the public; and (2) the inclusion of required public reporting of rebates and discounts by PBMs in federal and state PBM legislation.

Citation: Res. 813, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 936
(I-22)

Introduced by: Medical Student Section

Subject: Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room

Referred to: Reference Committee K

1 Whereas, The United States leads the world in solid waste production with 262 million tons per
2 year, with the healthcare industry as its second highest waste-producing industry, accounting for
3 9% of U.S. energy use and 8% of U.S. greenhouse gas emissions¹⁻⁷; and
4

5 Whereas, Approximately 70% of the total waste generated by the healthcare sector is produced
6 by operating rooms and labor and delivery suites, and surgical and medical instrument
7 manufacturing is the leading cause for ozone depletion^{8,9}; and
8

9 Whereas, According to the Centers for Medicare and Medicaid Services, the cost of healthcare
10 continues to increase each year, estimated at \$3.8 trillion in 2019 and projected to increase at
11 an average rate of 5.5% per year until 2027^{1,5}; and
12

13 Whereas, Expenditures for outpatient surgical care consisted of 36% of all outpatient costs, and
14 inpatient surgical admissions made up 49% of all inpatient healthcare spending in 2017¹⁰; and
15

16 Whereas, It has been shown that decreasing the use of disposable drapes, attire, and other
17 plastic materials in the operating room resulted in savings of thousands of dollars per year with
18 no change in the infection rate¹¹⁻¹⁶; and
19

20 Whereas, Converting to reusable products in the operating room can reduce up to 65% of
21 operating room waste, diverting up to 25 tons of medical waste, saving up to \$150,000 per
22 hospital per year, and reducing water, carbon footprint, and volatile organics¹⁷⁻¹⁹; and
23

24 Whereas, A “reusable” device is one that the manufacturer has demonstrated to the FDA can
25 safely withstand harsh sterilization processes, compared to “reprocessing” single-use devices,
26 which is the act of sterilizing and reusing devices that the manufacturer has not marketed for
27 reuse, and therefore did not have to meet FDA’s stringent criteria for adequate safe sterilization
28 to be sold²⁰; and
29

30 Whereas, Single-use devices are not intended to be reused by the original manufacturer, and
31 exposure to heat and chemicals during the sanitation process could weaken the product^{21,22};
32 and
33

34 Whereas, Overall, the safety standards for multi-use devices are much higher and stricter than
35 those for single-use devices, and some single-use devices are labeled single-use because there
36 is not sufficient evidence to categorize them as reusable^{21,22}; and
37

38 Whereas, The U.S. Government Accountability Office released a report in 2008 noting that
39 “neither existing FDA data nor studies performed by others are sufficient to draw definitive

1 conclusions about the safety of reprocessed single use devices compared to similar original
2 devices,"²⁰; and

3
4 Whereas, The Joint Commission International published a report in 2017 to raise awareness of
5 the risks associated with reprocessing certain single use devices and the need for stricter
6 regulatory requirements for third-party re-processors and hospitals that use reprocessed
7 devices²³; and

8
9 Whereas, Even with the increased FDA and Joint Commission oversight, the trends by hospitals
10 and surgical centers to decrease costs by reprocessing devices and utilizing sustainable
11 practices are counteracted by increased efforts by original manufacturers, who do not reprocess
12 their own single-use devices, to sell more single-use devices and discourage reprocessing
13 practices^{24,25}; and

14
15 Whereas, Current policy on the reprocessing of single-use devices (H-480.959) does not
16 adequately promote sustainable practices by the original device manufacturers as they continue
17 to increase production of single-use devices and are not held liable once their device labeled
18 "single-use" is reprocessed or reused; therefore be it

19
20 RESOLVED, That our American Medical Association advocate for research into and
21 development of intended multi-use operating room equipment and attire over devices,
22 equipment and attire labeled for "single-use" with verified similar safety and efficacy profiles.
23 (Directive to Take Action)

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

Received: 10/13/22

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RELEVANT AMA POLICY

Reprocessing of Single-Use Medical Devices H-480.959

1. Our AMA: (a) supports the Food and Drug Administration (FDA) guidance titled "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals" that was issued on August 2, 2000;(b) supports the development of device-specific standards for the reuse and reprocessing of single-use medical devices involving all appropriate medical and professional organizations and the medical device industry;(c) encourages increased research by the appropriate organizations and federal agencies into the safety and efficacy of reprocessed single-use medical devices; and(d) supports the proper reporting of all medical device failures to the FDA so that surveillance of adverse events can be improved.

2.Our AMA strongly opposes any rules or regulations regarding the repair or refurbishment of medical tools, equipment, and instruments that are not based on objective scientific data.

Citation: CSA Rep. 3, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 217, I-17

Expansion of Hazardous Waste Landfills Over Aquifers H-135.943

Our AMA:

- (1) recognizes that the expansion of hazardous waste landfills or the construction of new hazardous waste landfills over principal aquifers represents a potential health risk for the public water supply and is inconsistent with sound principles of public health policy, and therefore should be opposed;
- (2) will advocate for the continued monitoring of groundwater sources, including principal aquifers, that may be contaminated by hazardous waste landfill or other landfill leachate; and
- (3) supports efforts to improve hazardous waste treatment, recycling, and disposal methods in order to reduce the public health burden.

Citation: CSAPH Rep. 4, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Green Initiatives and the Health Care Community H-135.939

Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

Citation: CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of: Res. 504, A-16; Modified: Res. 516, A-18; Modified: Res. 923, I-19

Health Care Expenditures D-155.996

1. Our AMA will work to improve our health care system by: (a) researching and collating existing studies on how health care dollars are currently spent; (b) identifying the amount of public and private health care spending that is transferred to insurance administration compared to industry and corporate standards, including money spent on defensive medicine; and (c) disseminating these findings to the American public, US Congress, and appropriate agencies.

2. Our AMA will continue its efforts to identify ways to reduce waste in the health care sector so that the trend of increasing health care costs over the years could be reversed.

Citation: Res. 103, A-05; Appended: Res. 121, A-10; Reaffirmed: CMS Rep. 01, A-20

Expense of Biohazardous Waste Removal H-135.953

(1)The AMA encourages the Environmental Protection Agency (EPA): (a) to explore the feasibility of establishing a national definition of biohazardous waste, emphasizing the origins and relative importance of wastes that can plausibly transmit infection compared with wastes that cannot, and (b) to monitor the sources of medical waste in environmental settings and develop guidelines applicable to all waste generators, including home health care sites, to reduce these sources of environmental pollution. (2)The AMA will work with appropriate governmental agencies and medical societies to educate physicians about the management of biohazardous waste and advocate that these groups work collectively to attain cost savings in biohazardous waste management.(3) The AMA urges practicing physicians to develop a biohazardous waste management program that fulfills their county, state, and municipal regulations, and that considers the different health risks to employees and the general public.

Citation: CSA Rep. 4, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Toxicity of Computers and Electronics Waste H-135.948

Our AMA (1) encourages its members and US health institutions to adopt purchasing or leasing contracts only with electronics manufacturers and distributors who are committed to safely handling the products at the end of life, meaning that they reuse and recycle to the greatest extent possible, do not export hazardous electronic waste to developing countries and safely dispose of the waste that can not be reused or recycled; (2) encourages its members and US health institutions to provide purchasing/leasing preferences to electronics manufacturers that minimize the use of toxic and hazardous constituents, use recycled content and design products that can be easily recycled in order to minimize the adverse public health impacts from electronic waste; and (3) supports policies that hold electronics manufacturers and distributors responsible for taking back their products at the end of life, with the objective of redesigning their products for longevity and reduction of harmful materials.

Citation: (Res. 423, A-03; Reaffirmed: CSAPH Rep. 1, A-13)

Stewardship of the Environment H-135.973

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues;

(15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

Policy to Reduce Waste from Pharmaceutical Sample Packaging H-115.979

Our AMA: (1) supports reducing waste from pharmaceutical sample packaging by making sample containers as small as possible and by using biodegradable and recycled materials whenever possible; and (2) supports the modification of any federal rules or regulations that may be in conflict with this policy.

Citation: Res. 508, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21

Recycling of Nursing Home Drugs H-280.959

Our AMA supports the return and reuse of medications to the dispensing pharmacy to reduce waste associated with unused medications in long-term care facilities (LTCFs) and to offer substantial savings to the health care system, provided the following conditions are satisfied: (1) The returned medications are not controlled substances. (2) The medications are dispensed in tamper-evident packaging and returned with packaging intact (e.g., unit dose, unused injectable vials and ampules). (3) In the professional judgment of the pharmacist, the medications meet all federal and state standards for product integrity. (4) Policies and procedures are followed for the appropriate storage and handling of medications at the LTCF and for the transfer, receipt, and security of medications returned to the dispensing pharmacy. (5) A system is in place to track re-stocking and reuse to allow medications to be recalled if required. (6) A mechanism (reasonable for both the payer and the dispensing LTC pharmacy) is in place for billing only the number of doses used or crediting the number of doses returned, regardless of payer source.

Citation: CSA Rep. 2, I-97; Reaffirmed: BOT Rep. 33, A-07; Modified and Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 01, A-19;

Health Care Expenditures D-155.996

1. Our AMA will work to improve our health care system by: (a) researching and collating existing studies on how health care dollars are currently spent; (b) identifying the amount of public and private health care spending that is transferred to insurance administration compared to industry and corporate standards, including money spent on defensive medicine; and (c) disseminating these findings to the American public, US Congress, and appropriate agencies.

2. Our AMA will continue its efforts to identify ways to reduce waste in the health care sector so that the trend of increasing health care costs over the years could be reversed.

Citation: Res. 103, A-05; Appended: Res. 121, A-10; Reaffirmed: CMS Rep. 01, A-20

Medications Return Program H-135.925

1. Our AMA supports access to safe, convenient, and environmentally sound medication return for unwanted prescription medications

2. Our AMA supports such a medication disposal program be fully funded by the pharmaceutical industry, including costs for collection, transport and disposal of these materials as hazardous waste.

3. Our AMA supports changes in federal law or regulation that would allow a program for medication recycling and disposal to occur.

Citation: Res. 214, A-16; Reaffirmed in lieu of: Res. 928, I-16

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

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

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