

AMA House of Delegates Handbook

2022 Interim Meeting
Hawai'i Convention Center
Nov. 12-15



Visit ama-assn.org/hod-business
or scan the QR code to access
the handbook online.

MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

- **All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items to be considered by the House.**

- **No action has been taken on anything herein contained, and it is informational only.**

- **Only those items that have been acted on finally by the House can be considered official.**

- **The Interim Meeting is focused on advocacy issues. A resolution committee (see AMA Bylaw 2.13.3) considers each resolution and recommends that the item be considered or not considered at the Interim Meeting. Items that meet the following definition of advocacy or that are considered urgent are recommended for acceptance:**

Active use of communication and influence with public and private sector entities responsible for making decisions that directly affect physician practice, payment for physician services, funding and regulation of education and research, and access to and delivery of medical care.

Resolutions pertaining to ethics should also be included in the agenda. Remaining items are recommended against consideration, but any delegate may request consideration when resolutions are presented for consideration (during Sunday's "Second Opening" Session). A simple majority of those present and voting is required for consideration.

- **REMINDER: *Only the Resolve portions of the resolutions are considered by the House of Delegates. The Whereas portions or preambles are informational and explanatory only.***



UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

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

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

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

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

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

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

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

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

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

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

LIST OF MATERIAL INCLUDED IN THIS HANDBOOK (I-22)

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

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

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

FOLLOWING COLLATED BY REFERRAL

- 13. Report(s) of the Board of Trustees - Sandra Adamson Fryofer, MD, Chair**
 - 01 Opposition to Requirements for Gender-Based Treatments for Athletes (Amendments to C&B)
 - 02 Further Action to Respond to the Gun Violence Public Health Crisis (F)
 - 03 Delegate Apportionment and Pending Members (Amendments to C&B)
 - 04 Preserving Access to Reproductive Health Services (Amendments to C&B)
 - 05 Towards Diversity and Inclusion: A Global Nondiscrimination Policy Statement and Benchmark for our AMA (Amendments to C&B)
 - 06 Informal Inter-Member Mentoring (Info. Report)
 - 07 Transparency of Resolution Fiscal Notes (F)

- 08 The Resolution Committee as a Standing Committee of the House (F)
- 09 Employed Physicians (F)
- 10 Redefining the AMA's Position on ACA and Healthcare Reform (Info. Report)
- 11 2022 AMA Advocacy Efforts (Info. Report)
- 12 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment (Amendments to C&B)
- 14. Report(s) of the Council on Constitution and Bylaws - Kevin C. Reilly, Sr., MD, Chair**
 - 01 Updated Bylaws: Delegate Apportionment and Pending Members (Amendments to C&B)
- 15. Report(s) of the Council on Ethical and Judicial Affairs - Peter A. Schwartz, MD, Chair**
 - 01 Amendment to Opinion 4.2.7, "Abortion" (Amendments to C&B)
 - 02 Amendment to Opinion 10.8, "Collaborative Care" (Amendments to C&B)
 - 03 Pandemic Ethics and the Duty of Care (Amendments to C&B)
 - 04 Research Handling of De-Identified Patient Information (Info. Report)
- 16. Opinion(s) of the Council on Ethical and Judicial Affairs - Peter A. Schwartz, MD, Chair**
 - 01 Amendment to E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment" (Info. Report)
- 17. Report(s) of the Council on Long Range Planning and Development - Edmond B. Cabbabe, MD, Chair**
 - 01 Senior Physicians Section Five-Year Review (F)
- 18. Report(s) of the Council on Medical Education - John P. Williams, MD, Chair**
 - 01 The Impact of Private Equity on Medical Training (C)
 - 02 Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process (C)
- 19. Report(s) of the Council on Medical Service - Lynn L. C. Jeffers, MD, Chair**
 - 01 Incentives to Encourage Efficient Use of Emergency Departments (J)
 - 02 Corporate Practice of Medicine (J)
 - 03 Health System Consolidation (Info. Report)
- 20. Report(s) of the Council on Science and Public Health - Noel N. Deep, MD, Chair**
 - 01 Drug Shortages: 2022 Update (K)
 - 02 Climate Change and Human Health (K)
- 21. Report(s) of the HOD Committee on Compensation of the Officers - Ray C. Hsiao, MD, Chair**
 - 01 Report of the HOD Committee on Compensation of the Officers (F)
- 22. Report(s) of the Speakers - Bruce A. Scott, MD, Speaker; Lisa Bohman Egbert, MD, Vice Speaker**
 - 01 Election Committee - Interim Report (F)
- 23. Resolutions**
 - 002 Assessing the Humanitarian Impact of Sanctions (Amendments to C&B)
 - 003 Indigenous Data Sovereignty (Amendments to C&B)
 - 005 Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants (Amendments to C&B)
 - 006 Assessing the Humanitarian Impact of Sanctions (Amendments to C&B)
 - 007 Consent for Sexual and Reproductive Healthcare (Amendments to C&B)
 - 008 Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era (Amendments to C&B)

- 009* Medical Decision-Making Autonomy of the Attending Physician (Amendments to C&B)
- 011* Advocating for the Informed Consent for Access to Transgender Health Care (Amendments to C&B)
- 012* Guidelines on Chaperones for Sensitive Exams (Amendments to C&B)
- 013* Hospital Bans on Trial of Labor After Cesarean (Amendments to C&B)
- 015* Restricting Derogatory and Stigmatizing Language of ICD-10 Codes (Amendments to C&B)
- 201 Physician Reimbursement for Interpreter Services (B)
- 202 Advocating for State GME Funding (B)
- 203 International Medical Graduate Employment (B)
- 205 Waiver of Due Process Clauses (B)
- 206 The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training (B)
- 207 Preserving Physician Leadership in Patient Care (B)
- 208 Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals (B)
- 209 Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training (B)
- 211 Illicit Drug Use Harm Reduction Strategies (B)
- 213 Hazard Pay During a Disaster Emergency (B)
- 214 Universal Good Samaritan Statute (B)
- 215 Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies (B)
- 216* Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care in Medicare (B)
- 217* Restrictions on the Ownership of Hospitals by Physicians (B)
- 218* Screening and Approval Process for the Over-the-Counter Sale of Substances with Potential for Recreational Use and Abuse (B)
- 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 (B)
- 220* Extend Telemedicine to Out of State Enrolled College Students to Avoid Emergency Room and Inpatient Psychiatric Hospitalizations when in Crisis (B)
- 222* Allocate Opioid Funds to Train More Addiction Treatment Physicians (B)
- 223* Criminalization of Pregnancy Loss as the Result of Cancer Treatment (B)
- 224* Fertility Preservation (B)
- 227* Access to Methotrexate Based on Clinical Decisions (B)
- 302 Expanding Employee Leave to Include Miscarriage and Stillbirth (C)
- 303 Medical Student Leave Policy (C)
- 304 Protecting State Medical Licensing Boards from External Political Influence (C)
- 305 Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups (C)
- 306 Increased Credit for Continuing Medical Education Preparation (C)
- 307 Fair Compensation of Residents and Fellows (C)
- 308 Paid Family/Medical Leave in Medicine (C)
- 309 Bereavement Leave for Medical Students and Physicians (C)
- 310* Enforce AMA Principles on Continuing Board Certification (C)
- 311* Supporting a Hybrid Residency and Fellowship Interview Process (C)
- 313* Request a two-year delay in ACCME Changes to State Medical Society Recognition Program (C)
- 314* Balancing Supply and Demand for Physicians by 2030 (C)

315* Bedside Nursing and Health Care Staff Shortages (C)
601 AMA Withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity (F)
602 Finding Cities for Future AMA Conventions/Meetings (F)
606* Patient-Centered Health Equity Strategic Plan and Sustainable Funding (F)
607* Accountability for Election Rules Violations (F)
801 Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans (J)
802 FAIR Health Database (J)
803 Patient Centered Medical Home – Administrative Burdens (J)
804 Centers for Medicare & Medicaid Innovation Projects (J)
805 COVID Vaccine Administration Fee (J)
806 Healthcare Marketplace Plan Selection (J)
807 Medicare Advantage Record Requests (J)
808 Reinstatement of Consultation Codes (J)
809 Uniformity and Enforcement of Medicare Advantage Plans and Regulations (J)
810 Medicare Drug Pricing and Pharmacy Costs (J)
811 Covering Vaccinations for Seniors Through Medicare Part B (J)
812 Implant-Associated Anaplastic Large Cell Lymphoma (J)
813 Amending Policy on a Public Option to Maximize AMA Advocacy (J)
814 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored? (J)
815* Opposition to Debt Litigation Against Patients (J)
816* Medicaid and CHIP Coverage for Glucose Monitoring Devices for Patients with Diabetes (J)
817* Promoting Oral Anticancer Drug Parity (J)
818* Pediatric Obesity Treatment Insurance Coverage (J)
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 (J)
820* Third-Party Pharmacy Benefit Administrators (J)
902 Reducing the Burden of Incarceration on Public Health (K)
904 Immigration Status is a Public Health Issue (K)
905 Minimal Age of Juvenile Justice Jurisdiction in the United States (K)
906 Requirement for COVID-19 Vaccination in Public Schools Once Fully FDA-Authorized (K)
907 A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury (K)
908 Older Adults and the 988 Suicide and Crisis Timeline (K)
909 Decreasing Gun Violence and Suicide in Seniors (K)
910 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use (K)
911 Critical Need for National ECC System to Ensure Individualized, State-Wide, care for STEMI, CS and OHCA, and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies (K)
912* Reevaluating the Food and Drug Administration's Citizen Petition Process (K)
913* Supporting and Funding Sobering Centers (K)
915* Pulse Oximetry in Patients with Pigmented Skin (K)
916* Non-Cervical HPV Associated Cancer Prevention (K)
917* Care for Children with Obesity (K)
918* Opposition to Alcohol Industry Marketing Self-Regulation (K)

- 919* Decreasing Youth Access to E-cigarettes (K)
- 920* Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings (K)
- 921* Firearm Injury and Death Research and Prevention (K)
- 922* Firearm Safety and Technology (K)
- 923* Physician Education and Intervention to Improve Patient Firearm Safety (K)
- 924* Domestic Production of Personal Protective Equipment (K)
- 926* Limit the Pornography Viewing by Minors Over the Internet (K)
- 927* Off-Label Policy (K)
- 928* Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements (K)
- 929* Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive Populations (K)
- 930* Addressing Longitudinal Health Care Needs of Children in Foster Care (K)
- 931* Amending H-160.903 Eradicating Homelessness to Include Support for Street Medicine Programs (K)
- 933* Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV (K)
- 935* Government Manufacturing of Generic Drugs to Address Market Failures (K)
- 936* Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room (K)

24. Resolutions not for consideration

- 001 Updating Physician Job Description for Disability Insurance (Not for consideration)
- 004 Supporting Intimate Partner and Sexual Violence Safe Leave (Not for consideration)
- 010* Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates (Not for consideration)
- 014* Gender-Neutral Language in AMA Policy (Not for consideration)
- 204 Elimination of Seasonal Time Change (Not for consideration)
- 210 Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time (Not for consideration)
- 212 SNAP Expansion for DACA Recipients (Not for consideration)
- 221* Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses (Not for consideration)
- 225* Drug Policy Reform (Not for consideration)
- 226* Support for Mental Health Courts (Not for consideration)
- 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education (Not for consideration)
- 312* Reporting of Residency Demographic Data (Not for consideration)
- 603 AMA House of Delegates Resolution Process Review (Not for consideration)
- 604 Solicitation Using the AMA Brand (Not for consideration)
- 605* Decreasing Political Advantage Within AMA Elections (Not for consideration)
- 608* Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development (Not for consideration)
- 901 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies (Not for consideration)
- 903 Supporting Further Study of Kratom (Not for consideration)
- 914* Greenhouse Gas Emissions from Health Care (Not for consideration)
- 925* Incorporation of Social Determinants of Health Concepts into Climate Change Work of the AMA (Not for consideration)

932* Increase Employment Services Funding for People with Disabilities (Not for consideration)

934* Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
(Not for consideration)

* Contained in the Handbook Addendum

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

Preamble

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

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

Declaration

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

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

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

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

Delegate/Alternate Delegate Job Description, Roles and Responsibilities

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

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

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

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

A. Qualifications

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

B. Responsibilities

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

SEATING ALLOCATION – 2022 INTERIM MEETING

ADDICTION MEDICINE – 3

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

ALLERGY AND IMMUNOLOGY – 1

American College of Allergy, Asthma & Immunology (ACAAI) – 1

AMDA – 1

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

AMGA - 1

American Medical Group Association (AMGA) - 1

ANESTHESIOLOGY - 11

American Society of Anesthesiologists (ASA) - 9
Former Board Chair (Patchin) – 1
Delegates – 8
American Society of Regional Anesthesia and Pain Medicine (ASRAPM) - 2

ARS – 1

American Rhinologic Society (ARS) - 1

CARDIOLOGY - 15

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

CHEST PHYSICIANS - 3

American College of Chest Physicians (CHEST) (ACCP) - 3

CRITICAL CARE MEDICINE- 2

Society of Critical Care Medicine (SCCM) - 2

DERMATOLOGY - 10

American Academy of Dermatology (AAD) – 4
American College of Mohs Surgery (ACMS) – 1
American Contact Dermatitis Society (ACDS) - 1
American Society for Dermatologic Surgery (ASDS) - 2
American Society of Dermatopathology (ASD) - 1
Society for Investigative Dermatology (SID) - 1

EMERGENCY MEDICINE - 11

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

ENDOCRINOLOGY - 5

American Association of Clinical Endocrinology (AACE) - 1
American Soc for Reproductive Medicine (ASRM) - 2
The Endocrine Society (ES) - 2

FAMILY PHYSICIANS - 17

American Academy of Family Physicians (AAFP) - 17
Former Board Chair (Langston) - 1
Delegates - 16

GASTROENTEROLOGY - 7

American College of Gastroenterology (ACG) - 2
American Gastroenterological Association (AGA) - 2
American Society for Gastrointestinal Endoscopy (ASGE) - 3

GERIATRIC MEDICINE - 3

American Geriatrics Society (AGS) – 3
Delegates – 2
Resident and Fellow Section Delegate - 1

GREAT LAKES - 61

Illinois - 16
Delegates - 12
American College of Legal Medicine (ACLM) - 1
American Coll of Radiation Oncology (ACRO) - 1
American Med Women’s Association (AMWA) - 1
Society of Nuclear Medicine and Molecular Imaging (SNMMI) - 1
Indiana - 6
Delegates – 5
Medical Student Regional Delegate- 1
Michigan – 15
Trustee (Mukkamala) - 1
Delegates - 13
Medical Student Regional Delegate - 1
Ohio - 15
Delegates (minus Vice Speaker) - 13
Medical Student Regional Delegate - 2
Resident and Fellow Section Delegate - 1
Wisconsin - 9
Former Board Chair (Flaherty) - 1
Delegates - 5
Resident and Fellow Section Delegates - 2
Undersea & Hyperbaric Medical Society (UHMS) – 1

HEART OF AMERICA - 11

Kansas - 3
Missouri – 8
Former President (Barbe) - 1
Delegates - 6
Medical Student Regional Delegate- 1

HEMATOLOGY - 2

American Society of Hematology (ASH) - 2

HOSPITAL MEDICINE - 3

Society of Hospital Medicine (SHM) - 3

INFECTIOUS DISEASE - 3

Infectious Diseases Society of America (IDSA) - 3
Delegates - 2
Resident and Fellow Section Delegate - 1

INTERNAL MEDICINE - 35

American College of Physicians (ACP) – 34
Renal Physicians Association (RPA) - 1

MOBILITY CAUCUS - 14

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

NEUROSCIENCES - 33

American Academy of Child and Adolescent Psychiatry (AACAP) - 2
American Academy of Hospice and Palliative Medicine (AAHPM) - 2
American Academy of Neurology (AAN) – 5
Delegates – 4
Resident and Fellow Section Delegate - 1
American Academy of Pain Medicine (AAPM) - 1
American Acad of Psychiatry and the Law (AAPL) - 1
American Assoc for Geriatric Psychiatry (AAGP) - 1
American Association of Neurological Surgeons (AANS) - 3
Former President (Carmel) - 1
Delegates – 2
Amer Assn of Neuromuscular & Electrodiagnostic Med (AANEM) - 2
American Psychiatric Association (APA) - 10
Former President (Harris) – 1
Delegates - 8
Resident and Fellow Section Delegate – 1
American Society of Neuroimaging (ASNI) - 1
Congress of Neurological Surgeons (CNS) - 2
GLMA : Health Professionals Advancing LGBTQ Equality – 1
North American Neuromodulation Society (NANS) - 1
Spine Intervention Society (SIS) - 1

NEW ENGLAND - 30

Connecticut – 7
Trustee (Koirala) - 1
Delegates - 4
Medical Student Regional Delegates- 2
Maine - 4
Former President (McAfee) - 1
Delegates – 2
Medical Student Regional Delegate - 1
Massachusetts - 15
Delegates - 13
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
New Hampshire - 1
Rhode Island - 2
Vermont – 1

NEW YORK - 29

Former President (Nielsen) – 1
Trustee (Madejski) – 1
Delegates - 22
Medical Student Regional Delegate - 1
Resident and Fellow Section Delegate - 1
American College of Nuclear Medicine (ACNM) - 1
American Society of Neuroradiology (ASN) - 2

NORTH CENTRAL - 18

Iowa – 5
Delegates – 4
Outpatient Endovascular and Interventional Society (OEIS) - 1
Minnesota – 6
Delegates - 5
Medical Student Regional Delegate- 1
Nebraska – 4
Delegates – 2
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
North Dakota - 1
South Dakota - 2

OBSTETRICIANS AND GYNECOLOGISTS - 17

American Association of Gynecologic Laparoscopists (AAGL) - 2
American College of Medical Genetics and Genomics (ACMGG) - 1
American College of Obstetricians and Gynecologists (ACOG) - 14

ONCOLOGY - 4

Association for Clinical Oncology (ACO) – 4
Delegates - 3
Resident and Fellow Section Delegate - 1

PACWEST CONFERENCE - 87

Alaska - 1
Arizona - 8
Delegates - 5
Medical Student Regional Delegate- 1
American Institute of Ultrasound in Medicine (AIUM) – 2
California - 45
Former Presidents (Bristow, Corlin, Plested) – 3
Trustee (Aizuss, Ding) - 2
Delegates - 33
Medical Student Regional Delegates - 2
Resident and Fellow Section Delegates - 3
American Clinical Neurophysiology Soc (ACNS) – 1
North American Neuro-Ophthalmology Society (NANOS) – 1
Colorado - 7
Former President (Lazarus) - 1
Delegates - 5
Obesity Medicine Association (OMA) - 1
Hawaii - 2
Idaho - 1
Montana - 1
Nevada – 3
Delegates - 2
Resident and Fellow Section Delegate - 1
New Mexico – 5
Former President (McAneny) - 1
Delegates – 2
Medical Student Regional Delegate - 1
American Academy of Allergy, Asthma & Immunology (AAAAI) – 1

PACWEST CONFERENCE (cont’d)

Oregon - 3
Utah - 4
Former Presidents (A. Nelson, J. Nelson) - 2
Delegates - 2
Washington – 6
Delegates – 5
Resident and Fellow Section Delegate - 1
Wyoming – 1

PATHOLOGY - 11

American Society for Clinical Pathology (ASCP) – 3
American Society of Cytopathology (ASC) - 1
College of American Pathologists (CAP) – 4
National Association of Medical Examiners (NAME) - 1
United States and Canadian Academy of Pathology (USCAP) – 2

PEDIATRICS - 6

American Academy of Pediatrics (AAP) – 6
Trustee (Ajayi) - 1
Delegates - 5

PENNSYLVANIA - 20

Former President (Gurman) – 1
Trustee (Heine) - 1
Delegates - 13
Medical Student Regional Delegate- 1
American Association of Physicians of Indian Origin (AAPIO) – 1
American Osteopathic Association (AOA) – 1
American Hernia Society (AHS) - 1
National Medical Association (NMA) - 1

PHYSICAL MEDICINE AND REHABILITATION - 3

American Academy of Physical Med & Rehabilitation (AAPMR) – 3
Delegates – 2
Resident and Fellow Section Delegate - 1

PREVENTIVE MEDICINE - 8

Aerospace Medical Association (AsMA) - 1
American Academy of Insurance Medicine (AAIM) - 1
American Association of Public Health Physicians (AAPHP) – 2
Delegate - 1
Resident and Fellow Section Delegate - 1
American College of Medical Quality (ACMQ) - 1
American College of Occupational & Environmental Med (ACOEM) - 2
American College of Preventive Medicine (ACPM) - 1

RADIOLOGY - 19

American College of Radiology (ACR) – 11
Delegates - 8
Resident and Fellow Section Delegates - 3
American Roentgen Ray Society (ARRS) – 3
American Soc for Radiation Oncology (ASRO) – 2
Association of University Radiologists (AUR) - 1
Society of Interventional Radiology (SIR) - 2

RHEUMATOLOGY - 2

American College of Rheumatology (ACRrh) - 2

RSNA - 3

Radiological Society of North America (RSNA) – 3

SECTIONS - 12

Academic Physicians Section (APS) - 1
Integrated Physician Practice Section (IPPS) - 1
International Medical Graduates Section (IMG) - 1
Medical Student Section (MSS) - 2
Trustee (Harvey) - 1
Delegate – 1
Minority Affairs Section (MAS) - 1
Organized Medical Staff Section (OMSS) – 1
Private Practice Physician Section (PPPS) - 1
Resident and Fellow Section (RFS) – 1
Senior Physicians Section (SPS) - 1
Women Physicians Section (WPS) -1
Young Physicians Section (YPS) - 1

SERVICES - 6

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

SLEEP MEDICINE – 2

American Academy of Sleep Medicine (AASM) - 2

SOUTHEASTERN - 124

Alabama - 4
Arkansas – 4
Trustee (Ferguson) – 1
Delegates - 3
Delaware - 2
Former Board Chair (Permut) – 1
Delegate - 1
District of Columbia - 5
Former Board Chair (Scalettar) - 1
Delegates - 3
Resident and Fellow Section Delegate - 1
Florida – 23
Former Presidents (Coble, Wilson) – 2
Trustee (Butler) - 1
Delegates - 16
Medical Student Regional Delegates- 2
Resident and Fellow Section Delegate - 1
The Triological Society (TS) - 1
Georgia – 7
Delegates - 6
Medical Student Regional Delegate- 1
Kentucky - 7
Former President (Hoven) - 1
Delegates (minus Speaker) – 5
Resident and Fellow Section Delegates - 2
Louisiana - 10
Former Presidents (Johnson, Palmisano) - 2
Delegates - 6
Medical Student Regional Delegates- 2
Maryland - 8
Trustee (Edwards) - 1
Delegates – 5
Medical Student Regional Delegate - 1
Acad of Physicians in Clinical Research (APCR) - 1

SOUTHEASTERN (cont’d)

Mississippi - 5
Former President (Hill) - 1
Delegates – 3
Resident and Fellow Section Delegate - 1
New Jersey – 10
Delegates - 8
Medical Student Regional Delegate- 1
American Acad of Facial Plastic and Reconstructive Surgery (AAFPRS) - 1
North Carolina - 6
Oklahoma - 4
Puerto Rico - 2
South Carolina – 8
Former President (Smoak) – 1
Trustee (Pastides) - 1
Delegates - 5
Medical Student Regional Delegate- 1
Tennessee – 6
Delegates – 5
American Vein and Lymphatic Society (AVLS) - 1
Virginia - 11
Former President (Wootton) - 1
Delegates - 8
Medical Student Regional Delegate- 1
Resident and Fellow Section Delegate - 1
West Virginia – 2

SURGEONS - 43

American Academy of Cosmetic Surgery (AACS) - 1
American Academy of Ophthalmology (AAO) – 4
American Academy of Otolaryngic Allergy (AAOA) - 1
Amer Acad of Otolaryngology - Head & Neck Surgery (AAOHN) - 3
American Association for Thoracic Surgery (AATS) - 1
American Association of Plastic Surgeons (AAPS) - 1
American College of Surgeons (ACS) – 7
American Society for Metabolic and Bariatric Surgery (ASMBS) - 1
American Society for Reconstructive Microsurgery (ASRMS) - 1
American Society of Breast Surgeons (ASBS) - 2
American Society of Cataract and Refractive Surgery (ASCTRS) - 2
American Society of Colon and Rectal Surgeons (ASCRS) - 2
American Society of General Surgeons (ASGS) - 1
American Soc of Maxillofacial Surgeons (ASMS) - 1
Amer Soc of Ophthalmic Plastic & Reconstructive Surg (ASOPRS) - 1
American Society of Plastic Surgeons (ASPS) – 4
Delegates – 3
Resident and Fellow Section Delegate - 1
American Society of Retina Specialists (ASRS) - 1
American Society of Transplant Surgeons (ASTS) - 1
International Coll of Surgeons-US Section (ICS-US) - 1
Society for Vascular Surgery (SVS) - 1
Society of Amer Gastrointestinal Endoscopic Surgeons (SAGES) - 2
Society of Laparoendoscopic Surgeons (SLR) - 2
Society of Thoracic Surgeons (STS) - 2

TERRITORIES - 2

Guam - 1
Virgin Islands - 1

TEXAS - 29

Former Presidents (Bailey, Dickey, Rohack) - 3
Former Board Chair (Kridel) – 1
Delegates - 20
Medical Student Regional Delegates – 2
Resident and Fellow Section Delegates - 2
International Society of Hair Restoration Surgery (ISHRS) – 1

THORACIC MEDICINE - 2

American Thoracic Society (ATS) - 2

UROLOGY - 4

American Assoc of Clinical Urologists (AACU) - 1
American Urological Association (AUA) – 3
Delegates -2
Resident and Fellow Section Delegate – 1

OFFICIAL OBSERVERS - 28

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

TELLERS - 4

HOUSE OF DELEGATES - HAWAII CONVENTION CENTER (I-22)

Audience Left

Audience Right

SEAT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
ROW	EMERGENCY MEDICINE (11)											ND (1)	NEBRASKA (4)			MINNESOTA (6)	
1			RESIDENT	RESIDENT						RESIDENT	STUDENT						
2	CRITICAL CARE (2)		HOSPITAL MEDICINE (3)			EMERGENCY MEDICINE			IOWA (5)			MINNESOTA					
3	DERMATOLOGY (10)				CHEST PHYSICIANS (3)			SOUTH DAKOTA (2)		CALIFORNIA (45)							
4	DERMATOLOGY				ADDICTION MED (3)			CALIFORNIA									
5	ANESTHESIOLOGY (11)				AMGA (1)	AMDA (1)	CALIFORNIA										
6	ANESTHESIOLOGY				GERIATRIC MEDICINE (3)			CALIFORNIA									
7	THORACIC MED (2)		SLEEP MEDICINE (2)		INFECTIOUS DISEASE (3)		ALLERG (1)	CALIFORNIA									
8	ENDOCRINOLOGY (5)				RSNA (3)			CALIFORNIA						AK (1)			
9	CARDIOLOGY (15)								HAWAII (2)		ID (1)	MT (1)	UTAH (4)				
10	CARDIOLOGY								COLORADO (7)							WY (1)	
11	PREVENTIVE MEDICINE (8)								NEW MEXICO (5)				OREGON (3)				
12	SERVICES (6)				ARIZONA (8)				WASHINGTON (6)								
13	RHEUMATOLOGY (2)		PENNSYLVANIA (20)				HEMATOLOGY (2)		ARIZONA				NEVADA (3)				
14	PENNSYLVANIA								SECTIONS (12)								
15	PENNSYLVANIA								SECTIONS				GASTROENTEROLOGY (7)				
16	RHODE ISLAND (2)		MAINE (4)			PMR (3)		PATHOLOGY			GASTROENTEROLOGY						
17	VT (1)	CONNECTICUT (7)						PATHOLOGY (11)									
18	NH (1)	MASSACHUSETTS (15)								RADIOLOGY (19)							
19	MASSACHUSETTS								RADIOLOGY								
20	NEUROSCIENCES (33)								RADIOLOGY				OBSTETRICIANS & GYNECOLOGISTS (17)				
21	NEUROSCIENCES								OBSTETRICIANS & GYNECOLOGISTS								
22	NEUROSCIENCES								OBSTETRICIANS & GYNECOLOGISTS				MISSOURI (8)				
23	NEUROSCIENCES								KANSAS (3)			MISSOURI					
24	OFFICIAL OBSERVERS (28)																

SPEAKER

VICE SPEAKER

SEAT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	SEAT		
ROW	SURGEONS (43)											NEW YORK (29)							
1	T	T	ASRMS	AAPS	AACS	AATS	ASTS	STS	STS								1		
2	SURGEONS											NEW YORK							
3	SURGEONS											NEW YORK							
4	SURGEONS											NEW YORK							
5	ALABAMA (4)				SURGEONS						ARS (1)	TEXAS (29)							
6	OKLAHOMA (4)				DELAWARE (2)		SURGEONS				TEXAS								
7	TENNESSEE (6)						WEST VIRGINIA (2)			TEXAS									
8	NORTH CAROLINA (6)						PUERTO RICO (2)		TEXAS										
9	DISTRICT OF COLUMBIA (5)					INTERNAL MEDICINE (35)											TEXAS		
10	KENTUCKY (7)							INTERNAL MEDICINE											
11	LOUISIANA (10)										INTERNAL MEDICINE								
12	SOUTH CAROLINA (8)								LOUISIANA	INTERNAL MEDICINE									
13	MARYLAND (8)								INTERNAL MEDICINE				FAMILY PHYSICIANS (17)						
14	FLORIDA (23)												FAMILY PHYSICIANS						
15	FLORIDA								FAMILY PHYSICIANS				PEDIATRICS						
16	ARKANSAS (4)				FLORIDA				OHIO (15)				PEDIATRICS (6)						
17	GEORGIA (7)							VIRGINIA			OHIO								
18	VIRGINIA (11)											OHIO				ILLINOIS			
19	MISSISSIPPI (5)					NEW JERSEY			MICHIGAN (15)				ILLINOIS (16)						
20	NEW JERSEY (10)										MICHIGAN			ILLINOIS					
21	ONCOLOGY (4)				GU (1)	VI (1)	MICHIGAN				ILLINOIS								
22	MOBILITY (14)											MICHIGAN			WISCONSIN (9)		INDIANA (6)		
23	MOBILITY											WISCONSIN				INDIANA			
24	UROLOGY (4)				OFFICIAL OBSERVERS (28)														

FLOOR PLAN LEVEL 1

Kamehameha Exhibition Hall and Lobby



LEGEND

- Parking
- Bicycle parking
- Escalator (2nd FL parking)
- Escalator (3rd & 4th FL)
- Elevator
- Accessible passenger loading zone
- Restroom (Men)
- Restroom (Women)
- Restroom (Universal)
- ATM
- Vending area
- Water fountain
- Bottle filler
- Nursing pod
- Defibrillator
- Smoking area
- LCD board
- Automatic entry door
- Entrance
- Wi-Fi area
- 1801 CAFE + BAR

HAWAII
CONVENTION CENTER
Where Business and Aloha Meet

Hawai'i Convention Center

1801 Kalākaua Avenue, Honolulu, Hawai'i 96815
tel: 808-943-3500 • fax: 808-943-3599
email: info@hccasm.com • hawaii-convention.com

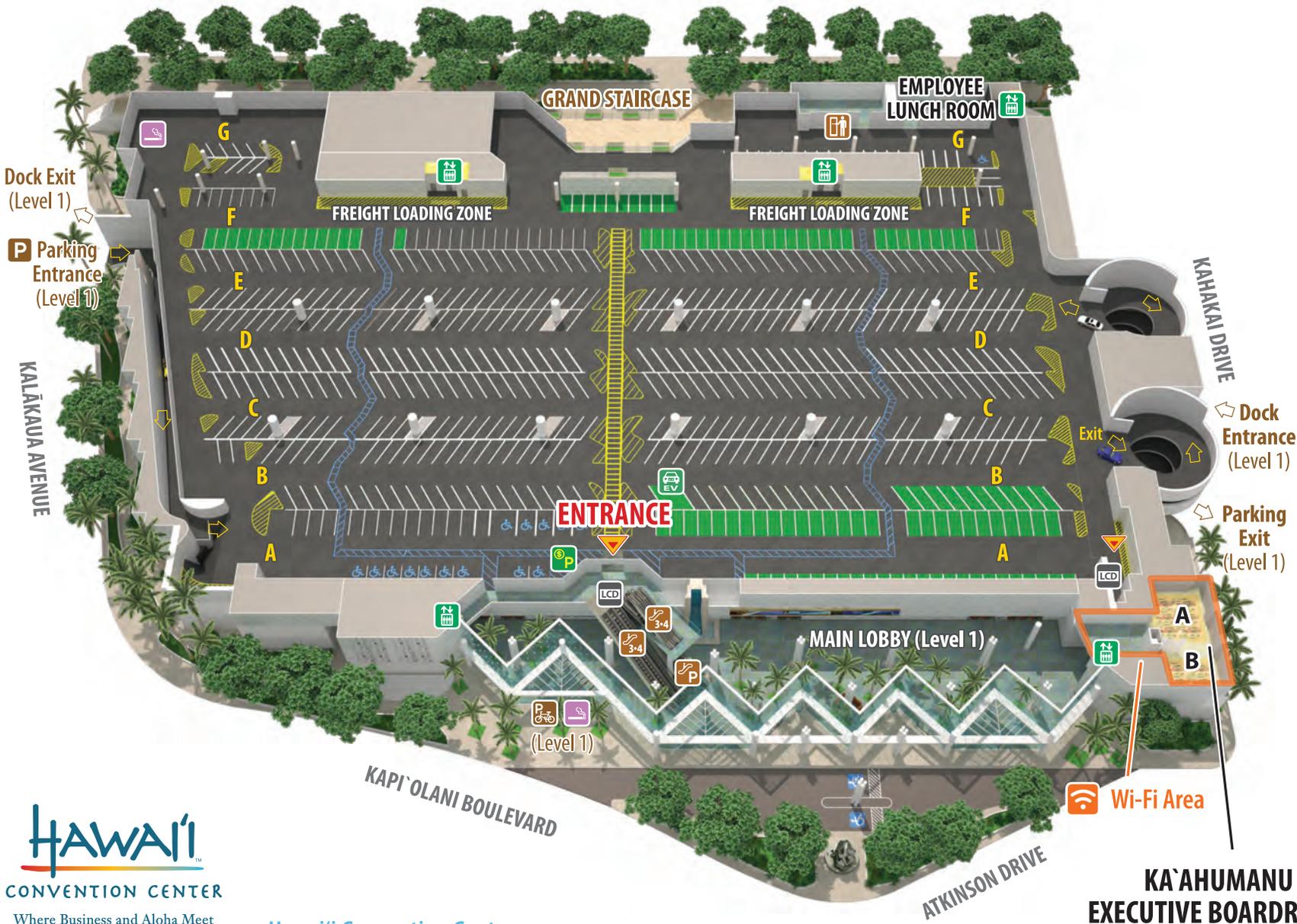


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Complimentary Wi-Fi Area
Connect to : Hawaii Free Wi-Fi

FLOOR PLAN LEVEL 2 Parking

~ ALA WAI CANAL ~



LEGEND

- Parking
- Bicycle parking
- Accessible passenger parking space
- Parking cashier
- Electric vehicle charging station
- Escalator (2nd FL parking)
- Escalator (3rd & 4th FL)
- Elevator
- Vending area
- Smoking area
- LCD board
- Entrance
- Exit
- Wi-Fi area

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KA'AHUMANU EXECUTIVE BOARDROOM

FLOOR PLAN LEVEL 3

Meeting Rooms

Complimentary Wi-Fi Area
Connect to : Hawaii Free Wi-Fi



LEGEND	
	Business center
	808 Café
	Escalator (2nd FL parking)
	Escalator (3rd & 4th FL)
	Elevator
	Restroom (Men)
	Restroom (Women)
	Water fountain
	Bottle filler
	Defibrillator
	First aid
	Art display
	Smoking area
	LCD board
	Entrance
	Wi-Fi area

HAWAII
CONVENTION CENTER
Where Business and Aloha Meet

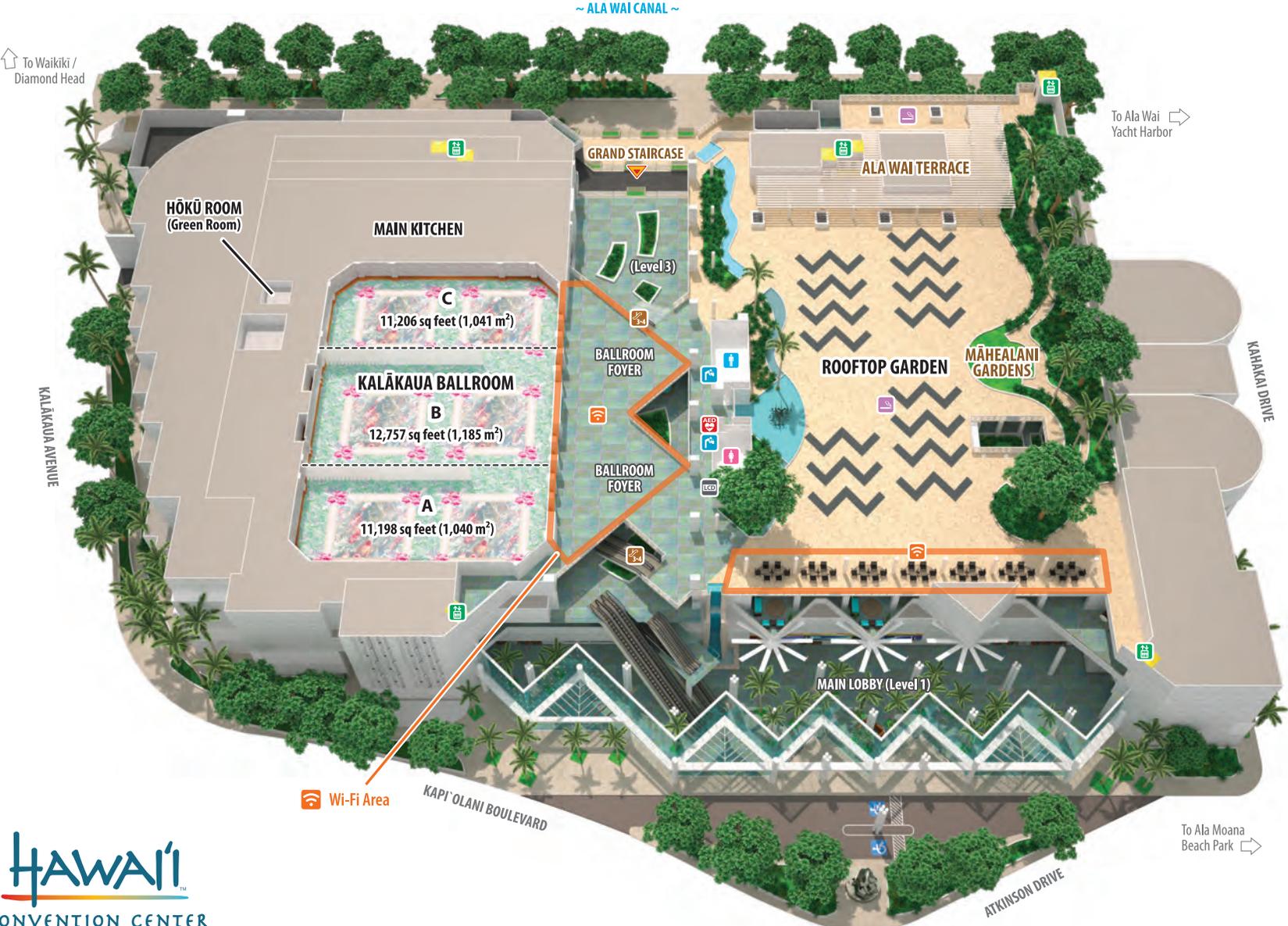
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FLOOR PLAN LEVEL 4

Ballroom and Rooftop Garden



LEGEND

- Escalator (3rd & 4th FL)
- Elevator
- Restroom (Men)
- Restroom (Women)
- Water fountain
- Defibrillator
- Smoking area
- LCD board
- Wi-Fi area

ROOFTOP GARDEN FEATURES:

- 2.5 acre open air rooftop garden
- Floor Load Limit, 100 lbs per net sq. ft.
- Grassy stage area approx. 37 x 42 ft.

Complimentary Wi-Fi Area
 Connect to : Hawaii Free Wi-Fi

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2022 INTERIM MEETING OF THE AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Official Call to the Officers and Members of the American Medical Association to attend the November 2022 Interim Meeting of the House of Delegates in Honolulu, Hawai'i, –November 12-15, 2022.

The House of Delegates will convene at 1:00 p.m., on November 12 at the Hawai'i Convention Center.

STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES

Alabama 4	Guam 1	Massachusetts 13	New York 22	Tennessee 5
Alaska 1	Hawaii 2	Michigan 13	North Carolina 6	Texas 20
Arizona 5	Idaho 1	Minnesota 5	North Dakota 1	Utah 2
Arkansas 3	Illinois 12	Mississippi 3	Ohio 13	Vermont 1
California 33	Indiana 5	Missouri 6	Oklahoma 4	Virgin Islands 1
Colorado 5	Iowa 4	Montana 1	Oregon 3	Virginia 8
Connecticut 4	Kansas 3	Nebraska 2	Pennsylvania 13	Washington 5
Delaware 1	Kentucky 5	Nevada 2	Puerto Rico 2	West Virginia 2
District of Columbia 3	Louisiana 6	New Hampshire 1	Rhode Island 2	Wisconsin 5
Florida 16	Maine 2	New Jersey 8	South Carolina 5	Wyoming 1
Georgia 6	Maryland 5	New Mexico 2	South Dakota 2	

SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES

American Academy of Child and Adolescent Psychiatry 2	American Society for Gastrointestinal Endoscopy 3
American Academy of Dermatology 4	American Society for Radiation Oncology 2
American Academy of Family Physicians 16	American Society for Reproductive Medicine 2
American Academy of Hospice and Palliative Medicine 2	American Society of Addiction Medicine 2
American Academy of Neurology 4	American Society of Anesthesiologists 8
American Academy of Ophthalmology 4	American Society of Breast Surgeons 2
American Academy of Orthopaedic Surgeons 5	American Society of Cataract and Refractive Surgery 2
American Academy of Otolaryngology-Head and Neck Surgery 3	American Society of Colon and Rectal Surgeons 2
American Academy of Pediatrics 5	American Society of Echocardiography 2
American Academy of Physical Medicine and Rehabilitation 2	American Society of Hematology 2
American Academy of Sleep Medicine 2	American Society of Interventional Pain Physicians 2
American Association of Gynecologic Laparoscopists 2	American Society of Neuroradiology 2
American Association of Neurological Surgeons 2	American Society of Nuclear Cardiology 2
American Association of Neuromuscular & Electrodiagnostic Medicine 2	American Society of Plastic Surgeons 3
American College of Cardiology 7	American Society of Regional Anesthesia and Pain Medicine 2
American College of Chest Physicians (CHEST) 3	American Thoracic Society 2
American College of Emergency Physicians 8	American Urological Association 2
American College of Gastroenterology 2	Association for Clinical Oncology 3
American College of Obstetricians and Gynecologists 14	College of American Pathologists 4
American College of Occupational and Environmental Medicine 2	Congress of Neurological Surgeons 2
American College of Physicians 34	Heart Rhythm Society 2
American College of Radiology 8	Infectious Diseases Society of America 2
American College of Rheumatology 2	North American Spine Society 2
American College of Surgeons 7	Radiological Society of North America 3
American Gastroenterological Association 2	Society of American Gastrointestinal Endoscopic Surgeons 2
American Geriatrics Society 2	Society of Critical Care Medicine 2
American Institute of Ultrasound in Medicine 2	Society of Hospital Medicine 3
American Psychiatric Association 8	Society of Interventional Radiology 2
American Roentgen Ray Society 3	Society of Laparoscopic and Robotic Surgeons 2
American Society for Clinical Pathology 3	Society of Thoracic Surgeons 2
American Society for Dermatologic Surgery 2	The Endocrine Society 2
	United States and Canadian Academy of Pathology 2

Remaining eligible national medical specialty societies (62) are entitled to one delegate each.

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

State Medical Associations	306
National Medical Specialty Societies	302
Professional Interest Medical Associations	3
Other National Societies (AMWA, AOA, NMA)	3
Medical Student Regional Delegates	28
Resident and Fellow Delegate Representatives	33
Sections	11
Services	5
Total Delegates	692

Registration facilities will be maintained at the Hawai'i Convention Center.

Jack Resneck, Jr., MD
President

Bruce A. Scott, MD
Speaker, House of Delegates

Michael Suk, MD, JD, MPH, MBA
Secretary

2022 - 2023

OFFICIALS OF THE ASSOCIATION

BOARD OF TRUSTEES (OFFICERS)

President - Jack Resneck San Rafael, California
President-Elect - Jesse M. Ehrenfeld Milwaukee, Wisconsin
Immediate Past President - Gerald E. Harmon Pawleys Island, South Carolina
Secretary - Michael Suk Danville, Pennsylvania
Speaker, House of Delegates - Bruce A. Scott Louisville, Kentucky
Vice Speaker, House of Delegates - Lisa Bohman Egbert Kettering, Ohio

David H. Aizuss (2024) Encino, California
Toluwalase A. Ajayi (2026) San Diego, California
Madelyn E. Butler (2025) Tampa, Florida
Alexander Ding (2026) Louisville, Kentucky
Willarda V. Edwards (2024) Baltimore, Maryland
Scott Ferguson (2026) West Memphis, Arkansas
Sandra Adamson Fryhofer (2026), *Chair* Atlanta, Georgia
Drayton Charles Harvey (2023) Los Angeles, California
Marilyn J. Heine (2026) Dresher, Pennsylvania
Pratistha Koirala (2023) Danbury, Connecticut
Ilse R. Levin (2024) Silver Spring, Maryland
Thomas J. Madejski (2024) Medina, New York
Bobby Mukkamala (2025) Flint, Michigan
Harris Pastides (2024) Columbia, South Carolina
Willie Underwood, III (2023), *Chair-Elect* Buffalo, New York

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS

Kevin C. Reilly, Sr., Elizabethtown, Kentucky, Chair (2026); Mark N. Bair, Highland, Utah, Vice Chair, (2023);
Jerry P. Abraham, Los Angeles, California (2025); Pino D. Colone, Howell, Michigan (2024);
Mary Ann Contogiannis, Greensboro, North Carolina (2025); Titus Hou, Chicago, Illinois (Student) (2023);
Christopher P. Libby, Anaheim, California (Resident) (2024); Steven C. Thornquist, Bethany, Connecticut (2026).
Ex Officio, without vote: Bruce A. Scott, Louisville, Kentucky; Lisa Bohman Egbert, Kettering, Ohio.
Secretary: Janice Robertson, Chicago, Illinois.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

Peter A. Schwartz, Sinking Springs, Pennsylvania, Chair (2023); David A. Fleming, Columbia, Missouri, Vice Chair
(2024); Rebecca W. Brendel, Boston, Massachusetts (2026); Michael G. Knight, Washington, DC (2029);
Jeremy A. Lazarus, Greenwood Village, Colorado (2025); Kelsey C. Mumford, Washington, DC (Student) (2023);
Larry E. Reaves, Fort Worth, Texas (2027); Daniel P. Sulmasy, Washington, DC (2028); Danish M. Zaidi,
New Haven, CT (Resident) (2024).
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Susan R. Bailey	2011-2018	Christopher K. Kay	2008-2012	Liana Puscas	1999-2001
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Stuart Gitlow, New York NY

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Alternate Delegate(s)

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Seth Flagg, Silver Spring MD

American Society of Anesthesiologists

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Alternate Delegate(s)

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Delegate(s)

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American Society of Neuroimaging

Delegate(s)

Jerome Graber, Seattle WA

American Society of Neuroradiology

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Jack Farinhas, Tampa FL

American Society of Nuclear Cardiology

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American Society of Ophthalmic Plastic and Reconstructive Surgery

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American Society of Plastic Surgeons

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Lynn LC. Jeffers, Camarillo CA

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Maristella Evangelista, Birmingham MI

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American Society of Regional Anesthesia and Pain Medicine

Delegate(s)

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Thomas Witkowski, Philadelphia PA

American Society of Retina Specialists

Delegate(s)

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American Society of Transplant Surgeons

Delegate(s)

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American Society of Transplant Surgeons

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American Thoracic Society

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Chris Worsham, Charlestown MA

Alternate Delegate(s)

Ai-Yui Maria Tan, Maywood IL

American Urological Association

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Association for Clinical Oncology

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Erin Schwab, Grand Rapids MI

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Thomas A. Marsland, Petaluma CA

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Association of University Radiologists

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Alternate Delegate(s)

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College of American Pathologists

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Mark S. Synovec, Topeka KS

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Joe Saad, Dallas TX

Joseph Sanfrancesco, Charleston SC

Susan Strate, Wichita Falls TX

Resident and Fellow Sectional Alternate Delegate(s)

Dana Martin, Richmond VA

Congress of Neurological Surgeons

Delegate(s)

Jason Schwalb, West Bloomfield MI

Ann R. Stroink, Bloomington IL

Alternate Delegate(s)

Maya A. Babu, Melbourne FL

GLMA: Health Professionals Advancing LGBT Equality

Delegate(s)

Jeremy Toler, New Orleans LA

GLMA: Health Professionals Advancing LGBT Equality

Alternate Delegate(s)

Jason S. Schneider, Atlanta GA

Heart Rhythm Society

Delegate(s)

Jim Cheung, New York NY

Steve Hao, San Francisco CA

Alternate Delegate(s)

Timothy Larsen, Chicago IL

Infectious Diseases Society of America

Delegate(s)

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Steven W. Parker, Reno NV

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Delegate(s)

Joshua Mammen, Omaha NE

Alternate Delegate(s)

Rifat Latifi, Valhalla NY

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Delegate(s)

Morgan P. Lorio, Nashville TN

Alternate Delegate(s)

David Polly, Minneapolis MN

International Society of Hair Restoration Surgery

Delegate(s)

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Alternate Delegate(s)

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Delegate(s)

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Alternate Delegate(s)

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National Medical Association

Delegate(s)

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Delegate(s)

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North American Neuro-Ophthalmology Society

Delegate(s)

Benjamin Frishberg, Carlsbad CA

North American Spine Society

Delegate(s)

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William Mitchell, Marlton NJ

Obesity Medicine Association

Delegate(s)

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Alternate Delegate(s)

Anthony Auriemma, Elmhurst IL

Outpatient Endovascular and Interventional Society

Delegate(s)

Eric J. Dippel, Davenport IA

Outpatient Endovascular and Interventional Society

Alternate Delegate(s)

Samuel Ahn, Diamond Bar CA

Radiological Society of North America

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Kevin C. Reilly, Elizabethtown KY

Laura E. Traube, San Luis Obispo CA

Alternate Delegate(s)

Shadi Abdar Esfahani, Boston MA

Michael C. Brunner, Madison WI

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Alternate Delegate(s)

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Society for Vascular Surgery

Delegate(s)

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Alternate Delegate(s)

Nicolas J. Mouawad, Bay City MI

Society of American Gastrointestinal Endoscopic Surgeons

Delegate(s)

Kevin Reavis, Portland OR

Paresh Shah, New York NY

Alternate Delegate(s)

Kellie Marie McFarlin, Detroit MI

Society of Cardiovascular Computed Tomography

Delegate(s)

Kanae Mukai, Salinas CA

Society of Critical Care Medicine

Delegate(s)

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Tina R. Shah, Atlanta GA

Alternate Delegate(s)

Devang Sanghavi, Jacksonville FL

Society of Interventional Radiology

Delegate(s)

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Charles Ray, Chicago IL

Alternate Delegate(s)

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Annie K Lim, Denver CO

Society of Nuclear Medicine and Molecular Imaging

Delegate(s)

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Alternate Delegate(s)

Munir Ghesani, Princeton Jct NJ

Resident and Fellow Sectional Alternate Delegate(s)

Domnique Newallo, Atlanta GA

Gbenga Shogbesan, Atlanta GA

Society of Thoracic Surgeons

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Spine Intervention Society

Delegate(s)

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Alternate Delegate(s)

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The Society of Laparoscopic and Robotic Surgeons

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Ceana Nezhat, Atlanta GA

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Daniel Zedek, Chapel Hill NC

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Nirali M. Patel, Chicago IL

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Veterans Affairs

Delegate(s)

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Alternate Delegate(s)

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Integrated Physician Practice Section

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Alternate Delegate(s)

Russell C. Libby, Fairfax VA

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Afifa Adiba, Wallingford CT

Alternate Delegate(s)

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Medical Student Section

Delegate(s)

Ryan Englander, Farmington CT

Alternate Delegate(s)

Brittany Ikwuagwu, Houston TX

Minority Affairs Section

Delegate(s)

Luis Seija, New York NY

Alternate Delegate(s)

Siobhan Wescott, Grand Forks ND

Organized Medical Staff Section

Delegate(s)

Matthew Gold, Winchester MA

Alternate Delegate(s)

Nancy Fan, Wilmington DE

Private Practice Physician Section

Delegate(s)

Timothy G. Mc Avoy, Waukesha WI

Alternate Delegate(s)

Daniel Eunsuk Choi, New Hyde Park NY

Resident and Fellow Section

Delegate(s)

Daniel Pfeifle, Rochester MN

Alternate Delegate(s)

Christopher T. Clifford, New York NY

Senior Physicians Section

Delegate(s)

Virginia E. Hall, Hummelstown PA

Alternate Delegate(s)

Douglas M. DeLong, Cherry Valley NY

Women Physicians Section

Delegate(s)

Nicole L. Plenty, Katy TX

Alternate Delegate(s)

Anna Laucis, Howard WI

Young Physicians Section

Delegate(s)

Alisha Reiss, Greenville OH

Alternate Delegate(s)

Sean Figy, Omaha NE

**Reference Committee Hearing Room Assignments
Sunday, November 13**

8:30am

Room

Amendments to Constitution & Bylaws

Room 313 A-C

B Legislative advocacy

Exhibit Hall III (Kamehameha III)

C Advocacy on medical education

Room 311

F AMA governance and finance

Kalakaua Ballroom

J Advocacy on medical service, practice, and insurance

Room 316 A-C

K Advocacy on science and public health

Room 323 A-C

**REFERENCE COMMITTEES OF THE HOUSE OF DELEGATES
(November 2022 Interim Meeting)**

Reference Committee on Amendments to Constitution and Bylaws

Susan L. Hubbell, MD, American Academy of Physical Medicine and Rehabilitation, Chair
Afifa Adiba, MD, International Medical Graduate Section*
Emily Briggs, American Academy of Family Physicians
Amish Dave, MD, Washington*
John C. Kincaid, MD, American Association of Neuromuscular & Electrodiagnostic Medicine*
Laila Koduri, Regional Medical Student
Carlos Latorre, MD, Mississippi

Reference Committee B (Legislation)

Hillary Johnson-Jahangir, MD, PhD, American Academy of Dermatology, Chair
Kenneth S. Blumenfeld, MD, American Association of Neurological Surgeons
Tilden L. Childs, III, MD, American College of Radiology
Daniel Choi, MD, Private Practice Physicians Section*
Kelly J. Clark, MD, American Society of Addiction Medicine*
Karl Steinberg, MD, AMDA - The Society for Post-Acute and Long-Term Care Medicine
Kiersten Woodyard, Ohio*

Reference Committee C (Medical Education)

Ramin Manshadi, MD, California, Chair
T. Jann Caison-Sorey, MD, Michigan
Marygrace Elson, MD, American College of Obstetricians and Gynecologists
Renato Guerrieri, American College of Physicians
Heidi Hullinger, MD, American Academy of Orthopaedic Surgeons
Pauline Huynh, MD, Sectional Resident
Alex Malter, MD, MPH, Alaska

Reference Committee F (AMA Finance; AMA Governance)

Cheryl Gibson Fountain, MD, American College of Obstetricians and Gynecologists, Chair
Brooks F. Bock, MD, American College of Emergency Physicians
Robyn F. Chatman, MD, MPH, Ohio
Rebecca L. Johnson, MD, Florida*
Shilpen A. Patel, MD, American Society for Radiation Oncology
William Reha, MD, American Association of Clinical Urologists*
Michael B. Simon, MD, American Society of Anesthesiologists

Reference Committee J (Advocacy Related to Medical Service, Medical Practice, Insurance and Related Topics)

Brigitta J. Robinson, MD, Colorado*, Chair
Sarah G. Candler, MD, American College of Physicians
M. Laurin Council, MD, American Society for Dermatologic Surgery
Amar Kelkar, MD, American Society of Hematology
Anne Mongiu, MD, American Society of Colon and Rectal Surgeons
Jason Schwalb, MD, Congress of Neurological Surgeons
Natalia Solenkova, MD, International Medical Graduate Section*

Reference Committee K (Advocacy Related to Medical Education, Science and Public Health Topics)

Robert H. Emmick, Jr., MD, Texas*, Chair
Elisa Choi, MD, American College of Physicians
Cee Ann Davis, MD, MPH, American College of Obstetricians and Gynecologists
Leanna (Leif) Knight, Regional Medical Student
Christopher Paprzycki, MD, Ohio*
Jennifer N. Stall, MD, American Society for Clinical Pathology
Raymond K. Tu, MD, District of Columbia

Committee on Rules and Credentials

Marilyn K. Laughead, MD, American Institute of Ultrasound in Medicine, Chair
Jerry P. Abraham, MD, MPH, California
Mark N. Bair, MD, Utah
Cheryl Hurd, MD, American Psychiatric Association
Niva Lubin-Johnson, MD, Illinois
Chand Rohatgi, MD, American Association of Physicians of Indian Origin
Whitney Stuard, Texas*

Chief Teller

Andrea Hillerud, MD, Minnesota

* *Alternate Delegate*

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

**2022 Interim Meeting
Note on Orders of Business
Kalakaua Ballroom, Hawai'i Convention Center**

FIRST SESSION, Saturday, November 12 – 1:00-2:30 pm

SECOND SESSION, Sunday, November 13 – 8:00-8:30 am

THIRD SESSION, Monday, November 14 – 1:00-6:00 pm

FOURTH SESSION, Tuesday, November 15 – 8:00 am - completion of business

SUMMARY OF FISCAL NOTES (I-22)

BOT Report(s)

- 01 Opposition to Requirements for Gender-Based Treatments for Athletes: Minimal
- 02 Further Action to Respond to the Gun Violence Public Health Crisis: None
- 03 Delegate Apportionment and Pending Members: Minimal
- 04 Preserving Access to Reproductive Health Services: Minimal
- 05 Towards Diversity and Inclusion: A Global Nondiscrimination Policy Statement and Benchmark for our AMA: Within current budget
- 06 Informal Inter-Member Mentoring: Informational report
- 07 Transparency of Resolution Fiscal Notes: None
- 08 The Resolution Committee as a Standing Committee of the House: Within current budget
- 09 Employed Physicians: Modest
- 10 Redefining the AMA's Position on ACA and Healthcare Reform: Informational report
- 11 2022 AMA Advocacy Efforts: Informational report
- 12 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment: Minimal

CC&B Report(s)

- 01 Updated Bylaws: Delegate Apportionment and Pending Members: Minimal

CEJA Opinion(s)

- 01 Amendment to E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment": Informational report

CEJA Report(s)

- 01 Amendment to Opinion 4.2.7, "Abortion": Minimal
- 02 Amendment to Opinion 10.8, "Collaborative Care": Minimal
- 03 Pandemic Ethics and the Duty of Care: Minimal
- 04 Research Handling of De-Identified Patient Information: Informational report

CLRPD Report(s)

- 01 Senior Physicians Section Five-Year Review: Within current budget

CME Report(s)

- 01 The Impact of Private Equity on Medical Training: Minimal
- 02 Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process: Minimal

CMS Report(s)

- 01 Incentives to Encourage Efficient Use of Emergency Departments: Minimal
- 02 Corporate Practice of Medicine: Minimal
- 03 Health System Consolidation: Informational report

CSAPH Report(s)

- 01 Drug Shortages: 2022 Update: Minimal
- 02 Climate Change and Human Health: Minimal

SUMMARY OF FISCAL NOTES (I-22)

HOD Comm on Compensation of the Officers

01 Report of the HOD Committee on Compensation of the Officers: none

Report of the Speakers

01 Election Committee - Interim Report: Up to \$5,00 annually

Resolution(s)

- 002 Assessing the Humanitarian Impact of Sanctions: Modest
- 003 Indigenous Data Sovereignty: Minimal
- 005 Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants: Modest
- 006 Assessing the Humanitarian Impact of Sanctions: Modest
- 007 Consent for Sexual and Reproductive Healthcare: Modest
- 008 Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era: Estimated cost of \$58,000 for staff costs and for work with external legal counsel to develop strategies and guidance to assist affected physicians.
- 009* Medical Decision-Making Autonomy of the Attending Physician: Minimal
- 011* Advocating for the Informed Consent for Access to Transgender Health Care: Modest
- 012* Guidelines on Chaperones for Sensitive Exams: Modest
- 013* Hospital Bans on Trial of Labor After Cesarean: Modest
- 015* Restricting Derogatory and Stigmatizing Language of ICD-10 Codes: Minimal
- 201 Physician Reimbursement for Interpreter Services: Modest
- 202 Advocating for State GME Funding: Modest
- 203 International Medical Graduate Employment: Minimal
- 205 Waiver of Due Process Clauses: Minimal
- 206 The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training: Estimated cost of \$50,000 includes staffing and professional fees.
- 207 Preserving Physician Leadership in Patient Care: Estimated cost of \$255K for a national targeted ad campaign includes professional fees and staffing.
- 208 Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals: Estimated cost to implement resolution is \$306K. Primary expense is for contracting externally to conduct research.
- 209 Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training: Modest
- 211 Illicit Drug Use Harm Reduction Strategies: Minimal
- 213 Hazard Pay During a Disaster Emergency: Modest
- 214 Universal Good Samaritan Statute: Modest
- 215 Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies: Modest
- 216* Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care in Medicare: Minimal
- 217* Restrictions on the Ownership of Hospitals by Physicians: Modest
- 218* Screening and Approval Process for the Over-the-Counter Sale of Substances with Potential for Recreational Use and Abuse: not yet determined
- 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: Minimal
- 220* Extend Telemedicine to Out of State Enrolled College Students to Avoid Emergency Room and Inpatient Psychiatric Hospitalizations when in Crisis: Modest
- 222* Allocate Opioid Funds to Train More Addiction Treatment Physicians: Minimal
- 223* Criminalization of Pregnancy Loss as the Result of Cancer Treatment: Modest
- 224* Fertility Preservation: Modest
- 227* Access to Methotrexate Based on Clinical Decisions: Modest

SUMMARY OF FISCAL NOTES (I-22)

Resolution(s)

- 302 Expanding Employee Leave to Include Miscarriage and Stillbirth: Minimal
- 303 Medical Student Leave Policy: Minimal
- 304 Protecting State Medical Licensing Boards from External Political Influence: Modest
- 305 Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups: Minimal
- 306 Increased Credit for Continuing Medical Education Preparation: Modest
- 307 Fair Compensation of Residents and Fellows: Modest
- 308 Paid Family/Medical Leave in Medicine: Minimal
- 309 Bereavement Leave for Medical Students and Physicians: Minimal
- 310* Enforce AMA Principles on Continuing Board Certification: Modest
- 311* Supporting a Hybrid Residency and Fellowship Interview Process: Modest
- 313* Request a two-year delay in ACCME Changes to State Medical Society Recognition Program: Modest
- 314* Balancing Supply and Demand for Physicians by 2030: Modest
- 315* Bedside Nursing and Health Care Staff Shortages: Modest
- 601 AMA Withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity: Estimated cost of \$415,000 to clarify sections of SP to be rewritten, rewrite, engage stakeholders, redo layout and design, production and printing, includes staffing, travel/meetings, and professional staff.
- 602 Finding Cities for Future AMA Conventions/Meetings: Minimal
- 606* Patient-Centered Health Equity Strategic Plan and Sustainable Funding: Modest
- 607* Accountability for Election Rules Violations: Minimal
- 801 Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans: Minimal
- 802 FAIR Health Database: Modest
- 803 Patient Centered Medical Home – Administrative Burdens: Modest
- 804 Centers for Medicare & Medicaid Innovation Projects: Modest
- 805 COVID Vaccine Administration Fee: Minimal
- 806 Healthcare Marketplace Plan Selection: Modest
- 807 Medicare Advantage Record Requests: Modest
- 808 Reinstatement of Consultation Codes: Modest
- 809 Uniformity and Enforcement of Medicare Advantage Plans and Regulations: Modest
- 810 Medicare Drug Pricing and Pharmacy Costs: Modest
- 811 Covering Vaccinations for Seniors Through Medicare Part B: Modest
- 812 Implant-Associated Anaplastic Large Cell Lymphoma: Minimal
- 813 Amending Policy on a Public Option to Maximize AMA Advocacy: Minimal
- 814 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?: Modest
- 815* Opposition to Debt Litigation Against Patients: Minimal
- 816* Medicaid and CHIP Coverage for Glucose Monitoring Devices for Patients with Diabetes: Modest
- 817* Promoting Oral Anticancer Drug Parity: Minimal
- 818* Pediatric Obesity Treatment Insurance Coverage: Modest
- 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: Modest
- 820* Third-Party Pharmacy Benefit Administrators: Modest
- 902 Reducing the Burden of Incarceration on Public Health: Modest

SUMMARY OF FISCAL NOTES (I-22)

Resolution(s)

- 904 Immigration Status is a Public Health Issue: Moderate
- 905 Minimal Age of Juvenile Justice Jurisdiction in the United States: Modest
- 906 Requirement for COVID-19 Vaccination in Public Schools Once Fully FDA-Authorized: Minimal
- 907 A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury: Est @ \$5M includes staffing, travel & meetings (\$500K), promotion (\$750K), printing, production, additional staffing (\$1M) and prof service firm (\$2.5M) to conduct IDIs/Focus groups and summarize findings, facilitate convening national public forums
- 908 Older Adults and the 988 Suicide and Crisis Timeline: Modest
- 909 Decreasing Gun Violence and Suicide in Seniors: Est @ \$500K includes publication costs, professional fees, printing, production, promotion, and staffing
- 910 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use: Minimal
- 911 Critical Need for National ECC System to Ensure Individualized, State-Wide, care for STEMI, CS and OHCA, and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies: Minimal
- 912* Reevaluating the Food and Drug Administration's Citizen Petition Process: Modest
- 913* Supporting and Funding Sobering Centers: Minimal
- 915* Pulse Oximetry in Patients with Pigmented Skin: Modest
- 916* Non-Cervical HPV Associated Cancer Prevention: Minimal
- 917* Care for Children with Obesity: Modest
- 918* Opposition to Alcohol Industry Marketing Self-Regulation: Minimal
- 919* Decreasing Youth Access to E-cigarettes: Minimal
- 920* Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings: Estimated cost of \$126,245 includes staffing (\$50K for CME development, AMA decarbonization efforts, annual reporting) and professional fees (\$75K for development of CME education module to be hosted by Ed Hub w/considerations and tool/resources for different practice settings.
- 921* Firearm Injury and Death Research and Prevention: Modest
- 922* Firearm Safety and Technology: Modest
- 923* Physician Education and Intervention to Improve Patient Firearm Safety: Moderate
- 924* Domestic Production of Personal Protective Equipment: Minimal
- 926* Limit the Pornography Viewing by Minors Over the Internet: Minimal
- 927* Off-Label Policy: Minimal
- 928* Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements: Minimal
- 929* Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive Populations: Modest
- 930* Addressing Longitudinal Health Care Needs of Children in Foster Care: Modest
- 931* Amending H-160.903 Eradicating Homelessness to Include Support for Street Medicine Programs: Modest
- 933* Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV: Minimal
- 935* Government Manufacturing of Generic Drugs to Address Market Failures: Modest
- 936* Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room: Modest

Resolutions not for consideration

- 001 Updating Physician Job Description for Disability Insurance: Modest
- 004 Supporting Intimate Partner and Sexual Violence Safe Leave: Minimal
- 010* Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates: Bylaws amendment minimal, ensuring steps up to \$10K depending on implementation
- 014* Gender-Neutral Language in AMA Policy: Modest
- 204 Elimination of Seasonal Time Change: Modest

SUMMARY OF FISCAL NOTES (I-22)

Resolutions not for consideration

- 210 Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time: Minimal
- 212 SNAP Expansion for DACA Recipients: Modest
- 221* Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses: Minimal
- 225* Drug Policy Reform: Modest
- 226* Support for Mental Health Courts: Minimal
- 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education: Minimal
- 312* Reporting of Residency Demographic Data: Minimal
- 603 AMA House of Delegates Resolution Process Review: Minimal
- 604 Solicitation Using the AMA Brand: Minimal
- 605* Decreasing Political Advantage Within AMA Elections: Minimal
- 608* Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development: Modest
- 901 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies: Minimal
- 903 Supporting Further Study of Kratom: Minimal
- 914* Greenhouse Gas Emissions from Health Care: Modest
- 925* Incorporation of Social Determinants of Health Concepts into Climate Change Work of the AMA: Minimal
- 932* Increase Employment Services Funding for People with Disabilities: Minimal
- 934* Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers: Modest

Minimal - less than \$1,000

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

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

*** Contained in the Handbook Addendum**

RESOLUTIONS - BY SPONSOR (I-22)

American Academy of Pediatrics

- 818* Pediatric Obesity Treatment Insurance Coverage
 - 921* Firearm Injury and Death Research and Prevention
 - 922* Firearm Safety and Technology
 - 923* Physician Education and Intervention to Improve Patient Firearm Safety
-

American Academy of Physical Medicine and Rehabilitation

- 603 AMA House of Delegates Resolution Process Review
 - 907 A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury
-

American Association of Clinical Urologists

- 201 Physician Reimbursement for Interpreter Services
-

American College of Cardiology

- 814 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?
-

American College of Preventive Medicine

- 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
 - 925* Incorporation of Social Determinants of Health Concepts into Climate Change Work of the AMA
-

American College of Radiology

- 308 Paid Family/Medical Leave in Medicine
-

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- 820* Third-Party Pharmacy Benefit Administrators
-

American Society of Addiction Medicine

- 216* Expanding Parity Protections and Coverage of Mental Health and Substance Use Disorder Care in Medicare
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- 307 Fair Compensation of Residents and Fellows
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 - 924* Domestic Production of Personal Protective Equipment
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Colorado

- 008 Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era

Garretson, Delegate

605* Decreasing Political Advantage Within AMA Elections

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305 Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups
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- 006 Assessing the Humanitarian Impact of Sanctions
- 010* Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates
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- 212 SNAP Expansion for DACA Recipients
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- 225* Drug Policy Reform
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- 302 Expanding Employee Leave to Include Miscarriage and Stillbirth
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- 311* Supporting a Hybrid Residency and Fellowship Interview Process
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- 608* Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development
- 815* Opposition to Debt Litigation Against Patients
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- 817* Promoting Oral Anticancer Drug Parity
- 901 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies
- 902 Reducing the Burden of Incarceration on Public Health
- 903 Supporting Further Study of Kratom
- 912* Reevaluating the Food and Drug Administration's Citizen Petition Process
- 913* Supporting and Funding Sobering Centers
- 916* Non-Cervical HPV Associated Cancer Prevention
- 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
- 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
- 932* Increase Employment Services Funding for People with Disabilities
- 933* Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV
- 934* Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
- 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

Michigan

- 310* Enforce AMA Principles on Continuing Board Certification
 - 314* Balancing Supply and Demand for Physicians by 2030
 - 315* Bedside Nursing and Health Care Staff Shortages
 - 926* Limit the Pornography Viewing by Minors Over the Internet
 - 927* Off-Label Policy
-

Mississippi

- 009* Medical Decision-Making Autonomy of the Attending Physician
 - 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
-

Missouri

- 203 International Medical Graduate Employment
 - 204 Elimination of Seasonal Time Change
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New England Delegation

- 813 Amending Policy on a Public Option to Maximize AMA Advocacy
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New York

- 213 Hazard Pay During a Disaster Emergency
 - 304 Protecting State Medical Licensing Boards from External Political Influence
 - 306 Increased Credit for Continuing Medical Education Preparation
 - 802 FAIR Health Database
 - 803 Patient Centered Medical Home – Administrative Burdens
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Oklahoma

- 313* Request a two-year delay in ACCME Changes to State Medical Society Recognition Program
- 606* Patient-Centered Health Equity Strategic Plan and Sustainable Funding

Resident and Fellow Section

- 002 Assessing the Humanitarian Impact of Sanctions
 - 206 The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training
 - 207 Preserving Physician Leadership in Patient Care
 - 208 Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals
 - 209 Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training
 - 210 Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time
 - 211 Illicit Drug Use Harm Reduction Strategies
 - 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education
 - 309 Bereavement Leave for Medical Students and Physicians
 - 604 Solicitation Using the AMA Brand
 - 812 Implant-Associated Anaplastic Large Cell Lymphoma
 - 910 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use
-

Senior Physicians Section

- 809 Uniformity and Enforcement of Medicare Advantage Plans and Regulations
 - 810 Medicare Drug Pricing and Pharmacy Costs
 - 811 Covering Vaccinations for Seniors Through Medicare Part B
 - 908 Older Adults and the 988 Suicide and Crisis Timeline
 - 909 Decreasing Gun Violence and Suicide in Seniors
-

Society for Cardiovascular Angiography & Interventions

- 911 Critical Need for National ECC System to Ensure Individualized, State-Wide, care for STEMI, CS and OHCA, and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies
-

Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)

- 917* Care for Children with Obesity
-

Southeast Delegation

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Texas

- 607* Accountability for Election Rules Violations
-

Utah

- 805 COVID Vaccine Administration Fee
-

Washington

- 011* Advocating for the Informed Consent for Access to Transgender Health Care
- 015* Restricting Derogatory and Stigmatizing Language of ICD-10 Codes
- 222* Allocate Opioid Funds to Train More Addiction Treatment Physicians
- 914* Greenhouse Gas Emissions from Health Care
- 915* Pulse Oximetry in Patients with Pigmented Skin

Women Physicians Section

227* Access to Methotrexate Based on Clinical Decisions

Young Physicians Section

001 Updating Physician Job Description for Disability Insurance

202 Advocating for State GME Funding

801 Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans

** contained in the Handbook Addendum*

Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

- 01 Opposition to Requirements for Gender-Based Treatments for Athletes
- 03 Delegate Apportionment and Pending Members
- 04 Preserving Access to Reproductive Health Services
- 05 Towards Diversity and Inclusion: A Global Nondiscrimination Policy Statement and Benchmark for our AMA
- 12 Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment

CC&B Report(s)

- 01 Updated Bylaws: Delegate Apportionment and Pending Members

CEJA Report(s)

- 01 Amendment to Opinion 4.2.7, “Abortion”
- 02 Amendment to Opinion 10.8, “Collaborative Care”
- 03 Pandemic Ethics and the Duty of Care

Resolution(s)

- 002 Assessing the Humanitarian Impact of Sanctions
- 003 Indigenous Data Sovereignty
- 005 Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants
- 006 Assessing the Humanitarian Impact of Sanctions
- 007 Consent for Sexual and Reproductive Healthcare
- 008 Support for Physicians Practicing Evidence-Based Medicine in a Post Dobbs Era
- 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

REPORT OF THE BOARD OF TRUSTEES

B of T Report 1-I-22

Subject: Opposition to Requirements for Gender-Based Treatments for Athletes
(Resolution 19-A-19)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Resolution 19-A-19, “Opposition to Requirements for Gender-Based Treatment for Athletes,”
2 sponsored by the Medical Student Section, was referred to the Board of Trustees. Resolution 19-A-
3 19 asked:

- 4
- 5 1. That our American Medical Association (AMA) oppose any regulations requiring
6 mandatory medical treatment or surgery for athletes with Differences of Sex Development
7 (DSD) to be allowed to compete in alignment with their identity; (New HOD Policy) and
8
- 9 2. That our AMA oppose the creation of distinct hormonal guidelines to determine gender
10 classification for athletic competitions. (New HOD Policy)

11
12 BACKGROUND

13
14 Resolution 19 reacts to guidelines issued in 2018 by the International Association of Athletics
15 Federations (IAAF)—now World Athletics—updating eligibility criteria for athletes with
16 differences of sex development (DSD) who wish to compete as women in certain international
17 track and field events. Under these guidelines, to be eligible to compete in the 400m, hurdles races,
18 800m, 1500m, one-mile races and combined events over the same distances, women with DSD
19 who have serum testosterone levels above 5 nmol/L and who are androgen sensitive must:

- 20
- 21 • be legally recognized as female or intersex
- 22 • reduce their circulating serum testosterone levels to below 5 nmol/L for a continuous
23 period of 6 months, and
- 24 • maintain their serum testosterone level below 5 nmol/L continuously for as long as they
25 wish to remain eligible to compete (regardless of whether they are in competition) [1].

26
27 Female athletes with DSD who choose not to reduce their serum testosterone levels will be eligible
28 to compete in all events that are not international competitions and in events in international
29 competitions other than those specifically prohibited [1].

30
31 In a separate report, World Athletics outlines eligibility criteria for transgender athletes competing
32 in international competitions. They specify that

- 33
- 34 • to be eligible to participate in the female category of competition, a transgender female
35 athlete must provide a written and signed declaration that her gender identity is female;

- 1 • she must demonstrate to the satisfaction of an expert panel that the concentration of
2 testosterone in her serum has been less than 5 nmol/L continuously for a period of at least
3 12 months; and
- 4 • she must keep her serum testosterone concentration below 5 nmol/L for so long as she
5 wishes to maintain her eligibility to compete in the female category [2].
6

7 They further specify that “no athlete will be forced to undergo any medical assessment and/or
8 treatment” and that neither “legal recognition of the athlete's gender identity” nor “surgical
9 anatomical changes” are required to compete [2].
10

11 These guidelines represent the most recent in a series of efforts by the international athletic
12 community to ensure fairness in women’s competitions that began with “gender verification”
13 policies in the 1960s. In 1968, following the extraordinary successes of Tamara and Irina Press in
14 the 1960 and 1964 Olympics, who were suspected of being male, female athletes were required to
15 prove their sex to be eligible to compete as women in international events [3]. Over time,
16 procedures to determine sex evolved from having female athletes parade naked before a panel of
17 judges, through gynecological examination of external genitalia, to the use of sex chromatin tests,
18 and ultimately DNA-based testing [3]. In 2000, the International Olympic Committee (IOC) and
19 IAAF discontinued routine gender verification in favor of “suspicion-based testing,” reserving the
20 right to test if officials or competitors raised questions about a female athlete’s sex.
21

22 In 2011, in the wake of controversy over South African runner Caster Semenya, the IOC’s Medical
23 Commission recommended hormone-based testing, that is, that individuals recognized in law as
24 female be eligible to compete in women’s competitions so long as their serum testosterone levels
25 were “below the male range” or if they had an androgen resistance and derived no competitive
26 advantage from testosterone levels in the male range [3]. The IAAF adopted hormonal testing and
27 implemented new policy that routinely tested all female athletes and required those who tested
28 outside the normal range to undergo treatment to normalize their androgen levels to be eligible to
29 compete.
30

31 In March 2019 the United Nations Human Rights Council adopted Resolution 40/5, “Elimination
32 of discrimination against women and girls in sport,” noting concern that the IAAF/World Athletics
33 eligibility criteria
34

35 are not compatible with international human rights norms and standards, including the rights of
36 women with differences of sex development, and concerned at the absence of legitimate and
37 justifiable evidence for the regulations to the extent that they may not be reasonable and
38 objective, and that there is no clear relationship of proportionality between the aim of the
39 regulations and the proposed measures and their impact [4].
40

41 The resolution further expressed concern that
42

43 discriminatory regulations, rules and practices that may require women and girl athletes with
44 differences of sex development, androgen sensitivity and levels of testosterone to medically
45 reduce their blood testosterone levels contravene international human rights norms and
46 standards ... [4]
47

48 In 2021 the IOC amended its stance and issued a new “Framework on Fairness, Inclusion and Non-
49 Discrimination on the Basis of Gender Identity and Sex Variations” that eliminated specific
50 instructions on eligibility to compete [5]. Rather, the framework sought to offer general guidance to
51 sports governing bodies:

1 to promote a safe and welcoming environment for everyone, consistent with the principles
2 enshrined in the Olympic Charter; it “acknowledges the central role that eligibility criteria play
3 in ensuring fairness, particularly in high-level organized sport in the women’s category” [5].
4

5 With the framework, the IOC recognized “that it is not in a position to issue regulations that define
6 eligibility for every sport” and explicitly left it “to each sport and its governing body to determine
7 how an athlete may be at disproportionate advantage to their peers” [5].
8

9 Also in 2021, the authors of a 2017 study on which World Athletics relied heavily in developing its
10 eligibility criteria published a correction in response to ongoing critique from independent
11 statisticians. The correction acknowledged that “there is no confirmatory evidence for causality in
12 the observed relationships reported” [6]. The authors further noted that the initial research was
13 “exploratory and not intend[ed] to prove a causal influence and that some statements in the original
14 publication could have been misleading” [6].
15

16 World Athletics has not modified its criteria [6], however, and controversy regarding participation
17 by female athletes with DSD continues.
18

19 The related controversy concerning participation of transgender athletes in all types of sports has
20 escalated in recent years. Since 2020, a number of state legislatures have introduced proposals to
21 prohibit transgender girls from competing in girls’ high school (and in some cases college) sports.
22 In March 2020, Idaho was the first state to impose a ban on transgender women and girls’
23 participation in school sports. In 2021, Alabama, Arkansas, Florida, Mississippi, Montana,
24 Tennessee, and West Virginia passed similar bans, and South Dakota’s governor issued two
25 Executive Orders which implemented a similar prohibition. At the same time the Connecticut court
26 case *Soule et al v. CT Association of Schools et al* was in process. In this case the Alliance
27 Defending Freedom sought to ban two Black, transgender girls from competing in high school
28 track and field [7].
29

30 The Idaho ban was blocked by a federal court in August 2020. The AMA, along with the American
31 Academy of Pediatrics and other health care organizations, submitted an amicus brief with the
32 Ninth Circuit Court of Appeals noting that the law undermines the accepted approach for treating
33 gender dysphoria. The brief stated that prohibiting transgender females from participating in
34 school-sponsored sports in keeping with their gender identity interferes with the treatment of
35 gender dysphoria by preventing transgender females from living openly in accordance with their
36 true gender [8].
37

38 The AMA, together with five other healthcare organizations, also submitted an amicus brief in
39 *Soule et al v. CT Association of Schools et al*. In it, they emphasize that untreated gender dysphoria
40 can cause debilitating distress, depression, impairment of function, self-mutilation, other self-
41 injurious behaviors, and suicide. They also note that transgender individuals are subject to
42 discrimination in multiple areas of their lives, and this both exacerbates negative health outcomes
43 and reinforces the stigma associated with being transgender. Being subject to stigmatization is
44 psychologically harmful and so creates additional negative mental health consequences [9].
45

46 *Soule et al* was dismissed at the state level and (as of August 2022) an appeal in the 2nd Circuit
47 Court remains undecided. As of May 2022, eighteen states have enacted laws or issued rules that
48 either ban or limit the participation of transgender athletes in public school sports [10]. As a result,
49 in some states regulations are more restrictive at lower levels of competition and in recreational
50 programs than they are at higher levels.

1 For instance, the IOC guidelines amended in 2021 reflect an inclusive and non-discriminatory
2 position with respect to transgender athletes, consistent with their guidelines for athletes with
3 DSDs. They state that

- 4
- 5 • eligibility criteria should be established and implemented fairly and in a manner that does
6 not systematically exclude athletes from competition based upon their gender identity,
7 physical appearance and/or sex variations;
- 8 • no athlete should be subject to targeted testing because of, or aimed at determining, their
9 sex, gender identity and/or sex variations;
- 10 • athletes should not be pressured to undergo medically unnecessary procedures or treatment
11 to meet eligibility criteria; and
- 12 • criteria to determine eligibility should not include gynecological examinations or other
13 invasive physical examinations aimed at determining an athlete's gender or sex [5].
- 14

15 FAIRNESS IN SPORT

16
17 Regulations intended to promote fairness in sport by restricting the participation of individuals
18 whose genetic characteristics are deemed to give them unfair advantage over competitors raise a
19 series of questions about what the goals of sport are, what counts as an “unfair” advantage, and
20 what should be done to “level the playing field.”

21 *Biological Advantage*

22
23
24 Policy restricting competition by female athletes who have serum testosterone levels above a
25 designated “normal” range rests on (at least) two problematic assumptions. The first of those
26 assumptions is that there is a straightforward relationship between testosterone and athletic
27 performance that unequivocally gives these athletes significant advantage over female competitors
28 whose bodies do not produce “excess” endogenous testosterone. The second is that serum
29 testosterone levels can meaningfully be measured, and that prescribed levels can be safely and
30 effectively maintained. The specific contribution of testosterone to overall athletic performance
31 continues to be a subject of debate. Critics of the research on which the IAAF based its regulations
32 on endogenous testosterone have argued that a key study concluding that women with the highest
33 testosterone levels significantly and consistently outperformed other female competitors rests on
34 flawed data [11]. Concerns have also been raised about the rigor of its statistical analysis [12]. The
35 main author, moreover, was the director for the IAAF Science and Health Department, raising
36 questions about possible conflict of interest [13]. More importantly, demonstrating a correlation
37 between testosterone and athletic performance in female athletes falls short of establishing the
38 unfairness of such advantage [13].

39
40 However, even if the effect of testosterone on athletic performance was conclusively established,
41 single point-in-time tests for overall level of serum testosterone cannot provide conclusive
42 evidence that the individual has or will benefit. It is known that women with androgen insensitivity
43 disorder physiologically cannot gain benefit from excess endogenous testosterone. Multiple factors
44 affect serum concentrations of testosterone, including time of day; age- and gender-corrected
45 normal ranges using a standard assay have not been established; and there is no universally
46 recognized standard for calibrating testosterone [14].

47
48 Further, “the relevance of free testosterone vs [sic] the fraction actually available to tissues (the
49 “bio-testosterone”) is not well understood” [15]. Nor do the IAAF regulations take into account the
50 existing lack of consensus about “how to use medications safely to lower testosterone levels when

1 used off-label, the side effects of the medications, [or] the difficulties of maintaining the
2 testosterone levels below the levels requested by IAAF owing to natural fluctuations” [13].

3 *Leveling the Playing Field*

4
5 Assuming, for purposes of analysis, that testosterone does confer a significant competitive
6 advantage in sport, knowing that does not in itself determine what steps should be taken to “level
7 the playing field.” The latter decision is a normative matter, not an empirical one.

8
9 To be defensible, rules and practices intended to ensure that no individual athlete enjoys an unfair
10 advantage over competitors requires that rules treat all relevantly similar advantage-conferring
11 attributes in a like manner. Testosterone testing for female athletes who have been singled out on
12 the basis of their appearance or performance for all practical purposes subjects these individuals to
13 genetic testing not imposed on their competitors.

14
15 Fairness would require that sports organizations test for *any* “performance enhancing genes that
16 predispose [individual athletes] to be athletically superior” [16]. In the present state of knowledge,
17 this is no more realistic an approach than are current testosterone assays. The influence of genetic
18 factors on athletic performance is multifactorial and sport specific [17]. Organizations would
19 further have to regulate all such advantage-conferring attributes consistently.

20
21 One way to categorize fair versus unfair advantages is by conceptualizing advantages as stable
22 (fair) or dynamic (unfair) [18]. Fair advantages are those the athlete largely cannot affect, (such as
23 chronological age, height, genetics, etc.). Unfair advantages are those the athlete can affect (such as
24 speed, strength, endurance, etc.). On this account, genetic differences in testosterone would be
25 stable advantages that could be subject to leveling or more fine-grained classification.

26
27 Thinking specifically about leveling the playing field with respect to inequalities in testosterone
28 levels, three approaches present themselves [13]. First, sports organizations could require athletes
29 to lower testosterone levels that exceed a defined threshold to below a predetermined level.
30 Second, organizations could create separate categories for competition based on the level of
31 biological variations, allowing all athletes with serum testosterone within a certain range to
32 compete against one another, regardless of sex or gender identification [13]. Or, third, they could
33 create categories based on modifying the external conditions of competition instead of intervening
34 in athletes’ bodies. Handicapped horse racing offers a model [13].

35 36 THE ROLE OF PHYSICIANS

37
38 World Athletics eligibility criteria take the first of these approaches: intervening in the bodies of
39 transgender athletes and athletes with DSDs. In doing so, they virtually require the participation of
40 physicians helping athletes achieve and maintain the stipulated levels of serum testosterone. To the
41 extent that medical interventions to lower testosterone may not be *clinically* indicated, is physician
42 participation appropriate? Overall, existing policies of the American Medical Association and the
43 World Medical Association (WMA) argue against physicians cooperating in the implementation of
44 these regulations.

45
46 Existing AMA policy in H-470.978, “[Blood Doping](#),” and H-470.976, “[Abuse of Anabolic](#)
47 [Steroids](#),” prohibit physician participation in blood doping or prescribing anabolic steroids. H-
48 470.994, “[Non-Therapeutic Use of Pharmacological Agents by Athletes](#),” opposes the use of
49 interventions to enhance athletic performance but is silent with respect to physicians’ specific
50 responsibilities.

1 [Principle VIII](#) of the AMA *Principles of Medical Ethics* states that “A physician shall, while caring
2 for a patient, regard responsibility to the patient as paramount.” Opinion 1.2.5, “[Sports Medicine](#),”
3 in the AMA *Code of Medical Ethics* limits its focus to physicians present during athletic events. It
4 directs those who “serve in a medical capacity at athletic, sporting, or other physically demanding
5 events should protect the health and safety of participants.” This is particularly relevant to minors
6 who wish to participate in sports in line with their gender identity, since CEJA Report 3-I-18
7 “Pediatric Decision-making” specifies that the best interests of a minor should be “understood
8 broadly” and treatment decisions should be made in light of “likely impact on the child’s
9 psychosocial wellbeing”[19]. Opinion 5.5, “[Medically Ineffective Interventions](#),” which
10 specifically addresses the use of life-sustaining interventions in contexts of terminal illness,
11 provides that physicians “should only recommend and provide interventions that are medically
12 appropriate.” It also notes that patients should not receive specific interventions simply because
13 they request them.

14
15 Further, Opinion 8.5, “[Disparities in Health Care](#),” states that “differences in treatment that are not
16 directly related to individual patients' clinical needs or preferences constitute inappropriate
17 variations in health care.” This can be construed as ruling out unnecessary testing or alteration of
18 treatment related to gender identity when these are required by third parties for participation in
19 sports. In Opinion 1.1.2, “[Prospective Patients](#),” physicians are required to refrain from
20 discrimination on the basis of gender and gender identity, which in accordance with principles of
21 justice, should extend to declining to participate in (and so refusing to legitimize) discriminatory
22 practices that violate patients' human rights.

23
24 In a press release in April 2019, the [World Medical Association](#) demanded that the IAAF
25 “immediately withdraw” its new eligibility regulations for classifying female athletes and urged
26 physicians to “take no part” in implementing them. In October 2021 WMA updated “[Declaration
27 on Principles of Health Care in Sports Medicine](#)” to oppose World Athletics eligibility regulations
28 and condemn “medical treatment solely to alter athletic performance,” as “unethical.”

29
30 These provide strong arguments that, as professionals committed to promoting first and foremost
31 the well-being of their patients, it is not appropriate for physicians to provide medical interventions
32 required to fulfill the World Athletics regulations mandating specific testosterone levels for either
33 athletes with DSDs or transgender athletes. These arguments also suggest it is inappropriate for a
34 physician to cooperate with any public school or recreational team that requires medical testing
35 and/or physician confirmation that an athlete is a particular gender in order for them to participate.

36 37 RECOMMENDATION

38
39 In view of these considerations, your AMA recommends that the following recommendations be
40 adopted in lieu of Resolution 19-A-19 and the remainder of this report be filed:

- 41
42 1. That our American Medical Association (AMA) oppose mandatory testing, medical treatment
43 or surgery for transgender athletes and athletes with Differences of Sex Development (DSD),
44 and affirm that these athletes be permitted to compete in alignment with their identity; (New
45 HOD Policy)
- 46
47 2. That our AMA oppose the use of specific hormonal guidelines to determine gender
48 classification for athletic competitions. (New HOD Policy)

- 1 3. That our AMA oppose physician participation in any practices intended to officially certify or
2 confirm an athlete's gender for the purposes of satisfying third party requirements. (New HOD
3 Policy)

Fiscal note: Less than \$500.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 3-I-22

Subject: Delegate Apportionment and Pending Members

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At June’s Annual Meeting, Board of Trustees Report 20 was considered, with the following
2 recommendations referred for report at this meeting (to avoid confusion with the original
3 recommendations, letters are used here to designate the recommendations):
4

- 5 A. That delegate apportionment for 2023 for constituent societies be based on official 2022 year-
6 end AMA membership data as recorded by the AMA.
- 7 B. That delegate apportionment for 2024 be based on then current bylaws.
- 8 C. That the Council on Constitution and Bylaws prepare bylaws amendments to implement these
9 recommendations, with the report to be considered no later than the November 2022 meeting
10 of the House of Delegates.
- 11 D. That Policy G-600.016, “Data Used to Apportion Delegates,” be rescinded.
12

13 The following recommendation from the same report was referred for decision.

- 14
- 15 E. That pending members no longer be considered in apportioning delegates in the House of
16 Delegates.
17

18 The recommendations labelled A-D above hinged on Recommendation E, which would have
19 ceased counting pending members for apportionment purposes. By and large Recommendations
20 A-D could be considered to have been subordinate to or contingent on Recommendation E.
21

22 PENDING MEMBERS DEFINED

23

24 Essential to dealing with the matter of pending members is the definition. Board Report 1-I-18
25 defined pending members as individuals who are not current members at the time they pay their
26 dues for the following calendar year. Two elements are required: the person is not a current
27 member at the time of dues payment and the person joins for the following calendar year. The
28 report had been prepared in response to a proposal to count these pending members for delegate
29 apportionment. To prevent gaming the system, by for example joining only every other year, the
30 House determined that a pending member would be counted for apportionment purposes the
31 following year if and only if they had again paid their dues early (i.e., before year end).
32

33 FOLLOW ON ACTION

34

35 As noted, Recommendation E (originally the first of six recommendations in the Board’s report)
36 was referred for decision. Acting in September, the Board adopted this recommendation, meaning
37 pending members will not be counted for apportionment purposes. As a practical matter, once
38 someone becomes a pending member, the individual must be tracked across time in perpetuity

1 solely for apportionment. Say an individual becomes a pending member in Year 0, meaning they
2 will be an actual member in Year 1. To be counted for apportionment purposes in Year 2, the
3 pending member must have paid their dues for Year 2 in Year 1. That will be true for successive
4 years without end (pay for Year 3 in Year 2, for Year 4 in Year 3, and so on). Note that a current
5 member (who has never been counted as a pending member) who always pays dues “early” is not a
6 pending member.

7
8 If that pending member’s dues payment is delayed to January 1 (or later) of Year 2, they will not
9 have been counted in apportioning Year 2 delegates but will be counted at the end of Year 2 for
10 Year 3 as a regular member, NOT as a pending member. At that point, the individual is a regular
11 member unless their membership lapses and they cycle back into the pending member category. In
12 other words, the timing of one’s dues payment and one’s membership status at the time of that
13 payment affect how and whether one is counted for apportionment purposes. These elements
14 cannot be captured by AMA’s membership accounting system across a potential 40- or 50-year
15 career in medicine. To track the information would require an estimated quarter million dollar
16 change to the membership accounting system.

17
18 Your Board acknowledges the arguments for counting pending members but believes counting
19 them not only unnecessarily complicates the apportionment process but that it devalues other
20 benefits of membership and active members themselves:

- 21
- 22 • The notion that pending members gain representation only by being counted for apportionment
23 purposes belies the fact that delegates represent the needs of not only members but patients,
24 their sponsoring societies, and the profession, including nonmembers.
 - 25 • Suggestions that being counted toward representation in the House of Delegates is attractive
26 are speculative at best. Physicians consistently report valuing the advocacy that emerges from
27 House of Delegates policy, not the House of Delegates per se.
 - 28 • Pending members are in fact NOT members. Individuals who join late in the year wishing to be
29 counted—a premise that is largely unsupported—could easily join for the current year by
30 paying half-year dues.
 - 31 • Some have argued that not counting pending members is tantamount to treating them as
32 second-class members. As just noted, they are not members, at least not initially, but decisions
33 about apportionment need not be linked to more concrete member benefits, which are a
34 separate business decision that can and should be addressed as a membership matter.
 - 35 • Finally, no evidence has emerged to suggest that the offer to count pending members for
36 apportionment purposes has led to membership gains. Virtually all the pending members in the
37 initial implementation had joined prior to the implementation of the experiment. Few states
38 gained delegates, meaning few have benefitted if at all.

39
40 While the makeup of the House is the province of the House, your Board believes that the
41 longstanding policy of counting actual members for apportionment has served our members well.
42 Counting pending members can be considered to diminish or discount actual members’ value as
43 much as it can be seen to enhance representation.

44
45 **POLICY ADOPTED AT A-22**

46
47 The following policy was adopted at June’s Annual Meeting and is the subject of Report 1 from the
48 Council on Constitution and Bylaws at this meeting. The policy was adopted in lieu of a proposal
49 to extend the delegate freeze into 2023. If implemented—bylaws amendments are required—in
50 2023 constituent societies will be apportioned delegates using the following formula, whereby each
51 society will get the greatest of the three calculated numbers:

- 1
- 2 • The number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA
- 3 members;
- 4 • The number of delegates apportioned for 2022 so long as that figure is not greater than 2 more
- 5 than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA members; or
- 6 • For societies that would lose more than five delegates from their 2022 apportionment, the
- 7 number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members
- 8 plus 5.
- 9

10 Although implementation depends on action to be taken at this Interim Meeting, your Board would
11 emphasize that this plan, which originated with the Board's report, was based on counting actual
12 members and was intended not to continue counting pending members. In addition, the Board's
13 action on the item referred for decision means pending members will not be counted for
14 apportionment purposes.

15 16 REFERRED ITEMS

17
18 Turning to the four referred items, each will be dealt with in turn. Recommendation A (as labelled
19 herein) called for constituent society apportionment in 2023 to be based on "official 2022 year-end
20 membership data" and simply flowed from the recommendation that preceded it to not count
21 pending members. That latter recommendation, labelled "E" in this report, has been adopted by
22 Board action. Existing bylaws or possible amendments at this meeting will suffice. No action is
23 therefore required on the referred recommendation.

24
25 Recommendation B calling for delegate apportionment in 2024 to be based on then current bylaws
26 is unnecessary. Current bylaws are by definition controlling. Moreover, the language does not
27 affect the ability of the House to amend bylaws, so again, no action is required.

28
29 The recommendation in Board of Trustees Report 20-A-22 calling for the Council on Constitution
30 and Bylaws to prepare a report essentially flagged the Council that bylaws amendments might be
31 necessary. It is more a style for AMA reports than a necessity, as the Council has the authority to
32 generate and offer reports on its own. The recommendation requires no action.

33
34 The fourth referred recommendation, labelled D, was simply a housekeeping matter, meant to cull
35 an unneeded policy from the compendium, which contains 3955 separate policy statements. Policy
36 G-600.016, "Data Used to Apportion Delegates," reads as follows:

- 37
- 38 1. Our AMA shall issue an annual, mid-year report on or around June 30 to inform each state
- 39 medical society and each national medical specialty society that is in the process of its 5-year
- 40 review of its current AMA membership count.
- 41 2. "Pending members" (defined as individuals who at the time they apply for membership are not
- 42 current in their dues and who pay dues for the following calendar year) will be added to the
- 43 number of active AMA members in the December 31 count for the purposes of AMA delegate
- 44 allocations to state medical societies for the following year and this total will be used to
- 45 determine the number of national medical specialty delegates to maintain parity.
- 46 3. Our AMA will track "pending members" from a given year who are counted towards delegate
- 47 allocation for the following year and these members will not be counted again for delegate
- 48 allocation unless they renew their membership before the end of the following year.
- 49 4. Our AMA Board of Trustees will issue a report to the House of Delegates at the 2022 Annual
- 50 Meeting on the impact of Policy G-600.016 and recommendations regarding continuation of
- 51 this policy.

1 Paragraphs two and three of the policy are not relevant if pending members are no longer counted.
2 Paragraph four was fulfilled by Board of Trustees Report 20-A-22, even though all but one of the
3 recommendations it contained were referred. While a case might be made for retaining paragraph
4 one, our AMA's Federation Relations and Membership units are in regular communication with
5 societies in the House, and any society can easily request its current data at any time. For specialty
6 societies not undergoing their five-year review, the report has no value, and little need for a
7 mandated report is apparent. Consequently, the policy is recommended for rescission.

8

9 RECOMMENDATION

10

11 Your Board is cognizant of the fact that some members of the House believe that counting pending
12 members is beneficial to membership and acknowledges the right of the House to determine its
13 makeup. Nevertheless, your Board has concluded that counting pending members for
14 apportionment lacks merit for the reasons outlined above. Also worth noting is that the House will
15 act on Council on Constitution and Bylaws Report 1, which will determine the path taken and may
16 also affect action on this report.

17

18 Your Board of Trustees recommends that Policy G-600.016 be rescinded and the remainder of the
19 report filed.

Fiscal Note: \$150 to update PolicyFinder

REPORT 4 OF THE BOARD OF TRUSTEES (I-22)
Preserving Access to Reproductive Health Services
(Reference Committee on Amendments to Constitution and Bylaws)

EXECUTIVE SUMMARY

At the 2022 American Medical Association (AMA) Annual Meeting, our AMA House of Delegates adopted Policy D-5.999, “Preserving Access to Reproductive Health Services,” which, among other things, instructs the AMA to review the AMA policy compendium and recommend policies to be amended or rescinded. This Board report, therefore, reviews AMA policy related to reproductive health, discusses policies for amendment or rescission, and provides recommendations.

In its review of the policy compendium, the Board identified three duplicative policies and recommends these policies be consolidated into one policy. The report also recommends modifying two policies related to physicians’ personal views on abortion and clinical determinations about the viability of a fetus to conform with new policy adopted at the 2022 Annual Meeting. Finally, the report recommends modifying policy to remove a reference to *Roe v. Wade*.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 4-I-22

Subject: Preserving Access to Reproductive Health Services

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 INTRODUCTION
2

3 At the 2022 American Medical Association (AMA) Annual Meeting (2022 Annual Meeting), our AMA
4 House of Delegates adopted Policy D-5.999, “Preserving Access to Reproductive Health Services,” which
5 states:
6

7 That our AMA:

- 8 1. Recognizes that healthcare, including reproductive health services like contraception and
9 abortion, is a human right;
- 10 2. Opposes limitations on access to evidence-based reproductive health services, including
11 fertility treatments, contraception, and abortion;
- 12 3. Will work with interested state medical societies and medical specialty societies to vigorously
13 advocate for broad, equitable access to reproductive health services, including fertility
14 treatments, contraception, and abortion;
- 15 4. Supports shared decision-making between patients and their physicians regarding
16 reproductive healthcare;
- 17 5. Opposes any effort to undermine the basic medical principle that clinical assessments, such as
18 viability of the pregnancy and safety of the pregnant person, are determinations to be made
19 only by healthcare professionals with their patients;
- 20 6. Opposes the imposition of criminal and civil penalties or other retaliatory efforts against
21 patients, patient advocates, physicians, other healthcare workers, and health systems for
22 receiving, assisting in, referring patients to, or providing reproductive health services;
- 23 7. Will advocate for legal protections for patients who cross state lines to receive reproductive
24 health services, including contraception and abortion, or who receive medications for
25 contraception and abortion from across state lines, and legal protections for those that
26 provide, support, or refer patients to these services;
- 27 8. Will review the AMA policy compendium and recommend policies which should be
28 amended or rescinded to reflect these core values, with report back at I-22.
29

30 This Board report, therefore, addresses paragraph 8 of the policy, reviews AMA policy related to
31 reproductive health, discusses policies for amendment or rescission, and provides recommendations.

1 AMA POLICY

2
3 Our AMA has many policies addressing access to abortion and other reproductive health care services.
4 These policies, including those adopted or amended during the 2022 Annual Meeting, are as follows:

5
6 *Policy D-5.999, “Preserving Access to Reproductive Health Services”*

7 Our AMA: (1) recognizes that healthcare, including reproductive health services like contraception
8 and abortion, is a human right; (2) opposes limitations on access to evidence-based reproductive
9 health services, including fertility treatments, contraception, and abortion; (3) will work with
10 interested state medical societies and medical specialty societies to vigorously advocate for broad,
11 equitable access to reproductive health services, including fertility treatments, contraception, and
12 abortion; (4) supports shared decision-making between patients and their physicians regarding
13 reproductive healthcare; (5) opposes any effort to undermine the basic medical principle that clinical
14 assessments, such as viability of the pregnancy and safety of the pregnant person, are determinations
15 to be made only by healthcare professionals with their patients; (6) opposes the imposition of criminal
16 and civil penalties or other retaliatory efforts against patients, patient advocates, physicians, other
17 healthcare workers, and health systems for receiving, assisting in, referring patients to, or providing
18 reproductive health services; (7) will advocate for legal protections for patients who cross state lines
19 to receive reproductive health services, including contraception and abortion, or who receive
20 medications for contraception and abortion from across state lines, and legal protections for those that
21 provide, support, or refer patients to these services; and (8) will review the AMA policy compendium
22 and recommend policies which should be amended or rescinded to reflect these core values, with
23 report back at I-22. (Res. 028, A-22)

24
25 *Policy H-5.995, “Abortion”*

26 Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly
27 licensed physician and surgeon in conformance with standards of good medical practice and the
28 Medical Practice Act of this state; and (2) no physician or other professional personnel shall be
29 required to perform an act violative of good medical judgment. Neither physician, hospital, nor
30 hospital personnel shall be required to perform any act violative of personally held moral principles.
31 In these circumstances, good medical practice requires only that the physician or other professional
32 withdraw from the case, so long as the withdrawal is consistent with good medical practice.
33 (Sub. Res. 43, A-73; Reaffirmed: I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Sub. Res.
34 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CMS Rep. 1, I-00; Reaffirmed: CEJA
35 Rep. 6, A-10; Reaffirmed: CEJA Rep. 01, A-20)

36
37 *Policy H-5.993, “Right to Privacy in Termination of Pregnancy”*

38 The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed
39 only by a duly licensed physician in conformance with standards of good medical practice and the
40 laws of the state; and (2) no physician or other professional personnel shall be required to perform an
41 act violative of good medical judgment or personally held moral principles. In these circumstances
42 good medical practice requires only that the physician or other professional withdraw from the case
43 so long as the withdrawal is consistent with good medical practice. The AMA further supports the
44 position that the early termination of pregnancy is a medical matter between the patient and the
45 physician, subject to the physician's clinical judgment, the patient's informed consent, and the
46 availability of appropriate facilities. (Res. 49, I-89; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by
47 BOT Rep. 26, A-97; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: CCB/CLRPD Rep. 2, A-14)

1 *Policy H-5.983, “Pregnancy Termination”*

2 The AMA adopted the position that pregnancy termination be performed only by appropriately
3 trained physicians (MD or DO). (Res. 520, A-95; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH
4 Rep. 1, A-13)

5
6 *Policy H-5.990, “Policy on Abortion”*

7 The issue of support of or opposition to abortion is a matter for members of the AMA to decide
8 individually, based on personal values or beliefs. The AMA will take no action which may be
9 construed as an attempt to alter or influence the personal views of individual physicians regarding
10 abortion procedures. (Res. 158, A-90; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep.
11 26, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 1, A-09; Reaffirmed: CEJA Rep. 03,
12 A-19)

13
14 *Policy H-5.988, “Accurate Reporting on AMA Abortion Policy”*

15 Our AMA HOD cautions members of the Board of Trustees, Councils, employees and members of
16 the House of Delegates to precisely state current AMA policy on abortion and related issues in an
17 effort to minimize public misperception of AMA policy and urges that our AMA continue efforts to
18 refute misstatements and misquotes by the media with reference to AMA abortion policy.
19 (Sub. Res. 21, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11; Reaffirmed:
20 CEJA Rep. 1, A-21)

21
22 *Policy H-5.989, “Freedom of Communication Between Physicians and Patients”*

23 It is the policy of the AMA: (1) to strongly condemn any interference by the government or other
24 third parties that causes a physician to compromise his or her medical judgment as to what
25 information or treatment is in the best interest of the patient;
26 (2) working with other organizations as appropriate, to vigorously pursue legislative relief from
27 regulations or statutes that prevent physicians from freely discussing with or providing information to
28 patients about medical care and procedures or which interfere with the physician-patient relationship;
29 (3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on
30 physician-patient communications; and
31 (4) to inform the American public as to the dangers inherent in regulations or statutes restricting
32 communication between physicians and their patients.
33 (Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-
34 96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-
35 98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09;
36 Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13)

37
38 *Policy H-100.948, “Supporting Access to Mifepristone (Mifeprex)”*

39 Our AMA will support mifepristone availability for reproductive health indications, including via
40 telemedicine, telehealth, and at retail pharmacies and continue efforts urging the Food and Drug
41 Administration to lift the Risk Evaluation and Mitigation Strategy on mifepristone.
42 (Res. 504, A-18; Modified: Res. 27, A-22)

43
44 *Policy H-140.835, “Political Interference in the Patient-Physician Relationship”*

45 Our AMA opposes any policies that interfere with the patient-physician relationship by giving
46 probate, inheritance, a social security number, or other legal rights to an undelivered pregnancy, or
47 imposing legislative barriers to medical decision-making by changes in tax codes or in definitions of
48 beneficiaries. (Alt. Res. 007, I-17)

1 *Policy H-5.998, “Public Funding of Abortion Services”*

2 The AMA reaffirms its opposition to legislative proposals that utilize federal or state health care
3 funding mechanisms to deny established and accepted medical care to any segment of the population.
4 (Sub. Res. 89, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: BOT Rep. 12, A-05; Reaffirmed:
5 CMS Rep. 1, A-15)

6
7 *Policy H-425.969, “Support for Access to Preventive and Reproductive Health Services”*

8 Our AMA supports access to preventive and reproductive health services for all patients and opposes
9 legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny
10 established and accepted medical care to any segment of the population.
11 (Sub. Res. 224, I-15 Reaffirmation: I-17)

12
13 *Policy H-185.937, “Reproductive Parity”*

14 Our AMA supports legislation and policies that require any health insurance products offering
15 maternity services to include all choices in the management of reproductive medical care.
16 (Res. 4, I-13)

17
18 *Policy H-295.923, “Medical Training and Termination of Pregnancy”*

19 1. Our AMA supports the education of medical students, residents and young physicians about the
20 need for physicians who provide termination of pregnancy services, the medical and public health
21 importance of access to safe termination of pregnancy, and the medical, ethical, legal and
22 psychological principles associated with termination of pregnancy.
23 2. Our AMA supports the availability of abortion education and exposure to procedures for
24 termination of pregnancy, including medication abortions, for medical students and resident/fellow
25 physicians and opposes efforts to interfere with or restrict the availability of this education and
26 training.
27 3. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently
28 enforce compliance with the standardization of abortion training opportunities as per the requirements
29 set forth by the Review Committee for Obstetrics and Gynecology and the American College of
30 Obstetricians and Gynecologists’ recommendations. (Res. 315, I-94; Reaffirmed: CME Rep. 2, A-04;
31 Modified: CME Rep. 2, A-14; Modified: CME Rep. 1, A-15; Appended: Res. 957, I-17; Modified:
32 Res. 309, I-21)

33
34 *Policy H-5.980, “Oppose the Criminalization of Self-Induced Abortion”*

35 Our AMA: (1) opposes the criminalization of self-managed abortion and the criminalization of
36 patients who access abortions as it increases patients’ medical risks and deters patients from seeking
37 medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-
38 managed abortion and the criminalization of patients who access abortions; and (3) will oppose
39 efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and
40 requirements that physicians function as agents of law enforcement—gathering evidence for
41 prosecution rather than as a provider of treatment. (Res. 007, A-18; Modified: Res. 27, A-22)

42
43 *Policy H-420.954, “Truth and Transparency in Pregnancy Counseling Centers”*

44 (1) It is AMA’s position that any entity that represents itself as offering health-related services should
45 uphold the standards of truthfulness, transparency, and confidentiality that govern health care
46 professionals.
47 (2) Our AMA urges the development of effective oversight for entities offering pregnancy related
48 health services and counseling.
49 (3) Our AMA advocates that any entity offering crisis pregnancy services

1 a. truthfully describes the services they offer or for which they refer—including prenatal care,
2 family planning, termination, or adoption services—in communications on site and in their
3 advertising, and before any services are provided to an individual patient; and
4 b. be transparent with respect to their funding and sponsorship relationships.

5 (4) Our AMA advocates that any entity licensed to provide medical or health services to pregnant
6 women

7 a. ensure that care is provided by appropriately qualified, licensed personnel; and

8 b. abides by federal health information privacy laws.

9 (5) Our AMA urges that public funding only support programs that provide complete, non-directive,
10 medically accurate, health information to support patients informed, voluntary decisions.

11 (Res. 7, I-11; Reaffirmed: CEJA Rep. 1, A-21; Modified: BOT Rep. 14, A-22)

12
13 *Policy H-5.982, “Late-Term Pregnancy Termination Techniques”*

14 (1) The term 'partial birth abortion' is not a medical term. The AMA will use the term “intact
15 dilatation and extraction” (or intact D&X) to refer to a specific procedure comprised of the following
16 elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental or manual
17 conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and
18 partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but
19 otherwise intact fetus. This procedure is distinct from dilatation and evacuation (D&E) procedures
20 more commonly used to induce abortion after the first trimester. Because 'partial birth abortion' is not
21 a medical term it will not be used by the AMA.

22 (2) According to the scientific literature, there does not appear to be any identified situation in which
23 intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been
24 raised about intact D&X. The AMA recommends that the procedure not be used unless alternative
25 procedures pose materially greater risk to the woman. The physician must, however, retain the
26 discretion to make that judgment, acting within standards of good medical practice and in the best
27 interest of the patient.

28 (3) The viability of the fetus and the time when viability is achieved may vary with each pregnancy.
29 In the second trimester when viability may be in question, it is the physician who should determine
30 the viability of a specific fetus, using the latest available diagnostic technology.

31 (4) In recognition of the constitutional principles regarding the right to an abortion articulated by the
32 Supreme Court in *Roe v. Wade*, and in keeping with the science and values of medicine, the AMA
33 recommends that abortions not be performed in the third trimester except in cases of serious fetal
34 anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the
35 life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in
36 extraordinary circumstances, maternal health factors which demand termination of the pregnancy can
37 be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of
38 the fetus argues for ending the pregnancy by appropriate delivery. (BOT Rep. 26, A-97; Modified and
39 Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17)

40
41 *Policy H-5.997, “Violence Against Medical Facilities and Health Care Practitioners and Their*
42 *Families”*

43 The AMA supports the right of access to medical care and opposes (1) violence and all acts of
44 intimidation directed against physicians and other health care providers and their families and (2)
45 violence directed against medical facilities, including abortion clinics and family planning centers, as
46 an infringement of the individual's right of access to the services of such centers.

47 (Res. 82, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; Res. 422, A-95; Reaffirmation I-99; Reaffirmed:
48 CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19)

1 DISCUSSION
2

3 In its review of the policy compendium, the Board identified some duplicative policies. Policy
4 H-5.993, “Right to Privacy in Termination of Pregnancy” and Policy H-5.995, “Abortion,” each contain
5 nearly identical language affirming: (1) that abortion is a medical procedure that should be performed in
6 conformance with standards of good medical practice and the laws of the state; (2) that no physician or
7 other professional personnel shall be required to perform an act violative of good medical judgment or
8 personally held moral principles; and (3) that a physician or other professional who wishes to withdraw
9 from a case must do so in conformance with good medical practice. Additionally, Policy H-5.983,
10 “Pregnancy Termination,” Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” and Policy
11 H-5.995, “Abortion,” each state that abortions should be performed only by physicians. Accordingly, the
12 AMA Board of Trustees (the Board) recommends that these policies (Policy H-5.993, “Pregnancy
13 Termination,” Policy H-5.995, “Abortion,” and Policy H-5.983, “Pregnancy Termination”) be
14 consolidated into one policy, Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” and that
15 the remaining two policies be rescinded.

16
17 The Board also identified some policies that require updating or amendment for clarification purposes.
18 Specifically, Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” states that physicians may
19 withdraw from cases they view as violative of good medical judgment or personally held moral principles
20 so long as withdrawal is consistent with good medical practice. The Board recommends that this policy
21 also state that withdrawal due to personally held moral principles must be consistent with ethical
22 obligations. *AMA Code of Medical Ethics* Opinion 1.1.7, “Physician Exercise of Conscience,” states,
23 among other things, that “physicians should refer a patient to another physician or institution to provide
24 treatment the physician declines to offer.”

25
26 Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” also states that the AMA supports the
27 position that “the early termination of pregnancy is a medical matter between the patient and the
28 physician [...]” The Board notes that inclusion of the word “early” has created some confusion. Since
29 Policy H-5.982, “Late-Term Pregnancy Termination Techniques,” already addresses determinations of
30 fetal viability and indications for abortion late in pregnancy, the Board recommends deletion of the word
31 “early.”

32
33 Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” also states that an abortion should only
34 be performed by a physician. This policy was adopted when most abortions were surgical; however, by
35 2020, an estimated 54% of abortions were induced with prescription medication. The Board recommends
36 this policy be amended to state that abortion is “the practice of medicine and requires the personal
37 performance or supervision by an appropriately licensed physician.” The amendment will enable the
38 AMA to advocate for broad, equitable access to abortion care in accordance with Policy D-5.999,
39 “Preserving Access to Reproductive Health Services,” by building capacity within the physician-led
40 healthcare teams that provide abortion care, while also advocating for continued physician supervision of
41 non-physicians who prescribe medication for abortions.

42
43 Policy H-5.993, “Right to Privacy in Termination of Pregnancy,” also states that abortion “is a medical
44 matter between the patient and the physician, subject to the physician's clinical judgment, the patient's
45 informed consent, and the availability of appropriate facilities.” The Board recommends replacing
46 “availability of appropriate facilities” with “ability to perform the procedure safely.” Because over half of
47 abortions are now induced with prescription medication, they do not necessarily require care in a facility.
48 Conditioning AMA support of abortion care on “availability of appropriate facilities” may be used by
49 some as justification for placing medically unnecessary facility requirements on abortion providers. By
50 amending the policy to emphasize safety generally, the policy is less likely to be misconstrued.

1 In addition, Policy H-5.990, “Policy on Abortion,” states that support of or opposition to abortion is a
2 matter for members to decide individually. Since newly adopted policy at the 2022 Annual Meeting,
3 Policy D-5.999, “Preserving Access to Reproductive Health Services,” supports access to abortion as an
4 organizational policy matter, the Board recommends that Policy H-5.990, “Policy on Abortion,” be
5 amended to clarify that the AMA believes members’ *personal* views on abortion should be decided
6 individually.
7

8 Additionally, Policy H-5.982, “Late-Term Pregnancy Termination Techniques,” states that the
9 determination of the viability of a fetus during the second trimester is to be made by a physician. Newly
10 adopted policy at the 2022 Annual Meeting, Policy D-5.999, “Preserving Access to Reproductive Health
11 Services,” is broader. Specifically, this new policy protects clinical determinations and assessments
12 regardless of the stage of pregnancy. The Board, therefore, recommends that Policy H-5.982, “Late-Term
13 Pregnancy Termination Techniques,” be amended to remove the reference to viability in the second
14 trimester. Policy H-5.982 also includes a recognition of the constitutional principles articulated by the
15 Supreme Court in *Roe v. Wade*. In light of the Supreme Court’s decision in *Dobbs v. Jackson Women’s*
16 *Health Organization*, the Board recommends that Policy H-5.982 be further amended to reflect this legal
17 activity.
18

19 Finally, with the completion of this report, the Board recommends that Policy D-5.999, “Preserving
20 Access to Reproductive Health Services,” be amended to remove the directive to review AMA policy,
21 recommend policies for amendment or rescission and report back at the 2022 Interim Meeting.
22

23 In addition to review of policy required by the new policy, the Board notes that Resolution 621-A-22,
24 Establishing a Task Force to Preserve the Patient-Physician Relationship When Evidence-Based,
25 Appropriate Care Is Banned or Restricted, instructs our AMA to convene a task force to respond to
26 restrictions on and criminalization of abortion and other evidence-based care. Importantly, at the time of
27 the writing of this report (August 2022), the AMA is in the process of developing the task force, with the
28 task force expected to be formed by the time of the AMA 2022 Interim Meeting in November. It is critical
29 to further note that activity—in both AMA Advocacy and AMA Office of General Counsel—to protect
30 the patient-physician relationship is robust and ongoing. The following is a summary of relevant activity
31 as of early August 2022 when this report was drafted.
32

33 Since the U.S. Supreme Court decision in *Dobbs v. Jackson Women’s Health Organization* which
34 overturned *Roe v. Wade* and *Planned Parenthood v. Casey*, the AMA has been pursuing multiple
35 strategies, at the state level, to address the broad spectrum of issues now facing physicians and patients.
36 Shortly after the decision was issued, the AMA convened state medical associations to understand state-
37 by-state dynamics and the concerns of physicians. The AMA has since held multiple meetings with state
38 medical associations and national medical specialty societies to understand the challenges facing
39 physicians and plan a coordinated strategy to protect access to care. The AMA Advocacy Resource
40 Center is working closely with the Federation to protect patients and physicians from legislative
41 intrusions into and criminalization of the practice of medicine. In many states, it is not clear how broadly
42 abortion restrictions will be interpreted, and confusion remains about how restrictions impact medically
43 necessary pregnancy terminations, prescribing of certain medications for reasons unrelated to pregnancy,
44 and the provision of other types of care. The AMA is working with the Federation and other stakeholders
45 to seek clarification from policymakers, as well as collecting information, producing resources, and
46 conducting legislative analyses to help states navigate this new regulatory scheme.
47

48 One way AMA Advocacy staff is collecting much-needed clinical information for states across the
49 country is by engaging expert physician members of the Board, Council on Legislation, and Council on
50 Medical Service. AMA Advocacy staff is also engaging attorneys in the American Society of Medical
51 Association Counsel to identify answers to legal questions raised in states across the country as legislation

1 and regulation is contemplated and introduced. The AMA Center for Health Equity is collaborating with
2 the AMA Advocacy team, as well, working to identify impact on historically marginalized and
3 minoritized communities and strategies related to health equity. Finally, at the 2022 AMA State
4 Advocacy Roundtable, the AMA hosted an interactive discussion among Federation staff about the
5 implications of the *Dobbs* decision and because of that discussion is working to create resources for the
6 Federation. This activity is ongoing.

7
8 At the federal level, the AMA immediately called for greater digital privacy for patients out of concern
9 that minimal oversight of data use by digital apps could place women in jeopardy in states seeking to
10 enforce abortion restrictions. The AMA joined the American College of Obstetricians and Gynecologists
11 (ACOG) in calling for the U.S. Food and Drug Administration to remove or modify the Risk Evaluation
12 and Mitigation Strategies (REMS) and Elements to Assure Safe Use (ETASU) requirements for
13 mifepristone. The Biden Administration also reminded hospitals and health care providers of their
14 obligation to comply with the provisions of the Emergency Medical Treatment and Labor Act
15 (EMTALA) that preempt any state laws that restrict access to stabilizing medical treatment, including
16 abortion procedures and other treatments that may result in the termination of a pregnancy, and reminded
17 pharmacies of their obligations related to prescription medications for reproductive health under federal
18 civil rights laws.

19
20 Finally, in the courts, the AMA has joined ACOG and the Society for Maternal-Fetal Medicine in amicus
21 briefs around the country seeking to protect access to reproductive care and combat intrusion on the
22 physician-patient relationship. As of early August, amicus briefs have been filed in Georgia, Kentucky,
23 Ohio, South Carolina, Utah, and West Virginia. Additional filings are expected in coming months. These
24 briefs have supported challenges to a range of harmful laws, including bans from the 1800s, trigger laws
25 intended to ban all abortion following the reversal of *Roe v. Wade*, and criminal penalties that potentially
26 include felony charges for physicians. In addition, the AMA has worked to support federal guidance and
27 litigation around access to care in the courts through its amicus efforts. The AMA will continue to work
28 with the Federation and external stakeholders in the courts and at the state and federal levels to protect the
29 physician-patient relationship and access to reproductive care.

30 31 RECOMMENDATIONS

32
33 The Board recommends that the following recommendations be adopted and that the remainder of the
34 report be filed.

- 35
36 1. That Policy H-5.993, “Right to Privacy in Termination of Pregnancy” be amended by addition
37 and deletion as follows:

38
39 The AMA reaffirms existing policy that (1) abortion is the practice of medicine and requires the
40 personal performance or supervision by an appropriately licensed physician a medical procedure
41 and should be performed only by a duly licensed physician in conformance with standards of
42 good medical practice and the laws of the state; and (2) no physician or other professional
43 personnel shall be required to perform an act violative of good medical judgment or personally
44 held moral principles. In these circumstances ~~good medical practice requires only that the a~~
45 physician or other professional may withdraw from the case so long as the withdrawal is
46 consistent with good medical practice and ethical guidance on the exercise of conscience;- (3)
47 ~~The~~ AMA further supports the position that the ~~early~~ termination of pregnancy is a medical
48 matter between the patient and the physician, subject to the physician's clinical judgment, the
49 patient's informed consent, and the ability to perform the procedure safely ~~availability of~~
50 ~~appropriate facilities.~~ (Modify Current HOD Policy)

1 2. That Policies H-5.995, “Abortion,” and Policy H-5.983, “Pregnancy Termination,” be rescinded.
2 (Rescind HOD Policy)

3
4 3. That Policy H-5.990, “Policy on Abortion,” be amended by addition as follows:
5

6 The issue of personal support of or opposition to abortion is a matter for members of the
7 AMA to decide individually, based on personal values or beliefs. The AMA will take no
8 action which may be construed as an attempt to alter or influence the personal views of
9 individual physicians regarding abortion procedures. (Modify HOD Policy)

10
11 4. That Policy H-5.982, “Late-Term Pregnancy Termination Techniques,” be amended by addition
12 and deletion as follows:
13

14 (1) The term “partial birth abortion” is not a medical term. The AMA will use the term “intact
15 dilatation and extraction” (or intact D&X) to refer to a specific procedure comprised of the
16 following elements: deliberate dilatation of the cervix, usually over a sequence of days;
17 instrumental or manual conversion of the fetus to a footling breech; breech extraction of the body
18 excepting the head; and partial evacuation of the intracranial contents of the fetus to effect
19 vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation and
20 evacuation (D&E) procedures more commonly used to induce abortion after the first trimester.
21 Because 'partial birth abortion' is not a medical term it will not be used by the AMA. (2)
22 According to the scientific literature, there does not appear to be any identified situation in which
23 intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been
24 raised about intact D&X. The AMA recommends that the procedure not be used unless
25 alternative procedures pose materially greater risk to the woman. The physician must, however,
26 retain the discretion to make that judgment, acting within standards of good medical practice and
27 in the best interest of the patient. (3) The viability of the fetus and the time when viability is
28 achieved may vary with each pregnancy. ~~In the second trimester w~~When viability may be in
29 question, it is the physician who should determine the viability of a specific fetus, using the latest
30 available diagnostic technology. (4) ~~In recognition of the constitutional principles regarding the~~
31 ~~right to an abortion articulated by the Supreme Court in Roe v. Wade, and~~In keeping with the
32 science and values of medicine, the AMA recommends that abortions not be performed in the
33 third trimester except in cases of serious fetal anomalies incompatible with life. Although third-
34 trimester abortions can be performed to preserve the life or health of the mother, they are, in fact,
35 generally not necessary for those purposes. Except in extraordinary circumstances, maternal
36 health factors which demand termination of the pregnancy can be accommodated without
37 sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for
38 ending the pregnancy by appropriate delivery. (Modify Current HOD Policy)

39
40 5. Policy D-5.999, “Preserving Access to Reproductive Health Services,” be amended by deletion as
41 follows:
42

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

1 patients; (6) opposes the imposition of criminal and civil penalties or other retaliatory efforts
2 against patients, patient advocates, physicians, other healthcare workers, and health systems for
3 receiving, assisting in, referring patients to, or providing reproductive health services; (7) will
4 advocate for legal protections for patients who cross state lines to receive reproductive health
5 services, including contraception and abortion, or who receive medications for contraception and
6 abortion from across state lines, and legal protections for those that provide, support, or refer
7 patients to these services; and (8) will review the AMA policy compendium and recommend
8 policies which should be amended or rescinded to reflect these core values, with report back at
9 the 2022 Interim Meeting. (Modify Current HOD Policy)

Fiscal Note: Less than \$500.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 5-I-22

Subject: Towards Diversity and Inclusion: A Global Non-discrimination Policy Statement and Benchmark for our AMA

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 BACKGROUND

2

3 At the November 2020 House of Delegates (HOD) meeting, the [House of Delegates referred](#)
4 Resolution 602, “Towards Diversity and Inclusion: A Global Non-discrimination Policy Statement
5 and Benchmark for our AMA.” [Resolution 602](#), introduced by the Women Physicians Section
6 asked that our American Medical Association (AMA):

7

8 Adopt an overarching non-discrimination policy on the basis of sex, color, creed, race, religion,
9 disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any
10 other reason unrelated to character, competence, ethics, professional status or professional
11 activities that applies to members, employees and patients. (New HOD Policy)

12

13 Demonstrate its commitment to complying with laws, rules or regulations against
14 discrimination on the basis of protected characteristics. (Directive to Take Action)

15

16 Reaffirm Policy H-65.988, “Organizations Which Discriminate,” and Policy G-630.040,
17 “Principles on Corporate Relationships,” in its overarching non-discrimination policy.
18 (Reaffirm HOD Policy)

19

20 Reaffirm Policy G-600.067, “References to Terms and Language in Policies Adopted to
21 Protect Populations from Discrimination and Harassment.” (Reaffirm HOD Policy)

22

23 Study the feasibility and need for a comprehensive business conduct standards policy to be
24 fully integrated with the conflict of interest policy, and report back to the AMA House of
25 Delegates within 18 months. (Directive to Take Action)

26

27 Provide an update on its comprehensive diversity and inclusion strategy to the AMA House of
28 Delegates within 24 months. (Directive to Take Action)

29

30 Resolution 602 calls upon our AMA to adopt an overarching non-discrimination policy; reaffirm
31 current AMA policy; study the feasibility and need for a comprehensive business conduct standards
32 policy to be fully integrated with the conflict of interest policy; and provide an update on our
33 AMA’s comprehensive diversity and inclusion strategy.

34

35 The reference committee received testimony supportive of the intent of Resolution 602 but noted
36 there were several amendments proffered to broaden inclusiveness, as well as to strengthen the

1 language contained in existing AMA policy. Still others advocated for referral of this item due to
2 the complexity of the requests and the need to develop an integrated response.

3
4 The reference committee supported referral of this item to allow our AMA House of Delegates to
5 receive a report back that codifies policies and activities and optimizes the language contained in
6 an overarching non-discrimination policy.

7
8 This report: 1) describes our AMA's commitment to human rights and health equity that would
9 support an overarching non-discrimination policy and 2) summarizes our AMA's existing non-
10 discrimination policies passed by the House of Delegates.

11 DISCUSSION

12
13
14 The federal landscape related to discrimination is constantly evolving, so any overarching policy
15 will need to be flexible in its wording and regularly updated.

16
17 The HOD's policy statements on health topics serve as a cornerstone of our AMA, making clear
18 what our AMA stands for as an organization, providing information and guidance to physicians and
19 others about health care issues.

20 *AMA's commitment to human rights and health equity*

21
22
23 Our AMA Policy H-65.965, "Support of Human Rights and Freedom," provides a clear statement
24 of our AMA's commitment to supporting and maintaining respect for human rights. It reads as
25 follows:

26
27 Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity
28 of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any
29 human being of equal rights, privileges and responsibilities commensurate with his or her
30 individual capabilities and ethical character because of an individual's sex, sexual orientation,
31 gender, gender identity or transgender status, race, religion, disability, ethnic origin, national
32 origin or age; (3) opposes any discrimination based on an individual's sex, sexual orientation,
33 gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and
34 any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat
35 to the public health and social welfare of the citizens of the United States, urges expedient
36 passage for appropriate hate crimes prevention legislation in accordance with our AMA's
37 policy through letters to members of Congress; and registers support for hate crimes prevention
38 legislation, via letter, to the President of the United States.

39
40 The policy provides a key foundation in fostering equity and inclusion both within the organization
41 and externally.

42
43 Additionally, our AMA has [made a commitment](#) to "actively work to dismantle racist and
44 discriminatory policies and practices across all of health care." Furthermore, "our AMA recognizes
45 that racism in its systemic, structural, institutional, and interpersonal forms as a serious threat to
46 public health, the advancement of health equity, and a barrier to appropriate medical care" and
47 "supports the development of policy to combat racism and its effects" (Policy H-65.952, "Racism
48 as a Public Health Threat").

49
50 By establishing the AMA Center for Health Equity, our AMA has demonstrated its intention and
51 commitment to [embed health equity into the DNA of the organization](#) and its work. As part of the

1 “Plan for Continued Progress Toward Health Equity” (Policy D-180.981) our AMA has made the
2 pursuit of diversity, equity, and inclusion a key strategy to operationalize health equity. This
3 pursuit includes a commitment to anti-racism/anti-discrimination/anti-harassment policies. Our
4 AMA has continued to expand on our diversity and inclusion strategy as outlined in Board Report
5 10-A-22 about 2021 progress on the AMA’s Organizational Strategic Plan to Embed Racial Justice
6 and Advance Health Equity.

7
8 *Existing AMA HOD non-discrimination policies*

9
10 A policy scan of our AMA’s HOD non-discrimination policies identified 88 non-discrimination
11 policies. This summary only includes policies currently published in our AMA’s PolicyFinder.
12 Policies that were rescinded are not included. The policies are grouped below based on the nature
13 of the protections covered by the policies. The number of policies matched to each grouping is
14 listed below (Please see Appendix A for details):

- 15
16 • Non-discrimination policies – AMA (3)
17 • Non-discrimination policies – Constitution and Bylaws (3)
18 • Non-discrimination policies listed under AMA governance (3)
19 • General non-discrimination policies that protect all individuals (11)
20 • Non-discrimination policies that apply to specific populations (17)
21 • Non-discrimination policies that protect physicians and/or their practices (23)
22 • Non-discrimination policies that protect international medical graduates (IMGs) (4)
23 • Non-discrimination policies that protect residents (5)
24 • Non-discrimination policies that protect medical students (4)
25 • Non-discrimination policies that protect patients (14)
26 • Non-discrimination related to terrorism (1)

27
28 Within HOD policies, H-65.965, “Support of Human Rights and Freedom,” modified in 2022,
29 provides the most comprehensive list of protected groups. Policy G-600.067, “References to Terms
30 and Language in Policies Adopted to Protect Populations from Discrimination and Harassment,”
31 mentioned in the original resolution, was rescinded and replaced [via Board Report 5-N-21](#) by
32 Policy H-65.950 stating that our AMA recommends preferred terminology for protected personal
33 characteristics to be used in AMA policies and position statements. Board Report 5-N-21 provides
34 a summary of categories or characteristics cited by AMA policy and a sampling from other
35 organizations.

36
37 Policy H-65.951, “Healthcare and Organizational Policies and Cultural Changes to Prevent and
38 Address Racism, Discrimination, Bias and Microaggressions,” provides guidelines for effective
39 non-discrimination policy for healthcare, including implementation considerations.

40
41 Eight other HOD policies provide a similar list of protections, 17 policies target discrimination of
42 very specific groups (e.g., victims of domestic violence), and seven policies used the word
43 “discrimination” in the title of the policy but not within the body of the policy statement.

44
45 Policy H-140.837, “Policy on Conduct at AMA Meetings,” sets forth our AMA’s policy of zero
46 tolerance for any type of harassing conduct by physicians and others attending AMA functions or
47 meetings and defines prohibited behaviors. The policy also provides multiple reporting options
48 available to both the targets of any harassment and witnesses to prohibited conduct, including an
49 option to register complaints confidentially to an external vendor online or via a toll-free hotline.

1 Multiple HOD policies seek to influence the non-discrimination policies and/or activities of other
2 organizations. In some (but not all) instances, the policies are membership related. Non-
3 discrimination policies related to membership include: G-600.020, "Admission of Specialty
4 Organizations to our AMA House," and G-600.014, "Guidelines for Admission of Constituent
5 Associations to our AMA House of Delegates." Policies unrelated to membership include:
6 D-255.995, "Discrimination Against IMGs in Classified Advertising," and H-295.955, "Teacher-
7 Learner Relationship in Medical Education."

8
9 Policy H-65.988, "Organizations Which Discriminate," also listed as a relevant AMA policy in
10 Resolution 602, provides the organization with guidance encouraging, but not mandating, that
11 meetings or other gatherings be held in organizational facilities that do not discriminate on the
12 basis of race, religion, or gender and encourages its constituent societies to adopt a similar policy.
13

14 RECOMMENDATIONS

15
16 Based on a review of internal policies, the Board of Trustees recommends that the following
17 recommendations be adopted in lieu of Resolution 602-N-20, and the remainder of this report be
18 filed.
19

- 20 • That our AMA reaffirm its commitment to complying with all applicable laws, rules or
21 regulations against discrimination on the basis of protected characteristics, including Title
22 VII of the Civil Rights Act, The Age Discrimination in Employment Act, and the
23 Americans with Disabilities Act, among other federal, state and local laws. (New HOD
24 Policy)
- 25 • That our AMA reaffirm Policy H-65.965, "Support of Human Rights and Freedom," as an
26 overarching non-discrimination policy for the Association. (Reaffirm HOD Policy)
- 27 • That our AMA reaffirm Policy H-65.988, "Organizations Which Discriminate," Policy G-
28 630.040, "Principles on Corporate Relationships," and Policy H-65.950, "Terms and
29 Language in Policies Adopted to Protect Populations from Discrimination and
30 Harassment." (Reaffirm HOD Policy)
- 31 • That our AMA provide updates on its comprehensive diversity and inclusion strategy as
32 part of the annual Board report to the AMA House of Delegates on health equity.
33 (Directive to Take Action)

Fiscal Note: Within current budget

APPENDIX A: AMA Non-Discrimination Policies

Note: This summary only includes policies currently published in our AMA's PolicyFinder. Policies that were rescinded are not included.

Non-discrimination policies – AMA (3)

- [Policy on Conduct at AMA Meetings and Events H-140.837](#)
- [Non-discrimination Policy H-65.983](#)
- [Organizations Which Discriminate H-65.988](#)

Non-discrimination policies – Constitution and Bylaws (3)

- [Discrimination. B-1.4](#)
- [Resident and Fellow Section. B-7.1.4 Other Representatives to the Business Meeting](#)
- [Medical Student Section. B-7.3.3.4 National Medical Student Organizations.](#)

Non-discrimination policies listed under governance (3)

- [Terms and Language in Policies Adopted to Protect Populations from Discrimination and Harassment H-65.950](#)
- [Admission of Specialty Organizations to our AMA House G-600.020](#)
- [Guidelines for Admission of Constituent Associations to our AMA House of Delegates G-600.014](#)

General non-discrimination policies that could potentially apply to/benefit all individuals: (11)

- [Support of Human Rights and Freedom H-65.965](#)
- [Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984](#)
- [Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions H-65.951](#)
- [Code of Medical Ethics 7.3.7 Safeguards in the Use of DNA Databanks](#)
- [Issues in Employee Drug Testing H-95.984](#)
- [Code of Medical Ethics 4.1.3 Third-Party Access to Genetic Information](#)
- [Code of Medical Ethics 11.1.1 Defining Basic Health Care](#)
- [Individual Health Insurance H-165.920](#)
- [Code of Medical Ethics 9.5.3 Accreditation](#)
- [Discriminatory Policies that Create Inequities in Health Care H-65.963](#)
- [Code of Medical Ethics 4.2.6 Cloning for Reproduction](#)

Non-discrimination policies that apply to specific populations (17)

- [Federal Drug Policy in the United States H-95.981](#)
- [Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations H-65.976](#)
- [Insurance Discrimination Against Victims of Domestic Violence H-185.976](#)
- [Racial and Ethnic Disparities in Health Care H-350.974](#)
- [Reducing Inequities and Improving Access to Insurance for Maternal Health Care H-185.917](#)
- [Retirement and Hiring Practices H-25.996](#)
- [Nondiscriminatory Policy for the Health Care Needs of LGBTQ Populations D-65.996](#)
- [Health Care Disparities in Same-Sex Partner Households H-65.973](#)
- [Code of Medical Ethics 4.2.1 Assisted Reproductive Technology](#)
- [Code of Medical Ethics 4.2.3 Therapeutic Donor Insemination](#)

- [Removing Financial Barriers to Living Organ Donation H-370.965](#)
- [Organ Transplant Equity for Persons with Disabilities D-370.980](#)
- [Ensuring the Best In-School Care for Children with Diabetes H-60.932](#)
- [Improving Screening and Treatment Guidelines for Intimate Partner Violence \(IPV\) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals \(LGBTQ\) D-515.980](#)
- [Juvenile Justice System Reform H-60.919](#)
- [Opposition to Discriminatory Treatment of Haitian Asylum Seekers H-350.951](#)
- [Parental Leave H-405.954](#)

Non-discrimination policies that protect physicians and/or their practices (23)

- [Advocacy for Physicians with Disabilities D-90.991](#)
- [Principles for Advancing Gender Equity in Medicine H-65.961](#)
- [Code of Medical Ethics 9.5.5 Gender Discrimination in Medicine](#)
- [Women in Organized Medicine H-525.998](#)
- [Volume Discrimination Against Physicians H-180.963](#)
- [Notification to Patients of Charge Amounts Prior to Service as Per Omnibus Reconciliation Act of 1986 H-390.962](#)
- [Discrimination of Women Physicians in Hospital Locker Facilities H-525.981](#)
- [Discrimination Against Physicians by Health Care Plans H-285.985](#)
- [Amend the Patient Protection and Affordable Care Act \(PPACA\) H-165.833](#)
- [Redefining AMA's Position on ACA and Healthcare Reform D-165.938](#)
- [Averting a Collision Course Between New Federal Law and Existing State Scope of Practice Laws H-35.968](#)
- [Protection of Medical Staff Members' Personal Proprietary Financial Information H-225.955](#)
- [PRO Readmission Review H-340.989](#)
- [Medical Specialty Board Certification Standards H-275.926](#)
- [Intrusion by Hospitals into the Private Practice of Medicine H-240.979](#)
- [Equal Payment for Services H-385.945](#)
- [Hospitals Limited to Participating Physicians H-390.971](#)
- [Code of Medical Ethics 5.7 Physician-Assisted Suicide](#)
- [AMA Principles for Physician Employment H-225.950](#)
- [Limitation of Physicians' Fees H-380.997](#)
- [Patient Protection and Clinical Privileges H-230.989](#)
- [Discrimination Against Physicians in Treatment with Medication for Opioid Use Disorders \(MOUD\) H-95.913](#)
- [Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism H-65.949](#)

Non-discrimination policies that protect IMGs (4)

- [Unfair Discrimination Against International Medical Graduates H-255.978](#)
- [AMA Principles on International Medical Graduates H-255.988](#)
- [Abolish Discrimination in Licensure of IMGs H-255.966](#)
- [Discrimination Against IMGs in Classified Advertising D-255.995](#)

Non-discrimination policies that protect residents (5)

- [Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919](#)
- [Eliminating Religious Discrimination from Residency Programs H-310.923](#)
- [Gender-Based Questioning in Residency Interviews H-310.976](#)
- [Discrimination Against Resident Candidates Based on Graduate Medical Education Medicare Funding H-305.971](#)
- [Non-discrimination Toward Residency Applicants H-295.969](#)

Non-discrimination policies that protect medical students (4)

- [Equal Fees for Osteopathic and Allopathic Medical Students H-295.876](#)
- [Underrepresented Student Access to US Medical Schools H-350.960](#)
- [Teacher-Learner Relationship In Medical Education H-295.955](#)
- [Principles of and Actions to Address Primary Care Workforce H-200.949](#)

Non-discrimination policies that protect patients (14)

- [Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act D-185.981](#)
- [Genetic Discrimination and the Genetic Information Non-discrimination Act H-65.969](#)
- [Consumer Genetic Testing and Privacy D-315.970](#)
- [Discrimination and Criminalization Based on HIV Seropositivity H-20.914](#)
- [Patient Privacy and Confidentiality H-315.983](#)
- [Addressing Discriminatory Health Plan Exclusions or Problematic Benefit Substitutions for Essential Health Benefits Under the Affordable Care Act H-185.925](#)
- [Fifty Percent Copayment Requirement for Codes 290-310 Mental Disorders H-345.986](#)
- [Non-discrimination in Health Care Benefits H-185.986](#)
- [Gender Rating and Discrimination Based on Prior Cesarean Section H-180.950](#)
- [Discrimination Against Patients by Medical Students H-295.865](#)
- [Discriminatory Payment Policies D-70.969](#)
- [The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987](#)
- [Code of Medical Ethics 1.1.7 Physician Exercise of Conscience](#)
- [Assistants at Surgery H-385.969](#)

Non-discrimination related to terrorism (1)

- [Non-discrimination in Responding to Terrorism H-65.978](#)

REPORT OF THE BOARD OF TRUSTEES

B of T Report 12-I-22

Subject: Terms and Language in Policies Adopted to Protect Populations from
Discrimination and Harassment

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 BACKGROUND

2

3 At the November 2021 Special Meeting of the House of Delegates (HOD), the HOD adopted
4 Policy H-65.950, which reads as follows:

5

6 Our AMA recommends preferred terminology for protected personal characteristics to be used
7 in AMA policies and position statements.

8

9 This report: 1) summarizes key points and findings of Board of Trustees Report 5-N-21, updates
10 from other policies adopted by our AMA in 2021, relevant information from the AMA’s Strategic
11 Plan to Embed Racial Justice and Advance Health Equity (“Strategic Plan”) and the AMA-AAMC
12 Advancing Health Equity: A Guide to Language, Narrative and Concepts, and feedback from
13 stakeholders (“Narrative Guide”); and 2) recommends preferred terminology for protected personal
14 characteristics to be used in AMA policies and position statements.

15

16 DISCUSSION

17

18 Language matters especially in medicine. How physicians transcribe and communicate about
19 healthcare with other healthcare workers and with patients adds context and framing to any
20 discussion. The significance of language is even more critical when it concerns sensitive topics,
21 including those involving race, ethnicity, gender, sexual orientation, and gender identity and how
22 their use, misuse, or non-use impact care. Engaging in such discussions within medicine provides a
23 chance to not only showcase language’s fluidity in action, essentially the manner in which terms
24 and/or phrases evolve as individuals and groups decide on new ways to identify themselves, but to
25 also advance health equity. Equity work within healthcare requires acknowledging and
26 reconsidering one’s beliefs about health, healthcare, health systems and society. Related to this is
27 the consideration of the language and narratives that consistently contribute to our thoughts and
28 actions.

29

30 Language and identity often go together and are critical within health equity. Both are fluid and
31 most importantly, social constructs, meaning they are derived from humans and can change as time
32 progresses. For example, the acronym BIPOC is used to collectively refer to those who identify as
33 Black, Indigenous, and People of Color; it was created within the last decade. Some view it as a
34 shift away from using other terms such as “marginalized” and “minority” and is another term used
35 to unify and amplify communities that have long been shunned and/or ignored. However, there are
36 others that have differing opinions. Jonathan Rosa, sociocultural and linguistic anthropologist, and
37 associate professor at Stanford University explains that BIPOC “presupposes a kind of solidarity

1 and a shared positionality that doesn't play out in practice for a lot of people, and in fact obscures
2 more than it reveals from some perspectives." It can also have an impact on research. Some
3 scholars have argued that aggregating data can mask critical in-group differences and disparities,
4 limiting efforts to specifically target resources. AMA has acknowledged this in recent years
5 through the adoption of Policy D-350.979 at the 2021 Interim Meeting directing the organization to
6 add "Middle Eastern/North African (MENA)" as a separate racial category on all AMA
7 demographics forms; (2) advocate for the use of "Middle Eastern/North African (MENA)" as a
8 separate race category in all uses of demographic data including but not limited to medical records,
9 government data collection and research, and within medical education. Therefore, the acronym
10 can be used in certain circumstances, but should not be used in quantitative reporting to
11 unnecessarily aggregate groups; instead, disaggregated data should be used to depict the
12 experiences of groups (see AMA AAPI Data [Report](#)).
13

14 Additional key terms to consider such as sex and gender are often mistakenly used interchangeably.
15 Within medicine, sex or "sex assigned at birth" is a label typically given by a physician based on
16 the genitals a person is born with, but over time that very label may not align with how they
17 identify. According to *The Oxford Handbook of Gender and Politics*, gender, refers to the social,
18 psychological, and emotional traits, attitudes, norms and behaviors, often influenced by society's
19 expectations, that classify someone as man, woman, both, or neither. The American Academy of
20 Pediatrics defines gender identity as "one's internal sense of who one is, which results from a
21 multifaceted interaction of biological traits, developmental influences, and environmental
22 conditions. It may be male, female, ... a combination of both, or neither (i.e., not conforming to a
23 binary conceptualization of gender)."
24

25 Language usage is critical. At a time when so many are working to not only diversify medicine, but
26 promote antiracism, the terms and phrases that are amplified can have lasting impacts that can
27 cause harm for both physicians and patients.
28

29 Board Report 5-N-21 notes: "Federal, state, and local law establish a baseline, identifying the
30 minimum constellation of characteristics with respect to which discrimination should not be
31 tolerated, based on the history of discrimination in the U.S." The landscape related to protected
32 personal characteristics is constantly evolving (e.g., update to Title IX), so any recommendation on
33 terminology will need to be flexible in its wording and regularly updated to remain in compliance.
34

35 Board of Trustees Report 5-N-21 also found protected personal characteristics mentioned in
36 existing policy of the AMA and other organizations at frequencies detailed in Appendix A, with
37 minor adjustments made accounting for additional policy adopted by the AMA since the report was
38 adopted (e.g., Policy H-350.960, Underrepresented Student Access to US Medical Schools).
39

40 Finally, while not policy, the Strategic Plan and the Narrative Guide offer language (see
41 Appendices B and C). The Strategic Plan at various points (see pages 11-16) mentions: "race,
42 ethnicity, gender, sexual orientation, ability and country of origin (i.e., International Medical
43 Graduates)," "gender, gender identity, sexual orientation, disability, age, class/socioeconomic
44 status, citizenship status and language," "marginalized (women, LGBTQ+, people with disabilities,
45 International Medical Graduates) and minoritized (Black, Indigenous, Latinx, Asian) physicians,"
46 "race/ethnicity, gender, sexual identity, immigration status, country of origin, language and
47 disability status," and "race/ethnicity, gender, socioeconomic status, ability status, LGBTQ+
48 identity, literacy." The Narrative Guide at various points (see pages 9-15) mentions: "formerly
49 incarcerated/returning citizen/persons with a history of incarceration," "sex assigned at birth," and
50 "ethnicity, nationality, class, or other status/identities." The Narrative Guide stresses the
51 importance of avoiding "dehumanizing language" and instead "offering equity-based, equity

1 explicit, and person-first alternatives” and advises us to “describe people as having a condition or
2 circumstance, not being a condition” and “humanize those you are referring to by using people or
3 persons.” Person-first or people-first formulations include: “people with...,” “people
4 experiencing...,” and “people identifying as...” However, the Narrative Guide notes that
5 “different communities and individuals have different standards and preferences” regarding person-
6 first language.

7
8 RECOMMENDATION

9
10 Based on a review of internal policies, the Strategic Plan and Narrative Guide, the Board of
11 Trustees recommends that the following be adopted, and the remainder of this report be filed:

- 12
13 1. That our AMA amend Policy H-65.950 by addition and deletion to read as follows:

14
15 Our AMA recognizes broad and evolving protected personal characteristics spanning
16 identity, origin, and status that include those outlined by regulatory authorities overlapping
17 with those prioritized by AMA. To prevent misunderstandings and facilitate collaboration
18 to move medicine forward, AMA recommends acknowledges preferred terminology for
19 protected personal characteristics outlined in the actual sources used in the 2021 AMA
20 Strategic Plan to Embed Racial Justice and Advance Health Equity and the AMA-AAMC
21 Advancing Health Equity such as the CDC’s Health Equity Guiding Principles for
22 Inclusive Communication ~~to~~ that may be used in AMA policies and position statements.
23 (Modify Current HOD Policy)

Fiscal Note: Less than \$500

APPENDIX A: Terminology Used in Existing Policy from AMA and Other Organizations

Characteristic	Federal Agencies (DOE, EEOC, HHS)	AMA Policy	Other Professional Societies (Convenience Sample)	Schools (Convenience Sample)
Affiliational preferences				1
Age	3	10	8	10
Ancestry			2	4
Appearance			1	1
Body habitus			1	
Citizenship		1	1	1
Color	3	4	7	10
Country of education or origin		1		
Creed		3	1	4
Culture		1		
Degree of medical dependency		1		
Dependent status				
Disability	3	8	10	10
Disability, present or predicted		1		
Drug abuse		1		
Economic		1		
Education			1	
Employment status				
Ethnic origin		5	8	3
Ethnicity		1		
Expected length of life		1		
Family status / responsibilities				1
Future plans for marriage or children		1		
Gender		7	7	2
Gender expression		2	3	3
Gender identity	1	10	7	10
Genetic information	1	3	1	8
Health / health status		1	1	
Immigration status			2	
International medical graduate		2		
Language preference			2	
Living donor status		1		
Marital status		4	2	4
Matriculation				1

Medical condition			1	2
Military/veteran status			5	10
National origin	3	7	8	10
Order of protection status				1
Other		4		1
Other legally protected basis				1
Other basis prohibited by law			2	
Other human condition or choice			1	
Other personal category			1	
Other protected group / category / characteristic			2	3
Other social category			1	
Participation in a PHP		1		
Political opinion / affiliation			1	1
Pregnancy	1		1	5
Professional experience			1	
Professional experience / profession		1		
Quality of life		1		
Race	3	11	12	10
Religion	1	8	11	10
Rurality		1		
Sex	3	9	5	10
Sexual orientation	1	10	11	10
Social status or condition			1	
Socioeconomic status			4	
Socioeconomic origin		1		
Unemployed status				1
Zip code			2	

APPENDIX B: Definitions and Levels of Racism and Related Terms

	Definitions	Notes
Racism	As defined by Camara Jones, MD, MPH, PhD, "racism is a system of structuring opportunity and assigning value based on phenotype ('race'), that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and undermines realization of the full potential of the whole society through the waste of human resources."	Racism can operate at different levels: structural, institutional, interpersonal, and internalized.
Structural Racism	As defined by Zinzi Bailey et al, structural racism "refers to the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources."	
Institutional Racism	Discriminatory treatment, unfair policies and practices, and inequitable opportunities and impacts within organizations and institutions, based on race.	Individuals within institutions take on the power of the institution when they act in ways that advantage and disadvantage people, based on race.
Interpersonal Racism	The expression of racism between individuals. These are interactions occurring between individuals that often take place in the form of harassing, racial slurs, or racial jokes.	It may also take more subtle forms of unequal treatment, including micro-aggressions.
Internalized Racism	Acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth.	
Prejudice	An unfavorable opinion or feeling formed beforehand or without knowledge, thought, or reason.	Prejudice also means an action in the sense that they are sequential steps by which an individual behaves negatively toward members of another group: verbal antagonism, avoidance, segregation, physical attack, and extermination. The term "prejudice" also refers to unfavorable opinions or feelings which lead groups to view members of other social groups as threatening adversaries who are inherently inferior or are actively pursuing immoral objectives.

Adapted from Lawrence 2004, David Wellman, Jones 2000 and Bailey, et al 2017, Greenwald and Banaji, 1995

	Definitions	Notes
Bias	<p>A form of prejudice in favor of or against one person or group compared with another usually in a way that's considered to be unfair to one group. Biases may be held by an individual, group, or institutions and can have negative or positive consequences and oftentimes are learned behaviors or habitual thoughts. Biases often emerge in relation to race/ethnicity, gender, socioeconomic status, ability status, LGBTQ+ identity, literacy, amongst other groupings.</p> <p>There are two main types of biases²⁰ discussed in scholarly research and in medicine^{21,22} that inhibit progress towards multiculturalism and equity in our society:</p> <ol style="list-style-type: none"> 1. Explicit or Conscious bias—This refers to the attitudes and beliefs we have about a person or group on a conscious level, that is we are aware and accepting of these beliefs, and they are usually expressed in the form of discrimination, hate speech or other overt expressions. 2. Implicit or Unconscious bias—This refers to the unconscious mental process that stimulates negative attitudes about people outside one's own 'in group'. For example, implicit racial bias leads to discrimination against people not of one's own group. Extensive research supports the notion that we all hold unconscious beliefs about various social and identity groups, and these biases stem from one's tendency to organize social worlds by categorizing and are influenced by power dynamics in a society. 	<p>It is important to note that biases, both explicit and implicit, have to be unlearned at the individual, group and institutional level in order to mitigate negative consequences as a result of existing and prevailing biases. Both first require an awareness and acknowledgment that the bias exists and require personal, group and institutional action to eliminate these biases.</p>

Adapted from Lawrence 2004, David Wellman, Jones 2000 and Bailey, et al 2017, Greenwald and Banaji, 1995

APPENDIX C: Key Principles and Associated Terms

Table 1: Key Principles and Associated Terms

Key principles	Instead of this ...	Try this ...
<p>Avoid use of adjectives such as vulnerable, marginalized and high-risk. These terms can be stigmatizing. These terms are vague and imply that the condition is inherent to the group rather than the actual causal factors. Try to use terms and language that explain why and/or how some groups are more affected than others. Also try to use language that explains the effect (i.e., words such as impact and burden are also vague and should be explained).</p>	<ul style="list-style-type: none"> • Vulnerable groups • Marginalized communities • Hard-to-reach communities • Underserved communities • Underprivileged communities • Disadvantaged groups • High-risk groups • At-risk groups • High-burden groups 	<ul style="list-style-type: none"> • Groups that have been economically/ socially marginalized • Groups that have been historically marginalized or made vulnerable; <i>historically</i> marginalized • Groups that are struggling against economic marginalization • Communities that are underserved by/with limited access to (specific service/resource) • Under-resourced communities • Groups experiencing disadvantage because of (reason) • Groups placed at increased risk/put at increased risk of (outcome) • Groups with higher risk of (outcome) • For scientific publications: <ul style="list-style-type: none"> – Disproportionately affected groups – Groups experiencing disproportionate prevalence/rates of (condition)
<p>Avoid dehumanizing language. Use person-first language instead. Describe people as having a condition or circumstance, not being a condition. A case is an instance of disease, not a person. Use patient to refer to someone receiving health care. Humanize those you are referring to by using people or persons.</p>	<ul style="list-style-type: none"> • The obese or the morbidly obese • COVID-19 cases • The homeless • Disabled person • Handicapped • Inmates • Victims • Cases or subjects (when referring to affected persons) • Individuals 	<ul style="list-style-type: none"> • People experiencing (health outcome or life circumstance) • People with obesity; people with severe obesity • Patients or persons with COVID-19 • People who are experiencing (condition or disability type) • Person with mobility disability • Person with vision impairments • People who are experiencing homelessness • Survivors
<p>Remember that there are many types of subpopulations. General use of the term minority/ minorities should be limited, in general, and should be defined when used. Be as specific as possible about the group you are referring to (e.g., be specific about the type of disability if you are not referring to people with any disability type).</p>	<ul style="list-style-type: none"> • Minorities • Minority • Ethnic groups • Racial groups 	<ul style="list-style-type: none"> • Specify the type of subpopulation: <ul style="list-style-type: none"> – (People from) racial and ethnic groups – (People from) racial and ethnic minority groups – (People from) sexual/gender /linguistic/religious minority groups – (People with/living with) mobility/ cognitive/vision/hearing/independent living/self-care disabilities
<p>Avoid saying target, tackle, combat or other terms with violent connotation when referring to people, groups or communities. These terms should also be avoided, in general, when communicating about public health activities.</p>	<ul style="list-style-type: none"> • Target communities for interventions • Target population • Tackle issues within the community • Aimed at communities • Combat (disease) • War against (disease) 	<ul style="list-style-type: none"> • Engage/prioritize/collaborate with/serve (population of focus) • Consider the needs of/Tailor to the needs of (population of focus) • Communities/populations of focus • Intended audience • Eliminate (issue/disease)
<p>Avoid unintentional blaming. Consider the context and the audience to determine if language used could potentially lead to negative assumptions, stereotyping, stigmatization, or blame. However, these terms may be appropriate in some instances.</p>	<ul style="list-style-type: none"> • Workers who do not use PPE • People who do not seek healthcare 	<ul style="list-style-type: none"> • People with limited access to (specific service/resource) • Workers under-resourced with (specific service/resource)

Adapted from: "Health Equity Guiding Principles for Unbiased, Inclusive Communication" (CDC).

REPORT OF THE COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-I-22

Subject: Updated Bylaws: Delegate Apportionment and Pending Members

Presented by: Kevin C. Reilly, Sr., MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 At the 2022 Annual Meeting, the House adopted Recommendation 3 of BOT Report 20, “Delegate
2 Apportionment and Pending Members,” in lieu of Resolution 618. This recommendation directs
3 “That delegates be apportioned to constituent societies for 2023 with each society getting the
4 greatest of the following numbers:

- 5
- 6 - The number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA
7 members;
- 8 - The number of delegates apportioned for 2022 so long as that figure is not greater than 2
9 more than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA
10 members; or
- 11 - For societies that would lose more than 5 delegates from their 2022 apportionment, the
12 number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA
13 members plus 5.”
- 14

15 Existing bylaw language on apportionment will sunset as of the close of business of the 2022
16 Interim Meeting; thus, the Council puts forth amended language consistent with the adopted
17 recommendation of BOT Report 20-A-22. In doing so, the Council acknowledges that the Board’s
18 actions on the other five referred recommendations in Board Report 20 may impact the House’s
19 action on apportionment, if not for 2023 but for future years. The Board’s report on the referred
20 items is also before the House at this meeting.

21 22 RECOMMENDATIONS

23
24 The Council on Constitution and Bylaws recommends that the following amendments to the AMA
25 Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative
26 vote of two-thirds of the members of the House of Delegates present and voting.

27
28 **2.1 Constituent Associations.** Each recognized constituent association granted representation
29 in the House of Delegates is entitled to delegate representation based on the number of
30 seats allocated to it by apportionment, and such additional delegate seats as may be
31 provided under Bylaw 2.1.4-2. Only one constituent association from each U.S. state,
32 commonwealth, territory, or possession shall be granted representation in the House of
33 Delegates.

34
35 **2.1.1 Apportionment.** The apportionment of delegates from each constituent
36 association is one delegate for each 1,000, or fraction thereof, active constituent
37 and active direct members of the AMA within the jurisdiction of each constituent
38 association, as recorded by the AMA as of December 31 of each year.

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2.1.1.1 ~~The December 31 count will include pending members for purposes of apportionment; however, pending members shall not be recounted the following year absent membership renewal. For 2023 only, the apportionment shall include the greatest of the following numbers: the number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members consistent with Bylaw 2.1.1; the number of delegates apportioned for 2022 so long as that figure is not greater than 2 more than the number apportioned at the rate of 1 per 1000, or fraction thereof, AMA members; or for societies that would lose more than 5 delegates from their 2022 apportionment, the number of delegates apportioned at the rate of 1 per 1000, or fraction thereof, AMA members plus 5. Bylaw 2.1.1.1 will sunset as of December 31, 2023 the close of business of the 2022 Interim Meeting unless the House of Delegates acts to retain it.~~

2.1.1.2 Effective Date. Such apportionment shall take effect on January 1 of the following year and shall remain effective for one year.

2.1.1.2.1 Retention of Delegate. If the membership information as recorded by the AMA as of December 31 warrants a decrease in the number of delegates representing a constituent association, the constituent association shall be permitted to retain the same number of delegates, without decrease, for one additional year, if it promptly files with the AMA a written plan of intensified AMA membership development activities among its members. At the end of the one year grace period, any applicable decrease will be implemented.

2.1.1.2.1.1 ~~A constituent association that shows a membership loss for 2020 and/or 2021 shall be granted an additional one year grace period beyond the one year grace period set forth in 2.1.1.2.1 without a decrease in the number of delegates. This Bylaw will sunset at the close of the 2022 Interim Meeting. A constituent society may not benefit from both this provision and 2.1.1.1. Bylaw 2.1.1.2.1.1 will sunset as of December 31, 2023.~~

2.2 National Medical Specialty Societies. The number of delegates representing national medical specialty societies shall equal the number of delegates representing the constituent societies. Each national medical specialty society granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seat as may be provided under Bylaw 2.2.2. The total number of delegates apportioned to national medical specialty societies under Bylaw 2.2.1 shall be adjusted to be equal to the total number of delegates apportioned to constituent societies under sections 2.1.1 and 2.1.1.1-2.1 using methods specified in AMA policy.

(Modify Bylaws)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 1-I-22

Subject: Amendment to Opinion 4.2.7, “Abortion”

Presented by: Peter A Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Current guidance on abortion in Opinion 4.2.7 of the AMA *Code of Medical Ethics* was issued in
2 1977 in the context of the U.S. Supreme Court decision in *Roe v. Wade*,¹ which recognized a
3 constitutional right to abortion. The Court’s recent decision in *Dobbs v. Jackson Women’s Health*
4 *Organization*² overturning *Roe* and returning debate about abortion to the states has significantly
5 altered the landscape for patients and their physicians.

6
7 As the American Medical Association immediately [noted](#), *Dobbs*:

8
9 overturn[s] nearly a half century of precedent protecting patients’ right to critical reproductive
10 health care—representing an egregious allowance of government intrusion into the medical
11 examination room, a direct attack on the practice of medicine and the patient-physician
12 relationship, and a brazen violation of patients’ rights to evidence-based reproductive health
13 services.

14
15 The AMA joined the American College of Obstetricians and Gynecologists and more than 70 other
16 professional medical associations in [condemning](#) the unacceptable effects *Dobbs* will have on
17 access to safe, accepted, essential reproductive health services; the privacy and integrity of patient-
18 physician relationships; and indeed, the safety of patients and physicians.

19
20 Guidance throughout the *Code* underscores physicians’ duty of fidelity to patients and to promote
21 access to care, as well as responsibility to support informed decision making in keeping with
22 patients’ individual goals and preferences as autonomous moral agents. The *Code* likewise
23 prohibits physicians acting as agents of government entities in conflict with their duties to patients.
24 At the same time, the *Code* acknowledges that physicians too are moral agents as individuals,
25 whose deeply held personal beliefs may at times conflict with the expectations held of them as
26 medical professionals, and offers guidance to help physicians navigate an ethically acceptable path
27 forward in the face of diverging commitments.

28
29 Finally, the *Code* [acknowledges](#) that although deeply intertwined, law and the ethical commitments
30 of the profession do not always align:

31
32 In some cases, the law mandates conduct that is ethically unacceptable. When physicians
33 believe a law violates ethical values or is unjust they should work to change in law. In
34 exceptional circumstances of unjust laws, ethical responsibilities should supersede legal duties.

35
36 When the letter of the law would foreclose urgently needed care physicians must have latitude to
37 act in accord with their best professional judgement.

1 RECOMMENDATION

2

3 With all of the foregoing considerations in mind, the Council on Ethical and Judicial Affairs
4 recommends that Opinion 4.2.7, "Abortion," be amended as follows and the remainder of this
5 report be filed:

6

7 Abortion is a safe and common medical procedure, about which thoughtful individuals hold
8 diverging, yet equally deeply held and well-considered perspectives. Like all health care
9 decisions, a decision to terminate a pregnancy should be made privately within the relationship
10 of trust between patient and physician in keeping with the patient's unique values and needs
11 and the physician's best professional judgment.

12

13 ~~The *Principles of Medical Ethics* of the AMA do not prohibit a physician from performing an~~
14 ~~abortion permit physicians to perform abortions in keeping with good medical practice under~~
15 ~~circumstances that do not violate the law.~~

16

(Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

¹ *Roe v. Wade*, 410 U. S. 113 (1973).

² *Dobbs v. Jackson Women's Health Organization*, 142 S.Ct. 2228.

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Report 2-I-22

Subject: Amendment to Opinion 10.8, “Collaborative Care”

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Recent years have seen the rise of nonphysician practitioners (e.g., nurse practitioners, physician
2 assistants, midwives) as a growing share of health care providers in the United States. Moreover,
3 nonphysician practitioners have gained increasing autonomy, authorized by state governments
4 (e.g., legislatures and licensing boards) in response to the lobbying from professional associations,
5 as part of an effort to ameliorate provider shortages, and in response to rising health care costs.
6 Expanded autonomy has increased the interactions of independent nonphysician practitioners and
7 physicians in care of patients. Increasingly nonphysician practitioners are seeking advanced
8 training that results in a doctorate degree, such as “Doctor of Nursing.” Such terminology
9 sometimes results in misconception or confusion for both patients and physicians about the
10 practitioner’s skillset, training, and experience.

11
12 The following is an analysis of the ethical concerns centering on issues of transparency and
13 misconception. In recognition of the growing relevance of the issue, the Council brings this
14 analysis on its own initiative, offering an amendment to the AMA *Code of Medical Ethics* Opinion
15 10.8 Collaborative Care.

16 17 DESCRIPTION OF NONPHYSICIAN PRACTITIONERS

18
19 The term “nonphysician practitioners” denotes a broad range of professionals including nurse
20 practitioners, physician assistants, midwives, doulas, pharmacists, and physical therapists. There
21 are “multiple pathways” for one to become a nonphysician practitioner, the most common is a
22 nurse earning a “master’s degree or doctoral degree in nursing” after initial completion of a
23 bachelor’s degree [1]. However, the skill sets and experience of nonphysician practitioners are not
24 the same as those of physicians. Hence, when a nonphysician practitioner identifies themselves as
25 “Doctor” consistent with the degree they received, it may create confusion and be misleading to
26 patients and other practitioners.

27 28 PATIENT CONFUSION AND MISCONCEPTION

29
30 Patient confusion and misconception about provider credentials is a significant concern. Data
31 suggest that many patients are not sure who is and who is not a physician. For example, 47% of
32 respondents in one survey indicated they believed optometrists were physicians (10% were unsure),
33 while some 15% believed ophthalmologists are *not* (with 12% being unsure) [2]. Nineteen percent

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1 of respondents to the same survey believed nurse practitioners (NPs) to be physicians, although
2 74% identified them as nonphysicians.

3
4 Meanwhile, the range of professional titles of various NPs is wide and the issue is compounded by
5 the fact that many NPs hold doctorate degrees [3]. While the PhD in nursing degree is the oldest
6 and most traditional doctorate in the nursing profession, having its roots in the 1960s and 70s [4],
7 Al-Agba and Bernard note how in “recent years, an explosion of doctorates in various medical
8 professions has made the label of ‘doctor’ far less clear”, a common example being that of the of
9 the “Doctor of Nursing Practice” (DNP) [3]. The DNP, a professional practice doctorate (distinct
10 from the research-oriented PhD), was first granted in the U.S. in 2001. As of 2020, there are now
11 348 DNP programs in the U.S. [3]. Critics argue that the rise of DNP programs is not about
12 providing better patient care, but is rather a “political maneuver, designed to appropriate the title of
13 ‘doctor’ and create a false sense of equivalence between nurse practitioners and physicians in the
14 minds of the public” [3].

15
16 The problem of identification has been recognized by some states where NPs with a doctorate are
17 only allowed to be “addressed as ‘doctor’ if the DNP clarifies that he or she is actually an NP” and
18 some jurisdictions require NPs without a doctorate to have special identification that
19 “unambiguously identifies them” [5]. From an ethical standpoint, NPs have a duty as do all health
20 care practitioners, including physicians, to be forthright with patients about their skill sets,
21 education, or training, and to not allow any situation where a misconception is possible.
22 Ambiguous representation of credentials is unethical, because it interferes with the patient’s
23 autonomy, as the patient is not able to execute valid informed consent if they misconstrue the
24 provider. For example, a patient may only want a certain procedure done by a physician and then
25 assent to an NP performing the procedure, under the mistaken belief that the NP is a physician.
26 However, such an assent to the medical procedure is neither a valid *consent* nor an adequately
27 informed *assent*, as the patient’s decision is founded on a flawed basis of key information, i.e., the
28 nature and extent of the practitioner’s skill set, education, and experience.

30 GUIDANCE IN AMA POLICY AND CODE OF MEDICAL ETHICS

31
32 AMA House Policy and the AMA *Code of Medical Ethics* respond to and recognize issues of
33 transparency of credentials and professional identification. However, the *Code* could be modestly
34 amended to offer specific guidance regarding transparency in the context of team-based care
35 involving nonphysician practitioners.

37 *House Policy*

38
39 [H-405.992](#) – “Doctor as Title,” states:

40
41 The AMA encourages state medical societies to oppose any state legislation or regulation that
42 might alter or limit the title ““Doctor,”” which persons holding the academic degrees of Doctor
43 of Medicine or Doctor of Osteopathy are entitled to employ.

44
45 [D-405.991](#) – “Clarification of the Title “Doctor” in the Hospital Environment,” states:

46
47 Our AMA Commissioners will, for the purpose of patient safety, request that The Joint
48 Commission develop and implement standards for an identification system for all hospital
49 facility staff who have direct contact with patients which would require that an identification
50 badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD,

1 DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a
2 Doctorate, and those with other types of credentials.

3
4 [H-405.969](#) – “Definition of a Physician”, states:

5
6 ... a physician is an individual who has received a “Doctor of Medicine” or a “Doctor of
7 Osteopathic Medicine” degree or an equivalent degree following successful completion of a
8 prescribed course of study from a school of medicine or osteopathic medicine.

9
10 AMA policy requires anyone in a hospital environment who has direct contact with a patient
11 who presents himself or herself to the patient as a "doctor," and who is not a “physician”
12 according to the AMA definition above, must specifically and simultaneously declare
13 themselves a “nonphysician” and define the nature of their doctorate degree.

14
15 *Code of Medical Ethics*

16
17 The Code already addresses transparency in context of residents and fellows. [Opinion 9.2.2](#),
18 “Resident & Fellow Physicians’ Involvement in Patient Care,” possesses some language regarding
19 transparency and identification where it states:

20
21 When they are involved in patient care, residents and fellows should:

22
23 (a) Interact honestly with patients, including clearly identifying themselves as members of a
24 team that is supervised by the attending physician and clarifying the role they will play in
25 patient care.

26
27 In the context of a team-based collaborative care involving nonphysician practitioners, [Opinion](#)
28 [10.8](#), “Collaborative Care” is the most relevant *Code* opinion. It gives guidance on the
29 collaborative team-based setting, where a mix of health professionals provide care. However,
30 Opinion 10.8 lacks guidance on the transparency of identification and credentials, ultimately
31 leaving the *Code* silent on the issue of transparency in the context of team-based collaborative care.
32 Hence, amendment to Opinion 10.8 is warranted.

33
34 RECCOMENDATION

35
36 In light of the foregoing, the Council on Ethical and Judicial Affairs recommends that Opinion
37 10.8, “Collaborative Care,” be amended as follows and the remainder of this report be filed:

38
39 In health care, teams that collaborate effectively can enhance the quality of care for individual
40 patients. By being prudent stewards and delivering care efficiently, teams also have the
41 potential to expand access to care for populations of patients. Such teams are defined by their
42 dedication to providing patient-centered care, ~~protecting the integrity of the patient-physician~~
43 ~~relationship~~, sharing mutual respect and trust, communicating effectively, sharing
44 accountability and responsibility, and upholding common ethical values as team members.

45
46 Health care teams often include members of multiple health professions, including physicians,
47 nurse practitioners, physician assistants, pharmacists, physical therapists, and care managers
48 among others. To foster the trust essential to healing relationships between patients and
49 physicians or nonphysician practitioners, all members of the team should be candid about their
50 professional credentials, their experience, and the role they will play in the patient’s care.

1 An effective team requires the vision and direction of an effective leader. In medicine, this
2 means having a clinical leader who will ensure that the team as a whole functions effectively
3 and facilitates decision-making. Physicians are uniquely situated to serve as clinical leaders. By
4 virtue of their thorough and diverse training, experience, and knowledge, physicians have a
5 distinctive appreciation of the breadth of health issues and treatments that enables them to
6 synthesize the diverse professional perspectives and recommendations of the team into an
7 appropriate, coherent plan of care for the patient.

8
9 As clinical leaders within health care teams, physicians individually should:

10
11 (a) Model ethical leadership by:

- 12
13 (i) Understanding the range of their own and other team members' skills and expertise and
14 roles in the patient's care
15 (ii) Clearly articulating individual responsibilities and accountability
16 (iii) Encouraging insights from other members and being open to adopting them and
17 (iv) Mastering broad teamwork skills

18
19 (b) Promote core team values of honesty, discipline, creativity, humility and curiosity and
20 commitment to continuous improvement.

21
22 (c) Help clarify expectations to support systematic, transparent decision making.

23
24 (d) Encourage open discussion of ethical and clinical concerns and foster a team culture in
25 which each member's opinion is heard and considered and team members share
26 accountability for decisions and outcomes.

27
28 (e) Communicate appropriately with the patient and family, ~~and~~ respecting their unique
29 relationship of patient and family as members of the team.

30
31 (f) Assure that all team members are describing their profession and role.

32
33 As leaders within health care institutions, physicians individually and collectively should:

34
35 (~~g~~) Advocate for the resources and support health care teams need to collaborate effectively in
36 providing high-quality care for the patients they serve, including education about the
37 principles of effective teamwork and training to build teamwork skills.

38
39 (~~gh~~) Encourage their institutions to identify and constructively address barriers to effective
40 collaboration.

41
42 (~~hi~~) Promote the development and use of institutional policies and procedures, such as an
43 institutional ethics committee or similar resource, to address constructively conflicts within
44 teams that adversely affect patient care.

45
46 (j) Promote a culture of respect, collegiality and transparency among all health care personnel.

47
48 (Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

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Subject: Pandemic Ethics and the Duty of Care

Presented by: Peter A. Schwartz, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Policy D-130.960, “Pandemic Ethics and the Duty of Care,” adopted by the American Medical
2 Association (AMA) House of Delegates in June 2021, asks the Council on Ethical and Judicial
3 Affairs (CEJA) to “reconsider its guidance on pandemics, disaster response and preparedness in
4 terms of the limits of professional duty of individual physicians, especially in light of the unique
5 dangers posed to physicians, their families and colleagues during the COVID-19 global pandemic.”
6

7 At the 2022 Annual Meeting, the Council’s informational report on this matter, CEJA Report 5-A-
8 22, was extracted and referred to Reference Committee on Amendments to Constitution and
9 Bylaws. Testimony acknowledged that the Council has disseminated interpretive materials to help
10 users apply guidance from multiple Opinions in the AMA *Code of Medical Ethics* relating to the
11 duty to treat in crisis situations but felt that additional guidance was nonetheless needed in the
12 *Code* itself. The present report proposes amendments to Opinion 8.3, “Physician Responsibility in
13 Disaster Response and Preparedness.”
14

15 A CONTESTED DUTY

16
17 As several scholars have noted, the idea that physicians have a professional duty to treat has waxed
18 and waned historically, at least in the context of infectious disease [1,2,3]. Many physicians fled
19 the Black Death; those who remained did so out of religious devotion, or because they were enticed
20 by remuneration from civic leaders [1]. Even in the early years of the AIDS epidemic, physicians
21 contested whether they had a responsibility to put themselves at risk for what was then a lethal and
22 poorly understood disease [3]. Yet the inaugural edition of the AMA *Code of Medical Ethics* in
23 1847 codified a clear expectation that physicians would accept risk:
24

25 When pestilence prevails, it is [physicians’] duty to face the danger, and to continue their
26 labors for the alleviation of suffering, even at the jeopardy of their own lives [[1847 Code](#), p.
27 105].
28

29 That same sensibility informs AMA’s [Declaration of Professional Responsibility](#) when it calls on
30 physicians to “apply our knowledge and skills when needed, though it may put us at risk.” And it is
31 embedded in current guidance in the *Code*. Based on physicians’ commitment of fidelity to
32 patients, [Opinion 8.3](#), “Physicians’ Responsibilities in Disaster Response and Preparedness,”
33 enjoins a duty to treat. This opinion provides that “individual physicians have an obligation to
34 provide urgent medical care during disasters . . . even in the face of greater than usual risks to

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1 physicians' own safety, health, or life." The *Code* is clear that this obligation isn't absolute,
2 however. Opinion 8.3 qualifies the responsibility when it notes that "physicians also have an
3 obligation to evaluate the risks of providing care to individual patients versus the need to be
4 available to provide care in the future."

5
6 From the perspective of the *Code*, then, the question isn't whether physicians have a duty to treat
7 but how to think about the relative strength of that duty in varying circumstances.

8 9 INTERPRETING ETHICS GUIDANCE

10
11 Over the course of the COVID-19 pandemic, AMA has drawn on the *Code* to explore this question
12 in reflections posted to its COVID-19 Resource Center on whether physicians may decline to treat
13 [unvaccinated patients](#) and under what conditions medical students may ethically be permitted to
14 [graduate early](#) to join the physician workforce.

15
16 Drawing particularly on guidance in [Opinion 1.1.2](#), "Prospective Patients," and—in keeping with
17 Opinion 8.3, taking physicians' expertise and availability as itself a health care resource—[Opinion](#)
18 [11.1.3](#), "Allocating Limited Health Care Resources," as well as [Opinion 8.7](#), "Routine Universal
19 Immunization of Physicians," these analyses offer key criteria for assessing the strength of the duty
20 to treat:

- 21
- 22 • urgency of medical need
- 23 • risk to other patients or staff in a physician's practice
- 24 • risk to the physician
- 25 • likelihood of occurrence and magnitude of risk
- 26

27 To these criteria should be added likelihood of benefit—that is, physicians should not be obligated
28 to put themselves at significant risk when patients are not likely to benefit from care [2]. Although
29 the *Code* does not link the question specifically to situations of infectious disease or risk to
30 physicians, it supports this position. [Opinion 5.5](#), "Medically Ineffective Interventions," provides
31 that physicians are not obligated to provide care that, in their considered professional judgment,
32 will not provide the intended clinical benefit or achieve the patient's goals for care.

33
34 Similarly, to the extent that the *Code* articulates a general responsibility on the part of physicians to
35 protect the well-being of patients and staff, it supports consideration of risk to others in assessing
36 the relative strength of a duty to treat. Thus, while Opinion 1.1.2 explicitly prohibits physicians
37 from declining a patient based solely on the individual's disease status, it permits them to decline to
38 provide care to patients who threaten the well-being of other patients or staff. In the context of a
39 serious, highly transmissible disease this responsibility to minimize risk to others in professional
40 settings may constrain the presumption of a duty to treat.

41
42 Yet the *Code* is also silent on important matters that have been noted in the literature. For example,
43 it doesn't address whether the duty to treat applies uniformly across all medical specialties. Some
44 scholars argue that the obligation should be understood as conditioned by physicians' expertise,
45 training, and role in the health care institution [4,5,6]. In essence, the argument is that the more
46 relevant a physician's clinical expertise is to the needs of the moment, the more reasonable it is to
47 expect physicians to accept greater personal risk than clinicians who do not have the same
48 expertise. The point is well taken. Guidance that addresses the duty to treat "as if it were the
49 exclusive province of any individual health profession" [2], risks undercutting its own value to
50 offer insight into that duty.

1 Moreover, for the most part the *Code* restricts its analysis of physicians’ responsibilities to the
 2 context of their professional lives, addressing their duties to patients, and to a lesser degree, to their
 3 immediate colleagues in health care settings. In this, guidance overlooks the implications of
 4 responsibilities physicians hold in their *nonprofessional* lives—as members of families, as friends,
 5 as participants in community outside the professional domain. Thus, it is argued, a physician whose
 6 household includes a particularly vulnerable individual—e.g., someone who has chronic underlying
 7 medical condition or is immune compromised and thus at high risk for severe disease—has a less
 8 stringent duty to treat than does a physician whose personal situation is different.

9
 10 Although the *Code* acknowledges that physicians indeed have lives as moral agents outside
 11 medicine ([Opinion 1.1.7](#), “Physician Exercise of Conscience”), it does not reflect as deeply as it
 12 might about the nature of competing personal obligations or how to balance the professional and
 13 the personal. In much the same way as understanding the duty to treat as the responsibility of a
 14 single profession, restricting analysis to a tension between altruism and physicians’ individual self-
 15 interests “fails to capture the real moral dilemmas faced by health care workers in an infectious
 16 epidemic” [7].

17 18 SUPPORTING THE HEALTH CARE WORKFORCE

19
 20 As adopted in 1847, the *Code* addressed physicians’ ethical obligations in the broader framework
 21 of reciprocal obligations among medical professionals, patients, and society. Over time, the *Code*
 22 came to focus primarily on physician conduct.

23
 24 Pandemic disease doesn’t respect conceptual boundaries between the professional and the personal,
 25 the individual and the institutional. Nor does it respect the borders of communities or catchment
 26 areas. In situations of pandemic disease, “the question is one of a social distribution of a
 27 biologically given risk within the workplace and society at large” [7].

28 29 *Health Care Institutions*

30
 31 Under such conditions, it is argued, the duty to treat “is not to be borne solely by the altruism and
 32 heroism of individual health care workers” [7]. Moreover, as has been noted,

33
 34 ... organizations, as well as individuals, can be virtuous. A virtuous organization encourages
 35 and nurtures the virtuous behavior of the individuals within it. At the very least, the virtuous
 36 institution avoids creating unnecessary barriers to the virtuous behavior of individuals [2].

37
 38 The *Code* is not entirely insensitive to the ethics of health care institutions. It touches on
 39 institutions’ responsibility to the communities they serve ([Opinion 11.2.6](#), “Mergers between
 40 Secular and Religiously Affiliated Health Care Institutions”) and the needs of physicians and other
 41 health care personnel who staff them (Opinions [11.1.2](#), “Physician Stewardship of Health Care
 42 Resources,” and [11.2.1](#), “Professionalism in Health Care Systems). Health care facilities and
 43 institutions are the locus within which the practice of today’s complex health care takes place. As
 44 such, institutions—notably nonprofit institutions—too have duties,

45
 46 ... fidelity to patients, service to patients, ensuring that the care is high quality and provided “in
 47 an effective and ethically appropriate manner”; service to the community the hospital serves,
 48 deploying hospital resources “in ways that enhance the health and quality of life” of the
 49 community; and institutional stewardship [[CEJA 2-A-18](#)].

1 Analyses posted to the AMA’s COVID-19 Resource Center look to this guidance to examine
2 institutional obligations to [protect health care personnel](#) and to respect physicians who voice
3 concern when institutional [policies and practices](#) impinge on clinicians’ ability to fulfill their
4 ethical duties as health care professionals.

5
6 Although existing guidance does not explicitly set out institutional responsibility to provide
7 appropriate resources and strategies to mitigate risk for health care personnel, it does support such
8 a duty. The obligation to be responsible stewards of resources falls on health care institutions as
9 well as individuals. To the extent that health care professionals themselves are an essential and
10 irreplaceable resource for meeting patient and community needs, institutions have an ethical duty
11 to protect the workforce (independent of occupational health and safety regulation). On this view,
12 institutions discharge their obligations to the workforce when, for example, they:

- 13
- 14 • support robust patient safety and infection control practices
- 15 • make immunization readily available to health care personnel
- 16 • provide adequate supplies of appropriate personal protective equipment (PPE)
- 17 • ensure that staffing patterns take into account the toll that patient care can exact on
18 frontline clinicians
- 19 • distribute burdens equitably among providers in situations when individual physicians or
20 other health care personnel *should not* put themselves at risk
- 21 • have in place fair and transparent mechanisms for responding to individuals who decline to
22 treat on the basis of risk. (Compare Opinion 8.7, “Routine Universal Immunization of
23 Physicians.”)
- 24

25 Equally, institutions support staff by gratefully acknowledging the contributions all personnel make
26 to the operation of the institution and providing psychosocial support for staff.

27 *Professional Organizations*

28
29
30 So too physicians and other health care professionals should be able to rely on their professional
31 organizations to advocate for appropriate support of the health care workforce, as in fact several
32 [organizations](#) have done over the course of the COVID-19 pandemic. In March 2020, the American
33 Medical Association, American Hospital Association, and American Nurses Association, for
34 example, jointly argued vigorously for and helped secure use of the Defense Production Act (DPA)
35 to [provide PPE](#). The [American College of Physicians](#) similarly urged use of the DPA to address the
36 shortage of PPE. [Physicians for Human Rights](#) led a coalition of organizations that called on the
37 National Governors Association to urge governors to implement mandatory standards for
38 protecting health workers during the pandemic.

39
40 The AMA further advocated for opening [visa processing](#) for international physicians to help
41 address workforce issues, and secured [financial support](#) for physician practices under the Provider
42 Relief Fund of the American Rescue Plan Act.

43 *Public Policy*

44
45
46 As noted, the *Code* originally delineated reciprocal obligations among physicians, patients, and
47 society. Such obligations on the part of communities and public policymakers should be
48 acknowledged as among the main factors that “contour the duty to treat” [1]. More specifically, it
49 is argued,

1 in preparation for epidemics communities should: 1) take all reasonable precautions to prevent
2 illness among health care workers and their families; 2) provide for the care of those who do
3 become ill; 3) reduce or eliminate malpractice threats for those working in high-risk emergency
4 situations; and 4) provide reliable compensation for the families of those who die while
5 fulfilling this duty [1].
6

7 In the face of the failure on the part of health care institutions and public agencies to ensure that
8 essential resources have been in place to reduce risk and lessen the burdens for individuals of
9 taking on the inevitable risk that remains, it is understandable that physicians and other health care
10 professionals may resent the expectation that they will unhesitatingly put themselves at risk. At
11 least one scholar has forcefully argued that, in the case of COVID-19, celebrations of medical
12 heroism were overwhelmingly insensitive to the fact such heroism was the “direct, avoidable
13 consequence” of institutional and public policy decisions that left the health care system
14 unprepared and transferred the burden of responding to the pandemic to individual health care
15 professionals [8].
16

17 ACKNOWLEDGING THE DUTY TO TREAT: SOLIDARITY

18

19 In the end, seeing the duty to treat as simply a matter of physicians’ altruistic dedication to patients
20 forecloses considerations that can rightly condition the duty in individual circumstances. As
21 Opinion 8.3 observes, providing care for individual patients in immediate need is not physicians’
22 only obligation in a public health crisis. They equally have an obligation to be part of ensuring that
23 care can be provided in the future. Equating duty to treat with altruism “makes invisible moral
24 conflicts between the various parties to whom a person may owe care and interferes with the need
25 of healthcare professionals to understand that they must take all possible measures consistent with
26 the social need for a functioning healthcare system to protect themselves in an epidemic” [7].
27

28 Further, such a view not only elides institutional and societal obligations but misrepresents how the
29 duty actually plays out in contemporary health care settings. The risks posed by pandemic disease
30 are distributed across the health care workforce, not uniquely borne by individuals, let alone by
31 individual physicians. Ultimately, the risk refused by one will be borne by someone else, someone
32 who is more often than not a colleague [2,7]. From this perspective, accepting the duty to treat is an
33 obligation physicians owe to fellow health care personnel as much as to patients or to society.
34

35 AN ENDURING PROFESSIONAL RESPONSIBILITY

36

37 Taken together, the foregoing considerations argue that physicians indeed *should* recognize the
38 duty to treat as a fundamental obligation of professional ethics. This is not to argue that the duty is
39 absolute and unconditional. However, as the Preface to Opinions of the Council on Ethical and
40 Judicial Affairs observes, recognizing when circumstances argue against adhering to the letter of
41 one’s ethical obligations
42

43 ... requires physicians to use skills of ethical discernment and reflection. Physicians are
44 expected to have compelling reasons to deviate from guidance when, in their best judgment,
45 they determine it is ethically appropriate or even necessary to do so.
46

47 Decisions to decline a duty to treat during a public health crisis carry consequences well beyond
48 the immediate needs of individual patients. In exercising the required discernment and ethical
49 reflection, physicians should take into account:

- 50 • the urgency of patients’ medical need and likelihood of benefit
51

- 1 • the nature and magnitude of risks to the physician and others to whom the physician also
- 2 owes duties of care
- 3 • the resources available or reasonably attainable to mitigate risk to patients, themselves and
- 4 others
- 5 • other strategies that could reasonably be implemented to reduce risk, especially for those
- 6 who are most vulnerable
- 7 • the burden declining to treat will impose on fellow health care workers

8
9 Physicians who themselves have underlying medical conditions that put them at high risk for
10 severe disease that cannot reasonably be mitigated, or whose practices routinely treat patients at
11 high risk, have a responsibility to protect themselves as well as their patients. But protecting
12 oneself and one's patients carries with it a responsibility to identify and act on opportunities to
13 support colleagues who take on the risk of providing frontline care.

14
15 Physicians and other health care workers *should* be able to rely on the institutions within which
16 they work to uphold the organization's responsibility to promote conditions that enable caregivers
17 to meet the ethical requirements of their professions. So too, physicians and other health care
18 workers *should* be able to trust that public policymakers will make and enforce well-considered
19 decisions to support public health and the health care workforce. When those expectations are not
20 met, physicians have a responsibility to advocate for change [[Principles III, IX](#)].

21
22 Yet, the failure of institutions or society does not in itself absolve physicians of their duty of
23 fidelity to patients and the professional obligation to treat.

24 25 RECOMMENDATION

26
27 In light of these considerations, the Council on Ethical and Judicial Affairs recommends that
28 Opinion 8.3, "Physician Responsibility in Disaster Response and Preparedness," be amended by
29 addition and deletion as follows and the remainder of this report be filed:

30 31 8.3 Physician Responsibility in Disaster Response and Preparedness

32
33 Whether at the national, regional, or local level, responses to disasters require extensive
34 involvement from physicians individually and collectively. Because of their commitment to
35 care for the sick and injured, individual physicians have an obligation to provide urgent
36 medical care during disasters. This obligation holds even in the face of greater than usual risks
37 to physicians' own safety, health, or life.

38
39 ~~However, the physician workforce is not an unlimited resource. Therefore, when providing~~
40 ~~care in a disaster with its inherent dangers, physicians also have an obligation to evaluate the~~
41 ~~risks of providing care to individual patients versus the need to be available to provide care in~~
42 ~~the future.~~

43
44 The duty to treat is foundational to the profession of medicine but is not absolute. The health
45 care work force is not an unlimited resource and must be preserved to ensure that care is
46 available in the future. For their part, physicians have a responsibility to protect themselves, as
47 well as a duty of solidarity to colleagues to share risks and burdens in a public health crisis. So
48 too, health care institutions have responsibilities to support and protect health care
49 professionals and to apportion the risks and benefits of providing care as equitably as possible.

1 Many physicians owe competing duties of care as medical professionals and as individuals
2 outside their professional roles. In a public health crisis, institutions should provide support to
3 enable physicians to meet compelling personal obligations without undermining the
4 fundamental obligation to patient welfare. In exceptional circumstances, when arrangements to
5 allow the physician to honor both obligations are not feasible, it may be ethically acceptable for
6 a physician to limit participating in care, provided that the institution has made available
7 another mechanism for meeting patients' needs. Institutions should strive to be flexible in
8 supporting physicians in efforts to address such conflicts. The more immediately relevant a
9 physician's clinical expertise is to the urgent needs of the moment and the less that alternative
10 care mechanisms are available, the stronger the professional obligation to provide care despite
11 competing obligations.

12

13 With respect to disaster, whether natural or manmade, individual physicians should:

14

15 (a) Take appropriate advance measures, including acquiring and maintaining appropriate
16 knowledge and skills to ensure they are able to provide medical services when needed.

17

18 Collectively, physicians should:

19

20 (b) Provide medical expertise and work with others to develop public health policies that:

21

22 (i) Are designed to improve the effectiveness and availability of medical services during a
23 disaster

24

(ii) Are based on sound science

25

(iii) Are based on respect for patients

26

27 (c) Advocate for and participate in ethically sound research to inform policy decisions.

28

(Modify HOD/CEJA Policy)

Fiscal Note: Less than \$500

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 002
(1-22)

Introduced by: Resident and Fellow Section

Subject: Assessing the Humanitarian Impact of Sanctions

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The Office of Foreign Assets Control (“OFAC”) of the US Treasury Department
2 administers and enforces financial, economic, and trade sanctions against foreign individuals,
3 organizations, and entire countries, based on US foreign policy and national security goals¹; and
4

5 Whereas, Primary sanctions prohibit U.S.-based individuals and entities from economic
6 transactions with the target nation, while secondary sanctions prohibit non-U.S. entities from
7 conducting any financial transaction that requires routing through U.S.-based institutions, such
8 as currency exchange²; and
9

10 Whereas, As of April 2022, the US had active, comprehensive economic sanctions against
11 seven nations (North Korea, Cuba, Iran, Syria, Venezuela, Afghanistan, and Russia) and
12 against individuals in nineteen other nations and territories (Bangladesh, Belarus, Central
13 African Republic, China, Democratic Republic of the Congo, Eritrea, Hong Kong, Iraq, Lebanon,
14 Liberia, Mali, Myanmar, Nicaragua, Somalia, South Sudan, Turkey, Ukraine, Yemen, and
15 Zimbabwe)³; and
16

17 Whereas, Research shows that while arms embargoes may reduce violence in armed conflicts,
18 economic sanctions fail to do so, and instead contribute to military escalation and increased
19 violence^{4,5}; and
20

21 Whereas, Economic sanctions are estimated to succeed in only 4-34% of cases, with the two
22 most notable successes being the fall of the apartheid regime in South Africa (after three
23 decades of economic sanctions and arms embargoes), and the fall of the government of
24 Rhodesia after over ten years of sanctions and civil war⁶; and
25

26 Whereas, Comprehensive economic sanctions have been compared to medieval siege warfare,
27 imposing suffering on innocent civilians within the targeted nations in order to force a surrender
28 by the ruling class⁷; and
29

30 Whereas, A study of economic sanctions in 98 countries over 35 years found that US-imposed
31 sanctions reduced life expectancy by 0.4-0.5 years in target nations, with a greater impact on
32 women, caused by an increase in child mortality and in deaths due to cholera⁸; and
33

34 Whereas, Nations targeted by US economic sanctions experience a higher poverty rate of 3.8%
35 compared to non-sanctioned nations, with the impact lasting for 21 years⁹; and
36

37 Whereas, Rates of HIV infection in children were 2.5% higher in 71 countries targeted by
38 sanctions between 1990 and 2012, and AIDS-related death rates were 1% higher, illustrating
39 the disproportionate impact of sanctions on marginalized populations¹⁰; and

1 Whereas, Despite the use of humanitarian carve-outs, foreign firms are reluctant to engage in
2 any trade with sanctioned nations for fear of triggering secondary sanctions, which place the
3 onus of compliance on these foreign firms, thus impairing access to food and medicines in
4 target nations^{11,12}; and

5
6 Whereas, Unilateral US-imposed economic sanctions have been shown to slow economic
7 growth in target nations and decrease their GDP per capita by 13.4%¹³; and

8
9 Whereas, An economic embargo imposed on Haiti between 1991 and 1994 contributed to a
10 decline in income, a rise in unemployment, poorer nutrition status, and a rise in mortality among
11 children aged 1-4 years old¹⁴; and

12
13 Whereas, An Oxfam report found that US-imposed sanctions on Cuba had restricted access to
14 basic medical supplies including syringes and masks, medicines, vaccines, and food¹⁵; and

15
16 Whereas, In 2019, Human Rights Watch documented shortages of antiepileptic drugs and
17 chemotherapy medications in Iran and concluded that due to US economic sanctions, “Iranians’
18 access to essential medicine and their right to health is being negatively impacted, threatening
19 the health of millions of Iranians”^{12,16}; and

20
21 Whereas, Journals including *JAMA* and the *New England Journal of Medicine* continued to
22 publish papers authored by Iranian scientists, while overcompliance with US-imposed sanctions
23 led the editors of several other journals to reject them, with one stating that “US owned journals
24 are unable to handle scientific manuscripts which are authored by Iranian scientists, employed
25 by the Government of Iran”¹⁷; and

26
27 Whereas, A 2018 systematic review of 55 papers found that US-led economic sanctions on Iran
28 led to an increase in inflation and unemployment, a devaluation of the nation’s currency, scarcity
29 of lifesaving medicines, with impacts disproportionately affecting Iranians who were poor, ill,
30 women, and children and found no positive effect from existing “humanitarian exemptions”¹⁸;
31 and

32
33 Whereas, Comprehensive economic sanctions on Syria, first imposed in 1985 and strengthened
34 in the past decade, have contributed to a breakdown in its healthcare system, including
35 shutdowns of MRI, CT, and dialysis machines as healthcare facilities are unable to import spare
36 parts to maintain these machines or license software to run them¹⁹; and

37
38 Whereas, Economic sanctions also drive up healthcare costs, as hospitals must assemble multi-
39 national legal teams to navigate EU and US sanctions exemption applications¹⁹; and

40
41 Whereas, US and EU-led economic sanctions on Syria have contributed to devaluation of the
42 Syrian currency, shortages of fuel, electricity, medicines, and water, a drop in agricultural and
43 pharmaceutical output, along with an inability to test, track, treat, or vaccinate against
44 COVID-19²⁰; and

45
46 Whereas, Twenty-three million Afghans face famine in 2022, with aid efforts hampered by US
47 sanctions imposed after the fall of the Afghan government in 2021²¹; and

48
49 Whereas, Thirteen thousand Afghan children died of malnutrition in the first ten weeks of 2022,
50 as sanctions caused a collapse of the banking sector and foreign banks are reluctant to transfer
51 aid money into the country for fear of triggering secondary sanctions²²; and

1 Whereas, In February 2022, the Biden administration announced it would relax some sanctions
2 on Afghanistan, including allowing half of the Afghan Central Bank’s assets in the US to be used
3 to pay for humanitarian purchases such as food and medicine, while continuing to freeze the
4 other half, in a move that was described as “aiming to make it harder to blame the US
5 government’s sanctions for the unfolding economic disaster in Afghanistan”²³; and
6

7 Whereas, Freezing the Afghan Central Bank’s reserves has contributed to a crash in the Afghan
8 currency’s value, leading to a rise in food prices over 40% since the previous year²⁴; and
9

10 Whereas, In its 2019 report, Human Rights Watch recommended that Congress request a study
11 on the humanitarian impact of economic sanctions¹²; and
12

13 Whereas, The United Nation’s (UN) Committee on Economic, Social, and Cultural Rights states
14 that nations that impose economic sanctions must take steps to respond to any disproportionate
15 suffering experienced by vulnerable groups within the targeted country²⁵; and
16

17 Whereas, The UN’s Office of the High Commissioner for Human Rights has found that unilateral
18 economic sanctions disproportionately harm women, children, and marginalized groups, and
19 that US-imposed sanctions are hindering reconstruction in war-torn nations, calling for lifting or
20 minimizing these sanctions^{26,27}; and
21

22 Whereas, The World Medical Association “urges national medical associations to ensure that
23 Governments employing economic sanctions against other States respect the agreed
24 exemptions for medicines, medical supplies, and basic food items”²⁸; and
25

26 Whereas, Lawmakers in the US have called for a report on the humanitarian impact of
27 sanctions, most recently through a February 2022 letter signed by over twenty members of
28 Congress^{29,30}; and
29

30 Whereas, Our AMA supports medical access in countries in turmoil (H-65.994), and broadly
31 urges all parties to minimize the health costs of war on civilian populations (D-65.993), it does
32 not have policy discussing the harmful health costs of economic sanctions; therefore be it
33

34 RESOLVED, That our American Medical Association recognize that economic sanctions can
35 negatively impact health and exacerbate humanitarian crises (New HOD Policy); and be it
36 further
37

38 RESOLVED, That our AMA support efforts to study the humanitarian impact of economic
39 sanctions imposed by the United States. (New HOD Policy)

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

Received: 09/14/22

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RELEVANT AMA POLICY

Medical Care in Countries in Turmoil H-65.994

The AMA (1) supports the provision of food, medicine and medical equipment to noncombatants threatened by natural disaster or military conflict within their country through appropriate relief organizations; (2) expresses its concern about the disappearance of physicians, medical students and other health care professionals, with resulting inadequate care to the sick and injured of countries in turmoil; (3) urges appropriate organizations to transmit these concerns to the affected country's government; and (4) asks appropriate international health organizations to monitor the status of medical care, medical education and treatment of medical personnel in these countries, to inform the world health community of their findings, and to encourage efforts to ameliorate these problems.

Citation: Sub. Res. 133, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CLRPD Rep. 1, A-05; Reaffirmed: CEJA Rep. 5, A-15

War Crimes as a Threat to Physicians' Humanitarian Responsibilities D-65.993

Our American Medical Association will (1) implore all parties at all times to understand and minimize the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular, (2) support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime or episodes of civil strife, and condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, by any party, wherever and whenever it occurs, and (3) advocate for the protection of physicians' rights to provide ethical care without fear of persecution.

Citation: BOT Action in response to referred for decision Res. 620, A-09; Modified: BOT Rep. 09, A-19

Promoting Equitable Resource Distribution Globally in Response to the COVID-19 Pandemic D-440.917

1. Our AMA will, in an effort to improve public health and national stability, explore possible assistance through the COVID-19 Vaccines Global Access (COVAX) initiative co-led by the World Health Organization, Gavi, and the Coalition for Epidemic Preparedness Innovations, as well as all other relevant organizations, for residents of countries with limited financial or technological resources.

2. Our AMA will work with governmental and appropriate regulatory bodies to encourage prioritization of equity when providing COVID-19 pandemic-related resources, such as diagnostics, low cost or free medications, therapeutics, vaccines, raw materials for vaccine production, personal protective equipment, and/or financial support.

3. Our AMA recognizes the extraordinary efforts of many dedicated physicians, physician and ethnic organizations assisting in this humanitarian COVID-19 pandemic crisis.

4. Our AMA will support World Health Organization (WHO) efforts and initiatives to increase production and distribution of therapeutics and vaccines necessary to combat COVID-19 and future pandemics in order to provide vaccine doses to low- and middle-income countries with limited access, including: (a) a temporary waiver of the Trade Related Aspects of Intellectual Property (TRIPS) agreement and other relevant intellectual property protections; (b) technological transfers relevant for vaccine production; (c) other support, financial and otherwise, necessary to scale up global vaccine manufacturing; and (d) measures that ensure the safety and efficacy of products manufactured by such means.

Citation: Res. 608, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 003
(I-22)

Introduced by: Medical Student Section

Subject: Indigenous Data Sovereignty

Referred to: Reference Committee on Amendments to Constitution and Bylaws

- 1 Whereas, There is a history of research misconduct against American Indian and Alaska Native
2 (AI/AN) Tribes and Villages¹; and
3
- 4 Whereas, One notable example of this misconduct was a psychiatric biomarkers study on
5 members of the Havasupai Indian Tribe conducted by researchers at Arizona State University
6 without prior, informed and free consent^{2,3}; and
7
- 8 Whereas, Havasupai Indian Tribe v. Arizona State University resulted in a punitive settlement
9 against Arizona State University and indirectly led to moratorium on all genetic research on
10 members of the neighboring Navajo Nation⁴; and
11
- 12 Whereas, The Indian Health Service and Tribal leaders developed frameworks and guidelines
13 for Tribal Institutional Review Boards (IRB)⁵; and
14
- 15 Whereas, All research conducted on an American Indian and Alaska Native reservation requires
16 the approval of the Indian Health Service Area IRB or respective Tribal IRB⁵; and
17
- 18 Whereas, A Tribal IRB assumes responsibility for the ethical review and oversight of all
19 research occurring on Tribal land, including the protection of human subjects, the Tribe, Tribal
20 communities, and Tribal resources (including environmental, animal, plant and cultural
21 resources)⁶; and
22
- 23 Whereas, A Tribal IRB differs from an Academic IRB by allowing for community members and
24 Tribal leadership to provide input into research design and conduct and the prioritization of
25 research linked to community priorities^{5,7}; and
26
- 27 Whereas, A Tribal IRB ensures that the principles of Indigenous Data Sovereignty, defined as
28 the right of each American Indian and Alaska Native Tribe and Villages to control the collection,
29 ownership, and application of their own data are upheld^{8,9}; and
30
- 31 Whereas, While federal research protections for American Indian and Alaska Native Tribes and
32 Villages are enforceable on Tribal lands and properties, there are complex jurisdictional issues
33 preventing their timely enforcement off of Tribal lands and properties¹⁰; and
34
- 35 Whereas, Federal programs such as the NIH All of Us Research Program have sought to
36 address these challenges by incorporating best practices and maximizing American Indian and
37 Alaska Native participation in policy and program design¹¹; and

1 Whereas, An example of a best practice used by All of Us includes ensuring “that research
2 using the program’s biospecimens and data from [T]ribal members is done in a way that is
3 respectful of applicable [T]ribal customs, culture, and laws”¹²; and
4

5 Whereas, Existing best practices for working with American Indian and Alaska Native Tribes
6 and Villages include the the use of data-sharing agreements, which also specify rules for data
7 sharing and ownership¹³; and
8

9 Whereas, Tribal government officials, liaisons, and elected leaders are recommended to have
10 shared decision-making and oversight over research affairs specific to their members⁵; and
11 therefore be it
12

13 RESOLVED, That our American Medical Association recognize that American Indian and
14 Alaska Native (AI/AN) Tribes and Villages are sovereign governments that should be consulted
15 before the conduct of research specific to their members, lands, and properties (New HOD
16 Policy); and be it further
17

18 RESOLVED, That our AMA support that AI/AN Tribes and Villages’ Institutional Review Boards
19 (IRBs) and research departments retain the right to oversee and regulate the collection,
20 ownership, and management of research data generated by their members, and that individual
21 members of AI/AN Tribes and Villages retain their autonomy and privacy regarding research
22 data shared with researchers, AI/AN Tribes and Villages, and governments, consistent with
23 existing protections under 45 CFR 46 (New HOD Policy); and it be further
24

25 RESOLVED, That our AMA encourage the use and regular review of data-sharing agreements
26 for all studies between academic medical centers and AI/AN Tribes and Villages (New HOD
27 Policy); and be it further
28

29 RESOLVED, That our AMA encourage the National Institutes of Health and other stakeholders
30 to provide flexible funding to AI/AN Tribes and Villages for research efforts, including the
31 creation and maintenance of IRBs. (New HOD Policy)

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

Received: 09/20/22

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RELEVANT AMA POLICY

E-7.3.7 Safeguards in the Use of DNA Databanks

DNA databanks facilitate population-based research into the genetic components of complex diseases. These databanks derive their power from integrating genetic and clinical data, as well as data on health, lifestyle, and environment about large samples of individuals. However, the use of DNA databanks in genomic research also raises the possibility of harm to individual participants, their families, and even populations.

Breach of confidentiality of information contained in DNA databanks may result in discrimination or stigmatization and may carry implications for important personal choices, such as reproductive choices. Human participants who contribute to research involving DNA databanks have a right to be informed about the nature and scope of the research and to make decisions about how their information may be used.

In addition to having adequate training to be able to discuss genomic research and related ethical issues with patients or prospective research participants, physician-researchers who are involved in genomic research using DNA databanks should:

Research involving individuals

- (a) Obtain informed consent from participants in genomic research, in keeping with ethics guidance. In addition, physicians should put special emphasis in the consent process on disclosing:
 - (i) the specific privacy standards to which the study will adhere, including whether the information or biological sample will be encrypted and remain identifiable to the researcher or will be completely de-identified;
 - (ii) whether participants whose data will be encrypted rather than de-identified can expect to be contacted in the future about findings or be invited to participate in additional research, either related to the current protocol or for other research purposes;
 - (iii) whether researchers or participants stand to gain financially from research findings, and any conflicts of interest researchers may have in regard to the research, in keeping with ethics guidance;
 - (iv) when, if ever, archived information or samples will be discarded;
 - (v) participants' freedom to refuse use of their biological materials without penalty.

Research involving identifiable communities

- (b) When research is to be conducted within a defined subset of the general population, physicians should:
 - (i) consult with the community in advance to design a study that is sensitive to community concerns and that will minimize harm for the community, as well as for individual participants. Physicians should not carry out a study when there is substantial opposition to the research within the community of interest;
 - (ii) protect confidentiality by encrypting any demographic or identifying information that is not required for the study's purpose.

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

Issued: 2016

Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a

position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

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

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

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

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

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.

(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

CLRPD Rep. 3, I-98, Reaffirmed: Res. 221, A-07, Reaffirmation A-12, Reaffirmed: Res. 233, A-13

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

(2) Federal Facilities: Based on the distribution of the eligible population, transportation facilities and roads, and the availability of alternative nonfederal resources, the AMA recommends that those Indian Health Service facilities currently necessary for American Indian care be identified and that an immediate construction and modernization program be initiated to bring these facilities up to current standards of practice and accreditation.

(3) Manpower: (a) Compensation for Indian Health Service physicians be increased to a level competitive with other Federal agencies and nongovernmental service; (b) Consideration should be given to increased compensation for service in remote areas; (c) In conjunction with improvement of Service facilities, efforts should be made to establish closer ties with teaching centers, thus increasing both the available manpower and the level of professional expertise available for consultation; (d) Allied health professional staffing of Service facilities should be maintained at a level appropriate to the special needs of the population served; (e) Continuing education opportunities should be provided for those health professionals serving these communities, and especially those in remote areas, and, increased peer contact, both to maintain the quality of care and to avert professional isolation; and (f) Consideration should be given to a federal statement of policy supporting continuation of the Public Health Service to reduce the great uncertainty now felt by many career officers of the corps.

(4) Medical Societies: In those states where Indian Health Service facilities are located, and in counties containing or adjacent to Service facilities, that the appropriate medical societies should explore the possibility of increased formal liaison with local Indian Health Service physicians. Increased support from organized medicine for improvement of health care provided under their direction, including professional consultation and involvement in society activities should be pursued.

(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

CLRPD Rep. 3, I-98, Reaffirmed: CLRPD Rep. 1, A-08, Reaffirmation A-12, Reaffirmed: Res. 233, A-13

Support for Institutional Review Boards H-460.921

Our AMA: (1) commends the thousands of Institutional Review Board (IRB) members who each have volunteered hundreds of hours annually; (2) urges medical schools and teaching hospitals to provide IRBs with adequate personnel and other resources to accomplish their mission to safeguard the rights

and welfare of human research subjects; and (3) encourages the National Institutes of Health to develop a program that provides flexible funding to institutions, including support directed at IRBs. Res. 317, I-98, Reaffirmed: Res. 528, A-00, Modified: CSAPH Rep. 1, A-10, Reaffirmed: CSAPH Rep. 01, A-20

Health Information Technology Principles H-478.981

Our AMA will promote the development of effective electronic health records (EHRs) in accordance with the following health information technology (HIT) principles. Effective HIT should:

1. Enhance physicians' ability to provide high quality patient care;
2. Support team-based care;
3. Promote care coordination;
4. Offer product modularity and configurability;
5. Reduce cognitive workload;
6. Promote data liquidity;
7. Facilitate digital and mobile patient engagement; and
8. Expedite user input into product design and post-implementation feedback.

Our AMA will utilize HIT principles to:

1. Work with vendors to foster the development of usable EHRs;
2. Advocate to federal and state policymakers to develop effective HIT policy;
3. Collaborate with institutions and health care systems to develop effective institutional HIT policies;
4. Partner with researchers to advance our understanding of HIT usability;
5. Educate physicians about these priorities so they can lead in the development and use of future EHRs that can improve patient care; and
6. Promote the elimination of "Information Blocking."

Our AMA policy is that the cost of installing, maintaining, and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules.

BOT Rep. 19, A-18, Reaffirmation: A-19

Strong Opposition to Cuts in Federal Funding for the Indian Health Service D-350.987

1. Our AMA will strongly advocate that all of the facilities that serve Native Americans under the Indian Health Service be adequately funded to fulfill their mission and their obligations to patients and providers.
2. Our AMA will ask Congress to take all necessary action to immediately restore full and adequate funding to the Indian Health Service.
3. Our AMA adopts as new policy that the Indian Health Service not be treated more adversely than other health plans in the application of any across the board federal funding reduction.
4. In the event of federal inaction to restore full and adequate funding to the Indian Health Service, our AMA will consider the option of joining in legal action seeking to require the federal government to honor existing treaties, obligations, and previously established laws regarding funding of the Indian Health Service.
5. Our AMA will request that Congress: (A) amend the Indian Health Care Improvement Act to authorize Advanced Appropriations; (B) include our recommendation for the Indian Health Service (IHS) Advanced Appropriations in the Budget Resolution; and (C) include in the enacted appropriations bill IHS Advanced Appropriations.

Res. 233, A-13, Appended: Res. 229, A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 005
(I-22)

Introduced by: Medical Student Section

Subject: Strengthening Interview Guidelines for American Indian and Alaska Native
Medical School, Residency, and Fellowship Applicants

Referred to: Reference Committee on Amendments to Constitution and Bylaws

- 1 Whereas, The Association of Native American Medical Students has communicated to the
2 AMA-MSS Committee on American Indian Affairs, Association of American Medical Colleges,
3 National Residency Matching Program, and Accreditation Council for Graduate Medical
4 Education that they have received reports of residency interviewers asking American Indian and
5 Alaska Native applicants inappropriate interview questions about blood quantum¹; and
6
7 Whereas, Mathematical blood quantum was implemented by the federal government, requiring
8 the Bureau of Indian Affairs (BIA) to issue a Certificate Degree of Indian Blood (CDIB) that
9 provided evidence of descent from pureblood (full-fraction) Tribal members^{2,3}; and
10
11 Whereas, The role of blood quantum in the identity of Indigenous Peoples is a topic of
12 controversy, with foundations in colonization and disenfranchisement^{2,4}; and
13
14 Whereas, There is no practical or biological basis for blood quantum and its persistence in these
15 communities is a relic of external governmental influences⁴; and
16
17 Whereas, Many Tribes have foregone blood quantum as a determinant in favor of direct lineage,
18 while the Tribes that continue to evaluate lineage by blood quantum have no absolute
19 minimum⁴; and
20
21 Whereas, Of the racial groups defined in the United States Census, American Indians and
22 Alaskan Natives are the only group that have identity associated with fractions of blood (blood
23 quantum), which may introduce significant potential for discrimination⁴; and
24
25 Whereas, Multiple evidence-based studies detailed the complexities of Indigenous identity
26 formation and the specific barriers that cause exclusion of Indigenous learners that lead to
27 continued underrepresentation of Indigenous students in all stages of medical training^{5,6}; and
28
29 Whereas, It is recognized that current admissions and interview practices, whether intentionally
30 or unintentionally, may be racially biased; studies suggest that creating a culturally safe
31 environment in interviews can successfully reduce racial biases⁵; and
32
33 Whereas, Compared to other residency interview methods, 64% of unstructured interviews were
34 found to include inappropriate questions about applicant marital status, family planning,
35 ethnicity, and religion, despite the presence of anti-discrimination laws, which greatly increases
36 bias and applicant stereotyping⁷; and

1 Whereas, The AAMC's Best Practice Guidelines for Residency Program Interviews encourage
2 the use of standardized interview content, clearly defined criteria, scoring guidelines, and
3 interview training to decrease bias and applicant stereotyping⁸; and
4

5 Whereas, Addressing structural, interpersonal, and individual bias in residency selection has
6 been shown to increase the percentage of entering underrepresented minority interns⁹;
7

8 Whereas, American Indian and Alaskan Native applicants subjected to questioning about their
9 blood quantum may discourage applicants from advancing their education, further exacerbating
10 the shortage of American Indian medical trainees¹⁰; and
11

12 Whereas, Our AMA supports the inclusion of American Indians in established medical training
13 programs in numbers adequate to meet their needs (H-350.981); and
14

15 Whereas, Our AMA opposes questions regarding applicant race during the medical school,
16 residency, and fellowship application process (H-310.919), but questioning based on American
17 Indian and Alaska Native "blood quantum" is not based on race¹¹; therefore be it
18

19 RESOLVED, That our American Medical Association work with the Accreditation Council for
20 Graduate Medical Education, the National Residency Matching Program, the Association of
21 American Medical Colleges, and other interested parties to eliminate questioning about or
22 discrimination based on American Indian and Alaska Native blood quantum during the medical
23 school, residency, and fellowship application process. (Directive to Take Action)

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

Received: 09/20/22

References:

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RELEVANT AMA POLICY

Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of

training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.

2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.

3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.

4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.

5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.

6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.

7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.

8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any

organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.

10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).

11. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.

12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

CME Rep. 8, A-11, Appended: Res. 303, A-14, Reaffirmed: Res. 915, I-15, [Appended: CME Rep. 04, A-16](#), [Modified: CME Rep. 06, I-18](#), Appended: Res. 324, A-19, Modified: Res. 304, A-21, Modified: Res. 305, A-21, Modified: BOT Rep. 18, I-21, Reaffirmation: A-22

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

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(5) Our AMA also support the removal of any requirement for competitive bidding in the Indian Health Service that compromises proper care for the American Indian population.

CLRPD Rep. 3, I-98, Reaffirmed: CLRPD Rep. 1, A-08, Reaffirmation A-12, Reaffirmed: Res. 233, A-13

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.

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.

Res. 960, I-17

Educating Competent and Caring Health Professionals H-295.975

(1) Programs of health professions education should foster educational strategies that encourage students to be independent learners and problem-solvers. Faculty of programs of education for the health professions should ensure that the mission statements of the institutions in which they teach include as an objective the education of practitioners who are both competent and compassionate.

(2) Admission to a program of health professions education should be based on more than grade point average and performance on admissions tests. Interviews, applicant essays, and references should continue to be part of the application process in spite of difficulties inherent in evaluating them. Admissions committees should review applicants' extra-curricular activities and employment records for indications of suitability for health professions education. Admissions committees should be carefully prepared for their responsibilities, and efforts should be made to standardize interview procedures and to evaluate the information gathered during interviews. Research should continue to focus on improving admissions procedures. Particular attention should be paid to improving evaluations of subjective personal qualities.

(3) Faculty of programs of education for the health professions must continue to emphasize that they have in the past on educating practitioners who are skilled in communications, interviewing and listening techniques, and who are compassionate and technically competent. Faculty of health professions education should be attentive to the environment in which education is provided; students should learn in a setting where respect and concern are demonstrated. The faculty and administration of programs of health professions education must ensure that students are provided with appropriate role models; whether a faculty member serves as an appropriate role model should be considered when review for promotion or tenure occurs. Efforts should be made by the faculty to evaluate the attitudes of students toward patients. Where these attitudes are found lacking, students should be counseled. Provisions for dismissing students who clearly indicate personality characteristics inappropriate to practice should be enforced.

(4) In spite of the high degree of specialization in health care, faculty of programs of education for the health professions must prepare students to provide integrated patient care; programs of education should promote an interdisciplinary experience for their students.

BOT Rep. NN, A-87, Modified: Sunset Report, I-97, Reaffirmed: CME Rep. 2, A-07, Reaffirmed: CME Rep. 01, A-17

Residency Interview Schedules H-310.998

1. Our AMA encourages residency and fellowship programs to incorporate in their interview dates increased flexibility, whenever possible, to accommodate applicants' schedules. Our AMA encourages the ACGME and other accrediting bodies to require programs to provide, by electronic or other means, representative contracts to applicants prior to the interview. Our AMA encourages residency and fellowship programs to inform applicants in a timely manner confirming receipt of application and ongoing changes in the status of consideration of the application.

2. Our AMA will: (a) oppose changes to residency and fellowship application requirements unless (i) those changes have been evaluated by working groups which have students and residents as representatives, (ii) there are data which demonstrates that the proposed application components contribute to an accurate representation of the candidate, (iii) there are data available to demonstrate that the new application requirements reduce, or at least do not increase, the impact of bias that affects medical students and residents from underrepresented minority backgrounds, and (iv) the costs to medical students and residents are mitigated; and (b) continue to work with specialty societies, the Association of American Medical Colleges, the National Resident Matching Program and other relevant stakeholders to improve the application process in an effort to accomplish these requirements.

Res. 93, I-79, Reaffirmed: CLRPD Rep. B, I-89, Appended: Res. 302 and Res. 313, I-97, Reaffirmed: CME Rep. 2, A-07, Modified: Res. 302, A-14, Appended: Res. 314, A-19

Gender-Based Questioning in Residency Interviews H-310.976

The AMA (1) opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination; (2) supports inclusion in the AMA Fellowship and Residency Interactive Database Access (FREIDA) system information on residency Family and Medical Leave policies; and (3) supports monitoring the Accreditation Council for Graduate Medical Education as it proposes

changes to the "Common Requirements" and the "Institutional Requirements" of the "Essentials of Accredited Residencies," to ensure that there is no gender-based bias.

Res. 125, I-88, Reaffirmed: Sunset Report, I-98, Modified and Reaffirmed: CME Rep. 2, A-08, Reaffirmed: CCB/CLRPD Rep. 4, A-13

Housestaff Input During the ACGME Review Process H-310.952

The AMA asks its representatives to the Accreditation Council for Graduate Medical Education to support a requirement that site visitors to both residency training programs and institutions conduct interviews with residents, including peer-selected residents, as well as with administrators and faculty.

Res. 314, I-92, Reaffirmed: CME Rep. 2, A-03, Reaffirmed: CME Rep. 2, A-13

Improving Health Care of American Indians H-350.976

Our AMA recommends that: (1) All individuals, special interest groups, and levels of government recognize the American Indian people as full citizens of the U.S., entitled to the same equal rights and privileges as other U.S. citizens.

(2) The federal government provide sufficient funds to support needed health services for American Indians.

(3) State and local governments give special attention to the health and health-related needs of nonreservation American Indians in an effort to improve their quality of life.

(4) American Indian religions and cultural beliefs be recognized and respected by those responsible for planning and providing services in Indian health programs.

(5) Our AMA recognize the "medicine man" as an integral and culturally necessary individual in delivering health care to American Indians.

(6) Strong emphasis be given to mental health programs for American Indians in an effort to reduce the high incidence of alcoholism, homicide, suicide, and accidents.

(7) A team approach drawing from traditional health providers supplemented by psychiatric social workers, health aides, visiting nurses, and health educators be utilized in solving these problems.

(8) Our AMA continue its liaison with the Indian Health Service and the National Indian Health Board and establish a liaison with the Association of American Indian Physicians.

(9) State and county medical associations establish liaisons with intertribal health councils in those states where American Indians reside.

(10) Our AMA supports and encourages further development and use of innovative delivery systems and staffing configurations to meet American Indian health needs but opposes overemphasis on research for the sake of research, particularly if needed federal funds are diverted from direct services for American Indians.

(11) Our AMA strongly supports those bills before Congressional committees that aim to improve the health of and health-related services provided to American Indians and further recommends that members of appropriate AMA councils and committees provide testimony in favor of effective legislation and proposed regulations.

CLRPD Rep. 3, I-98, Reaffirmed: Res. 221, A-07, Reaffirmation A-12, Reaffirmed: Res. 233, A-13

Continued Support for Diversity in Medical Education D-295.963

Our AMA will: (1) publicly state and reaffirm its stance on diversity in medical education; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; and (5) work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates.

Res. 325, A-03, Appended: CME Rep. 6, A-11, [Modified: CME Rep. 3, A-13](#), [Appended: CME Rep. 5, A-21](#)

AMA Support of American Indian Health Career Opportunities H-350.981

AMA policy on American Indian health career opportunities is as follows: (1) Our AMA, and other national, state, specialty, and county medical societies recommend special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.

(2) Our AMA support the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals.

(3) Our AMA utilize its resources to create a better awareness among physicians and other health providers of the special problems and needs of American Indians and that particular emphasis be placed on the need for additional health professionals to work among the American Indian population.

(4) Our AMA continue to support the concept of American Indian self-determination as imperative to the success of American Indian programs, and recognize that enduring acceptable solutions to American Indian health problems can only result from program and project beneficiaries having initial and continued contributions in planning and program operations.

CLRPD Rep. 3, I-98, Reaffirmed: Res. 221, A-07, Reaffirmation A-12, Reaffirmed: CME Rep. 1, A-22

Competency-Based Portfolio Assessment of Medical Students D-295.318

1. Our AMA will work with the Association of American Medical Colleges, the American Osteopathic Association and the Accreditation Council for Graduate Medical Education, and other organizations to examine new and emerging approaches to medical student evaluation, including competency-based portfolio assessment.

2. Our AMA will work with the NRMP, ACGME and the 11 schools in the AMA's Accelerating Change in Medical Education consortium to develop pilot projects to study the impact of competency-based frameworks on student graduation, the residency match process and off-cycle entry into residency programs.

Res. 314, A-10, Appended: Res. 311, A-14

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919

Our AMA: 1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion; 2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process; 3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants; 4. encourages the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Advisory Committee to develop steps to minimize bias in the ERAS and the residency training selection process; and 5. will advocate that modifications in the ERAS Residency Application to minimize bias consider the effects these changes may have on efforts to increase diversity in residency programs.

Res. 307, A-09 Appended: Res. 955, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 006
(1-22)

Introduced by: Medical Student Section

Subject: Assessing the Humanitarian Impact of Sanctions

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The Office of Foreign Assets Control (“OFAC”) of the US Treasury Department
2 administers and enforces financial, economic, and trade sanctions against foreign individuals,
3 organizations, and entire countries, based on US foreign policy and national security goals¹;
4 and

5
6 Whereas, Primary sanctions prohibit US-based individuals and entities from economic
7 transactions with the target nation, while secondary sanctions prohibit non-US entities from
8 conducting any financial transaction that requires routing through US-based institutions, such as
9 currency exchange²; and

10
11 Whereas, As of April 2022, the US had active, comprehensive economic sanctions against
12 seven nations (North Korea, Cuba, Iran, Syria, Venezuela, Afghanistan, and Russia) and
13 against individuals in 19 other nations and territories (Bangladesh, Belarus, Central African
14 Republic, China, Democratic Republic of the Congo, Eritrea, Hong Kong, Iraq, Lebanon, Liberia,
15 Mali, Myanmar, Nicaragua, Somalia, South Sudan, Turkey, Ukraine, Yemen, and Zimbabwe)³;
16 and

17
18 Whereas, Research shows that while arms embargoes may reduce violence in armed conflicts,
19 economic sanctions fail to do so, and instead contribute to military escalation and increased
20 violence^{4,5}; and

21
22 Whereas, Economic sanctions are estimated to succeed in only 4-34% of cases, with the two
23 most notable successes being the fall of the apartheid regime in South Africa (after three
24 decades of economic sanctions and arms embargoes), and the fall of the government of
25 Rhodesia after over ten years of sanctions and civil war⁶; and

26
27 Whereas, Comprehensive economic sanctions have been compared to medieval siege warfare,
28 imposing suffering on innocent civilians within the targeted nations in order to force a surrender
29 by the ruling class⁷; and

30
31 Whereas, A study of economic sanctions in 98 countries over 35 years found that US-imposed
32 sanctions reduced life expectancy by 0.4-0.5 years in target nations, with a greater impact on
33 women, caused by an increase in child mortality and in deaths due to cholera⁸; and

34
35 Whereas, Nations targeted by US economic sanctions experience a higher poverty rate of 3.8%
36 compared to non-sanctioned nations, with the impact lasting for 21 years⁹; and

37
38 Whereas, Rates of HIV infection in children were 2.5% higher in 71 countries targeted by
39 sanctions between 1990 and 2012, and AIDS-related death rates were 1% higher, illustrating
40 the disproportionate impact of sanctions on marginalized populations¹⁰; and

1 Whereas, Despite the use of humanitarian carve-outs, foreign firms are reluctant to engage in
2 any trade with sanctioned nations for fear of triggering secondary sanctions, which place the
3 onus of compliance on these foreign firms, thus impairing access to food and medicines in
4 target nations^{11,12}; and

5
6 Whereas, Unilateral US-imposed economic sanctions have been shown to slow economic
7 growth in target nations and decrease their GDP per capita by 13.4%¹³; and

8
9 Whereas, An economic embargo imposed on Haiti between 1991 and 1994 contributed to a
10 decline in income, a rise in unemployment, poorer nutrition status, and a rise in mortality among
11 children aged 1-4 years old¹⁴; and

12
13 Whereas, An Oxfam report found that US-imposed sanctions on Cuba had restricted access to
14 basic medical supplies including syringes and masks, medicines, vaccines, and food¹⁵; and

15
16 Whereas, In 2019, Human Rights Watch documented shortages of antiepileptic drugs and
17 chemotherapy medications in Iran and concluded that due to US economic sanctions, “Iranians’
18 access to essential medicine and their right to health is being negatively impacted, threatening
19 the health of millions of Iranians”^{12,16}; and

20
21 Whereas, Journals including *JAMA* and the *New England Journal of Medicine* continued to
22 publish papers authored by Iranian scientists, while overcompliance with US-imposed sanctions
23 led the editors of several other journals to reject them, with one stating that “US owned journals
24 are unable to handle scientific manuscripts which are authored by Iranian scientists, employed
25 by the Government of Iran”¹⁷; and

26
27 Whereas, A 2018 systematic review of 55 papers found that US-led economic sanctions on Iran
28 led to an increase in inflation and unemployment, a devaluation of the nation’s currency, scarcity
29 of lifesaving medicines, with impacts disproportionately affecting Iranians who were poor, ill,
30 women, and children and found no positive effect from existing “humanitarian exemptions”¹⁸;
31 and

32
33 Whereas, Comprehensive economic sanctions on Syria, first imposed in 1985 and strengthened
34 in the past decade, have contributed to a breakdown in its healthcare system, including
35 shutdowns of MRI, CT, and dialysis machines as healthcare facilities are unable to import spare
36 parts to maintain these machines or license software to run them¹⁹; and

37
38 Whereas, Economic sanctions also drive up healthcare costs, as hospitals must assemble multi-
39 national legal teams to navigate EU and US sanctions exemption applications¹⁹; and

40
41 Whereas, US- and EU-led economic sanctions on Syria have contributed to devaluation of the
42 Syrian currency, shortages of fuel, electricity, and medicines, water, a drop in agricultural and
43 pharmaceutical output, along with an inability to test, track, treat, or vaccinate against COVID-
44 19²⁰; and

45
46 Whereas, Twenty-three million Afghans face famine in 2022, with aid efforts hampered by US
47 sanctions imposed after the fall of the Afghan government in 2021²¹; and

48
49 Whereas, Thirteen thousand Afghan children died of malnutrition in the first ten weeks of 2022,
50 as sanctions caused a collapse of the banking sector and foreign banks are reluctant to transfer
51 aid money into the country for fear of triggering secondary sanctions²²; and

1 Whereas, In February 2022, the Biden administration announced it would relax some sanctions
2 on Afghanistan, including allowing half of the Afghan Central Bank’s assets in the US to be used
3 to pay for humanitarian purchases such as food and medicine, while continuing to freeze the
4 other half, in a move that was described as “aiming to make it harder to blame the US
5 government’s sanctions for the unfolding economic disaster in Afghanistan”²³; and
6

7 Whereas, Freezing the Afghan Central Bank’s reserves has contributed to a crash in the Afghan
8 currency’s value, leading to a rise in food prices over 40% since the previous year²⁴; and
9

10 Whereas, In its 2019 report, Human Rights Watch recommended that Congress request a study
11 on the humanitarian impact of economic sanctions¹²; and
12

13 Whereas, The United Nation’s (UN) Committee on Economic, Social, and Cultural Rights states
14 that nations that impose economic sanctions must take steps to respond to any disproportionate
15 suffering experienced by vulnerable groups within the targeted country²⁵; and
16

17 Whereas, The UN’s Office of the High Commissioner for Human Rights has found that unilateral
18 economic sanctions disproportionately harm women, children, and marginalized groups, and
19 that US-imposed sanctions are hindering reconstruction in war-torn nations, calling for lifting or
20 minimizing these sanctions^{26,27}; and
21

22 Whereas, The World Medical Association “urges national medical associations to ensure that
23 Governments employing economic sanctions against other States respect the agreed
24 exemptions for medicines, medical supplies, and basic food items”²⁸; and
25

26 Whereas, Lawmakers in the US have called for a report on the humanitarian impact of
27 sanctions, most recently through a February 2022 letter signed by over twenty members of
28 Congress^{29,30}; and
29

30 Whereas, Our AMA supports medical access in countries in turmoil (H-65.994), and broadly
31 urges all parties to minimize the health costs of war on civilian populations (D-65.993), it does
32 not have policy discussing the harmful health costs of economic sanctions; therefore be it
33

34 RESOLVED, That our American Medical Association recognize that economic sanctions can
35 negatively impact health and exacerbate humanitarian crises (New HOD Policy); and be it
36 further
37

38 RESOLVED, That our AMA support legislative and regulatory efforts to study the humanitarian
39 impact of economic sanctions imposed by the United States. (New HOD Policy)

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

Received: 09/20/22

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RELEVANT AMA POLICY

Medical Care in Countries in Turmoil H-65.994

The AMA (1) supports the provision of food, medicine and medical equipment to noncombatants threatened by natural disaster or military conflict within their country through appropriate relief organizations; (2) expresses its concern about the disappearance of physicians, medical students and other health care professionals, with resulting inadequate care to the sick and injured of countries in turmoil; (3) urges appropriate organizations to transmit these concerns to the affected country's government; and (4) asks appropriate international health organizations to monitor the status of medical care, medical education and treatment of medical personnel in

these countries, to inform the world health community of their findings, and to encourage efforts to ameliorate these problems.

Sub. Res. 133, A-83, Reaffirmed: CLRPD Rep. 1, I-93, Reaffirmed: CLRPD Rep. 1, A-05, Reaffirmed: CEJA Rep. 5, A-15

War Crimes as a Threat to Physicians' Humanitarian Responsibilities D-65.993

Our American Medical Association will (1) implore all parties at all times to understand and minimize the health costs of war on civilian populations generally and the adverse effects of physician persecution in particular, (2) support the efforts of physicians around the world to practice medicine ethically in any and all circumstances, including during wartime or episodes of civil strife, and condemn the military targeting of health care facilities and personnel and using denial of medical services as a weapon of war, by any party, wherever and whenever it occurs, and (3) advocate for the protection of physicians' rights to provide ethical care without fear of persecution.

BOT Action in response to referred for decision Res. 620, A-09, Modified: BOT Rep. 09, A-19

Promoting Equitable Resource Distribution Globally in Response to the COVID-19 Pandemic D-440.917

1. Our AMA will, in an effort to improve public health and national stability, explore possible assistance through the COVID-19 Vaccines Global Access (COVAX) initiative co-led by the World Health Organization, Gavi, and the Coalition for Epidemic Preparedness Innovations, as well as all other relevant organizations, for residents of countries with limited financial or technological resources.

2. Our AMA will work with governmental and appropriate regulatory bodies to encourage prioritization of equity when providing COVID-19 pandemic-related resources, such as diagnostics, low cost or free medications, therapeutics, vaccines, raw materials for vaccine production, personal protective equipment, and/or financial support.

3. Our AMA recognizes the extraordinary efforts of many dedicated physicians, physician and ethnic organizations assisting in this humanitarian COVID-19 pandemic crisis.

4. Our AMA will support World Health Organization (WHO) efforts and initiatives to increase production and distribution of therapeutics and vaccines necessary to combat COVID-19 and future pandemics in order to provide vaccine doses to low- and middle-income countries with limited access, including: (a) a temporary waiver of the Trade Related Aspects of Intellectual Property (TRIPS) agreement and other relevant intellectual property protections; (b) technological transfers relevant for vaccine production; (c) other support, financial and otherwise, necessary to scale up global vaccine manufacturing; and (d) measures that ensure the safety and efficacy of products manufactured by such means.

Res. 608, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 007
(1-22)

Introduced by: International Medical Graduates Section

Subject: Consent for Sexual and Reproductive Healthcare

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, The ability of minors to provide consent for health care services including sexual and
2 reproductive health care, mental health care has expanded over the past decades; and
3
4 Whereas, Involving parents or guardians in the decision of children and adolescent health care
5 is desirable, many young people will not seek important services if they are forced to involve
6 their parents/guardian. The sexual and reproductive health care services is one of those
7 services; and
8
9 Whereas, Twenty-three states and the District of Columbia have laws that explicitly give minors
10 the authority to consent to contraceptive services. Nineteen states allow only certain categories
11 of people younger than eighteen to consent to contraceptive services; and
12
13 Whereas, Twenty-seven states and the District of Columbia specifically allow pregnant minors
14 to obtain prenatal care and delivery services without parental consent or notification; and
15
16 Whereas, There are some states which allow specific minors such as those who are married,
17 pregnant, or already parents, and high school graduates to consent for oral contraception;
18 therefore be it
19
20 RESOLVED, That our American Medical Association work with state and county medical
21 societies to advocate for legislation and legal protections: 1) allowing minors (age 12 or above)
22 to consent for sexual and reproductive health care; 2) allowing minors to consent for prenatal
23 care and delivery services; and 3) protecting physician autonomy to provide sexual and
24 reproductive health care with minor consent, without parental consent. (Directive to Take Action)

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

Received: 09/27/22

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RELEVANT AMA POLICY

Health Care Rights of Pregnant Minors H-60.907

Our AMA will: (1) work with appropriate stakeholders to support legislation allowing pregnant minors to consent to related tests and procedures from the prenatal stage through postpartum care; and (2) oppose any law or policy that prohibits a pregnant minor from consenting to prenatal and other pregnancy related care, including, but not limited to, prenatal genetic testing, epidural block, pain management, Cesarean section, diagnostic imaging, procedures, and emergency care. (Resolution 008, A-18)

Opinion 2.2.2 Confidential Health Care for Minors

Physicians who treat minors have an ethical duty to promote the developing autonomy of minor patients by involving children in making decisions about their health care to a degree commensurate with the child's abilities. A minor's decision-making capacity depends on many factors, including not only chronological age, but also emotional maturity and the individual's medical experience. Physicians also have a responsibility to protect the confidentiality of minor patients, within certain limits.

In some jurisdictions, the law permits minors who are not emancipated to request and receive confidential services relating to contraception, or to pregnancy testing, prenatal care, and delivery services. Similarly, jurisdictions may permit unemancipated minors to request and receive confidential care to prevent, diagnose, or treat sexually transmitted disease, substance use disorders, or mental illness.

When an unemancipated minor requests confidential care and the law does not grant the minor decisionmaking authority for that care, physicians should:

(a) Inform the patient (and parent or guardian, if present) about circumstances in which the physician is obligated to inform the minor's parent/guardian, including situations when:

(i) involving the patient's parent/guardian is necessary to avert life- or health- threatening harm to the patient;

(ii) involving the patient's parent/guardian is necessary to avert serious harm to others;

(iii) the threat to the patient's health is significant and the physician has no reason to believe that parental involvement will be detrimental to the patient's well- being.

(b) Explore the minor patient's reasons for not involving his or her parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve parents.

(c) Encourage the minor patient to involve his or her parents and offer to facilitate conversation between the patient and the parents.

(d) Inform the patient that despite the physician's respect for confidentiality the minor patient's parents/guardians may learn about the request for treatment or testing through other means (e.g., insurance statements).

(e) Protect the confidentiality of information disclosed by the patient during an exam or interview or in counseling unless the patient consents to disclosure or disclosure is required to protect the interests of others, in keeping with ethical and legal guidelines.

(f) Take steps to facilitate a minor patient's decision about health care services when the patient remains unwilling to involve parents or guardians, so long as the patient has appropriate decision-making capacity in the specific circumstances and the physician believes the decision is in the patient's best interest. Physicians should be aware that states provide mechanisms for unemancipated minors to receive care without parental involvement under conditions that vary from state to state.

(g) Consult experts when the patient's decision-making capacity is uncertain.

(h) Inform or refer the patient to alternative confidential services when available if the physician is unwilling to provide services without parental involvement.

AMA Principles of Medical Ethics: 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: 008
(I-22)

Introduced by: Colorado

Subject: Support for Physicians Practicing Evidence-Based Medicine in a
Post Dobbs Era

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, In some states, physicians may face criminal penalties for providing medical
2 treatments that are the standard of care according to multiple professional organizations; and
3

4 Whereas, The failure to provide standard of care when requested by a patient and agreed to by
5 the physician violates professional legal obligations as well as primary principles of medical
6 ethics including beneficence, non-maleficence and patient autonomy; and
7

8 Whereas, Being precluded from providing quality care due to fear of legal prosecution creates
9 moral injury to the physician who would otherwise offer that care; and
10

11 Whereas, Some state laws are putting physicians in the untenable position wherein withholding
12 appropriate care that results in harm to a patient puts physicians at risk for civil liability, while
13 providing that care may expose them to state criminal sanctions; and
14

15 Whereas, The AMA Code of Ethics states that “In some cases, the law mandates conduct that
16 is ethically unacceptable. When physicians believe a law violates ethical values or is unjust,
17 they should work to change the law. In exceptional circumstances of unjust laws, ethical
18 responsibilities should supersede legal duties.”; and
19

20 Whereas, Recent commentary has encouraged professional civil disobedience reflecting “a
21 professional group’s deciding together, after frank and rational debate, to support disobedience
22 of an unjust law [which] might eventually reinforce social cohesion, elevate trust in the
23 profession, and help communities avoid tragic errors.”¹; and
24

25 Whereas, The US Supreme Court overturned Roe v Wade in June 2022, and now each state’s
26 legislature will decide if and when its citizens will have legal access to abortion care and if and
27 when its physicians will be criminalized for providing what is considered to be the standard of
28 care by multiple health-related organizations. This extraordinary change in the medico-legal
29 landscape requires reevaluation of health profession codes of ethics related to clinician
30 conscience. These codes must now be expanded to address affirmative protection for
31 “conscientious provision” in hostile environments on par with protection of conscientious
32 refusal.²; therefore be it
33

34 RESOLVED, That our American Medical Association Task Force developed under HOD Policy
35 G-605.009, “Establishing A Task Force to Preserve the Patient-Physician Relationship When
36 Evidence-Based, Appropriate Care Is Banned or Restricted,” provide policy and strategies to
37 support physicians individually and through their medical organizations when they are required
38 by medical and ethical standards of care to act against state and federal laws (Directive to Take
39 Action); and be it further

1 RESOLVED, That our AMA work to provide support, including legal support through the AMA
2 Litigation Center, as may be appropriate, to physicians that are targeted for practicing in
3 accordance with accepted standards of medical care and medical ethics in the face of legal
4 constraint or any other disciplinary action (Directive to Take Action); and be it further
5

6 RESOLVED, That our AMA advocate for affirmative protections for “conscientious provision” of
7 care in accordance with accepted standards of medical care and medical ethics in hostile
8 environments on par with protection of “conscientious objection.” (Directive to Take Action)

Fiscal Note: Estimated cost of \$58,000 to implement this resolution.

Received: 09/30/22

1. Wynia, MK, Professional Civil Disobedience — Medical-Society Responsibilities after Dobbs, NEJM, 387;11, 9/15/2022, pp 955-961.
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RELEVANT AMA POLICY

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: 009
(1-22)

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: 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

- 1 Whereas, Transgender and gender-diverse individuals experience several challenges in
2 accessing appropriate health care, including gatekeeping and difficulty with insurance coverage;
3 and
4
5 Whereas, Providing gender-affirming care is a medical necessity as determined by the World
6 Professional Association for Transgender Health and supported by the American Medical
7 Association, the American Academy of Family Physicians, the American Academy of Pediatrics,
8 and several other medical organizations; and
9
10 Whereas, Gender-affirming health care improves quality of life, mental health, and overall well-
11 being in gender-diverse people; and
12
13 Whereas, Currently, under the mainstream diagnostic model for transgender health, to be
14 deemed eligible for gender transition services, transgender clients must meet criteria for a
15 diagnosis of “gender dysphoria” as described in the DSM-5; and
16
17 Whereas, An alternative to that diagnostic model for transgender health is the informed consent
18 model, which allows for clients who are transgender to access hormone treatments and surgical
19 interventions without undergoing mental health evaluation or referral from a mental health
20 specialist; therefore be it
21
22 RESOLVED, That our American Medical Association advocate and encourage the adoption of
23 an informed consent model when determining coverage for transgender health care services.
24 (Directive to Take Action)

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

Received: 10/10/22

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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

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

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

6
7 Whereas, Opinion 1.1.1 in the AMA Code of Medical Ethics supports shared decision making
8 between patient and physician in order to help patients make informed decisions about their
9 health care; therefore be it

10
11 RESOLVED, That our American Medical Association encourage hospitals that can provide
12 basic maternal care as defined by the American College of Obstetrics and Gynecology not to
13 prohibit trial of labor after cesarean (TOLAC) (New HOD Policy); and be it further

14
15 RESOLVED, That our AMA encourage hospitals that do not have resources to perform TOLAC
16 to assist in the transfer of care of patients who desire TOLAC to a hospital that is equipped to
17 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: 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

Reference Committee B

Resolution(s)

- 201 Physician Reimbursement for Interpreter Services
- 202 Advocating for State GME Funding
- 203 International Medical Graduate Employment
- 205 Waiver of Due Process Clauses
- 206 The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training
- 207 Preserving Physician Leadership in Patient Care
- 208 Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals
- 209 Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training
- 211 Illicit Drug Use Harm Reduction Strategies
- 213 Hazard Pay During a Disaster Emergency
- 214 Universal Good Samaritan Statute
- 215 Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies
- 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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(I-22)

Introduced by: American Association of Clinical Urologists, American Urological Association

Subject: Physician Reimbursement for Interpreter Services

Referred to: Reference Committee B

1 Whereas, CMS Report 07, JUN 21, reaffirms Policy D-385.957 which advocates for legislative
2 and/or regulatory changes to require that payers including Medicaid programs and Medicaid
3 managed care plans cover interpreter services and directly pay interpreters for such services;
4 and

5
6 Whereas, Antidiscrimination provisions in federal law require health programs and clinicians
7 receiving federal financial assistance to take reasonable steps to provide meaningful access to
8 individuals with limited English proficiency (LEP) who are likely to be encountered in their
9 medical practice; and

10
11 Whereas, The cost of interpreter services can be considerable ranging up to \$150.00/hour
12 which often is charged to the physician without any reimbursement; and

13
14 Whereas, Many physicians serve communities with patients who have LEP; and

15
16 Whereas, The use of qualified interpreters has shown to result in better and more efficient
17 patient care for those patients with LEP; therefore be it

18
19 RESOLVED, That our American Medical Association prioritize physician reimbursement for
20 interpreter services and advocate for legislative and/or regulatory changes to federal health care
21 programs such as Medicare, Medicare Advantage plans, Tricare, Veterans Administration, etc.,
22 for payment for such services (Directive to Take Action); and be it further

23
24 RESOLVED, That our AMA develop model state legislation for physician reimbursement for
25 interpreter services for commercial health plans, worker compensation plans, Medicaid,
26 Medicaid managed care plans, etc., for payment for such services. (Directive to Take Action)

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

Received: 08/04/22

Reference:
Jacobs,B. et.al, (Ann Fam Med, 2018 Jan; 16(1): 70-76). Medical Interpreters in Outpatient Practice.

RELEVANT AMA POLICY

Certified Translation and Interpreter Services D-385.957

Our AMA will: (1) work to relieve the burden of the costs associated with translation services implemented under Section 1557 of the Affordable Care Act; and (2) advocate for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services, with a progress report at the 2017 Interim Meeting of the AMA House of Delegates.

Citation: Res. 703, A-17; Reaffirmed: CMS Rep. 7, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(1-22)

Introduced by: Young Physicians Section
Subject: Advocating for State GME Funding
Referred to: Reference Committee B

1 Whereas, “The number of Medicare-funded graduate medical education (GME) positions has
2 been capped at 1996 levels, and there is little political will for increasing Medicare’s contribution
3 to GME”;¹ and
4

5 Whereas, Our “AMA has long been an advocate for preservation and expansion of GME funding
6 to mitigate projected physician shortages and ensure that positions are available for medical
7 school graduates applying to residency programs;”^{2,3} and
8

9 Whereas, In some states, state legislatures have funded several graduate medical education
10 positions; and
11

12 Whereas, For example, the Commonwealth of Virginia has been funding 25 new residency slots
13 (the “majority of which must be in primary care,” and “encouraging applications from programs
14 that offer the opportunity to train in underserved areas”) since 2018;⁴⁻⁵ and
15

16 Whereas, Information about these state-funded GME positions⁶⁻⁹ is not easy to find online; and
17

18 Whereas, There have been some news reports about how some state budgets are flush with
19 cash these days;¹⁰ therefore be it
20

21 **RESOLVED**, That our American Medical Association publicize best practice examples of state-
22 funded Graduate Medical Education positions and develop model state legislation where
23 appropriate. (Directive to Take Action)

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

Received: 08/19/22

References:

1. AMA Council on Medical Education Report 1 (I-15) on “Sources of Funding for Graduate Medical Education,” at <<https://www.ama-assn.org/system/files/2021-06/i15-cme-01.pdf>>. Accessed 30 April 2022.
2. AMA Council on Medical Education Report 6-I-19 on “Veterans Health Administration Funding of Graduate Medical Education,” at <<https://www.ama-assn.org/system/files/2020-04/cme-report-6-i19-annotated.pdf>>. Accessed 30 April 2022.
3. Heisler EJ, Mendez BHP, Mitchell A, Panangala SV, Villagrana MA. 2018. Federal Support for Graduate Medical Education: An Overview. (CRS Report No. R44376) Retrieved from Congressional Research Service website: <https://crsreports.congress.gov/product/pdf/R/R44376>. Accessed 30 April 2022.
4. “Virginia med students, residents help open 25 more GME spots,” 5/24/17 at <<https://www.ama-assn.org/education/gme-funding/virginia-med-students-residents-help-open-25-more-gme-spots>>
5. “Graduate Medical Education” at the Virginia Medicaid Dept of Medical Assistance Services (DMAS), at <<https://www.dmas.virginia.gov/for-providers/rates-and-rate-setting/graduate-medical-education/>>
6. 303#31s (DMAS) Graduate Medical Education Residency Slots. SB30 - Member Request (virginia.gov), at <<https://budget.lis.virginia.gov/amendment/2018/1/SB30/Introduced/MR/303/31s/>>
7. 303#14h (DMAS) Allow Supplemental Funding for UVA Medical Center and VCU Health System. HB30 - Committee Approved (virginia.gov), at <<https://budget.lis.virginia.gov/amendment/2018/1/HB30/Introduced/CA/303/14h/>>
8. 303#14s (DMAS) Graduate Medical Education Residency Slots. SB30 - Committee Approved (virginia.gov), at <<https://budget.lis.virginia.gov/amendment/2018/1/SB30/Introduced/CA/303/14s/>>

9. 313#21c (DMAS) Fully Fund Medicaid Graduate Medical Education Residency Slots. HB30 - Conference Report (virginia.gov), at <https://budget.lis.virginia.gov/amendment/2020/1/HB30/Introduced/CR/313/21c/>
10. California's budget surplus has exploded to \$68B - POLITICO, at <https://www.politico.com/news/2022/04/28/californias-budget-surplus-has-exploded-to-68b-00028680>
11. savegme.org

RELEVANT AMA POLICY

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).
4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.

15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.
20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.
21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.
22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.
23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.
24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.
25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.
26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.
27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.
28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.
29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.
30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.
31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten

years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep. 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19; Reaffirmed: CME Rep. 3, A-21

Proposed Revisions to AMA Policy on the Financing of Medical Education Programs H-305.929

1. It is AMA policy that:

- A. Since quality medical education directly benefits the American people, there should be public support for medical schools and graduate medical education programs and for the teaching institutions in which medical education occurs. Such support is required to ensure that there is a continuing supply of well-educated, competent physicians to care for the American public.
- B. Planning to modify health system organization or financing should include consideration of the effects on medical education, with the goal of preserving and enhancing the quality of medical education and the quality of and access to care in teaching institutions are preserved.
- C. Adequate and stable funding should be available to support quality undergraduate and graduate medical education programs. Our AMA and the federation should advocate for medical education funding.
- D. Diversified sources of funding should be available to support medical schools' multiple missions, including education, research, and clinical service. Reliance on any particular revenue source should not jeopardize the balance among a medical school's missions.
- E. All payers for health care, including the federal government, the states, and private payers, benefit from graduate medical education and should directly contribute to its funding.
- F. Full Medicare direct medical education funding should be available for the number of years required for initial board certification. For combined residency programs, funding should be available for the longest of the individual programs plus one additional year. There should be opportunities to extend the period of full funding for specialties or subspecialties where there is a documented need, including a physician shortage.
- G. Medical schools should develop systems to explicitly document and reimburse faculty teaching activity, so as to facilitate faculty participation in medical student and resident physician education and training.
- H. Funding for graduate medical education should support the training of resident physicians in both hospital and non-hospital (ambulatory) settings. Federal and state funding formulas must take into account the resources, including volunteer faculty time and practice expenses, needed for training residents in all specialties in non-hospital, ambulatory settings. Funding for GME should be allocated to the sites where teaching occurs.

1. New funding should be available to support increases in the number of medical school and residency training positions, preferably in or adjacent to physician shortage/underserved areas and in undersupplied specialties.
 2. Our AMA endorses the following principles of social accountability and promotes their application to GME funding: (a) Adequate and diverse workforce development; (b) Primary care and specialty practice workforce distribution; (c) Geographic workforce distribution; and (d) Service to the local community and the public at large.
 3. Our AMA encourages transparency of GME funding through models that are both feasible and fair for training sites, affiliated medical schools and trainees.
 4. Our AMA believes that financial transparency is essential to the sustainable future of GME funding and therefore, regardless of the method or source of payment for GME or the number of funding streams, institutions should publically report the aggregate value of GME payments received as well as what these payments are used for, including: (a) Resident salary and benefits; (b) Administrative support for graduate medical education; (c) Salary reimbursement for teaching staff; (d) Direct educational costs for residents and fellows; and (e) Institutional overhead.
 5. Our AMA supports specialty-specific enhancements to GME funding that neither directly nor indirectly reduce funding levels for any other specialty.
- Citation: CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmed: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmation A-11; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13; Appended: CME 05, A-16; Appended: Res. 319, A-16; Reaffirmation A-16

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-22)

Introduced by: Missouri

Subject: International Medical Graduate Employment

Referred to: Reference Committee B

- 1 Whereas, International Medical Graduates (IMGs) play a vital role in Missouri's health care
2 system; and
3
4 Whereas, IMGs provide medical care to a disproportionately higher number of patients in
5 underserved communities; and
6
7 Whereas, IMGs provide medical care to a disproportionately higher number of patients using
8 Medicaid (including those dually eligible for Medicare and Medicaid) or SCHIP as their primary
9 payment source; and
10
11 Whereas, Patients of IMGs are more likely to live in lower median income and incomes below
12 federal poverty level neighborhoods; and
13
14 Whereas, The number of IMGs serving in medically underserved areas has declined during the
15 last decade; and
16
17 Whereas, The process to recruit IMGs on visas is too onerous, especially for small independent
18 physician practices; therefore be it
19
20 RESOLVED, That our American Medical Association support federal legislation that reduces the
21 paperwork burden on hiring of International Medical Graduates in rural communities. (New HOD
22 Policy)

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

Received: 09/07/22

The topic of this resolution is currently under study by the Council on Medical Education.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(I-22)

Introduced by: Missouri
Subject: Waiver of Due Process Clauses
Referred to: Reference Committee B

1 Whereas, Due process is a fundamental right of employment and due process protections are
2 essential to allow healthcare workers to act in the best interest of their patients and co-workers;
3 and
4
5 Whereas, When due process is waived by an employee, that employee’s power to advocate for
6 their patients and co-workers is constrained by a reasonable fear of loss of employment; and
7
8 Whereas, Some healthcare employers insert “Waiver of Due Process” clauses into the
9 employment contracts; and
10
11 Whereas, It is in the interest of society for healthcare workers to be able to freely raise patient
12 and healthcare worker safety concerns; and
13
14 Whereas, Federal legislation proposing to ban “Waiver of Due Process” provisions in health
15 care worker employment contracts was introduced in the 116th Congress of the United States of
16 America, the “ER Hero and Patient Safety Act”, also known as HR 6910; therefore be it
17
18 RESOLVED, That our American Medical Association support legislation that bans the use of
19 “Waiver of Due Process” provisions within employment contracts and declares such current
20 provisions to be declared void. (New HOD Policy)

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

Received: 09/07/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(1-22)

Introduced by: Resident and Fellow Section

Subject: The Shortage of Bedside Nurses and Intersection with Concerns in Nurse Practitioner Training

Referred to: Reference Committee B

- 1 Whereas, There are nearly three million registered nurses (RNs) in the United States, making
2 up three times the number of doctors in healthcare¹; and
3
4 Whereas, The shortage of bedside nurses is not a new phenomenon. Over the last century, the
5 nursing student supply has transitioned from ample to scarce²; and
6
7 Whereas, The COVID-19 pandemic exacerbated the issue and resulted in many RNs retiring or
8 quitting, moving into non-direct care roles, returning to school for advanced degrees, or leaving
9 the profession to pursue other career paths. Major motivating factors were insufficient staffing,
10 unmanageable workloads, and emotional toll³; and
11
12 Whereas, Despite efforts for improvement, the shortage has persisted, and with it have come
13 consequences for nurses and their patients; therefore be it
14
15 RESOLVED, That our American Medical Association study, and encourage relevant advocacy
16 organizations to study, the links between the bedside nursing shortage, expansion of nurse
17 practitioner programs, and the impact of this connection on patient health outcomes (Directive to
18 Take Action); and be it further
19
20 RESOLVED, That our AMA reaffirm existing policies H-160.947, "Physician Assistants and
21 Nurse Practitioners," and H-35.996, "Status and Utilization of New or Expanding Health
22 Professionals in Hospitals." (Reaffirm HOD Policy)

Fiscal Note: Estimated cost of 53K to implement resolution.

Received: 09/14/22

REFERENCES:

1. Bakhamis L, Paul DP 3rd, Smith H, Coustasse A. Still an Epidemic: The Burnout Syndrome in Hospital Registered Nurses. *Health Care Manag (Frederick)*. 2019 Jan/Mar;38(1):3-10.
2. Abdellah FG. The nursing shortage: dynamics and solutions. *Reflections on a recurring theme. Nurs Clin North Am*. 1990 Sep;25(3):509-16.
3. Hansen A, Tuttas C. Professional Choice 2020-2021: Travel Nursing Turns the Tide. *Nurse Lead*. 2022 Feb 9. doi: 10.1016/j.mnl.2021.12.018. Epub ahead of print.

RELEVANT AMA POLICY

Physician Assistants and Nurse Practitioners H-160.947

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

- (1) The physician is responsible for managing the health care of patients in all settings.
- (2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.
- (3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.
- (4) The physician is responsible for the supervision of the physician assistant in all settings.
- (5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.
- (6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.
- (7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.
- (8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.
- (9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.
- (10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.

Citation: BOT Rep. 6, A-95; Reaffirmed: Res 240 and Reaffirmation A-00; Reaffirmed: Res. 213, A-02; Modified: CLRPD Rep. 1, A-03; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed: Joint CME-CMS Rep., I-12; Reaffirmed: BOT Rep. 16, A-13

Status and Utilization of New or Expanding Health Professionals in Hospitals H-35.996

(1) The services of certain new health professionals, as well as those professionals assuming an expanded medical service role, may be made available for patient care within the limits of their skills and the scope of their authorized practice. The occupations concerned are those whose patient care activities involve medical diagnosis and treatment to such an extent that they meet the three criteria specified below: (a) As authorized by the medical staff, they function in a newly expanded medical support role to the physician in the provision of patient care. (b) They participate in the management of patients under the direct supervision or direction of a member of the medical staff who is responsible for the patient's care. (c) They make entries on patients' records, including progress notes, only to the extent established by the medical staff. Thus this statement covers regulation of such categories as the new physician-support occupations generically termed physician assistants, nurse practitioners, and those allied health professionals functioning in an expanded medical support role.

(2) The hospital governing authority should depend primarily on the medical staff to recommend the extent of functions which may be delegated to, and services which may be provided by, members of these emerging or expanding health professions. To carry out this obligation, the following procedures should be established in medical staff bylaws: (a) Application for use of such professionals by medical staff members must be processed through the credentials committee or other medical staff channels in the same manner as applications for medical staff membership and privileges. (b) The functions delegated to and the services provided by such personnel should be considered and specified by the medical staff in each instance, and should be based upon the individual's professional training, experience, and demonstrated competency, and upon the physician's capability and competence to supervise such an assistant. (c) In those cases involving use by the physician of established health professionals functioning in an expanded medical support role, the organized medical staff should work closely with members of the appropriate discipline now employed in an administrative capacity by the hospital (for example, the director of nursing services) in delineating such functions.

Citation: BOT Rep. G, A-73 Reaffirmed: CLRPD Rep. C, A-89 Reaffirmed: Sunset Report, A-00 Modified: CMS Rep. 6, A-10 Reaffirmation A-12 Reaffirmed: CMS Rep. 1, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(I-22)

Introduced by: Resident and Fellow Section

Subject: Preserving Physician Leadership in Patient Care

Referred to: Reference Committee B

1 Whereas, The term “provider” has become a nationally accepted term; however, its origins and
2 impact are rarely discussed; and
3

4 Whereas, What began as a word to distinguish physicians quickly broadened into a term
5 describing a wide variety of healthcare workers, from medical doctors to clinical social workers,
6 and such a broad term can be misleading and confusing to patients since the term gives no
7 identifying information regarding role or training level; and
8

9 Whereas, As the roles of midlevel providers continue to grow, it is more important than ever to
10 distinguish physicians from other “providers” and protect the physician-patient relationship; and
11

12 Whereas, The AMA, AAFP, and other physician advocacy groups have policy explicitly rejecting
13 the use of an overarching term such as “provider” that equates the training of physicians with
14 that of non-physician clinicians;¹ therefore be it
15

16 RESOLVED, That our American Medical Association create a national targeted ad campaign to
17 educate the public about the training pathway of physicians compared to non-physician
18 providers (Directive to Take Action); and be it further
19

20 RESOLVED, That our AMA reaffirm our opposition to physicians being referred to as “providers”
21 in healthcare settings (New HOD Policy); and be it further
22

23 RESOLVED, That our AMA conduct a review of the AMA policy compendium and replace
24 conflicting policies referring to physicians as “providers” with the term “physician” when
25 appropriate and report back at the 2023 Annual Meeting. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is \$255,000

Received: 09/14/22

REFERENCES

1. American Academy of Family Physicians. "NON-PHYSICIAN PROVIDERS (NPPs) Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants." 2000-2001 AAFP Policies on Health Issues.

RELEVANT AMA POLICY

Clarification of the Term "Provider" in Advertising, Contracts and Other Communications H-405.968

1. Our AMA supports requiring that health care entities, when using the term "provider" in contracts, advertising and other communications, specify the type of provider being referred to by using the provider's recognized title which details education, training, license status and other recognized qualifications; and supports this concept in state and federal health system reform.

2. Our AMA: (a) considers the generic terms "health care providers" or "providers" as inadequate to describe the extensive education and qualifications of physicians licensed to practice medicine in all its branches; (b) will institute an editorial policy prohibiting the use of the term "provider" in lieu of "physician" or other health professionals for all AMA publications not otherwise covered by the existing JAMA Editorial Governance Plan, which protects editorial independence of the Editor in Chief of JAMA and The JAMA Network journals; and (c) will forward to the editorial board of JAMA the recommendation that the term "physician" be used in lieu of "provider" when referring to MDs and DOs.

Citation: Sub. Res. 712, I-94; Reaffirmed: Res. 226, I-98; Reaffirmation I-99; Res. 605, A-09; Reaffirmed: CLRPD Rep. 1, A-09; Modified: Speakers Rep., A-15; Reaffirmed: BOT Rep. 09, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(I-22)

Introduced by: Resident and Fellow Section

Subject: Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction Metrics in Physicians v. Other Health Professionals

Referred to: Reference Committee B

1 Whereas, Our healthcare system has had a steady increase in the amount of physician
2 assistants (PAs) and nurse practitioners (NPs) assuming physician duties and responsibilities;
3 and
4
5 Whereas, PAs and NPs have also advocated successfully for increased pay as evidenced in
6 multiple state legislatures and even federal legislation; and
7
8 Whereas, Student debt of physicians is notoriously some of the highest in American education;
9 and
10
11 Whereas, PAs and NPs have access to the same programs as physicians which include public
12 service loan forgiveness, national health service corps, Indian health services loan repayment
13 program, armed forces, income-driven repayment, etc.^{1,2}; and
14
15 Whereas, A recent report on resident salary and debt found that 57% of resident physicians
16 were dissatisfied with their compensation, 81% felt that their compensation did not adequately
17 reflect the number of hours they worked, and 77% felt that their compensation was not
18 comparable to what physician's assistants, nurses, and other medical staff were paid³; and
19
20 Whereas, Today, burnout among physicians in training such as medical students and trainees
21 ranges from 50-70%; and
22
23 Whereas, Within nursing, burnout is discussed in terms of turnover rate at hospitals, as
24 registered nurses (RN) turnover rate ranges between 20-30%⁴; and
25
26 Whereas, Among nurse practitioners, 25% of those in primary care environments have
27 experienced burnout⁵; and
28
29 Whereas, Current research on burnout indirectly being used to measure work-life balance does
30 not account for differences among individuals, especially those with varying socioeconomic,
31 racial and/or sexual minoritized backgrounds; therefore be it
32
33 RESOLVED, That our American Medical Association's advocacy efforts be informed by the fact
34 that student debt burden is higher for physicians when compared to physician assistants and
35 nurse practitioners (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA work with relevant stakeholders to study: (a) how total career
2 earnings of physicians compare to those physician assistants and nurse practitioners in order to
3 specifically discern if there is a financial disincentive to becoming a physician, considering the
4 relatively high student debt burden and work hours of physicians; (b) if resident physicians
5 provide a net financial benefit for hospitals and healthcare institutions; (c) best practices for
6 increasing resident physician compensation so that their services may be more equitably
7 reflected in their earnings; and (d) burnout metrics using a standardized system to compare
8 differences among physicians, physician assistants and nurse practitioners (Directive to Take
9 Action); and be it further
10
11 RESOLVED, That our AMA recognize that burnout-centered metrics do not fully characterize
12 work-life balance, particularly for individuals with varying socioeconomic, racial and/or sexual
13 minoritized backgrounds (New HOD Policy); and be it further
14
15 RESOLVED, That our AMA seek to publish its findings in a peer-reviewed medical journal.
16 (Directive to Take Action)

Fiscal Note: Estimated cost of \$306K to implement this resolution.

Received: 09/14/22

REFERENCES

1. <https://students-residents.aamc.org/financial-aid-resources/postponing-loan-repayment-during-residency>
2. <https://www.aamc.org/news-insights/7-ways-reduce-medical-school-debt#:~:text=According%20to%20a%20recent%20AAMC,debt%20was%20%24200%2C000%20in%202019>
3. <https://www.medscape.com/slideshow/2021-residents-salary-debt-report-6014074#:~:text=As%20in%20previous%20years%2C%20average,making%20about%20the%20same%20salary>
4. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775923>
5. <https://pubmed.ncbi.nlm.nih.gov/34519700/>

RELEVANT AMA POLICY

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new policies and novel approaches to prevent debt from influencing specialty and subspecialty choice.

23. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21; Reaffirmation: A-22

Competency Based Medical Education Across the Continuum of Education and Practice D-295.317

1. Our AMA Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients. 2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation. 3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents' compensation and lifetime earnings.

Citation: CME Rep. 3, A-14; Appended: CME Rep. 04, A-16

Resident/Fellow Clinical and Educational Work Hours H-310.907

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training: 1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as "duty hours"). 2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents. 3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice. 4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities. 5. Our AMA encourages the ACGME to: a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation. b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits. c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules. d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours. 6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to: a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards. b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor. c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home. d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue. 7. Our AMA supports the following statements related to clinical and educational work hours: a) Total clinical and educational work hours must not exceed 80 hours per week, averaged

over a four-week period (Note: "Total clinical and educational work hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients). b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time. c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period." f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated. g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty. h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians. i) Scheduled time providing patient care services of limited or no educational value should be minimized. j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics. k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians. l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy. m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system. o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations. 8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety. 9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(I-22)

Introduced by: Resident and Fellow Section

Subject: Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training

Referred to: Reference Committee B

- 1 Whereas, Fully trained physicians are in shortage now and forecasted to be in shortage in the
2 future¹; and
3
4 Whereas, This shortage does not extend to all specialties and several specialties such as
5 Emergency Medicine² and Radiation Oncology³ are projected to be in oversupply; and
6
7 Whereas, No current body with direct regulatory oversight over residencies can act to allocate
8 and re-allocate funding and positions from fields projected to be in oversupply to fields in greater
9 shortage due to antitrust restrictions; and
10
11 Whereas, Almost all other countries allocate residency positions based to some extent on the
12 future workforce needs of the nation, instead of local factors; and
13
14 Whereas, The United States population could benefit greatly from available governmental
15 funding for first year categorical positions being allocated in ratio to the projected physician
16 workforce needs of the nation; and
17
18 Whereas, Many US allopathic and osteopathic medical school graduates cannot make the time
19 or location commitment to a residency program due to personal, financial, or other
20 commitments; therefore be it
21
22 RESOLVED, That our American Medical Association work with US Centers for Medicare and
23 Medicaid Services and other relevant stakeholders to create a commission to estimate future
24 physician workforce needs and suggest re-allocation of available residency funding and
25 available first-year positions accordingly (Directive to Take Action); and be it further
26
27 RESOLVED, That our AMA work with relevant stakeholders to study the possibility of alternative
28 pathways to ACGME certification of training, ABMS board certification, and medical practice for
29 unmatched medical school graduates. (Directive to Take Action)

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

Received: 09/14/22

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RELEVANT AMA POLICY

Securing Funding for Graduate Medical Education H-310.917

Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

Citation: CME Rep. 3, I-09; Modified: CME Rep. 15, A-10; Reaffirmed in lieu of Res. 324, A-12; Reaffirmed: CME Rep. 5, A-13; Appended: CME Rep. 1, I-15

Proposed Revisions to AMA Policy on the Financing of Medical Education Programs D-305.973

Our AMA will work with:

- (1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes:
 - (a) ensure adequate Medicaid and Medicare funding for graduate medical education;
 - (b) ensure adequate Disproportionate Share Hospital funding;
 - (c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions;
 - (d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings;
 - (e) stabilize funding for pediatric residency training in children's hospitals;
 - (f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need;
 - (g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and
 - (h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and
- (2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions.

Citation: (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: Res. 921, I-12; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13)

The Preservation, Stability and Expansion of Full Funding for Graduate Medical Education D-305.967

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and

other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

32. Our AMA will: (a) encourage all existing and planned allopathic and osteopathic medical schools to thoroughly research match statistics and other career placement metrics when developing career guidance plans; (b) strongly advocate for and work with legislators, private sector partnerships, and existing and planned osteopathic and allopathic medical schools to create and fund graduate medical education (GME) programs that can accommodate the equivalent number of additional medical school graduates consistent with the workforce needs of our nation; and (c) encourage the Liaison Committee on Medical Education (LCME), the Commission on Osteopathic College Accreditation (COCA), and other accrediting bodies, as part of accreditation of allopathic and osteopathic medical schools, to prospectively and retrospectively monitor medical school graduates' rates of placement into GME as well as GME completion.

33. Our AMA encourages the Secretary of the U.S. Department of Health and Human Services to coordinate with federal agencies that fund GME training to identify and collect information needed to effectively evaluate how hospitals, health systems, and health centers with residency programs are utilizing these financial resources to meet the nation's health care workforce needs. This includes information on payment amounts by the type of training programs supported, resident training costs and revenue generation, output or outcomes related to health workforce planning (i.e., percentage of primary

care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

Citation: Sub. Res. 314, A-07; Reaffirmation I-07; Reaffirmed: CME Rep. 4, I-08; Reaffirmed: Sub. Res. 314, A-09; Reaffirmed: CME Rep. 3, I-09; Reaffirmation A-11; Appended: Res. 910, I-11; Reaffirmed in lieu of Res. 303, A-12; Reaffirmed in lieu of Res. 324, A-12; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 320, A-13; Appended: CME Rep. 5, A-13; Appended: CME Rep. 7, A-14; Appended: Res. 304, A-14; Modified: CME Rep. 9, A-15; Appended: CME Rep. 1, I-15; Appended: Res. 902, I-15; Reaffirmed: CME Rep. 3, A-16; Appended: Res. 320, A-16; Appended: CME Rep. 04, A-16; Appended: CME Rep. 05, A-16; Reaffirmation A-16; Appended: Res. 323, A-17; Appended: CME Rep. 03, A-18; Appended: Res. 319, A-18; Reaffirmed in lieu of: Res. 960, I-18; Modified: Res. 233, A-19; Modified: BOT Rep. 25, A-19; Reaffirmed: CME Rep. 3, A-21

National Resident Matching Program Reform D-310.977

Our AMA:

- (1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;
- (2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
- (3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
- (4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;
- (5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
- (6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
- (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
- (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;
- (9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
- (10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
- (11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
- (12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
- (13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;

(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;

(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;

(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;

(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine;

(18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and

(19) will work with appropriate stakeholders to study options for improving transparency in the resident application process.

Citation: CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21; Modified: CME Rep. 1, A-22; Appended: Res. 328, A-22

Preliminary Year Program Placement H-310.910

1. Our AMA encourages the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.

2. Our AMA encourages appropriate stakeholders to explore options to decrease the burden upon medical students who must apply to separate preliminary PGY-1 and categorical PGY-2 positions.

3. Our AMA will work with the Accreditation Council for Graduate Medical Education to encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) with insufficient availability of local PGY-1 positions to create local PGY-1 positions that will enable coordinated applications and interviews for medical students.

4. Our AMA encourages the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, including barriers to “couples matching,” and to ensure that all applicants have access to robust, informative statistics to assist in decision-making.

5. Our AMA encourages the NRMP, San Francisco Match, American Urological Association, Electronic Residency Application Service, and other stakeholders to collect and publish data on a) the impact of separate matches on the personal and professional lives of medical students and b) the impact on medical students who are unable to successfully “couples match” with their significant others due to staggered entry into residency, utilization of unlinked match services, or other causes.

Citation: Res. 306, A-12; Appended: CME Rep. 03, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(I-22)

Introduced by: Resident and Fellow Section

Subject: Illicit Drug Use Harm Reduction Strategies

Referred to: Reference Committee B

1 Whereas, 2021 was the worst year on record for opioid overdoses in the US, with over 75,000
2 reported¹; and
3
4 Whereas, The involvement of synthetic opioids, including fentanyl, in drug overdoses across
5 America is rising drastically year after year, and was 11-fold higher in 2019 than 2013^{2,3}; and
6
7 Whereas, Fentanyl test strips are a point-of-care test that identifies fentanyl contamination in a
8 drug supply with a specificity of 87.5% and a sensitivity of 95.2%⁴; and
9
10 Whereas, Fentanyl test strips are readily available and as inexpensive as \$1 per test⁵; and
11
12 Whereas, In a survey of young adults who use drugs, 95% reported that they were willing to use
13 fentanyl test strips to identify fentanyl in their drug supply⁶; and
14
15 Whereas, A positive test with a fentanyl test strip has been shown to lead to modification of
16 behaviors in order to reduce risk of overdose^{7,8}; and
17
18 Whereas, Possession of fentanyl test strips is explicitly legal in only 22 states⁹; and
19
20 Whereas, Our AMA sent a federal correspondence denouncing laws that allow possessors of
21 fentanyl test strips to be subject to civil and/or criminal penalties; and
22
23 Whereas, Drug checking services can also serve as a point of contact with users of recreational
24 drugs for other harm reduction services and advice, and that accessibility to these resources
25 through drug checking services is overwhelmingly supported by the target market¹⁰; therefore
26 be it

1 RESOLVED, That our American Medical Association amend current policy D-95.987,
2 "Prevention of Drug-Related Overdose," by addition to read as follows:

3
4 4. Our AMA will advocate for and encourage state and county medical societies
5 to advocate for harm reduction policies that provide civil and criminal immunity
6 for the possession, distribution, and use of "drug paraphernalia" designed for
7 harm reduction from drug use, including but not limited to drug contamination
8 testing and injection drug preparation, use, and disposal supplies.

9
10 5. Our AMA will implement an education program for patients with substance use
11 disorder and their family/caregivers to increase understanding of the increased
12 risk of adverse outcomes associated with having a substance use disorder and a
13 serious respiratory illness such as COVID-19.

14
15 6. Our AMA supports efforts to increase access to fentanyl test strips and other
16 drug checking supplies for purposes of harm reduction. (Modify Current HOD
17 Policy)

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

Received: 09/14/22

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RELEVANT AMA POLICY

Prevention of Drug-Related Overdose D-95.987

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

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
 4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of "drug paraphernalia" designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
 5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.
- Citation: Res. 526, A-06 Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21; Appended: Res. 513, A-22

Increasing Availability of Naloxone H-95.932

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
 2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
 3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
 4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
 5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
 6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
 7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
 8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
 9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.
- Citation: BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19; Reaffirmed: BOT 09, I-19; Reaffirmed: Res. 219, A-21

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

Harmful Drug Use in the United States - Strategies for Prevention H-95.978

Our AMA: (1) Urges the Substance Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical strategies that are most effective in ameliorating risk factors.

(2) Urges the Center for Substance Abuse Prevention to continue to support community-based prevention strategies which include: (a) Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level. (b) Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of harmful drug and alcohol use prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction. (c) Development of innovative programs that train and involve parents, educators, physicians, and other community leaders in "state of the art" prevention approaches and skills.

(3) Urges major media programming and advertising agencies to encourage the development of more accurate and prevention-oriented messages about the effects of harmful drug and alcohol use.

- (4) Supports the development of advanced educational programs to produce qualified prevention specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial, and other special populations.
- (5) Supports investigating the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of prevention activities.
- (6) Urges federal, state, and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on prevention and eradication of harmful alcohol and drug use.

Citation: Res. 910, I-12

Reduction of Medical and Public Health Consequences of Drug Abuse: Update D-95.999

Our AMA encourages state medical societies to advocate for the expansion of and increased funding for needle and syringe-exchange programs and methadone maintenance and other opioid treatment services and programs in their states.

Citation: CSA Rep. 12, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(I-22)

Introduced by: New York

Subject: Hazard Pay During a Disaster Emergency

Referred to: Reference Committee B

1 Whereas, The US Labor Department defines Hazard Pay as “additional pay for performing a
2 hazardous duty or work involving physical hardship”; and
3

4 Whereas, A 25 percent hazard bonus is authorized for federal employees working directly with
5 or close to substances “of micro-organic nature which when introduced into the body are likely
6 to cause serious disease or fatality and for which protective devices do not afford complete
7 protection”; and
8

9 Whereas, This definition reflects the situation of physicians’ working in emergency departments,
10 intensive care units, and COVID wards; therefore be it
11

12 RESOLVED, That our American Medical Association work with the federation of medicine to
13 advocate for state or federal programs that would provide hazard pay bonuses to physicians
14 and other healthcare staff delivering care during a state or federal disaster emergency.
15 (Directive to Take Action)

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

Received: 09/20/22

RELEVANT AMA POLICY

AMA Leadership in the Medical Response to Terrorism and Other Disasters H-130.946

Our AMA: (1) Condemns terrorism in all its forms and provide leadership in coordinating efforts to improve the medical and public health response to terrorism and other disasters.

(2) Will work collaboratively with the Federation in the development, dissemination, and evaluation of a national education and training initiative, called the National Disaster Life Support Program, to provide physicians, medical students, other health professionals, and other emergency responders with a fundamental understanding and working knowledge of their integrated roles and responsibilities in disaster management and response efforts.

(3) Will join in working with the Department of Homeland Security, the Department of Health and Human Services, the Department of Defense, the Federal Emergency Management Agency, and other appropriate federal agencies; state, local, and medical specialty societies; other health care associations; and private foundations to (a) ensure adequate resources, supplies, and training to enhance the medical and public health response to terrorism and other disasters; (b) develop a comprehensive strategy to assure surge capacity to address mass casualty care; (c) implement communications strategies to inform health care professionals and the public about a terrorist attack or other major disaster, including local information on available medical and mental health services; (d) convene local and regional workshops to share "best practices" and "lessons learned" from disaster planning and response activities; (e) organize annual symposia to share new scientific knowledge and information for enhancing the medical and public health response to terrorism and other disasters; and (f) develop joint educational programs to enhance clinical collaboration and increase physician knowledge of the diagnosis and treatment of depression, anxiety, and post traumatic stress disorders associated with exposure to disaster, tragedy, and trauma.

(4) Believes all physicians should (a) be alert to the occurrence of unexplained illness and death in the

community; (b) be knowledgeable of disease surveillance and control capabilities for responding to unusual clusters of diseases, symptoms, or presentations; (c) be knowledgeable of procedures used to collect patient information for surveillance as well as the rationale and procedures for reporting patients and patient information; (d) be familiar with the clinical manifestations, diagnostic techniques, isolation precautions, decontamination protocols, and chemotherapy/prophylaxis of chemical, biological, and radioactive agents likely to be used in a terrorist attack; (e) utilize appropriate procedures to prevent exposure to themselves and others; (f) prescribe treatment plans that may include management of psychological and physical trauma; (g) understand the essentials of risk communication so that they can communicate clearly and nonthreateningly with patients, their families, and the media about issues such as exposure risks and potential preventive measures (e.g., smallpox vaccination); and (h) understand the role of the public health, emergency medical services, emergency management, and incident management systems in disaster response and the individual health professional's role in these systems.

(5) Believes that physicians and other health professionals who have direct involvement in a mass casualty event should be knowledgeable of public health interventions that must be considered following the onset of a disaster including: (a) quarantine and other movement restriction options; (b) mass immunization/chemoprophylaxis; (c) mass triage; (d) public education about preventing or reducing exposures; (e) environmental decontamination and sanitation; (f) public health laws; and (g) state and federal resources that contribute to emergency management and response at the local level.

(6) Believes that physicians and other health professionals should be knowledgeable of ethical and legal issues and disaster response. These include: (a) their professional responsibility to treat victims (including those with potentially contagious conditions); (b) their rights and responsibilities to protect themselves from harm; (c) issues surrounding their responsibilities and rights as volunteers, and (d) associated liability issues.

(7) Believes physicians and medical societies should participate directly with state, local, and national public health, law enforcement, and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals, and practices in preparation for terrorism and other disasters.

(8) Urges Congress to appropriate funds to support research and development (a) to improve understanding of the epidemiology, pathogenesis, and treatment of diseases caused by potential bioweapon agents and the immune response to such agents; (b) for new and more effective vaccines, pharmaceuticals, and antidotes against biological and chemical weapons; (c) for enhancing the shelf life of existing vaccines, pharmaceuticals, and antidotes; and (d) for improving biological chemical, and radioactive agent detection and defense capabilities.

Citation: (BOT Rep. 26, I-01; Reaffirmed: BOT Rep. 3, I-02; Modified: CSA Rep. 1, I-03; Reaffirmed: CME Rep. 1, I-11; Reaffirmation A-15)

Domestic Disaster Relief Funding D-130.966

1. Our American Medical Association lobby Congress to a) reassess its policy for expedited release of funding to disaster areas; b) define areas of disaster with disproportionate indirect and direct consequences of disaster as "public health emergencies"; and c) explore a separate, less bureaucratic process for providing funding and resources to these areas in an effort to reduce morbidity and mortality post-disaster.

2. Our AMA will lobby actively for the recommendations outlined in the AMA/APHA Linkages Leadership Summit including: a) appropriate funding and protection of public health and health care systems as critical infrastructures for responding to day-to-day emergencies and mass casualty events; b) full integration and interoperable public health and health care disaster preparedness and response systems at all government levels; c) adequate legal protection in a disaster for public health and healthcare responders and d) incorporation of disaster preparedness and response competency-based education and training in undergraduate, graduate, post-graduate, and continuing education programs.

Citation: (Res. 421, A-11; Reaffirmation A-15)

Impact of SARS-CoV-2 Pandemic on Post-Acute Care Services and Long-Term Care and Residential Facilities D-280.983

Our AMA will collaborate with other stakeholders to develop policy to guide federal, state, and local public health authorities to ensure safe operation of Post-Acute Care (PAC) and long-term care (LTC) facilities during public health emergencies and natural disasters with policy recommendations to include but not limited to:

- a) Planning for adequate funding and access to resources;
- b) Planning for emergency staffing of health care and maintenance personnel;
- c) Planning for ensuring safe working conditions of PAC and LTC staff; and
- d) Planning for mitigation of the detrimental effects of increased isolation of residents during a natural disaster, other environmental emergency, or pandemic, or similar crisis.

Citation: Res. 407, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(I-22)

Introduced by: Georgia

Subject: Universal Good Samaritan Statute

Referred to: Reference Committee B

1 Whereas, Good Samaritan statutes exist in all 50 states and the District of Columbia for the
2 purpose of promoting aid to individuals in need of emergency care; and
3

4 Whereas, These statutes widely vary from state to state. This impedes the desired intent of
5 these laws and may prevent physicians from rendering much needed care to patients who are in
6 need of emergency care for a medical condition outside of healthcare settings due to fear of
7 litigation; and
8

9 Whereas, Some states only cover physicians licensed in that state. Physicians without the local
10 state license may be held liable for Good Samaritan acts if physicians are from a different state
11 and may be unfamiliar with the details of the local statutes; and
12

13 Whereas, "Enumeration of Immunity" of Good Samaritan statutes may vary from state to state in
14 such a way that it may not protect every rescuer depending upon the location of the event; and
15

16 Whereas, "Good faith requirement" in the statute may differ from state to state; and
17

18 Whereas, "Specific site of covering" may also vary based on the location of the accident and the
19 rescue; and
20

21 Whereas, "Minimal standard of care" may vary from state to state; and
22

23 Whereas, Federal laws only exist for specific circumstances, such as Aviation Medical
24 Assistance Act and Federal Law Enforcement Officers' Good Samaritan Act of 1998; therefore
25 be it
26

27 RESOLVED, That our American Medical Association help protect patients in need of emergency
28 care and protect physicians and other responders by advocating for a national "universal" Good
29 Samaritan Statute (Directive to Take Action); and be it further
30

31 RESOLVED, That our AMA advocate for the unification of the disparate statutes by creation of a
32 national standard via either federal legislation or through policy directed by the Department of
33 Health and Human Services [HHS] to specify terms that would protect rescuers from legal
34 repercussion as long as the act by the rescuer meets the specified universal minimal standard
35 of conduct and the good faith requirement, regardless of the event location; thus, effectively
36 eliminating variations in the state statutes to facilitate the intent of the Good Samaritan statutes
37 removing barriers that could impede the prompt rendering of emergency care. (Directive to Take
38 Action)

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

Received: 09/26/22

RELEVANT AMA POLICY

Delivery of Health Care by Good Samaritans H-130.937

1. Our AMA will work with state medical societies to educate physicians about the Good Samaritan laws in their states and the extent of liability immunity for physicians when they act as Good Samaritans.
 2. Our AMA encourages state medical societies in states without "Good Samaritan laws," which protect qualified medical personnel, to develop and support such legislation.
 3. Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, the AMA supports the following basic guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance. For the purpose of this policy, "bystander physicians" shall refer to those physicians rendering assistance voluntarily, in the absence of pre-existing patient-physician relationships, to those in need of medical assistance, in a service area in which the physician would not ordinarily respond to requests for emergency assistance. (a) Bystander physicians should recognize that prehospital EMS systems operate under the authority and direction of a licensed EMS physician, who has both ultimate medical and legal responsibility for the system. (b) A reasonable policy should be established whereby a bystander physician may assist in an emergency situation, while working within area-wide EMS protocols. Since EMS providers (non-physicians) are responsible for the patient, bystander physicians should work collaboratively, and not attempt to wrest control of the situation from EMS providers. (c) It is the obligation of the bystander physician to provide reasonable self-identification. (d) Where voice communication with the medical oversight facility is available, and the EMS provider and the bystander physician are collaborating to provide care on the scene, both should interact with the local medical oversight authority, where practicable. (e) Where voice communication is not available, the bystander physician may sign appropriate documentation indicating that he/she will take responsibility for the patient(s), including provision of care during transportation to a medical facility. Medical oversight systems lacking voice communications capability should consider the addition of such communication linkages to further strengthen their potential in this area. (f) The bystander physician should avoid involvement in resuscitative measures that exceed his or her level of training or experience. (g) Except in extraordinary circumstances or where requested by the EMS providers, the bystander physician should refrain from providing medical oversight of EMS that results in deviation from existing EMS protocols and standing orders.
 4. Our AMA urges the International Civil Aviation Organization to make explicit recommendations to its member countries for the enactment of regulations providing "Good Samaritan" relief for those rendering emergency medical assistance aboard air carriers and in the immediate vicinity of air carrier operations.
- Citation: (CCB/CLRPD Rep. 3, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(I-22)

Introduced by: International Medical Graduates Section

Subject: Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies

Referred to: Reference Committee B

1 Whereas, Minoritized populations, including people of color, immigrants, and people with
2 chronic diseases were disproportionately affected by the pandemic; and
3

4 Whereas, International medical graduates, board-certified and trained in the U.S. institutions,
5 are often the frontline physicians in the federally designated health professional shortage areas
6 (HPSA) for their waiver requirements; and
7

8 Whereas, Physicians in the HPSA serve the lower income and immigrant population, and the
9 older and sicker population covered by Medicare and Medicaid; and
10

11 Whereas, In response to the COVID-19 pandemic, most states took measures to alleviate
12 practice restrictions for in-training, out-of-state, and retired physicians to allow the additional
13 workforce to join hands in managing critical staff shortages during public health emergencies;
14 and
15

16 Whereas, IMG physicians serving in the HPSA are restricted to one healthcare organization,
17 further limited to one geographical location by definition of the work location listed in their Labor
18 Condition Application (ETA Form 9035) as a prerequisite to their work Visa, H1B; and
19

20 Whereas, Except for a few specific instances like that in New York and New Jersey states, IMG
21 physicians were excluded from the special provisions for in and out-of-state expedited
22 physicians licensing, preventing them from helping out the workforce shortage during the public
23 health emergency, and providing urgent access to medical care for underserved patient
24 populations; therefore be it
25

26 RESOLVED, That our American Medical Association advise the state medical boards and other
27 stakeholders to allow physicians in the health professional shortage areas to have temporary
28 access to all unique and expedited licensing options, both inside and outside of the state of their
29 practice during public health emergencies, to facilitate workforce utilization at the time of critical
30 shortage (Directive to Take Action); and be it further
31

32 RESOLVED, That our AMA advocate at the state and national level and advise the Department
33 of Labor and the Department of Homeland Security to allow temporary provisions for such
34 licensing inclusions for the physicians on a Visa during public health emergencies. (Directive to
35 Take Action)

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

Received: 09/27/22

References

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2. Thompson MJ, Hagopian A, Fordyce M, Hart LG. Do international medical graduates (IMGs) "fill the gap" in rural primary care in the United States? A national study. J Rural Health. 2009;25(2):124-134. doi:10.1111/j.1748-0361.2009.00208.x
3. Foreign-trained doctors are critical to serving many U.S. communities. Americanimmigrationcouncil.org.,2018. <https://www.americanimmigrationcouncil.org/research/foreign-trained-doctors-are-critical-serving-many-us-communities>.
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5. Griswold D. Lower Barriers to Immigrant Healthcare Workers to Help Combat the COVID-19 Pandemic. April 2020. <https://www.mercatus.org/publications/covid-19-policy-brief-series/lower-barriers-immigrant-healthcare-workers-help-combat>. Accessed September 2, 2022.

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

1 Whereas, The aforementioned coverage gaps, limitations, and restrictions result in a denial of
2 the full continuum of MH/SUD benefits available to Medicare beneficiaries; and
3

4 Whereas, There has been an observed increase in the number of people seeking MH/SUD
5 services related to the COVID-19 pandemic;^x and
6

7 Whereas, Almost 2 million Medicare beneficiaries report having a SUD, yet only 11% received
8 any SUD treatment in 2021,^{xi} and opioid overdose deaths and hospitalizations continue to
9 increase among older adults;^{xii} and
10

11 Whereas, Black and Hispanic Medicare beneficiaries with SUD have more difficulty accessing
12 care and have worse outcomes than White beneficiaries,^{xiii} and Black and Indigenous Medicare
13 beneficiaries have experienced a significant increase in opioid-related overdoses and have the
14 highest rate of opioid-related fatalities; therefore be it^{xiv}
15

16 RESOLVED, That our American Medical Association amend policy H-185.974, "Parity for
17 Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs," by addition
18 and deletion to read as follows:
19

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

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

24 2. Our AMA supports federal legislation, standards, policies, and funding that expand the
25 parity and non-discrimination protections of the Paul Wellstone and Peter Domenici
26 Mental Health Parity and Addiction Equity Act of 2008 to Medicare (Parts A, B, C, and
27 D).

28 3. Our AMA supports federal legislation, standards, policies, and funding that require
29 Medicare coverage (Parts A, B, C, and D) of all levels of mental health and substance
30 use disorder care, consistent with nationally recognized medical professional
31 organization level of care criteria for mental health or substance use disorders. (Modify
32 Current HOD Policy)

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

Received: 10/07/22

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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

- 1 Whereas, “Direct supervision of emergency services” refers to an individual actively practicing
2 clinical medicine in the emergency department and overseeing all medical decisions in the
3 emergency department at the point of care¹; and
4
- 5 Whereas, Direct supervision of emergency care is distinct from medical direction; and
6
- 7 Whereas, Only 10% of nurse practitioners nationwide are trained in emergency care²; and
8
- 9 Whereas, Nursing and medical leaders strongly recommend that, because of variations in
10 training, licensure, and certification, nurse practitioners should not work alone in emergency
11 departments²⁻⁴; and
12
- 13 Whereas, CMS provides clear regulations on the direct supervision of emergency care in
14 hospitals¹; and
15
- 16 Whereas, In the conditions of participation, CMS requires that for a hospital to provide
17 emergency care, all emergency departments must have direct supervision by a qualified
18 member of medical staff present in the hospital at all hours emergency services are provided;
19 and
20
- 21 Whereas, “Direct supervision for emergency services” is defined as being physically in the
22 hospital and not telemedicine; and
23
- 24 Whereas, The word “must” indicates without exception; and
25
- 26 Whereas, The words “qualified member” are clearly proscribed by the American College of
27 Emergency Physicians (ACEP) and American Association of Emergency Medicine (AAEM)^{2,3};
28 and
29
- 30 Whereas, While the words “medical staff,” according to CMS, may include physicians, nurse
31 practitioners, and physicians assistants¹, there is a clear requirement for additional specialized
32 training; and
33
- 34 Whereas, It is the responsibility of the national organizations of emergency medicine physicians
35 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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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-zVHh0tiaGSL34SfQWmsWjaJBiGVwIfc>. 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: 222
(I-22)

Introduced by: Washington

Subject: Allocate Opioid Funds to Train More Addiction Treatment Physicians

Referred to: Reference Committee B

1 Whereas, There are not enough medical physicians in the U.S. actively prescribing medications
2 for opioid use disorder, especially in rural areas; and
3

4 Whereas, \$26 billion in opioid settlement funds are available nationally from the “Big Three”
5 drug distributors AmerisourceBergen, Cardinal Health, and McKesson, and opioid manufacturer
6 Johnson & Johnson; therefore be it
7

8 RESOLVED, That our American Medical Association amend Policy H-95.918, “Holding the
9 Pharmaceutical Industry Accountable for Opioid-Related Costs,” by addition to read as follows:
10

11 Our AMA will advocate that any monies paid to the states, received as a result of a
12 settlement or judgment, or other financial arrangement or agreement as a result of
13 litigation against pharmaceutical manufacturers, distributors, or other entities alleged to
14 have engaged in unethical and deceptive misbranding, marketing, and advocacy of
15 opioids, be used exclusively for research, education, prevention, and treatment of
16 overdose, opioid use disorder, and pain, as well as expanding physician training
17 opportunities to provide clinical experience in the treatment of opioid use disorders.
18

(Modify Current HOD Policy)

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

Received: 10/10/22

REFERENCES:

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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

- 1 Whereas, The Supreme Court ruling in *Dobbs vs. Jackson* overruled *Roe vs. Wade*, returning
2 an individual's right to access abortion to state law¹; and
3
4 Whereas, Each year, one in 1,000 pregnant people will be diagnosed with cancer, and there are
5 patients who become pregnant after having been diagnosed with cancer²; and
6
7 Whereas, The most common cancers diagnosed during pregnancy are breast, lymphoma, and
8 cervical cancer³; and
9
10 Whereas, Cancer diagnoses during pregnancy can be delayed, since symptoms like fatigue,
11 anemia, and nausea, can be similar for both conditions⁴; and
12
13 Whereas, Some cancer treatments and diagnostic services can harm a fetus or cause serious
14 birth defects and for that reason, experts recommend avoiding radiation therapy during the
15 entire pregnancy and most chemotherapies during the first trimester; and
16
17 Whereas, Some cancer therapies should not be used during any stage of pregnancy; and
18
19 Whereas, Pregnant individuals diagnosed with cancer, or who become pregnant during cancer
20 treatment, face difficult choices about whether to initiate, delay, or continue life-saving cancer
21 treatment, or whether to terminate their pregnancy; and
22
23 Whereas, These medical decisions are complex because timely cancer treatment improves a
24 person's likelihood of survival; and
25
26 Whereas, Every patient with cancer should receive evidence-based information about all
27 treatment options, including known side effects of those options; and
28
29 Whereas, Every patient should be able to maximize their chance for survival by receiving
30 recommended care promptly; and
31
32 Whereas, A growing number of current and pending laws insert government into the patient-
33 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 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: 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

1 Whereas, Methotrexate is on the World Health Organization's list of essential medicines for a
2 basic health-care system due to efficacy, safety, and cost-effectiveness;¹³ and
3

4 Whereas, Our American Medical Association issued a statement regarding state laws that limit
5 patient access to medically necessary treatment and impede use of professional judgment by
6 physicians;¹⁵ therefore be it
7

8 RESOLVED, That our American Medical Association work to create a formal process to review
9 pharmaceutical practices related to refusal of methotrexate and other drugs on the basis that it
10 could be used off-label for pregnancy termination (Directive to Take Action); and be it further
11

12 RESOLVED, That our AMA work to provide educational guidance on state-specific laws that
13 have impacted the distribution of methotrexate given post Dobbs vs. Jackson Women's Health
14 Organization restrictions. (Directive to Take Action)
15

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

Reference Committee C

CME Report(s)

- 01 The Impact of Private Equity on Medical Training
- 02 Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process

Resolution(s)

- 302 Expanding Employee Leave to Include Miscarriage and Stillbirth
- 303 Medical Student Leave Policy
- 304 Protecting State Medical Licensing Boards from External Political Influence
- 305 Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups
- 306 Increased Credit for Continuing Medical Education Preparation
- 307 Fair Compensation of Residents and Fellows
- 308 Paid Family/Medical Leave in Medicine
- 309 Bereavement Leave for Medical Students and Physicians
- 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

REPORT 1 OF THE COUNCIL ON MEDICAL EDUCATION (I-22)
The Impact of Private Equity on Medical Training
(Reference Committee C)

EXECUTIVE SUMMARY

Private equity (PE) refers broadly to any activity where investors buy an ownership, or equity, stake in companies or other financial assets that are not traded on public stock or bond exchanges. In recent years, the AMA Council on Medical Education and Council on Medical Service have studied related issues as demonstrated in their reports, “Graduate Medical Education and the Corporate Practice of Medicine” (CME 2-N-20), “Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure” (CME 3-N-20), “Corporate Investors” (CMS 11-A-19), and “Sources of Funding for Graduate Medical Education” (CME 1-I-15). Per a new directive from the House of Delegates, the AMA has been asked to study the level of financial involvement and influence private equity firms have in graduate medical education training programs and report back to the House of Delegates with possible publication of their findings.

PE’s role in health care has increased in recent years, as has its influence on graduate medical education (GME). This report reviews the extent of PE in health care and provides examples of PE and for-profit ownership of GME. It also summarizes the impact of PE on the GME learning environment and trainees and offers perspectives from key stakeholders, including the AMA and its related policies.

Understanding of the impact and mitigating any potential negative consequences of PE and for-profit entities in GME will take a concerted effort on the part of the medical and academic communities. There are numerous layers of complexity in what is a rapidly evolving health care practice model, and increasing data collection to recognize trends and ultimately outcomes is warranted. As PE involvement evolves, sponsoring institutions must be open to many kinds of partnerships that can support excellent residency and fellowship programs. This includes diligent monitoring of these programs to minimize disruptions to training and ensure that continuity of excellent education is maintained. The commitment to the educational mission is not only a commitment to residents, fellows, and faculty, but also to the communities and patients they serve.

This report proposes amendments to current AMA policy as well as new recommendations which support institutions or medical education training programs in upholding current policies and developing new policies; protect trainees and empower designated institutional officials (DIOs); encourage transparency as well as changes to the Public Student Loan Forgiveness Program (PSLF); and promote more research and public statements on PE in order to heighten awareness among the physician community.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-22

Subject: The Impact of Private Equity on Medical Training

Presented by: John Williams, MD, Chair

Referred to: Reference Committee C

1 INTRODUCTION

2
3 American Medical Association (AMA) Policy D-310.947, adopted at the June 2021 Special
4 Meeting, asks that our AMA:

5
6 Work with relevant stakeholders including specialty societies and the Accreditation Council for
7 Graduate Medical Education to study the level of financial involvement and influence private
8 equity firms have in graduate medical education training programs and report back to the
9 House of Delegates with possible publication of their findings.

10
11 This report is in response to the directive. Testimony on this item raised concern for recent
12 incidents where private equity has impacted graduate medical education (GME) funded training
13 positions, such as the Hahnemann closure in the fall of 2019. Additional testimony recognized the
14 importance of recent Council reports on similar topics.

15 BACKGROUND

16
17 *What is private equity?*

18
19
20 The American Investment Council (AIC), an advocacy and resource organization established to
21 develop and provide information about the private investment industry, describes private equity
22 (PE) such that “private equity invests capital in companies that are perceived to have growth
23 potential and then works with these companies to expand or turnaround the business. This capital is
24 contributed by large institutional investors and is organized into a fund. After three to seven years
25 of ownership and working with the company, the fund manager will seek to ‘exit’ the company by
26 taking the business public or selling it for a higher valuation than it was purchased. This exit
27 distributes profits from the sale (‘returns’) to the investors in the fund and the fund manager.”¹

28
29 The Medicare Payment Advisory Commission (MedPAC) adds to this definition: “Private equity
30 refers broadly to any activity where investors buy an ownership, or equity, stake in companies or
31 other financial assets that are not traded on public stock or bond exchanges.”²

32
33 According to the National Association of Securities Dealers Automated Quotations (NASDAQ), a
34 private equity firm is one that uses its own capital or capital raised from investors to take
35 companies private with the aim of running them better and later taking them public or selling them
36 at a profit.³

1 Simply put, PE firms invest in health systems and in health care to make a profit. Investors pool
 2 money to accumulate large sums of cash that are used to invest through the purchase of a business
 3 (e.g., physician practice or health system) with the goal of streamlining operations and cutting costs
 4 to make a short-term profit after selling the business. Sometimes, the return on the investment can
 5 be 20-30% of the original investment.

6
 7 Strategies used by PE firms to ultimately turn a profit include the merging of multiple health care
 8 practices, reducing staff, closing down portions of a hospital or health care practice's operations,
 9 focusing on growing a specific aspect of a health care practice's offerings, and renegotiating
 10 reimbursement rates with insurers.⁴ As PE is not publicly traded, there is little transparency to the
 11 public regarding the business dealings of the PE firm, and with a focus on short-term profit, there is
 12 often little regard to the downstream effects of these strategies on employees, patients, or in the
 13 present case, the residents/fellows training at the institution.

14
 15 In 2020, it was found that hospitals acquired by PE were associated with larger increases in net
 16 income, charges, charge to cost ratios, and case mix index as well as with improvement in some
 17 quality measures when compared to control.⁵ In 2018, PE hospitals were on average located in
 18 lower-income, more-rural areas and had fewer patients discharged and employees per bed.⁶

19
 20 In recent years, the AMA Council on Medical Education and Council on Medical Service have
 21 studied related issues as demonstrated in their reports, "Graduate Medical Education and the
 22 Corporate Practice of Medicine" (CME 2-N-20), "Protection of Resident and Fellow Training in
 23 the Case of Hospital or Training Program Closure" (CME 3-N-20), "Corporate Investors" (CMS
 24 11-A-19) and related issue brief, and "Sources of Funding for Graduate Medical Education" (CME
 25 1-I-15). Further, the AMA developed a guide designed to answer some of the frequently asked
 26 questions posed by trainees faced with closure of their hospital or residency program.

27 *Extent of Private Equity in Health Care*

28
 29
 30 Investments by PE firms in U.S. health care increased from \$23.1B in 2015 to \$78.9B in 2019⁷
 31 with hospitals that are owned by PE firms being a subset of investor-owned hospitals that has
 32 increased in recent years.

<u>American Hospital Association (AHA) Annual Survey</u>	<u>FY 2019⁸</u>	<u>FY 2015⁹</u>
Total Number of All U.S. Hospitals⁸	6,090	5,564
Number of U.S. Community Hospitals (i.e., all nonfederal, short-term general, and other special hospitals)	5,141	4,862
<ul style="list-style-type: none"> • Number of Nongovernment Not-for-Profit Community Hospitals 	2,946	2,845
<ul style="list-style-type: none"> • Number of Investor-Owned (For-Profit) Community Hospitals 	1,233	1,034
<ul style="list-style-type: none"> • Number of State and Local Government Community Hospitals 	962	983

Number of Federal Government Hospitals	208	212
Number of Nonfederal Psychiatric Hospitals	625	401
Other Hospitals (i.e., nonfederal long term care hospitals and hospital units within an institution such as a prison hospital or school infirmary)	116	89

1
2 While there is no clear picture of how many for-profit hospitals, or those owned by PE, have one or
3 more GME programs, the most recent results of the National GME Census of active GME
4 programs provide a glimpse. Results indicated that 7,695 programs' trainees are paid by a nonprofit
5 entity; 1,620 programs' trainees are paid by a for-profit; while 3,550 programs did not answer.¹⁰
6 When analyzing this data, it is important to note that the salary-paying entity may not always be the
7 same as the sponsoring institution or hospital.

8
9 As the number of investor-owned (for-profit) hospitals grows in GME, the greater the dependency
10 of GME programs on their stability and success. Conversely, the closure of such institutions
11 directly impacts GME programs including the residents, fellows, and physician faculty who rely on
12 them for training and employment. One such recent example was the sudden closure of
13 Hahnemann.

14 15 EXAMPLES OF PRIVATE EQUITY AND FOR-PROFIT OWNERSHIP OF GME

16 17 *Closure of Hahnemann University Hospital*

18
19 In fall 2019, Hahnemann University Hospital (HUH), a 500-bed teaching hospital and community
20 safety net in downtown Philadelphia, closed. The closure was the culmination of 20+ years of
21 financial troubles and changing ownerships. Tenet Healthcare Corporation, a for-profit health care
22 company, acquired the hospital in 1998. American Academic Health System, LLC (AAHS), an
23 affiliate of the private equity firm Paladin Healthcare Capital, LLC, purchased HUH in 2018 in
24 partnership with a Chicago-based health care real estate private equity firm, Harrison Street Real
25 Estate Capital, LLC. At the time, suspicions loomed that the purchase of the hospital was really a
26 means to acquire and develop the valuable Center City Philadelphia real estate property rather than
27 to provide patient care in service to the community. While there is a state law that a hospital cannot
28 be closed with less than 90 days' notice, AAHS filed for bankruptcy and shut down HUH's service
29 to the community in about half that time. This left 572 trainee physicians without an Accreditation
30 Council for Graduate Medical Education (ACGME)-accredited program in which to continue their
31 medical education.¹¹ This included 140 newly matched trainees and 59 individuals on J-1 visas
32 who were required to find a position with another GME program within 30 days of the hospital
33 closing or face deportation from the U.S.¹²

34
35 To improve their financial gain, AAHS attempted to sell its government-funded residency slots as
36 "assets" during bankruptcy proceedings, which was allowed by the presiding judge at the time.⁶
37 Bids included a coalition of local hospitals (\$55 million) intending to keep the residency positions
38 in the Philadelphia region, as well as a health care firm in California (\$60 million) that wanted to
39 increase the number of funded physicians in its hospitals. However, the Centers for Medicare &
40 Medicaid Services (CMS) objected to the judge's ruling, arguing that the allocation of Medicare-
41 funded slots is their sole purview and that the auction would set a dangerous precedent. As a result,
42 the auction did not go forward,¹³ and the residency positions were redistributed by CMS using their
43 existing process which prioritizes local hospitals without charge.¹⁴

1 Not only were these professionals left to endure the stress of finding new training positions
2 elsewhere throughout the country, but they were also faced with the loss of the long-tail medical
3 liability insurance coverage needed to continue practice. The [AMA](#) and other organizations took
4 action in support of the affected trainees. Specifically, the AMA joined the Pennsylvania Medical
5 Society (PAMED) and the Philadelphia County Medical Society (PCMS), as well as the
6 Educational Commission for Foreign Medical Graduates (ECFMG), Association of American
7 Medical Colleges (AAMC), and ACGME to pursue a solution for the physicians affected by the
8 closure. This advocacy included encouraging the purchasing of tail coverage by the institutions that
9 accepted HUH trainees among a host of other measures.

10
11 Ultimately, a federal bankruptcy judge approved a settlement with AAHS in early 2020 to pay for
12 the long-tail medical liability insurance coverage for the residents, fellows, and alumni of the
13 hospital's training programs.¹⁵ Since Pennsylvania required that all physicians have tail coverage
14 from previous employers, this effort was particularly important.¹⁶

15
16 Together, the AMA and AMA Foundation committed \$70,000 to assist the trainees affected. Many
17 other organizations contributed to the Hahnemann University Displaced Resident Fund including
18 the American Osteopathic Association, American Board of Medical Specialties, Council of
19 Medical Specialty Societies, National Board of Medical Examiners, PAMED, PCMS, and AAMC.
20 In addition, the ECFMG, now a member of Intealth, created a fund for trainees who had J-1 visas.¹⁷
21 The ACGME also took several steps to support these trainees such as the enactment of their
22 Extraordinary Circumstances Policy to expediently arrange for the transfer of trainees, drafting a
23 compilation of available positions, and making two separate filings with the bankruptcy court.¹⁸

24 25 *Closure of Emergency Medicine department at Summa Health Care*

26
27 Summa HealthTM is an integrated nonprofit health care delivery system in the Akron, OH area that
28 sponsors 19 GME programs, of which 15 are ACGME-accredited residency and fellowship
29 programs. While Summa's employed physician group provided most of the educational and clinical
30 services for these programs, the emergency medicine (EM) services (i.e., staffing of five
31 emergency departments; faculty for EM residency program) were provided by a contracted third-
32 party vendor owned by the private equity company U.S. Acute Care Solutions (USACS). A
33 contract dispute between Summa HealthTM and USACS in late 2016 ended in nonrenewal of the
34 longstanding contract. The EM service physicians were forced to leave the institution and program.
35 The program acquired new leadership and faculty but ultimately lost accreditation causing
36 disruption of services for patients as well as for the trainees within the EM residency program.¹⁹

37
38 The experience for the trainees who went through the change in groups and subsequent closure of
39 the program was difficult for all and devastating for some. It was particularly difficult for the
40 PGY3s given they had long-standing relationships and mentoring from their former attendings,
41 faculty, and program leadership, not to mention a familiarity and comfort from working in a stable
42 learning environment. The AMA, AMA Foundation, and others offered financial support to the
43 affected trainees in need of relocating.²⁰

44
45 This experience led to a revision of Summa's GME Disaster or Interruption in Patient Care Policy
46 as well as a comprehensive restructuring of the institutional contracting process. This overhaul
47 included clarifying the definition of a disaster to include a "catastrophic loss of faculty";
48 reinforcing the authority and responsibilities of the GME Committee (GMEC) members to call an
49 emergency GMEC meeting to discuss a potential impending disaster; making transparent the
50 disaster action steps and procedure; creating a linkage of the GME Disaster Policy to the new
51 contracting process; cataloging all clinical and education service agreements and contracts that

1 involved third-party groups; and quarterly review by the Designated Institutional Official (DIO) of
 2 the status of each agreement at a GMEC meeting to provide the committee oversight of this aspect
 3 of the learning environment. USACS continues to invest in education and has shared best practices
 4 from other institutions where they provide care and operate residencies. In September 2019,
 5 Summa's EM Program was given initial accreditation status by the ACGME effective
 6 immediately.²¹ Emergency medicine training at Summa is once again thriving.

7
 8 *Example of extensive PE ownership of GME*

9
 10 HCA Healthcare is the nation's leading provider of GME and has 5000+ trainees working across
 11 61 hospitals in 16 states. They were responsible for 20% of the 667 new EM residency slots created
 12 in the U.S. from 2016-2019.²² In 2006, HCA was acquired by Bain Capital, Kohlberg Kravis
 13 Roberts & Co. (KKR), and Merrill Lynch and facilitated massive multi-hospital consolidation with
 14 seemingly marginal benefit for patients as well as increased cost-to-charge ratios/profits.^{23,24,25} In
 15 2011, HCA became a public company again. In the meantime, the PE investors had turned a \$956
 16 million contribution into \$3.14 billion in proceeds.²⁵ HCA bought back 3.8 million shares from
 17 Bain for about \$294 million and spent \$750 million to buy back 9.4 million of its common shares
 18 from KKR in 2016.²⁶ The potential impacts of HCA's enormous market share within GME is
 19 concerning and highlights the need for publicly funded, independent research on the impact of
 20 private equity in GME and health care delivery alike.

21
 22 PRIVATE EQUITY AND THE GME LEARNING ENVIRONMENT

23
 24 As mentioned previously, PE is fundamentally driven by the desire to generate a positive margin
 25 for investors through a variety of strategies. Ultimately, these strategies are to grow, repackage, and
 26 sell.²⁷ While it does not appear that PE invests in hospitals, health systems, or practices with the
 27 intent of eliminating or dramatically altering GME, such programs as well as their trainees can be
 28 impacted. Examples include but are not limited to:

- 29
 30 • Erosion of educational mission: One key outcome of GME training is the intentional
 31 exploration of self-directed learning and pursuit of scholarly activity. The focus of PE is on
 32 creating a wide profit margin through operational decisions and efficiencies, and these are
 33 likely to directly or indirectly impact a trainee's ability to learn. Education and learning
 34 require time and mentoring, especially in GME, and thus it is inherently inefficient. PE
 35 firms driven toward profit are likely to eliminate or minimize key aspects of trainee
 36 professional development.
- 37 • Disruption to trainee supervision: A sudden transition of leadership can result in new
 38 faculty not familiar with ACGME common program requirements and/or institutional
 39 requirements which mandate resident supervision of trainees.
- 40 • Residents are not employees: Trainees are commonly in a unique situation in which they
 41 are able to provide significant value to a health system by caring for patients and making
 42 independent decisions that generate clinical revenue. For institutions driven by profit,
 43 however, there may be undue pressure for trainees to contribute to the positive margin
 44 either through their medical practice or being utilized as a relatively low-cost employee
 45 (e.g., shift scheduling).
- 46 • Replacing residents with non-physicians: There is concern that some for-profit institutions
 47 are driving to replace resident physicians with non-physicians in order to not be beholden
 48 to regulatory rules, reduce recruiting budgets, and pay lower cumulative salaries over the
 49 long term.

- 1 • Academic instability: The situation at Hahnemann has been described as a "...concerning
2 trend that underscores the dissonance in mission of private equity and academic
3 medicine."²⁸ This dissonance creates an unstable, if not adverse, working and learning
4 environment that unquestionably impacts trainees and their professional growth.
5

6 IMPACT ON PHYSICIANS IN TRAINING 7

8 As referenced in the above examples, trainees and faculty are significantly impacted by disruptions
9 to GME imposed by PE. The interruption to a trainee's education and experience can impact their
10 ability to finish as scheduled, which has natural implications for their future careers and leaves
11 them at financial risk. The potential loss of long-tail medical liability insurance coverage needed to
12 continue practice as well as confusion regarding the amount of funding that would travel with a
13 transferring trainee from a suddenly closed program is problematic.
14

15 Additionally, the stress of uncertainty, having to find a new GME program, needing to upend their
16 lives to move to the next location, and the cost of moving and rehoming place a heavy weight on
17 the shoulders of residents, faculty, and their families. This problem is further compounded by the
18 likely change of mentorship and planned educational trajectory for learners as they re-enter at
19 another institution.
20

21 International medical graduates (IMGs) with J-1 visas must adhere to rules set forth by their J-1
22 visa status. In the event of a sudden hospital/GME program closure, the implication for these
23 trainees is that they face deportation to their home country if they do not find a new position at
24 another GME program within 30 days of such closure. This short timeline presents significant
25 challenges to professional continuity for reasons in which the IMG has no control.
26

27 Further, the trainees may not have received clarity from all the boards on how the closure could
28 impact the number of rotations or number of procedures (especially those nearing the end of
29 training) they need to complete. The ABIM did state that "all accredited training continues to meet
30 ABIM's policies for initial certification eligibility. Additionally, should a trainee have a 'gap' in
31 training due to relocation, we are committed to working with you and the receiving
32 institutions/program directors to ensure that the maximum flexibility possible under ABIM's Leave
33 and Deficits in Required Training Time policies can be applied."²⁹
34

35 As a result of the Hahnemann closure, CMS changed its rules related to the transfer of indirect
36 medical education (IME) and direct graduate medical education (DGME) funding to accepting
37 institutions. Current Medicare policy allows a temporary cap adjustment for hospitals that accept
38 displaced residents from a hospital or program that is closing so that these hospitals can receive
39 Medicare funding for the displaced residents for the duration of their training. The definition of a
40 displaced resident was such that the resident be physically present at the hospital training on the
41 day prior to or the day of hospital or program closure; however, the revised definition now states
42 that a resident will be considered displaced from the day the hospital or training program publicly
43 announces the closure.³⁰ This rule, however, does not impact GME trainees whose salaries are not
44 paid for through Medicare funds (e.g., trainees in programs that are not accredited by the ACGME,
45 such as sub-specialties that receive approval/certification from specialty societies). Without
46 guarantees for ongoing trainees, the educational continuity of these learners is dramatically
47 impacted.
48

49 The impact on the income of trainees is another important consideration. One study found that
50 while there was significant growth of newly ACGME accredited for-profit affiliated EM residency
51 programs from 2016–2021, the for-profit affiliated programs paid lower salaries to first-year

1 trainees than the nonprofit affiliated programs (even after controlling for other factors that could
2 influence salary). It concluded that better oversight of the salary determination process is needed to
3 protect trainees from underpayment and ensure equity.³¹ While this study was specific to EM
4 programs, there could be broader implications to other specialties where PE investment is a factor.

5
6 Finally, the emotional and psychological toll on trainees working in an unfamiliar, possibly
7 unwelcoming, learning environment likely has significant implications on professional identity
8 formation. Most trainees do not understand and have not received formal education regarding the
9 corporate practice of medicine and thus may not understand or appreciate the economic forces that
10 directly or indirectly impact their education.

11 *Public Service Loan Forgiveness Program*

12
13
14 The involvement of private equity can also impact a physician's eligibility for the Public Service
15 Loan Forgiveness Program (PSLF). The PSLF Program forgives the remaining balance on an
16 individual's direct loans after making 120 qualifying monthly payments under a qualifying
17 repayment plan while working full-time for a qualifying employer. From the 2019 data presented in
18 the AHA table above, 4,116 hospitals are PSLF-eligible, or roughly about 68 percent of hospitals in
19 the U.S. Although most residency and fellowship programs are in nonprofit institutions, the for-
20 profit or nonprofit status of programs is not generally readily discernible to a medical student or
21 resident investigating training options. Additionally, residents and fellows who are training in a
22 nonprofit university-based residency or fellowship program will be excluded from the PSLF
23 Program if they are officially employees of an affiliated for-profit hospital or health system. During
24 the match process, medical students may not be aware of or have access to information about the
25 for-profit status of the entity that will pay their salary as GME often takes place within complicated
26 institutional arrangements of "sponsoring" and "participating" institutions. Even if residents and
27 fellows rotate to several nonprofit clinical sites and funds are contributed to that salary by nonprofit
28 or government institutions, the institution writing the salary check may not be a nonprofit and thus
29 not be a qualifying employer for the PSLF Program. This system can create multiple hurdles for
30 physicians hoping to enter the PSLF Program and means that students will need to be cautious
31 about choosing institutions as part of the residency matching process and physicians must do the
32 same when picking their future place of employment.

33
34 In July 2022, the Department of Education (DOE) announced [proposed rule changes](#) including
35 amendments to regulations governing PSLF in the Direct Loan program to improve the application
36 process and to clarify and expand definitions for full-time employment, qualifying employers, and
37 qualifying monthly payments. The AMA responded to the open comment period encouraging the
38 DOE to adopt the clarifying language developed by the California Medical Association and Texas
39 Medical Association following the definition of "employee" or "employed" so that CA and TX
40 physicians working full-time in private nonprofit hospitals and other organizations that meet the
41 definition of "public service organization" and satisfy all the other PSLF requirements may
42 lawfully participate in the program. The AMA letter also encouraged extension of the current PSLF
43 waiver deadline and expansion of the program so that more associations and a larger range of
44 nonprofits be considered "qualified employers." Further, the letter urged reconsideration of the
45 proposed definition of "public education service" as being too narrow and unclear, as well as
46 reconsideration of the proposal which would allow a total and permanent disability discharge
47 application to be certified by a nurse practitioner, physician's assistant, or a licensed certified
48 psychologist, in addition to an MD or DO.

49 50 PERSPECTIVES FROM STAKEHOLDERS

51

1 Medical specialties that have notably attracted the majority of PE investment include dermatology,
2 orthopaedics, radiology, cardiology, gastroenterology, urgent care/emergency medicine,
3 anesthesiology, and ophthalmology.

4
5 To illustrate, dermatology practices represent 15 percent of recent private equity acquisitions of
6 medical practices even though dermatologists account for only one percent of physicians in the
7 U.S.³² PE firms invest in dermatology management groups (DMGs) which operate multiple clinics
8 and have been known to acquire smaller, physician-owned practices. Research suggests that this
9 consolidation of dermatology practices may be associated with changes in practice management
10 and that PE firms have a financial stake in an increasing number of dermatology practices in the
11 U.S.³³ PE's interest in dermatology points to several factors including: treatment of skin cancer,
12 which is the most common cancer in the U.S.³⁴; a growing older population in need of skin care; a
13 specialty with a history of fragmentation; demand for dermatologists; and profitability of the
14 specialty as well as its specialized services such as Mohs and dermatopathology.³⁵ However, there
15 are considerations for dermatologists. As stated by AMA President Jack Resneck, Jr., MD,
16 "Practice acquisitions at inflated prices in a competitive quest to quickly consolidate fragmented
17 markets and sell practices at a profit to future investors may eventually lead to bankruptcies,
18 leaving dermatologists without practices and patients without services."³⁶ Further, the impact on
19 dermatology training programs is unclear. The American Academy of Dermatology and American
20 Board of Dermatology do not appear to have issued statements regarding private equity and its role
21 in the specialty or impact on GME.

22
23 Another example of PE growth is within ophthalmology, for reasons similar to dermatology. As of
24 2019, 30-35 PE firms were in this market.²⁷ PE's focus is on large and regionally important
25 practices as well as those with a strong ambulatory surgery center (ASC) component. It is believed
26 that such interest in ASCs will increase, as "stable ASC profits and comparatively low enterprise
27 complexity are most in keeping with a corporate environment—much more so than the massive
28 complexity and volatility of the underlying practices themselves."⁴⁶ The American Academy of
29 Ophthalmology (AAO) notes, "Purchases of private equity in the health care market have soared in
30 recent years with hospitals and larger practice acquiring smaller practices. The Academy urges
31 every physician who is considering a practice equity acquisition to perform careful due diligence
32 and seek good counsel." The [AAO](#) offers information to physicians who are considering such
33 opportunities.⁴⁷

34
35 In April 2022, the American College of Emergency Physicians (ACEP) issued a statement on
36 Private Equity and Corporate Investment in Emergency Medicine. In it, they expressed increased
37 concerns about the expanding presence of PE and corporate investment in health care, including
38 emergency medicine.⁴⁸

39
40 Prior to this, the American Academy of Emergency Medicine (AAEM) Resident and Student
41 Association issued an open letter addressing their concerns with regards to training in an
42 environment influenced by corporate entities. Specifically, they urge the profession to, "Purge our
43 specialty societies from the influence and funding from corporate entities" among other
44 recommendations.⁴⁹ Further, this letter calls for a moratorium on new EM residency training
45 programs until issues are addressed, namely concerns about program quality as well as the
46 oversupply of EM physicians.

47
48 Likewise, a 2021 position paper from the American College of Physicians (ACP) concluded,
49 "Ultimately, professionalism, medical ethics, and the patient-physician relationship must guide
50 how physicians navigate the business side of medicine. Nonprofits must act like nonprofits and
51 have a community-oriented mission, private equity firms and investor-owned organizations must

1 attend to the needs of patients and not just shareholders, and physicians should not have a financial
2 stake in an organization with which they have a referral relationship.”⁵⁰

3
4 The ACGME is actively monitoring this situation as indicated in the 2021 National Reporting of
5 Findings from their Clinical Learning Environment Review (CLER) Site Visits. This report noted,
6 “Over the past few years, U.S. health care has experienced a number of accelerated changes. There
7 has been a dramatic increase in mergers and acquisitions of hospitals and related health care
8 entities, resulting in increasingly large and complex health care organizations. There has also been
9 rapid entry of private equity in ownership of physician group practices, particularly among certain
10 specialty-based clinical practices.” By examining clinical learning environments (CLE) during this
11 rapid evolution of the U.S. health care system, the ACGME can illuminate the challenges and
12 opportunities related to how CLEs engage their trainees in planning for and implementing system
13 changes. ACGME programs continue to assist the GME community in testing and sharing new
14 approaches to improving complex challenges in the CLE. Also, the ACGME will revise its
15 institutional requirements in 2022 as part of a 10-year major revision cycle. Thus, the CLER
16 Evaluation Committee is studying the results of their current report and past reports to highlight
17 opportunities for improvement to be considered by the Institutional Review Committee.⁵¹

18
19 Despite the significant level of concern that has been expressed, not all stakeholders have
20 implemented policies designed to combat the impact of PE on GME. The associations and societies
21 that represent residents and physicians should have a vested interest in the impact that PE may have
22 on trainees who belong in the GME programs of said specialties. However, few have released
23 policy statements or positions on the subject; for those who have not, such action may be
24 considered. Further, the water gets muddied when physicians associated with PE firms are
25 outspoken in their societies or if the leadership of such societies has financial relationships with
26 PE-backed management firms.

27
28 Clearly there is concern about PE and its impact on the practice of medicine, but little is known or
29 commented about the impact of PE on GME, whether that be for an individual residency program
30 or for an institution.

31 32 CHANGES TO DATE

33
34 As a result of the Hahnemann closure, CMS implemented a rule change related to the transfer of
35 GME funding from one institution to another in the case of sudden closure of an institution or a
36 program. As described earlier, this change updated the definition of a “displaced resident” and
37 applies to residents currently training in the closing program as well as residents who are not
38 physically present because they have not started training or do not intend to return to training at the
39 closing institution.³⁰ Allowing the closing hospital to temporarily transfer the slots as soon as the
40 closing is made public allows trainees flexibility in finding new programs and allows for more
41 certainty in the continuity of training. This change was encouraged by AMA and AAMC.⁵²

42
43 The Summa example provides other changes that have occurred at an institutional or systemic level
44 that have helped to optimize training at that institution while also taking provisional steps to
45 prevent dramatic closures from recurring in the future.

46
47 While positive developments, there remains concern that the positive changes implemented to date
48 are only temporary and may not lead to lasting change or prevent dramatic closures from
49 happening again as a result of PE investment.

50
51 *Proposed federal legislation*

1 In October 2021, the Stop Wall Street Looting Act ([S. 3022](#)) was introduced to subject certain
2 private funds to joint and several liability with respect to the liabilities of firms acquired and
3 controlled by those funds. The sponsor described it as “a comprehensive bill to fundamentally
4 reform the private equity industry and level the playing field by forcing private investment firms to
5 take responsibility for the outcomes of companies they take over, empowering workers, and
6 protecting investors.”⁵³ A similar bill by the same name, [H.R. 5648](#), also was introduced. Such
7 legislation could pave the way for greater scrutiny and accountability of PE, and ultimately, more
8 protection for trainees and residency programs.

9 10 RELEVANT AMA POLICY

11
12 The AMA has extensive policy addressing the financial involvement of for-profit institutions in
13 GME and the influence of private equity firms on the practice of medicine. The most specific
14 policies related to this topic are as follows:

- 15 • [D-310.948](#), “Protection of Resident and Fellow Training in the Case of Hospital or
16 Training Program Closure,” addresses concerns related to the protection of residents and
17 fellows in the case of training program closures and specifically encourages the AMA to
18 work with other stakeholders to ensure that GME trainees can continue safely on their
19 training pathway despite needing to change institutions mid-training.
20
- 21 • [H-310.904](#), “Graduate Medical Education and the Corporate Practice of Medicine,”
22 acknowledges that the learning environment for trainees must be free of conflict between
23 fiduciary responsibilities of an institution and the educational mission.
24
- 25 • [H-310.943](#), “Closing of Residency Programs,” provides recommendations for some
26 medical education regulatory bodies to actively monitor GME programs for non-
27 educational closing and accommodate those trainees who are impacted when GME
28 programs close for this reason. In addition, it calls for federal regulation to increase
29 transparency and accountability of the training institution in the event of hospital or
30 training program closure.
31
- 32 • [H-310.929](#), “Principles for Graduate Medical Education,” identifies a list of principles for
33 GME including the institutional responsibility as it relates to supporting trainees and their
34 program as well as promoting an environment that is conducive to learning.
35
- 36 • [H-160.891](#), “Corporate Investors,” provides a list of detailed guidelines for physicians who
37 are contemplating investor partnerships.
38
- 39 • [H-215.981](#), “Corporate Practice of Medicine,” opposes federal legislation that preempts
40 state laws prohibiting the corporate practice of medicine, offers guidance to state societies,
41 and encourages continued monitoring of the corporate practice of medicine.
42

43 These policies addressing PE are listed in full detail in Appendix A.

44 45 SUMMARY AND RECOMMENDATIONS

46
47 Understanding of the impact and mitigating any potential negative consequences of PE and for-
48 profit entities in GME will take a concerted effort on the part of the medical and academic
49 communities. There are numerous layers of complexity in what is a rapidly evolving health care
50 practice model and increasing data collection to recognize trends and ultimately outcomes is

1 warranted. AMA Policy D-310.948 instructs the AMA to work with the ACGME to monitor issues
2 related to training programs run by corporate entities and the effect on medical education. Research
3 into this work should continue in concert with affected specialty societies and others.

4
5 Specialty associations and societies that represent trainees and physicians have a vested interest in
6 the impact of PE on GME training, yet few have studied the issue and released policy or statements
7 on the subject. The AMA Council on Medical Education encourages this work from the physician
8 and medical education communities.

9
10 The AMA must continue to advocate that full GME funding follows trainees of a suddenly closed
11 institution to the new location and that funding stays with the institution for the duration of the
12 displaced resident's term. For institutions and systems, tail coverage for malpractice insurance
13 should be mandated and institutional transparency increased to trainees on the closure process as
14 well as disclosure of the intent to sell or close. Benefits (such as COBRA) should be continued in
15 instances where new residency programs are not found in a timely manner. Finally, upon a
16 shutdown, all trainees should be protected from being held captive at a hospital that is not actively
17 admitting patients but hasn't officially "closed." The AMA must also continue to work with the
18 ACGME, ABMS, and ABOMS to accommodate trainees who have been displaced because of
19 program or institutional closure.

20
21 *Conclusion*

22
23 It is likely that the involvement of PE in health care systems, physician practices, and thus, GME
24 programs, is not going away. As this space evolves, sponsoring institutions must be open to many
25 kinds of partnerships that can support excellent residency and fellowship programs. This includes
26 diligent monitoring of these programs to minimize disruptions to training and ensure that continuity
27 of excellent education is maintained. The commitment to the educational mission is not only a
28 commitment to residents, fellows, and faculty, but also to the communities and patients they serve.

29
30 The Council on Medical Education therefore recommends that the following recommendations be
31 adopted, and the remainder of this report be filed. That our AMA:

- 32
33 1. Affirm that an institution or medical education training program academic mission should
34 not be compromised by a clinical training site's fiduciary responsibilities to an external
35 corporate or for-profit entity. (New HOD Policy)
- 36
37 2. Encourage GME training institutions, programs, and relevant stakeholders to:
- 38 a. demonstrate transparency on mergers and closures, especially as it relates to
39 private equity acquisition of GME programs and institutions, and demonstrate
40 institutional accountability to their trainees by making this information available to
41 current and prospective trainees;
 - 42 b. uphold comprehensive policies which protect trainees, including those who are not
43 funded by Medicare dollars, to ensure the obligatory transfer of funds after
44 institution closure;
 - 45 c. empower designated institutional officials (DIOs) to be involved in institutional
46 decision-making to advance such transparency and accountability in protection of
47 their residents, fellows, and physician faculty;
 - 48 d. develop educational materials that can help trainees better understand the business
49 of medicine, especially at the practice, institution, and corporate levels;
 - 50 e. develop policies highlighting the procedures and responsibilities of sponsoring
51 institutions regarding the unanticipated catastrophic loss of faculty or clinical

- 1 training sites and make these policies available to current and prospective GME
2 learners. (Directive to Take Action)
3
- 4 3. Encourage necessary changes in Public Service Loan Forgiveness Program (PSLF) to
5 allow medical students and physicians to enroll in the program even if they receive some or
6 all of their training at a for-profit or governmental institution. (Directive to Take Action)
7
- 8 4. Support publicly funded independent research on the impact that private equity has on
9 graduate medical education. (New HOD Policy)
10
- 11 5. Encourage physician associations, boards, and societies to draft policy or release their own
12 issue statements on private equity to heighten awareness among the physician community.
13 (Directive to Take Action)
14
- 15 6. Encourage physicians who are contemplating corporate investor partnerships to consider
16 the ongoing education and welfare for trainee physicians who train under physicians in that
17 practice, including the financial implications of existing funding that is used to support that
18 training. (Directive to Take Action)
19
- 20 7. Amend Policy [D-310.948](#) “Protection of Resident and Fellow Training in the Case of
21 Hospital or Training Program Closure” by addition to read as follows:
22
- 23 Our AMA: (6) will continue to work with ACGME, interested specialty societies,
24 and others to monitor issues, collect data, and share information related to training
25 programs run by corporate and nonprofit entities and their effect on medical
26 education. (Modify HOD Policy)
27
- 28 8. Reaffirm the following policies:
29
- 30 • [H-310.904](#) “Graduate Medical Education and the Corporate Practice of Medicine”
 - 31 • [H-310.943](#) “Closing of Residency Programs”
 - 32 • [H-310.929](#) “Principles for Graduate Medical Education”
 - 33 • [H-215.981](#) “Corporate Practice of Medicine” (Reaffirm HOD policy)
- 34 9. Rescind AMA Policy D-310.947 as having been accomplished by this report. (Rescind
35 HOD policy)

Fiscal note: \$1,000

APPENDIX A: RELEVANT AMA POLICY

Corporate Investors H-160.891

1. Our AMA encourages physicians who are contemplating corporate investor partnerships to consider the following guidelines:
 - a. Physicians should consider how the practice's current mission, vision, and long-term goals align with those of the corporate investor.
 - b. Due diligence should be conducted that includes, at minimum, review of the corporate investor's business model, strategic plan, leadership and governance, and culture.
 - c. External legal, accounting and/or business counsels should be obtained to advise during the exploration and negotiation of corporate investor transactions.
 - d. Retaining negotiators to advocate for best interests of the practice and its employees should be considered.
 - e. Physicians should consider whether and how corporate investor partnerships may require physicians to cede varying degrees of control over practice decision-making and day-to-day management.
 - f. Physicians should consider the potential impact of corporate investor partnerships on physician and practice employee satisfaction and future physician recruitment.
 - g. Physicians should have a clear understanding of compensation agreements, mechanisms for conflict resolution, processes for exiting corporate investor partnerships, and application of restrictive covenants.
 - h. Physicians should consider corporate investor processes for medical staff representation on the board of directors and medical staff leadership selection.
 - i. Physicians should retain responsibility for clinical governance, patient welfare and outcomes, physician clinical autonomy, and physician due process under corporate investor partnerships.
2. Our AMA supports improved transparency regarding corporate investment in physician practices and subsequent changes in health care prices.
3. Our AMA encourages national medical specialty societies to research and develop tools and resources on the impact of corporate investor partnerships on patients and the physicians in practicing in that specialty.
4. Our AMA supports consideration of options for gathering information on the impact of private equity and corporate investors on the practice of medicine.

Graduate Medical Education and the Corporate Practice of Medicine H-310.904

Our AMA: (1) recognizes and supports that the environment for education of residents and fellows must be free of the conflict of interest created between a training site's fiduciary responsibility to shareholders and the educational mission of residency or fellowship training programs; (2) encourages the Accreditation Council for Graduate Medical Education (ACGME) to update its "Principles to Guide the Relationship between Graduate Medical Education, Industry, and Other Funding Sources for Programs and Sponsoring Institutions Accredited by the ACGME" to include corporate-owned lay entity funding sources; and (3) will continue to monitor issues, including waiver of due process requirements, created by corporate control of graduate medical education sites.

Corporate Practice of Medicine H-215.981

1. Our AMA vigorously opposes any effort to pass federal legislation preempting state laws prohibiting the corporate practice of medicine.
2. At the request of state medical associations, our AMA will provide guidance, consultation, and model legislation regarding the corporate practice of medicine, to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings, and physicians contracting with corporately owned management service organizations.

3. Our AMA will continue to monitor the evolving corporate practice of medicine with respect to its effect on the patient-physician relationship, financial conflicts of interest, patient-centered care, and other relevant issues.

Protection of Resident and Fellow Training in the Case of Hospital or Training Program Closure D-310.948

Our AMA:

1. will ask the Centers for Medicare & Medicaid Services (CMS) to stipulate in its regulations that residency slots are not assets that belong to the teaching institution;
2. will encourage the Association of American Medical Colleges (AAMC), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to develop a process similar to the Supplemental Offer and Acceptance Program (SOAP) that could be used in the event of a sudden teaching institution or program closure;
3. will encourage the Accreditation Council for Graduate Medical Education (ACGME) to specify in its Institutional Requirements that sponsoring institutions are to provide residents and residency applicants information regarding the financial health of the institution, such as its credit rating, or if it has recently been part of an acquisition or merger;
4. will work with AAMC, AACOM, ACGME, and relevant state and specialty societies to coordinate and collaborate on the communication with sponsoring institutions, residency programs, and resident physicians in the event of a sudden institution or program closure to minimize confusion, reduce misinformation, and increase clarity;
5. will encourage ACGME to revise its Institutional Requirements, under section IV.E., Professional Liability Insurance, to state that sponsoring institutions must create and maintain a fund that will ensure professional liability coverage for residents in the event of an institution or program closure; and
6. will continue to work with ACGME to monitor issues related to training programs run by corporate entities and the effect on medical education.

Closing of Residency Programs H-310.943

1. Our AMA: (a) encourages the Accreditation Council for Graduate Medical Education (ACGME) to address the problem of non-educational closing or downsizing of residency training programs; (b) reminds all institutions involved in educating residents of their contractual responsibilities to the resident; (c) encourages the ACGME and the various Residency Review Committees to reexamine requirements for “years of continuous training” to determine the need for implementing waivers to accommodate residents affected by non-educational closure or downsizing; (d) will work with the American Board of Medical Specialties Member Boards to encourage all its member boards to develop a mechanism to accommodate the discontinuities in training that arise from residency closures, regardless of cause, including waiving continuity care requirements and granting residents credit for partial years of training; (e) urges residency programs and teaching hospitals be monitored by the applicable Residency Review Committees to ensure that decreases in resident numbers do not place undue stress on remaining residents by affecting work hours or working conditions, as specified in Residency Review Committee requirements; (f) opposes the closure of residency/fellowship programs or reductions in the number of current positions in programs as a result of changes in GME funding; and (g) will work with the Centers for Medicare and Medicaid Services (CMS), ACGME, and other appropriate organizations to advocate for the development and implementation of effective policies to permit graduate medical education funding to follow the resident physician from a closing to the receiving residency program (including waivers of CMS caps), in the event of temporary or permanent residency program closure.
2. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to establish regulations that protect residents and fellows impacted by program or hospital closure, which may include recommendations for:

- A. Notice by the training hospital, intending to file for bankruptcy within 30 days, to all residents and fellows primarily associated with the training hospital, as well as those contractually matched at that training institution who may not yet have matriculated, of its intention to close, along with provision of reasonable and appropriate procedures to assist current and matched residents and fellows to find and obtain alternative training positions that minimize undue financial and professional consequences, including but not limited to maintenance of specialty choice, length of training, initial expected time of graduation, location and reallocation of funding, and coverage of tail medical malpractice insurance that would have been offered had the program or hospital not closed;
 - B. Revision of the current CMS guidelines that may prohibit transfer of funding prior to formal financial closure of a teaching institution;
 - C. Improved provisions regarding transfer of GME funding for displaced residents and fellows for the duration of their training in the event of program closure at a training institution; and
 - D. Protections against the discrimination of displaced residents and fellows consistent with H-295.969.
3. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to identify a process by which displaced residents and fellows may be directly represented in proceedings surrounding the closure of a training hospital or program.
4. Our AMA will work with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, National Resident Matching Program, Educational Commission for Foreign Medical Graduates, Centers for Medicare and Medicaid Services, and other relevant stakeholders to:
- A. Develop a stepwise algorithm for designated institutional officials and program directors to assist residents and fellows with finding and obtaining alternative training positions;
 - B. Create a centralized, regulated process for displaced residents and fellows to obtain new training positions; and
 - C. Develop pathways that ensure that closing and accepting institutions provide liability insurance coverage to residents, at no cost to residents.

Principles for Graduate Medical Education H-310.929

Our AMA urges the Accreditation Council for Graduate Medical Education (ACGME) to incorporate these principles in its Institutional Requirements, if they are not already present.

1) **PURPOSE OF GRADUATE MEDICAL EDUCATION AND ITS RELATIONSHIP TO PATIENT CARE.** There must be objectives for residency education in each specialty that promote the development of the knowledge, skills, attitudes, and behavior necessary to become a competent practitioner in a recognized medical specialty.

Exemplary patient care is a vital component for any residency/fellowship program. Graduate medical education enhances the quality of patient care in the institution sponsoring an accredited program. Graduate medical education must never compromise the quality of patient care.

Institutions sponsoring residency programs and the director of each program must assure the highest quality of care for patients and the attainment of the program's educational objectives for the residents.

(2) **RELATION OF ACCREDITATION TO THE PURPOSE OF RESIDENCY TRAINING.**

Accreditation requirements should relate to the stated purpose of a residency program and to the knowledge, skills, attitudes, and behaviors that a resident physician should have on completing residency education.

(3) **EDUCATION IN THE BROAD FIELD OF MEDICINE.** GME should provide a resident physician with broad clinical experiences that address the general competencies and

professionalism expected of all physicians, adding depth as well as breadth to the competencies introduced in medical school.

(4) **SCHOLARLY ACTIVITIES FOR RESIDENTS.** Graduate medical education should always occur in a milieu that includes scholarship. Resident physicians should learn to appreciate the importance of scholarly activities and should be knowledgeable about scientific method. However, the accreditation requirements, the structure, and the content of graduate medical education should be directed toward preparing physicians to practice in a medical specialty. Individual educational opportunities beyond the residency program should be provided for resident physicians who have an interest in, and show an aptitude for, academic and research pursuits. The continued development of evidence-based medicine in the graduate medical education curriculum reinforces the integrity of the scientific method in the everyday practice of clinical medicine.

(5) **FACULTY SCHOLARSHIP.** All residency faculty members must engage in scholarly activities and/or scientific inquiry. Suitable examples of this work must not be limited to basic biomedical research. Faculty can comply with this principle through participation in scholarly meetings, journal club, lectures, and similar academic pursuits.

(6) **INSTITUTIONAL RESPONSIBILITY FOR PROGRAMS.** Specialty-specific GME must operate under a system of institutional governance responsible for the development and implementation of policies regarding the following; the initial authorization of programs, the appointment of program directors, compliance with the accreditation requirements of the ACGME, the advancement of resident physicians, the disciplining of resident physicians when this is appropriate, the maintenance of permanent records, and the credentialing of resident physicians who successfully complete the program. If an institution closes or has to reduce the size of a residency program, the institution must inform the residents as soon as possible. Institutions must make every effort to allow residents already in the program to complete their education in the affected program. When this is not possible, institutions must assist residents to enroll in another program in which they can continue their education. Programs must also make arrangements, when necessary, for the disposition of program files so that future confirmation of the completion of residency education is possible. Institutions should allow residents to form house staff organizations, or similar organizations, to address patient care and resident work environment concerns. Institutional committees should include resident members.

(7) **COMPENSATION OF RESIDENT PHYSICIANS.** All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.

(8) **LENGTH OF TRAINING.** The usual duration of an accredited residency in a specialty should be defined in the "Program Requirements." The required minimum duration should be the same for all programs in a specialty and should be sufficient to meet the stated objectives of residency education for the specialty and to cover the course content specified in the Program Requirements. The time required for an individual resident physician's education might be modified depending on the aptitude of the resident physician and the availability of required clinical experiences.

(9) **PROVISION OF FORMAL EDUCATIONAL EXPERIENCES.** Graduate medical education must include a formal educational component in addition to supervised clinical experience. This component should assist resident physicians in acquiring the knowledge and skill base required for practice in the specialty. The assignment of clinical responsibility to resident physicians must permit time for study of the basic sciences and clinical pathophysiology related to the specialty.

(10) **INNOVATION OF GRADUATE MEDICAL EDUCATION.** The requirements for accreditation of residency training should encourage educational innovation and continual improvement. New topic areas such as continuous quality improvement (CQI), outcome

management, informatics and information systems, and population-based medicine should be included as appropriate to the specialty.

(11) THE ENVIRONMENT OF GRADUATE MEDICAL EDUCATION. Sponsoring organizations and other GME programs must create an environment that is conducive to learning. There must be an appropriate balance between education and service. Resident physicians must be treated as colleagues.

(12) SUPERVISION OF RESIDENT PHYSICIANS. Program directors must supervise and evaluate the clinical performance of resident physicians. The policies of the sponsoring institution, as enforced by the program director, and specified in the ACGME Institutional Requirements and related accreditation documents, must ensure that the clinical activities of each resident physician are supervised to a degree that reflects the ability of the resident physician and the level of responsibility for the care of patients that may be safely delegated to the resident. The sponsoring institution's GME Committee must monitor programs' supervision of residents and ensure that supervision is consistent with: (A) Provision of safe and effective patient care; (B) Educational needs of residents; (C) Progressive responsibility appropriate to residents' level of education, competence, and experience; and (D) Other applicable Common and specialty/subspecialty specific Program Requirements. The program director, in cooperation with the institution, is responsible for maintaining work schedules for each resident based on the intensity and variability of assignments in conformity with ACGME Review Committee recommendations, and in compliance with the ACGME clinical and educational work hour standards. Integral to resident supervision is the necessity for frequent evaluation of residents by faculty, with discussion between faculty and resident. It is a cardinal principle that responsibility for the treatment of each patient and the education of resident and fellow physicians lies with the physician/faculty to whom the patient is assigned and who supervises all care rendered to the patient by residents and fellows. Each patient's attending physician must decide, within guidelines established by the program director, the extent to which responsibility may be delegated to the resident, and the appropriate degree of supervision of the resident's participation in the care of the patient. The attending physician, or designate, must be available to the resident for consultation at all times.

(13) EVALUATION OF RESIDENTS AND SPECIALTY BOARD CERTIFICATION. Residency program directors and faculty are responsible for evaluating and documenting the continuing development and competency of residents, as well as the readiness of residents to enter independent clinical practice upon completion of training. Program directors should also document any deficiency or concern that could interfere with the practice of medicine and which requires remediation, treatment, or removal from training. Inherent within the concept of specialty board certification is the necessity for the residency program to attest and affirm to the competence of the residents completing their training program and being recommended to the specialty board as candidates for examination. This attestation of competency should be accepted by specialty boards as fulfilling the educational and training requirements allowing candidates to sit for the certifying examination of each member board of the ABMS.

(14) GRADUATE MEDICAL EDUCATION IN THE AMBULATORY SETTING. Graduate medical education programs must provide educational experiences to residents in the broadest possible range of educational sites, so that residents are trained in the same types of sites in which they may practice after completing GME. It should include experiences in a variety of ambulatory settings, in addition to the traditional inpatient experience. The amount and types of ambulatory training is a function of the given specialty.

(15) VERIFICATION OF RESIDENT PHYSICIAN EXPERIENCE. The program director must document a resident physician's specific experiences and demonstrated knowledge, skills, attitudes, and behavior, and a record must be maintained within the institution.

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REPORT 2 OF THE COUNCIL ON MEDICAL EDUCATION (I-22)
Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection
Process
(Reference Committee C)

EXECUTIVE SUMMARY

American Medical Association (AMA) Policy D-295.963 (5) calls on our AMA to:

work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates.

This report, which is in response to this directive, reviews the current status of the residency selection process, which has led to increasing pressures for both applicant and program; responses to those pressures; and the potential downstream consequences of the residency selection process on perpetuating demographic and socioeconomic inequities. (Note: This report uses the term “residency selection process” to comprise both residency and fellowship program selection.)

To provide context, the report starts by providing data regarding recent trends in application processing, including specific factors used by program directors when determining which applicants to interview for residency. Specific discussion about the use of “filters” of objective metrics is included. Next the report reviews three medical honor societies—Alpha Omega Alpha, Gold Humanism Honor Society, and Sigma Sigma Phi—and their efforts to address the perpetuation of inequities within their honoree selection processes.

Lastly, the report reviews various attempts, including several pilot programs, designed to optimize the residency selection process, including a review of various standardized tools and other innovations designed to help minimize the burden on program directors while ensuring ample opportunity for applicants and programs to find a good “fit” with each other. It concludes with recommendations calling for AMA action to promote equity in the residency application and selection process.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 2-I-22

Subject: Mitigating Demographic and Socioeconomic Inequities in the Residency and Fellowship Selection Process

Presented by: John P. Williams, MD, Chair

Referred to: Reference Committee C

1 American Medical Association (AMA) Policy D-295.963 (5) calls on our AMA to:

2
3 work with appropriate stakeholders to study reforms to mitigate demographic and
4 socioeconomic inequities in the residency and fellowship selection process, including but not
5 limited to the selection and reporting of honor society membership and the use of standardized
6 tools to rank applicants, with report back to the House of Delegates.
7

8 This report is in response to that directive and encompasses a review of the current residency
9 selection process, which has led to increasing pressures for both applicant and program; responses
10 to those pressures, including the use of innovative processes and tools; and the potential
11 downstream consequences of the residency selection process on perpetuating demographic and
12 socioeconomic inequities. Examination of these issues is important as disparities in the medical
13 student population are transmitted into residency and fellowship, as matriculants of U.S. medical
14 schools comprise the largest pool of applicants to those programs.
15

16 BACKGROUND

17 *Current Medical Student and Resident/Fellow Demographics*

18
19
20 Racial, ethnic, socioeconomic, and geographic diversity is lacking in the physician workforce. A
21 2019 study of allopathic medical school programs revealed that, “Hispanic individuals are
22 underrepresented among medical school applicants and matriculants by nearly 70% relative to the
23 age-adjusted US population; black male applicants and matriculants, nearly 60%; black female
24 applicants, nearly 30%; and black female matriculants, nearly 40%. Similarly, [American Indian
25 and Alaska Native] AIAN individuals are underrepresented by more than 60% among applicants
26 and matriculants.”¹ Likewise, data from the Association of American Medical Colleges (AAMC)
27 for academic years 2018-2019 through 2021-22 show little appreciable change in disparities in
28 socioeconomic status among applicants and matriculants to medical school as determined by
29 parental occupation and highest level of education completed.² Examination of family income of
30 medical students also indicates a lack of diversity, with approximately three-quarters of medical
31 school matriculants from the top two household-income quintiles—a distribution that has not
32 changed in three decades.³
33

34 Furthermore, Shipman et al. reported a 15-year decline in the number of medical students from
35 rural areas, to fewer than five percent of all incoming medical students in 2017. In addition, fewer
36 than 0.5 percent of new medical students in 2017 with rural backgrounds were from
37 underrepresented racial/ethnic minoritized groups in medicine (URM). The authors conclude,

1 “Both URM and non-URM students with rural backgrounds are substantially and increasingly
2 underrepresented in medical school. If the number of rural students entering medical school were to
3 become proportional to the share of rural residents in the US population, the number would have to
4 quadruple.”⁴

5
6 Current trends, however, have shown positive outcomes stemming from efforts to diversify the
7 physician workforce in recent years. For allopathic medical schools, the number of Black or
8 African American students increased by 21.0 percent from 2020 to 2021, which is likely due to a
9 9.5 percent increase in matriculants (first-year students), with Black or African American men
10 making the most significant gains. Likewise, matriculants who identify as Hispanic, Latino, or of
11 Spanish origin increased by 7.1 percent (although American Indian or Alaska Native matriculants
12 declined by 8.5 percent during this time period).⁵ While these gains are important, disparities
13 remain.

14
15 Existing disparities in the applicant pool may also be exacerbated as URM applicants match
16 disproportionately into certain specialties (e.g., primary care fields) versus more competitive and
17 remunerative specialties (e.g., surgical subspecialties). Overall, these disparities influence the
18 composition of the physician workforce, which may have repercussions for patient care. For
19 example, studies have demonstrated that health outcomes are improved when there is racial
20 concordance between physician and patient.⁶

21 22 *Residency Selection Process*

23
24 After completion of medical school, nearly all medical students enter a residency program to
25 continue their training. The competition for these programs can be intense, especially for some
26 specialties with a limited number of residency positions. While competition between students is
27 nothing new, the pressure felt by a student to match into a residency program in their specialty of
28 choice has increased over recent years. A proxy measure for this perceived pressure is an increase
29 in the number of applications per applicant.

	2017	2021	% change
31 Applicants using Electronic Residency			
32 Application Service (ERAS)	45,395	50,830	+12.0%
33 Average number of applications			
34 per applicant	90	101	+12.3%
35 Average number of applications			
36 received by program (all applicants)	1,206	1,058	-13.3%
37 Average number of applications			
38 received by program (USMGs only)	387	469	+21.2%

39
40
41 Source: [AAMC ERAS Statistics website](#)

42
43 The reasons for this increase in the number of applications per applicant are numerous and likely
44 include the perception of an increasing number of students applying to a relatively static number of
45 residency positions, the ever-increasing medical education debt in relation to potential future
46 earning potential, and lifestyle priorities of younger generations. The increasing number of
47 applications likely has been exacerbated since the onset of the COVID-19 pandemic, when
48 residency interviews transitioned to a fully virtual format, thereby allowing students to apply to,
49 accept, and conduct interviews at a larger number of programs.

1 This trend causes significant pressure on program directors, as the administrative burden to review
 2 such a large volume of applications per residency position can understandably lead to the use of
 3 objective metrics such as GPA, standardized test scores, or honor society membership to narrow a
 4 large pool of applications to a more manageable size for detailed review. Program directors can use
 5 these and other objective metrics that are reported on the ERAS application as searchable “filters”
 6 to help determine which candidates to consider.

7
 8 The National Resident Matching Program (NRMP) program director survey provides insight into
 9 how program directors review applications and choose to offer interview positions. The 2021
 10 survey⁷ showed the percentage of program directors (all specialties) who cite a specific factor when
 11 considering whether to offer an interview to an applicant and, for those who cite these factors, their
 12 average importance on a scale of 1 (not important at all) to 5 (very important). These factors can be
 13 broken out into those that reflect academic performance and those that reflect personal
 14 characteristics. The following tables highlight the top five factors identified for each category; see
 15 Appendix C for graphics illustrating the full data. (Note: The survey response rate was 24.3
 16 percent.)

17
 18 *Factors Reflecting Education and Academic Performance*

	Percent Citing as a Factor	Average Weight
United States Medical Licensing Examination [®]		
(USMLE [®]) Step 1 Score	86.2	3.7
Medical Student Performance Evaluation		
(MSPE/Dean’s Letter)	85.9	4.0
USMLE Step 2 CK Score	78.8	3.8
Grades in required clerkships	74.6	3.9
Any failed attempt at USMLE	74.1	4.4

28
 29 *Factors Reflecting Personal Characteristics*

	Percent Citing as a Factor	Average Weight
Letters of recommendation in specialty	85.1	4.2
Personal statement (overall)	83.8	3.9
Diversity characteristics	80.9	4.1
Perceived commitment to specialty	79.5	4.3
Having overcome significant obstacles	75.5	4.1

30
 31
 32 While providing insight into what program directors consider important, this survey only
 33 tangentially looks at the process of filtering the objective metrics that are available through the
 34 ERAS application. Other data available in the same survey show that of those programs that use
 35 USMLE Step 1 scores in determining which applicants to interview, 60 percent use a set target
 36 score while 41 percent require only a passing score. These numbers are 68 percent and 25 percent,
 37 respectively, for those programs that screen using USMLE Step 2 CK. Comparable data for
 38 graduates of osteopathic medical school programs who take the Comprehensive Osteopathic
 39 Medical Licensing Examination of the United States (COMLEX-USA) Level 1 are 51 percent and
 40 31 percent, respectively, with COMLEX-USA Level 2-CE scores 57 percent and 23 percent,
 41 respectively. (Note: These data on USMLE and COMLEX were gathered before conversion of
 42 USMLE Step 1 and COMLEX Level 1 reporting to pass/fail, which may have impact on program
 43 interpretation of Step 1/Level 1 and Step 2/Level 2 scores.)
 44
 45
 46
 47
 48
 49

1 It should be noted that while considering academic performance as a factor in choosing whom to
2 interview, the weight provided to those factors is relatively low compared to some other factors,
3 with the exception of “any USMLE failure.” Still, a significant number of programs acknowledge
4 filtering applicants based upon academic performance on standardized exams.

5
6 One positive sign is that a significant number of program directors use an applicant’s diversity
7 characteristics as an influence on their decision regarding whether to interview that applicant. This
8 practice is in alignment with the intent of the Common Program Requirements of the Accreditation
9 Council for Graduate Medical Education, which state that residency programs and their sponsoring
10 institutions “must engage in practices that focus on mission-driven, ongoing, systematic
11 recruitment and retention of a diverse and inclusive workforce of residents, fellows, faculty
12 members, senior administrative staff members and other relevant members of the academic
13 community.”⁸

14
15 Overall, in the 2021 Residency Match, the average number of residency positions for all programs
16 was nine, for which the average number of applications received by a program was 1,013. Of these
17 applications, 506 (49.9 percent) were rejected based upon a standardized screening process and 423
18 (41.8 percent) received an in-depth holistic review.⁷

19
20 Although these data do not provide information on what the standardized screening process
21 entailed, one survey of internal medicine program directors (who can receive up to 3,000 applicants
22 per program) found that USMLE Step 2 CK score, USMLE Step 1 score, and attendance at a
23 specific medical school were the top three filters used for initial application review.⁹

24
25 While evidence is limited, there is concern that the use of test scores for this type of initial
26 screening review may introduce and exacerbate racial and socioeconomic biases into the selection
27 process. Numerous studies have demonstrated the link between standardized tests—common in K-
28 12 as well as higher education, along with the medical education continuum—and perpetuation of
29 racial and socioeconomic bias. It is not the examinations themselves, however, that are the issue
30 (for example, the Medical College Admission Test, or MCAT, for which the psychometric
31 literature shows no evidence of bias) but rather the larger and more insidious patterns of systemic
32 racism, which limit economic success and educational opportunity for minoritized populations.
33 Finally, and most importantly, research shows that the ability to pass a test is not especially
34 relevant to one’s ability to provide quality medical care. Emotional intelligence, empathy, and
35 communication are more valuable to the successful practice of medicine than sheer raw
36 intelligence. Indeed, as Lucey and Saguil note, “the MCAT exam is designed to measure
37 applicants’ academic preparation for medical school . . . not . . . to measure or predict their
38 performance related to other, essential competencies, such as interpersonal skills and
39 communication, professionalism, and ethical behavior, or to take the place of other attributes that
40 nonexam aspects of the admissions process evaluate.”¹⁰

41 42 MEDICAL HONOR SOCIETIES AND THEIR ROLE IN RESIDENCY SELECTION

43 44 *Background*

45
46 Similar to concerns about overreliance on standardized testing for advancement in higher education
47 and medical education, the use of medical honor society membership to screen applicants has
48 become a subject of increasing scrutiny in recent years. The next section considers three medical
49 honor societies, their role in the residency selection process, and their respective work to increase
50 attention to diversity and equity.

Alpha Omega Alpha

Formed in 1902, Alpha Omega Alpha (AΩA) has as its mission recognizing high educational achievement, honoring gifted teaching, encouraging the development of leaders in academia and the community, supporting the ideals of humanism, and promoting service to others. With over 200,000 members, AΩA has chapters in the majority of Liaison Committee on Medical Education (LCME)-accredited medical schools in the US, including all historically Black colleges and universities (HBCUs).

According to the AΩA website, “Membership in AΩA may be attained as a medical student, resident, fellow, faculty member, alumni, clinician, or distinguished leader in medicine. Each school may elect up to 20% of the graduating class of students, up to 25 residents/fellows, up to 10 faculty, and three to five alumni, who, based on merit, demonstrate the characteristics of excellent physicians in alignment with AΩA’s mission and values.”¹¹ Each chapter makes decisions on proposed members in alignment with that institution’s mission statement. As to diversity of membership, individual chapters may collect those data, but at the national level, the AΩA collects only member name, school, year of induction, and contact information (along with specialty if provided by the member).

Gold Humanism Honor Society

The Gold Foundation was founded in 1988 to preserve and elevate the tradition of humanism in health care. To focus and enhance the foundation’s efforts, the Gold Humanism Honor Society (GHHS) was founded in 2002; this international program now comprises 180 chapters and has close to 45,000 members. As stated in a February 7, 2022, memorandum from the Gold Foundation to the AMA (see Appendix A), the GHHS “identifies medical student exemplars of humanism using a validated, peer-nomination system.” No information is available regarding the diversity of its membership.

Sigma Sigma Phi

Founded in 1921, Sigma Sigma Phi (SSP) is an honorary service organization for osteopathic medical students who are selected by peers. Selection into SSP includes a blinded process that considers a minimum grade requirement and good standing by the medical school and then predominately the contributions made by the candidate to serve the community and humanity. Membership is open to all who apply and meet the minimum standards and is limited to no more than 25 percent of the total population of the student body. Students must have completed at least one semester of classroom work and show a high degree of scholarship and service to the college and/or profession. The SSP website lists 47 chapters as of February 2022. No information is available regarding the diversity of its membership.

Role of honor societies in the residency selection process

Medical honor societies are intended to recognize excellence in academic achievement and other markers of future success as physicians, including scholarship, aptitude for research, humanism, and professionalism. As with other variables previously mentioned, induction into these organizations may be used by program directors and other program personnel to evaluate applicants during the residency selection process; evidence suggests, however, that this factor is not as important as others.

1 In the 2021 NRMP data set, student membership in ΑΩΑ was 13th on the list of important factors
2 of an applicant, cited by 50.6 percent of program directors. Comparable data showed GHHS
3 membership at 14th (50.5 percent) and SSP membership at 22nd (21 percent).

4
5 *Concern about perpetuating disparities*

6
7 Despite the perceived value of recognizing excellence, medical honor societies have come under
8 criticism in recent years as potentially exclusionary if not antithetical to efforts to increase equity,
9 diversity, and belonging (EDB) in medical education and practice. One of the first institutions to
10 address this concern was the Icahn School of Medicine at Mount Sinai, which in 2018 put a
11 moratorium on student nominations to ΑΩΑ “because it determined the selection process
12 discriminates against students of color.”¹² Additionally, in May 2020, the University of California
13 – San Francisco School of Medicine announced that it was suspending its ΑΩΑ affiliation,
14 beginning with the class of 2021, stating, in part, that the selection process and membership
15 limitations may subvert efforts toward increased equity, through a misplaced emphasis on grades,
16 assessments, and performance and demonstrated bias against non-white students.¹³

17
18 Evidence to support these concerns exists. One study, published in *JAMA*, found that, “the odds of
19 ΑΩΑ membership for white students were nearly 6 times greater than those for black students and
20 nearly 2 times greater than for Asian students” which “may undermine the pipeline of minorities
21 entering the academic health care workforce.”¹⁴ Other research shows that these trends extend
22 beyond race/ethnicity to socioeconomic status, as students from backgrounds with lower income
23 than their peers were less likely to be ΑΩΑ members.”¹⁵ This phenomenon has been described as
24 an “amplification cascade,” in which “small differences in assessed performance lead to larger
25 differences in grades and selection for awards,” such that medical students from populations
26 underrepresented in medicine (UIM) “received approximately half as many honors grades as not-
27 UIM students and were three times less likely to be selected for honor society membership.”¹⁶

28
29 *Addressing disparities in medical honor society selection*

30
31 ΑΩΑ

32
33 The upper limit for the percentage of medical student electees from a given chapter rose from 16
34 percent to 20 percent in October 2020, when the organization changed its constitution. This change
35 was intended to help reduce the focus on grades as one of the highest determinants of achievement
36 and instead highlight character attributes such as “trustworthiness, character, caring, knowledge,
37 scholarship, proficiency in the doctor-patient relationship, leadership, compassion, empathy,
38 altruism, and servant leadership,” as described on the ΑΩΑ website. The move reflects changes at
39 many medical schools to eliminate or reduce grading and use a more holistic approach to selection
40 and advancement.

41
42 In 2020, ΑΩΑ declared a renewed focus on EDB to mitigate both conscious and unconscious bias
43 in medical education, including assessments of medical students, resident physicians, and faculty in
44 the nominations, selection, and election processes for the ΑΩΑ.¹⁷ These principles are reflected in
45 a statement on the ΑΩΑ website, which notes that the organization “advocates for diversity in all of
46 its forms – identity, cultural, geographic, experiential, race, ethnicity, gender, age, economic and
47 social status, physical abilities, aptitude, and religious beliefs, political beliefs, and other
48 ideologies.” In addition, an ΑΩΑ award recognizes medical schools that “demonstrate exemplary
49 leadership, innovation, and engagement in fostering an inclusive culture that transforms the ideals
50 of inclusion, diversity, and equity into successful programs.” This work has also included efforts to
51 increase the diversity of the ΑΩΑ board. Potential future reforms include the annual reporting of

1 member demographic data; standardized, transparent criteria for selecting members that mitigate
2 the potential for bias; and increased diversity within organizational leadership. Individual chapters
3 also have a role to play, through such actions as implementing holistic review of potential members
4 and annually reviewing newly elected cohorts to ensure that they match the institution's overall
5 demographics.¹⁸

6 7 GHHS

8
9 In the memo noted above, the Gold Foundation states, "In the past 23 months, the foundation and
10 the GHHS have pivoted to respond vigorously to the challenges of COVID-19 and have redoubled
11 our efforts to address [diversity, equity, and inclusion] in response to the racial reckoning following
12 George Floyd's murder to support healthcare in which human interests, values, and dignity
13 predominate." One of the organization's actions in this regard is the 2020-2021 GHHS national
14 initiative, "Humanism and Healing: Structural Racism and its Impact on Medicine," which was
15 followed by a virtual conference of the same name hosted by GHHS. In addition, the Gold
16 Foundation is engaged in a continuous improvement project to determine best practices in diversity
17 and inclusivity through work with the AAMC and individual GHHS chapters. To further the
18 collective understanding of this issue, the Foundation and GHHS are also conducting research on
19 the socio-demographic makeup of GHHS members to determine where differences exist to mitigate
20 future issues. The results of this analysis are forthcoming.

21 22 SSP

23
24 Related to diversity of applicants or honorees, SSP staff indicate that such data are not tracked at
25 the national level, but that meetings with chapter presidents and review of the lists of graduating
26 seniors indicate an appropriate level of diversity. Staff added, "At this point we see no problems
27 with the selection process. This has not been an issue or a problem with our organization, but if this
28 is brought up and becomes a concern, we are ready to do whatever needs to be done to address this
29 situation."

30
31 That said, it is important to provide context and note that DO schools report even lower levels of
32 diversity than allopathic schools. Data from the AAMC and the American Association of Colleges
33 of Osteopathic Medicine Application Services (AACOMAS) show a medical school matriculation
34 rate of 16.9 percent for URM individuals entering allopathic programs¹⁹ versus 12.1 percent for
35 osteopathic programs.²⁰ In short, the "appropriate" level of diversity may be proportionate to the
36 overall level of diversity in a given field, but that does not mitigate the core issue of inequity.

37 38 ATTEMPTS TO OPTIMIZE THE RESIDENCY SELECTION PROCESS

39 40 *Standardized Tools*

41
42 In 2018, the AAMC piloted a standardized video interview (SVI) for emergency medicine
43 programs, with the intent of providing a useful supplementary tool for selecting applicants to
44 interview. Its intent was to measure knowledge of professional behaviors along with interpersonal
45 skills and communication. The SVI, however, was discontinued after three cycles due to lack of
46 interest among both applicants and program directors. A letter from key stakeholders in emergency
47 medicine to the AAMC delineated three reasons for the program's dissolution: "lack of evidence to
48 support the SVI as an assessment tool, uncertainty around the cost of the program, and student
49 perceptions."²¹

1 In addition to helping program directors decide which applicants to interview, it was hoped that use
2 of the SVI would reduce bias in the selection process, as the interviews were scored by trained
3 reviewers not associated with the programs, and the performance of those reviewers was subject to
4 quality control. During the pilot phase, however, this standardized approach was subverted, in that
5 the videos were shared with programs in addition to the scores.

6
7 Other standardized approaches to ranking applicants include CASPer (Computer-based Assessment
8 for Sampling Personal characteristics (<https://takealtus.com/casper/>), an online, open-response
9 situational judgment test. CASPer is used by some medical schools in the application process and
10 has seen limited but increasing use in the residency selection process as well. For the 2022-23
11 application cycle, ophthalmology²² is piloting the use of the Altus Suite for Graduate Medical
12 Education,²³ comprising supplemental applications that include CASPer and two other tests:

- 13 • Snapshot, a one-way video interview designed to assess communication skills, self-
14 reflection, and motivation for the profession, and
- 15 • Duet, designed to assess alignment of values between an applicant and a program.

16
17 One article notes the use of CASPer in some general surgery residency programs led to a greater
18 number of interview offers to applicants from minoritized populations.²⁴ With growing interest in
19 ensuring professionalism, communication skills, and emotional intelligence among the physician
20 workforce, the use of this and similar tools may grow. Currently, these are either used too
21 infrequently or by so few programs that evidence is lacking to support or refute their use, especially
22 in the context of equity.

23
24 Another tool, described in a 2017 study, “validates a process for selecting and weighting
25 components of the ERAS application and interview day to create a customizable, institution-
26 specific tool for ranking candidates to postgraduate medical education programs.”²⁵ The authors do
27 not discuss whether this tool might have any impact on equity or diversity of applicants.

28 29 *Holistic Review*

30
31 Holistic review of applicants to medical school has been defined as “a flexible, individualized way
32 of assessing an applicant’s capabilities by which balanced consideration is given to experiences,
33 attributes, and academic metrics... and, when considered in combination, how the individual might
34 contribute value as a medical student and future physician.”²⁶ The authors of a 2021 *NEJM*
35 Perspective note that holistic review “has been shown to enhance diversity without affecting the
36 average grade-point average or exam scores for the entering class.”²⁷ Extending this process,
37 holistic review has been encouraged to mitigate biases in the residency selection process and shift
38 focus to factors associated with success in residency

39
40 While holistic review is viewed favorably by most, its practical use continues to face significant
41 barriers. Widespread adoption is hampered by the growing number of residency applications,
42 which exacerbates the administrative burden of reviewing a large volume of applications per open
43 residency slot and can lead to the use of objective metrics to filter applications. One experiment
44 seeks to use augmented intelligence and “big data” as tools for holistic screening of applicants to
45 improve the process at the medical school admissions level. Research at New York University
46 Grossman School of Medicine used clustering and other statistical techniques to develop profiles or
47 “signatures” that charted the academic success and trajectory of four different types of applicants—
48 “risers,” “improvers,” “solids,” and “statics.” Using this approach “can more sensitively uncover
49 success potential since it takes into account the inherent heterogeneity within the student
50 population.”²⁸

1 *Supplemental ERAS Application and Preference Signaling*

2
3 A recent effort by the AAMC, the Supplemental ERAS Application, seeks to empower applicants
4 to share more information about themselves using a fair process and driving holistic review in the
5 context of a high volume of applications. A list of FAQs on the AAMC website (see
6 <https://students-residents.aamc.org/applying-residencies-eras/supplemental-eras-application-faq>)
7 indicates that the application is “intended to help programs better identify applicants who are
8 genuinely interested in their program, and whose interests and experience align well with the
9 program’s setting, mission, and goals.” The supplemental application comprises three sections: past
10 experiences about the applicant’s most meaningful work, volunteer or research experiences;
11 geographic information (by region and by urban/rural setting); and preference signals for specific
12 programs. It shows promise as a vehicle to communicate information more relevant to residency
13 selection in these early pilots, but its impact on equity is still unknown. Use of the supplemental
14 application is growing, from the three fields of dermatology, general surgery, and internal medicine
15 in 2021 to 16 specialties planning to use it for the 2023 ERAS season, representing more than
16 2,900 programs.

17 *Interview capping*

18
19
20 In response to the COVID-19 pandemic, ophthalmology, which participates in the San Francisco
21 Match and thus has a different match timeline compared to most other specialties, has placed caps
22 on the number of programs to which a student can apply.²⁹ This cap is currently at 15 programs for
23 the 2022-23 application cycle.

24 *AMA ChangeMedEd Initiative*

25
26
27 The AMA funds a number of collaborative projects to address the transition from medical school to
28 residency. During its ChangeMedEd[®] 2021 conference, for example, the AMA funded three
29 submissions out of an initial pool of 135 applicants from institutions or collaborations related to
30 improving EDB in medical education. One program looks to view medical student evaluation and
31 assessment through an equity lens to make needed changes that support increased diversity. The
32 other two aim to help future physicians representing first-generation college attendees and students
33 from socioeconomically disadvantaged backgrounds make the transition from community college
34 to medical school in an expeditious and cost-effective way and to provide mentorship and
35 physician role models to young people considering a career in medicine.³⁰

36 37 RELEVANT AMA POLICY

38
39 The AMA has a number of policies related to increased diversity in medical education and
40 (ultimately) practice, as shown in Appendix B. In particular, edits to D-200.985, “Strategies for
41 Enhancing Diversity in the Physician Workforce,” are noted in this report’s recommendations, to
42 extend policy in favor of holistic review from solely medical school admissions to encompass
43 residency/fellowship program application as well.

44 45 CONCLUSION

46
47 A 2020 article describes the opportunity for reform in the program application, interview, and
48 matching process occasioned by the pandemic and the potential for positive impact related to EDB:
49 “This transformation to virtual interviews may allow us to reconsider how our present systems
50 perpetuate sociocultural biases.” The article also notes, “In the current social climate, it is

1 incumbent on program leaders to consider their own processes to minimize bias—both at a
2 personal level for their interviewers, but also at a systemic level within the systems we use.^{31[00]}

3
4 A related article from the same authors, in a three-part series on recruiting, interviewing, and
5 ranking residency program applicants, calls on program leadership to “deliberately incorporate
6 procedures that ensure equity.”³² When considering equity, virtual interviews have both pros and
7 cons. On the plus side, students with less means, who were not as able as their more affluent peers
8 to travel to multiple interviews, had greater access via virtual interviews. On the other hand,
9 candidates and programs may not attain a true sense of each other, making ranking difficult and
10 likely defaulting to familiarity and certainty, as opposed to choosing the best “fit.” This may
11 perpetuate existing bias. A secondary concern is the potential for a digital divide, with some
12 candidates lacking the technology and/or expertise with visual rhetoric to ensure a professionally
13 enhancing video image; this may also exacerbate existing inequities.

14
15 In their 2020 article, Lucey et al. classify equity in medical assessment and advancement as a
16 “wicked problem”—in other words, one that is multilayered, complex, complicated, and rife with
17 inherent conflict and dynamic tensions.³³ Addressing this problem will require continued
18 innovation and sustained attention.

19 20 SUMMARY AND RECOMMENDATIONS

21
22 The current pressures related to the residency selection process contributed to the use of readily
23 accessible comparative metrics (e.g., membership in one or more medical honor societies) when
24 determining which applicants to interview. Overreliance on these “objective” measures can
25 unintentionally perpetuate inequities and inhibit diversity in medical education. The current
26 pressures related to the residency selection process contributed to the use of readily accessible
27 comparative metrics (e.g., membership in one or more medical honor societies) when determining
28 which applicants to interview. However, measures once viewed as objective can unintentionally
29 perpetuate inequities and inhibit diversity in medical education. Numerous projects are underway
30 to optimize the residency selection process, including several sponsored by our AMA. Moving
31 forward, the profession must develop a resident selection process that is mutually beneficial for
32 applicants as well as program directors and institutions, while ensuring a commitment to a diverse,
33 equitable, and inclusive workforce.

34
35 The Council on Medical Education therefore recommends that the following recommendations be
36 adopted and the remainder of this report be filed:

- 37
38 1. That our AMA encourage medical schools, medical honor societies, and
39 residency/fellowship programs to work toward ethical, equitable, and transparent recruiting
40 processes, which are made available to all applicants. (New HOD Policy)
41
42 2. That AMA Policy D-200.985, “Strategies for Enhancing Diversity in the Physician
43 Workforce,” be amended by addition and deletion, to read as follows:

44
45 Our AMA will recommend that medical school admissions committees and
46 residency/fellowship programs use holistic assessments of ~~admission~~ applicants that take
47 into account the diversity of preparation and the variety of talents that applicants bring to
48 their education with the goal of improving health care for all communities. (Modify
49 Current HOD Policy)

- 1 3. That our AMA advocate for residency and fellowship programs to avoid using objective
2 criteria available in the Electronic Residency Application Service (ERAS) application
3 process as the sole determinant for deciding which applicants to offer interviews.
4 (Directive to Take Action)
5
- 6 4. That our AMA advocate to remove membership in medical honor societies as a mandated
7 field of entry on the Electronic Residency Application Service (ERAS)—thereby limiting
8 its use as an automated screening mechanism—and encourage applicants to share this
9 information within other aspects of the ERAS application. (Directive to Take Action)
10
- 11 5. That our AMA advocate for and support innovation in the undergraduate medical
12 education to graduate medical education transition, especially focusing on the efforts of the
13 Accelerating Change in Medical Education initiative, to include pilot efforts to optimize
14 the residency/fellowship application and matching process. (New HOD Policy)
15
- 16 6. That our AMA monitor use of novel online assessments for sampling personal
17 characteristics for the purpose of medical school admissions or residency/fellowship
18 selection and consider their impact on equity and diversity of the physician workforce.
19 (New HOD Policy)
20
- 21 7. That AMA Policy D-295.963(5), “Continued Support for Diversity in Medical Education,”
22 be rescinded, as having been fulfilled through this report:
23
- 24 Our AMA will: ... ~~work with appropriate stakeholders to study reforms to mitigate~~
25 ~~demographic and socioeconomic inequities in the residency and fellowship selection~~
26 ~~process, including but not limited to the selection and reporting of honor society~~
27 ~~membership and the use of standardized tools to rank applicants, with report back to the~~
28 ~~House of Delegates.~~ (Rescind HOD Policy)

Fiscal note: \$1,000.

APPENDIX A: MEMORANDUM FROM THE ARNOLD P. GOLD FOUNDATION TO THE AMA, FEBRUARY 7, 2022

This briefing by The Arnold P. Gold Foundation (Gold Foundation) is in response to the request from the American Medical Association (AMA) for information on honor societies in American medical schools as they relate to equity and diversity in medical education and practice.

The Gold Foundation was founded in 1988 to preserve and elevate the tradition of humanism in healthcare (see <https://www.gold-foundation.org/>). As a means to focus and enhance the foundation's efforts, we created the Gold Humanism Honor Society (GHHS) in 2002 (<https://www.gold-foundation.org/programs/ghhs/>), and it now is an international program with 180 chapters and close to 45,000 members.

As an expression of the Gold Foundation itself, and as described below, the GHHS identifies medical student exemplars of humanism using a validated, peer-nomination system (McCormack et al., 2007). In the past 23 months, the foundation and the GHHS have pivoted to respond vigorously to the challenges of COVID-19 and have redoubled our efforts to address DEI in response to the racial reckoning following George Floyd's murder to support healthcare in which human interests, values, and dignity predominate.

We appreciate that AMA is also working on ensuring diversity and equity in medical education and practice, and we are pleased to share these updates on our work with the AMA House of Delegates. Should you have any questions regarding this response, please let us know.

Response to AMA regarding the GHHS in American Medical Education and Practice

The Gold Foundation established the Gold Humanism Honor Society (GHHS) twenty years ago as a signature program to recognize exemplary medical students, residents, and faculty who practice patient-centered care by modeling the qualities of integrity, excellence, compassion, respect, and empathy.

What began in 2002 at only a few medical schools now includes 180 chapters, with more than 3,000 students inducted each year and a total membership that numbers close to 45,000. The GHHS is an active society promoting humanism within medical schools and hospitals. Chapters participate in annual programs such as Thank a Resident Day and Solidarity Week for Compassionate Patient Care, and also undertake individual chapter-initiated projects on their campuses and within their communities. GHHS members are expected to be leaders of humanism on their campus and throughout their careers.

The GHHS leadership structure includes a national Advisory Council of 23 members comprising both the career stages and the broad functions represented in healthcare and academic medicine. The Advisory Council provides guidance and support to the society with committees and working groups, and the GHHS Advisory Council Chair and the Chair-Elect sit on the Gold Foundation Board of Trustees. Medical schools wishing to start a GHHS chapter apply and are thoroughly vetted. As noted, student selection into a GHHS chapter is based on peer nomination using a validated tool ([McCormack et al., 2007](#)). The initial group of peer-nominated students is then typically evaluated by a selection committee that considers academic eligibility, program director evaluations, an additional essay, interview, or other indication of the nominee's demonstrated humanism. While GHHS allows for some flexibility, all selection processes are vetted and approved when a medical school applies for a chapter and then reviewed periodically thereafter.

The Gold Foundation has long understood that equity, diversity, and inclusion are part of the very fabric of humanism. This was further spurred by the pandemics of COVID-19 and racism, which have highlighted inequalities and disparities, and compelled a closer look at flaws within our healthcare system. Within this broad context, the Gold Foundation reviewed all its programming through the lens of diversity, equity, inclusion, and anti-racism and has placed explicit emphasis on these issues within our work and strategic plan. (Click to read [Gold Foundation statement on diversity, equity, inclusion and anti-racism](#))

The GHHS has specifically addressed this topic throughout the past two years in a number of ways, including:

1. Engaging a researcher to assess the demographics of GHHS
2. Establishing a National Initiative in 2020-21 for chapters on the impact of structural racism in medicine, which concluded with a large international conference in May 2021 to share what had been learned, as well as steps that schools and systems could take to begin addressing racism in medicine
3. Engaging in a continuous improvement project to determine best practices in diversity and inclusivity through work with the AAMC and individual GHHS chapters.

Research on GHHS Demographics

While racial/ethnic disparities in Alpha Omega Alpha (ΑΩΑ) membership have been documented ([Boatright et al., 2017](#)) and formally responded to by the ΑΩΑ ([Byyny et al., 2020](#)), less is known about how the demographic composition of GHHS reflects the diversity of medical schools nationally. One study of GHHS published in *Academic Medicine* in 2019 demonstrated no difference in the likelihood of Black or African-American medical students being inducted into GHHS compared to white medical students ([Wijesekera, et al., 2019](#)).

Recognizing the importance of more deeply understanding the demographic composition of our members, the Gold Foundation decided in 2020 to reach out to an academic researcher to examine this issue. With the assistance of a Gold Foundation Board of Trustees advisory committee, [Dr. Dowin Boatright](#), MD, MBA, MHS, Assistant Professor of Emergency Medicine and Officer for Diversity and Inclusion at Yale School of Medicine, was identified and agreed to include GHHS in his work.

Dr. Boatright and his research team are examining the association between GHHS membership and several aspects of student identity including race/ethnicity, sex, sexual orientation, and socioeconomic status (SES) in a national cohort of medical students. Although the results are preliminary and currently unpublished, per Dr. Boatright, *so far, they are finding no disparities by sex, sexual orientation, or SES. Additionally, they are finding no difference in the likelihood of membership between Black, Hispanic, and Native American students and white students, but they are seeing some differences between white and Asian students favoring white students. The cause of this disparity is unknown and warrants further examination* (D. Boatright, personal communication, January 19, 2022). Dr. Boatright expects to finalize his analysis and publish later this year, and the Gold Foundation has committed to supporting open access publication of this research.

The Gold Foundation is committed to continuing to transparently assess, understand, and address inequities. To that end, Dr. Boatright notes:

“Disparities in honor society membership are important to acknowledge and address. Nevertheless, it is unclear if removing honor societies from the ERAS application will solve the underlying problem contributing to these disparities nor ameliorate the downstream implication of these disparities on the physician workforce as medical students could always self-report honor society membership on the ERAS application.

Instead, it is likely more important for honor societies, like GHHS, to continuously examine honor society membership for systematic disparities and investigate evidence-based interventions to ensure equity in membership. Moreover, honor societies should be transparent in their findings and make data concerning disparities public. Additionally, as GHHS is committed to doing, the national honor societies should work with local chapters to promote equity and inclusion in membership selection.” (D. Boatright, personal communication, January 19, 2022)

GHHS Programmatic Focus on Diversity, Equity, Inclusion and Anti-Racism

GHHS chapters have undertaken many projects dedicated to serving populations most in need. Recent projects include: Engagement in Justice in Middle Tennessee and the Nation (Vanderbilt), Chicago Street Medicine (University of Chicago, Illinois), The Invisible Minority: Healthcare Disparities in Appalachia (West Virginia University), How We Heal: Applying Structural Competency to Care for Immigrant Communities (UC Riverside), and many others.

The events of 2020 compelled GHHS leadership to create a focused National Initiative for 2020-2021 titled “Humanism and Healing: Structural Racism and its Impact on Medicine.” Chapters were encouraged to use their leadership roles to start or extend conversations about racism and its impact on healthcare in their local communities and beyond, to create space for grieving, processing, and bearing witness around this topic, or to take action in one of many powerful ways that humanism can begin to heal. Chapter projects included such activities as:

- Creation of an anti-racism library collection (Cooper Medical School)
- Video Vignettes of Bias and Racism workshop (Central Michigan University)
- Panel discussion titled “A Calculated Risk: Engaging with Black Patients in Discussion About the Covid-19 Vaccine” (Emory University)
- Panel discussion titled “Fad-vocacy Armchair Empathy: Maintaining Social Justice Momentum” (joint project with Howard University and University of Michigan)
- Panel discussion titled “The Dismissal of Black Suffering” (University of California Irvine)
- Panel discussion titled “Medical Students Partner and Learn from Women Who are Incarcerated” (GHHS member Michelle Harper, MD, and the Ohio State University)

The National Initiative concluded with a large virtual conference on May 6-8, 2021. The conference, hosted by GHHS, included presentations from GHHS members (including panel discussions, workshops, and poster sessions) as well as many other Gold Foundation partners. Keynote presentations included:

- “The Ultimate ‘Anti-Racism Statement’ that Medicine Can Make is to Diversify Our Ranks” (Quinn Capers, MD, Associate Dean for Faculty Diversity and Vice Chair for Diversity and Inclusion, Department of Internal Medicine, UT Southwestern)
- “Partnership with HBCUs: Challenging Systemic Racism in Health Education, A Nursing Story” (Dr. Gina S. Brown, Dean, College of Nursing and Allied Health Sciences at Howard University; Dr. Eileen Sullivan-Marx, Dean of the New York University Rory Meyers College of Nursing; Dr. George Thibault (Ignitor), Immediate Past President of the Josiah Macy Junior Foundation)
- “COVID-19 and the Racial Reckoning” (Dr. Richard I. Levin, President and CEO of the Gold Foundation; Dr. Wayne Riley, President of SUNY Downstate Health Sciences University)

Many insightful and thought-provoking sessions encouraging participants to work toward increased health equity and racial equality were part of the conference, including a panel discussion on advocacy and grassroots change, a film screening of *Black Men in White Coats*, a panel on vaccine deliberation, and many more. The 2021-23 GHHS International Initiative expands on this work, titled “Healing the Heart of Healthcare: Reimagining How We Listen, Connect and Collaborate.” GHHS members are leaders in humanism and will, with Gold Foundation support, continue to work toward greater diversity, equity, and inclusion within healthcare for years to come.

Continuous Improvement Project to Determine Best Practices in Diversity and Inclusivity

The Gold Foundation is continually working with GHHS chapters to provide guidance and determine best practices for ensuring that membership is inclusive and diverse. Currently, the GHHS leadership is nearing the conclusion of a biennial check-in with chapters. The 2021 check-in added questions to gather information regarding how each chapter is working to ensure and improve diversity and inclusion within its selection process, including members of the selection committee. The Gold Foundation is concurrently working with the AAMC to consider URM medical student representation within chapters as it compares with each chapter's medical school at large. These efforts will be used to create best practice strategies for GHHS chapters to ensure inclusivity and diversity.

Summary

The Gold Foundation established the Gold Humanism Honor Society (GHHS) twenty years ago as a signature program to recognize exemplary medical students, residents, and faculty who practice patient-centered care by modeling the qualities of integrity, excellence, compassion, respect, and empathy. What began in 2002 at only a few medical schools now includes 180 chapters, with more than 3,000 students inducted each year, and a membership that numbers close to 45,000. The Gold Foundation is committed to ensuring that the society is diverse and inclusive.

- Research on GHHS demographic makeup is underway by a Yale research team led by Dr. Dowin Boatright. Publication is expected shortly.
- The 2020-2021 GHHS National Initiative, "Humanism and Healing: Structural Racism and its Impact on Medicine," was followed by a virtual conference of the same name hosted by GHHS.
- The Gold Foundation is engaged in a continuous improvement project to determine best practices in diversity and inclusivity through work with the AAMC and individual GHHS chapters.

APPENDIX B: RELEVANT AMA POLICY

D-200.985, "Strategies for Enhancing Diversity in the Physician Workforce"

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.
- (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)

D-295.963, "Continued Support for Diversity in Medical Education"

Our AMA will: (1) publicly state and reaffirm its stance on diversity in medical education; (2) request that the Liaison Committee on Medical Education regularly share statistics related to compliance with accreditation standards IS-16 and MS-8 with medical schools and with other stakeholder groups; (3) work with appropriate stakeholders to commission and enact the recommendations of a forward-looking, cross-continuum, external study of 21st century medical education focused on reimagining the future of health equity and racial justice in medical education, improving the diversity of the health workforce, and ameliorating inequitable outcomes among minoritized and marginalized patient populations; (4) advocate for funding to support the creation and sustainability of Historically Black College and University (HBCU), Hispanic-Serving Institution (HSI), and Tribal College and University (TCU) affiliated medical schools and residency programs, with the goal of achieving a physician workforce that is proportional to the racial, ethnic, and gender composition of the United States population; and (5) work with appropriate stakeholders to study reforms to mitigate demographic and socioeconomic inequities in the residency and fellowship selection process, including but not limited to the selection and reporting of honor society membership and the use of standardized tools to rank applicants, with report back to the House of Delegates.

(Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13; Appended: CME Rep. 5, A-21)

H-350.960, "Underrepresented Student Access to US Medical Schools"

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; and (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students.

(Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15)

D-295.963, "Continued Support for Diversity in Medical Education"

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

(Res. 325, A-03; Appended: CME Rep. 6, A-11; Modified: CME Rep. 3, A-13)

H-295.888, "Progress in Medical Education: the Medical School Admission Process"

1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.

2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities

in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school.

(CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11)

H-65.952, "Racism as a Public Health Threat"

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA will identify a set of current, best practices for healthcare institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, providers, international medical graduates, and populations.
4. 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.
5. 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.
6. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

(Res. 5, I-20)

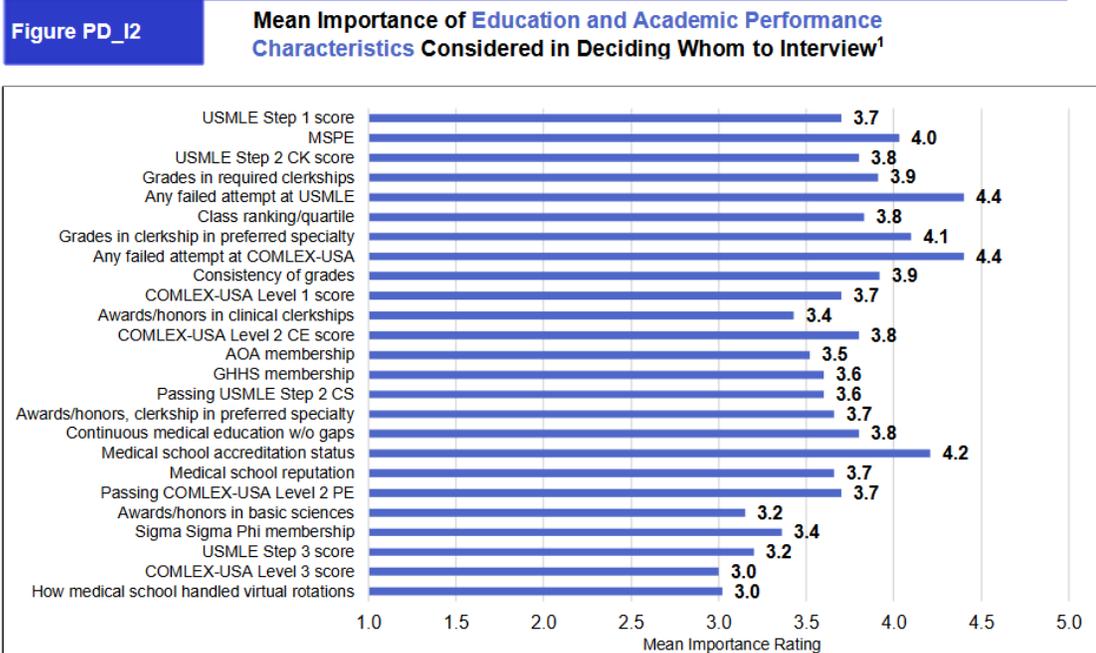
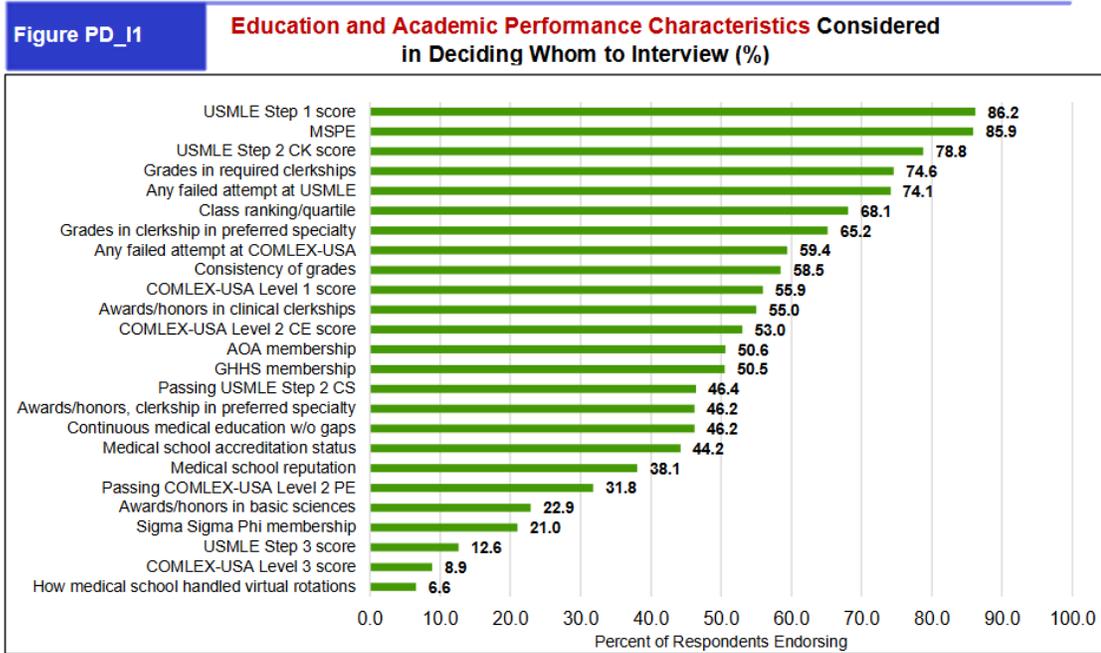
APPENDIX C – NRMP PROGRAM DIRECTOR SURVEY RESULTS

Source:

Results of the 2021 NRMP Program Director Survey.

National Resident Matching Program, August 2021.

<https://www.nrmp.org/wp-content/uploads/2021/11/2021-PD-Survey-Report-for-WWW.pdf>



¹ Rated on a scale of 1 (not at all important) to 5 (very important)

Figure PD_13

Personal Characteristics and Other Knowledge of Applicants Considered in Deciding Whom to Interview (%)

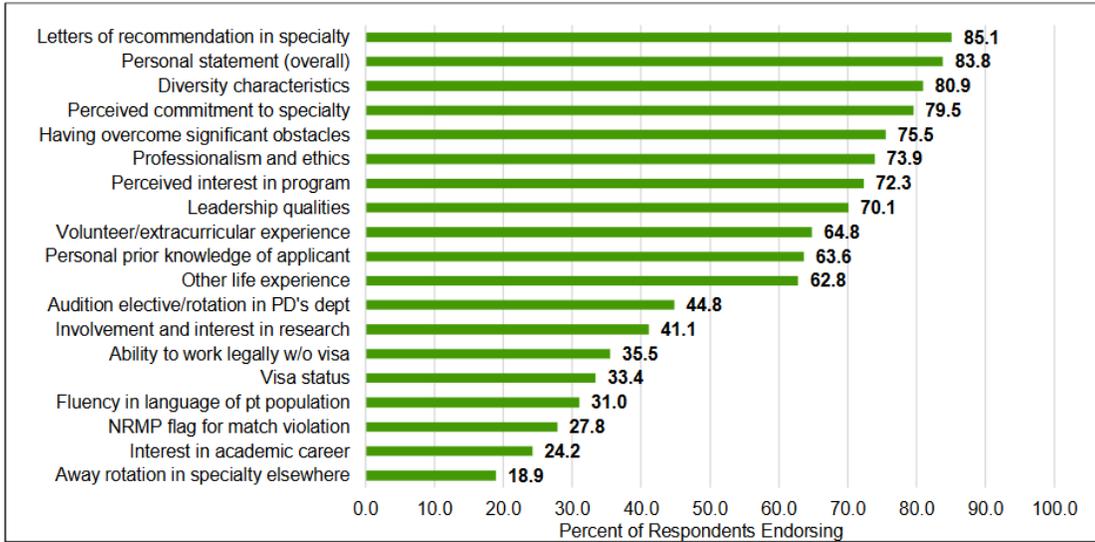
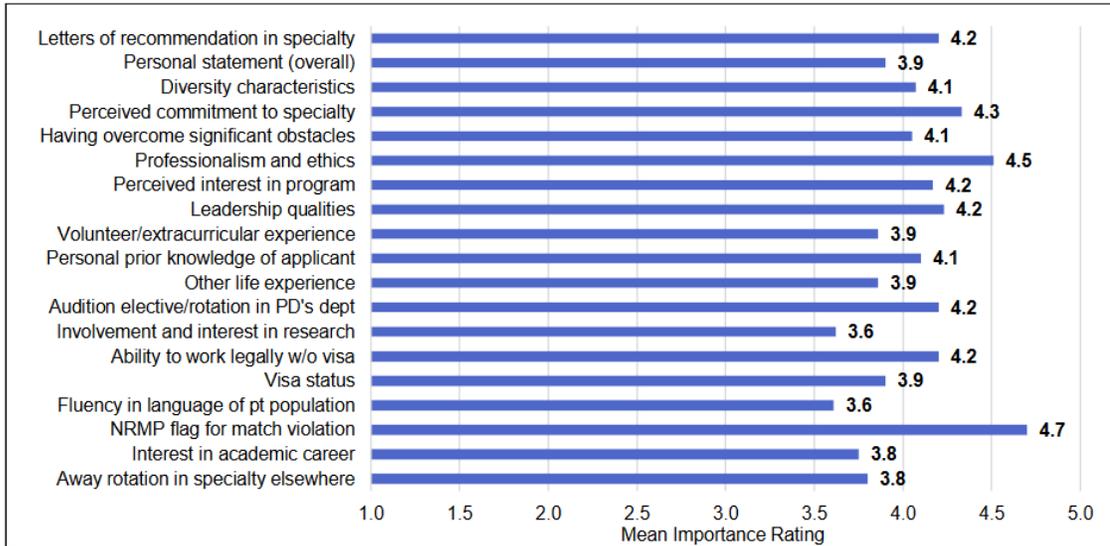


Figure PD_14

Mean Importance of Personal Characteristics and Other Knowledge of Applicants Considered in Deciding Whom to Interview¹



¹ Rated on a scale of 1 (not at all important) to 5 (very important)

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 302
(1-22)

Introduced by: Medical Student Section

Subject: Expanding Employee Leave to Include Miscarriage and Stillbirth

Referred to: Reference Committee C

1 *We use the word "women" in the whereas clauses of this resolution when referring to people*
2 *who have experienced pregnancy to stay consistent with the language of the sources and*
3 *studies we have cited. However, this is not meant to be exclusionary, and we recognize that all*
4 *people with a uterus, regardless of gender identity, can experience pregnancy loss.*

5
6 Whereas, An estimated 26% of all pregnancies and 10% of clinically recognized pregnancies
7 end in miscarriage¹; and

8
9 Whereas, An estimated 24,000 stillbirths occur each year in the United States²; and

10
11 Whereas, It takes at least two weeks to physically recover from a miscarriage and the World
12 Health Organization (WHO) recommends waiting 6 months after a miscarriage to try again to
13 get pregnant^{3,4}; and

14
15 Whereas, The risk of severe maternal morbidity is more than four times higher for stillbirths
16 compared with live birth deliveries^{5,6}; and

17
18 Whereas, In multiple studies, PTSD prevalence ranged from 33.3% to 60% after pregnancy
19 loss, and the prevalence of anxiety was 20%, the prevalence of depression ranged from 5% to
20 54% respectively, and 77% of parents experienced emotional and psychological distress
21 following a stillbirth^{7,8,9,10}; and

22
23 Whereas, Black women and women of lower socioeconomic status are twice as likely to
24 experience late miscarriage and stillbirth, have limited access to bereavement support, and are
25 less likely to have access to paid leave time after miscarriage or stillbirth¹¹; and

26
27 Whereas, Paid sick leave has been shown to lead to an increase in employment, reduction in
28 workforce turnover, and increases in household incomes¹²; and

29
30 Whereas, The District of Columbia recently expanded bereavement leave to include leave for
31 loss of a pregnancy, several states, including Illinois, Maryland, Oregon, and Washington, have
32 bereavement of family leave policies but do not specify if pregnancy loss meets criteria for such
33 leave, and multiple countries, including New Zealand and South Korea, mandate paid leave for
34 miscarriages and similar legislation, such as the Support through Loss Act, has been introduced
35 in the United States^{13, 14, 15, 16, 17, 18}; and

36
37 Whereas, Our AMA supports medical and family leave (H-420.979 and H-405.960) but we do
38 not have policy that explicitly notes that this should include leave for pregnancy loss; therefore
39 be it

1 RESOLVED, That our American Medical Association amend Policy H-405.960, "Policies for
2 Parental, Family, and Medical Necessity Leave," by addition and deletion to read as follows:
3

4 **Policies for Parental, Family and Medical Necessity Leave H-405.960**

5 AMA adopts as policy the following guidelines for, and encourages the implementation
6 of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

7 1. Our AMA urges medical schools, residency training programs, medical specialty
8 boards, the Accreditation Council for Graduate Medical Education, and medical group
9 practices to incorporate and/or encourage development of leave policies, including
10 parental, family, and medical leave policies, as part of the physician's standard benefit
11 agreement.

12 2. Recommended components of parental leave policies for medical students and
13 physicians include: (a) duration of leave allowed before and after delivery; (b) category
14 of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for
15 continuation of insurance benefits during leave, and who pays the premium; (e) whether
16 sick leave and vacation time may be accrued from year to year or used in advance; (f)
17 how much time must be made up in order to be considered board eligible; (g) whether
18 make-up time will be paid; (h) whether schedule accommodations are allowed; ~~and~~ (i)
19 leave policy for adoption; and (j) leave policy for miscarriage or stillbirth.

20 3. AMA policy is expanded to include physicians in practice, reading as follows: (a)
21 residency program directors and group practice administrators should review federal law
22 concerning maternity leave for guidance in developing policies to assure that pregnant
23 physicians are allowed the same sick leave or disability benefits as those physicians
24 who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible
25 enough to allow for coverage without creating intolerable increases in other physicians'
26 workloads, particularly in residency programs; and (c) physicians should be able to
27 return to their practices or training programs after taking parental leave without the loss
28 of status.

29 4. Our AMA encourages medical schools, residency programs, specialty boards, and
30 medical group practices to incorporate into their parental leave policies a six-week
31 minimum leave allowance, with the understanding that no parent should be required to
32 take a minimum leave.

33 5. Residency program directors should review federal and state law for guidance in
34 developing policies for parental, family, and medical leave.

35 6. Medical students and physicians who are unable to work because of pregnancy,
36 childbirth, and other related medical conditions should be entitled to such leave and
37 other benefits on the same basis as other physicians who are temporarily unable to work
38 for other medical reasons.

39 7. Residency programs should develop written policies on parental leave, family leave,
40 and medical leave for physicians. Such written policies should include the following
41 elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and
42 after delivery; (c) duration of leave allowed after miscarriage or stillbirth; ~~(e)~~(d) category
43 of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); ~~(d)~~(e)
44 whether leave is paid or unpaid; ~~(e)~~(f) whether provision is made for continuation of
45 insurance benefits during leave and who pays for premiums; ~~(f)~~(g) whether sick leave
46 and vacation time may be accrued from year to year or used in advance; ~~(g)~~(h) extended
47 leave for resident physicians with extraordinary and long-term personal or family medical
48 tragedies for periods of up to one year, without loss of previously accepted residency
49 positions, for devastating conditions such as terminal illness, permanent disability, or
50 complications of pregnancy that threaten maternal or fetal life; ~~(h)~~(i) how time can be
51 made up in order for a resident physician to be considered board eligible; ~~(i)~~(j) what
52 period of leave would result in a resident physician being required to complete an extra

1 or delayed year of training; ~~(j)~~(k) whether time spent in making up a leave will be paid;
2 and ~~(k)~~(l) whether schedule accommodations are allowed, such as reduced hours, no
3 night call, modified rotation schedules, and permanent part-time scheduling.

4 8. Our AMA endorses the concept of equal parental leave for birth, stillbirth, miscarriage,
5 and adoption as a benefit for resident physicians, medical students, and physicians in
6 practice regardless of gender or gender identity.

7 9. Staffing levels and scheduling are encouraged to be flexible enough to allow for
8 coverage without creating intolerable increases in the workloads of other physicians,
9 particularly those in residency programs.

10 10. Physicians should be able to return to their practices or training programs after
11 taking parental leave, family leave, or medical leave without the loss of status.

12 11. Residency program directors must assist residents in identifying their specific
13 requirements (for example, the number of months to be made up) because of leave for
14 eligibility for board certification and must notify residents on leave if they are in danger of
15 falling below minimal requirements for board eligibility. Program directors must give
16 these residents a complete list of requirements to be completed in order to retain board
17 eligibility.

18 12. Our AMA encourages flexibility in residency training programs, incorporating parental
19 leave and alternative schedules for pregnant house staff.

20 13. In order to accommodate leave protected by the federal Family and Medical Leave
21 Act, our AMA encourages all specialties within the American Board of Medical
22 Specialties to allow graduating residents to extend training up to 12 weeks after the
23 traditional residency completion date while still maintaining board eligibility in that year.

24 14. These policies as above should be freely available online and in writing to all
25 applicants to medical school, residency or fellowship. (Modify Current HOD Policy); and
26 be it further
27

28 RESOLVED, That due to the prevalence of miscarriage and stillbirth and the need for physical
29 and psychological healing afterwards, our AMA amend Policy H-420.979 "AMA Statement on
30 Family and Medical Leave," by addition to read as follows:
31

32 **AMA Statement on Family and Medical Leave H-420.979**

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

37 (1) medical leave for the employee, including pregnancy; miscarriage, and stillbirth;

38 (2) maternity leave for the employee-mother;

39 (3) leave if medically appropriate to care for a member of the employee's immediate
40 family, i.e., a spouse or children; and

41 (4) leave for adoption or for foster care leading to adoption. Such periods of leave may
42 differ with respect to each of the foregoing classifications, and may vary with
43 reasonable categories of employers. Such policies should encourage voluntary
44 programs by employers and may provide for appropriate legislation (with or without
45 financial assistance from government). Any legislative proposals will be reviewed
46 through the Association's normal legislative process for appropriateness, taking into
47 consideration all elements therein, including classifications of employees and
48 employers, reasons for the leave, periods of leave recognized (whether paid or
49 unpaid), obligations on return from leave, and other factors involved in order to achieve
50 reasonable objectives recognizing the legitimate needs of employees and employers.

51 (Modify Current HOD Policy)

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

Received: 09/20/22

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RELEVANT AMA POLICY

Policies for Parental, Family and Medical Necessity Leave H-405.960

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity

leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.

5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.

6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

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12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

CCB/CLRPD Rep. 4, A-13, Modified: Res. 305, A-14, Modified: Res. 904, I-14, Modified: Res. 307, A-22

AMA Statement on Family and Medical Leave H-420.979

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and (4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

BOT Rep. A, A-88, Reaffirmed: Sunset Report, I-98, Reaffirmed: CLRPD Rep. 1, A-08, Reaffirmation A-12, Reaffirmed: CMS Rep. 03, A-16

Parental Leave H-405.954

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.

2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.

3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.

4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.

Res. 215, I-16, Appended: BOT Rep. 11, A-19, Appended: Res. 403, A-22

Paid Sick Leave H-440.823

Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome.

CMS Rep. 03, A-16, Reaffirmed: BOT Rep. 11, A-19

FMLA Equivalence H-270.951

Our AMA will advocate that Family and Medical Leave Act policies include any individual related by blood or affinity whose close association with the employee is the equivalent of a family relationship.

Res. 002, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 303
(I-22)

Introduced by: Medical Student Section

Subject: Medical Student Leave Policy

Referred to: Reference Committee C

1 Whereas, The age of matriculation to medical school has been gradually increasing over the
2 past several years resulting in an increase in trainees whose peak reproductive years now
3 overlap partially or entirely with their medical school education^{1,2}; and
4

5 Whereas, As of 2021, over seven percent of graduating medical students had at least one non-
6 spouse dependent, the majority of whom are likely children³; and
7

8 Whereas, A 2017 single-institution study conducted at the University of South Dakota Sanford
9 School of Medicine revealed that parenthood may affect an even larger proportion of the student
10 body at some institutions, as they reported that 25 of 185 (13%) of surveyed students had
11 become parents or were currently pregnant at the time of the study⁴; and
12

13 Whereas, Further, more than half of matriculants to medical school now are female, meaning
14 that these trainees bear the responsibility of coping with the physical, mental, and emotional
15 changes of pregnancy, labor, and delivery, as well as infant- and child-care, in addition to the
16 high-stakes, demanding, and often exhausting rigors of medical school¹; and
17

18 Whereas, Despite a growing number of medical students pursuing parenthood concomitantly
19 with medical training, medical schools lag behind other levels of medical training—namely
20 graduate medical education (GME), aka residency—in providing their trainee-parents supportive,
21 accessible, and clear parental leave policies; and
22

23 Whereas, For many medical students, even locating the parental leave policy for their school
24 can be time-consuming and ultimately fruitless, as many medical schools fail to publish or do
25 not have—a parental leave policy for their students and a 2019 study sifted through the websites
26 and student-handbooks of 199 allopathic and osteopathic medical schools in the US⁵; and
27

28 Whereas, The researchers found that only 65 of 199 (33%) of schools had parental leave
29 policies available on their website or in their handbook and the policies located were far from
30 standardized; and
31

32 Whereas, Only 38 of the 65 (58%) available policies specifically included maternity AND
33 paternity leave; 23 (35%) policies allowed for maternity leave only; of the 65 available policies,
34 only 21 (32%) included an option to maintain the student's original graduation date following the
35 leave; and only 3 (5%) school policies included parental leave for adoption⁵; and
36

37 Whereas, The stress of having to locate parental leave policies, request and/or advocate for
38 time off at a school which does not have a published parental leave policy, and, at most
39 institutions, face the financial and psychological barriers of delay of graduation, and can be
40 prohibitive to students wanting to begin families during their training; and

1 Whereas, The American Board of Medical Specialties (ABMS), recently recognized the need for
2 parental leave policies and standardized requirements among all GME institutions nationwide,
3 citing issues of trainee mental and physical wellness and work-life balance as well as “helping to
4 narrow the gender gap in [women’s] career advancement” as chief reasons for implementing
5 such policies⁶; and
6

7 Whereas, Like medical students, GME matriculants are becoming parents, and having
8 institutional support for the critical adjustment and bonding period of having a newborn is
9 important to both mothers and fathers; and
10

11 Whereas, As of July 2021, the ABMS required that all Accreditation Council for Graduate
12 Medical Education (ACGME)-accredited residency programs “allow for a minimum of six weeks
13 away once during training for purposes of parental, caregiver, and medical leave, without
14 exhausting time allowed for vacation or sick leave and without requiring an extension in training”
15 ⁶; and
16

17 Whereas, This new requirement indicates a recognition among the medical community that a
18 visible and non-negotiable parental leave policy is important for the health and well-being of
19 medical trainees and should be in place at all institutions with graduate medical learners; and
20

21 Whereas, In fact, the American College of Obstetricians and Gynecologists (ACOG), the leading
22 experts in pregnancy and transition to parenthood, agree with the ABMS policy, and endorse a
23 6-week minimum parental leave, which they note has several benefits, including improving
24 maternal health and decreasing infant mortality, as well as increasing worker morale,
25 productivity, and likelihood to return to work⁷; and
26

27 Whereas, Evidence supports the statements made by ABMS and ACOG that parental leave
28 contributes to the overall health and wellness of new parents and studies have demonstrated
29 that returning to work too early after childbearing is associated with negative mental health
30 outcomes for mothers, including an increase in the rate of postpartum depression⁸; and
31

32 Whereas, Further, a 2018 study found that each additional week of maternity leave (for leaves
33 totaling <12 weeks) proportionally decreased the risk of experiencing postpartum depression⁹;
34 and
35

36 Whereas, In another 2018 study, specifically focused on medical residents, early return to work
37 translated to a decreased length of breastfeeding (impacting maternal-infant bonding and infant
38 health), decreased perceived support, and overall decreased satisfaction with parenthood^{10,11};
39 and
40

41 Whereas, Although the challenges presented by taking parental leave in medical school are
42 different than those presented in residency and fellowship, the costs to families—parents and
43 their children— of being denied parental leave of adequate length and/or being denied the peace
44 of mind of having an easily accessible, comprehensive parental leave policy available from their
45 institution, are the same; and
46

47 Whereas, Thus, it is of paramount importance that our AMA have policies to support them in
48 advocating on behalf of current and future medical student parents, that they receive the
49 equitable, appropriate, and visible parental leave policies and benefits already guaranteed to
50 their trainee counterparts in GME; and

1 Whereas, While current AMA policy (H-405.960) demonstrates a clear intent to include medical
2 students in these leave protections, a large proportion of the policies which address this
3 population are not applicable and thus do not offer any true protections to them; therefore be it
4

5 RESOLVED, That our American Medical Association amend policy H-405.960 "Policies for
6 Parental, Family and Medical Necessity Leave" by addition and deletion to read as follows:
7

8 **Policies for Parental, Family and Medical Necessity Leave, H-405.960**

9 AMA adopts as policy the following guidelines for, and encourages the
10 implementation of, Parental, Family and Medical Necessity Leave for Medical
11 Students and Physicians:

12 1. Our AMA urges ~~medical schools,~~ residency training programs, medical specialty
13 boards, the Accreditation Council for Graduate Medical Education, and medical group
14 practices to incorporate and/or encourage development of leave policies, including
15 parental, family, and medical leave policies, as part of the physician's standard benefit
16 agreement.

17 2. Recommended components of parental leave policies for ~~medical students and~~
18 physicians include: (a) duration of leave allowed before and after delivery; (b)
19 category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision
20 is made for continuation of insurance benefits during leave, and who pays the
21 premium; (e) whether sick leave and vacation time may be accrued from year to year
22 or used in advance; (f) how much time must be made up in order to be considered
23 board eligible; (g) whether make-up time will be paid; (h) whether schedule
24 accommodations are allowed; and (i) leave policy for adoption.

25 3. AMA policy is expanded to include physicians in practice, reading as follows: (a)
26 residency program directors and group practice administrators should review federal
27 law concerning maternity leave for guidance in developing policies to assure that
28 pregnant physicians are allowed the same sick leave or disability benefits as those
29 physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged
30 to be flexible enough to allow for coverage without creating intolerable increases in
31 other physicians' workloads, particularly in residency programs; and (c) physicians
32 should be able to return to their practices or training programs after taking parental
33 leave without the loss of status.

34 4. Our AMA encourages medical schools, residency programs, specialty boards, and
35 medical group practices to incorporate into their parental leave policies a six-week
36 minimum leave allowance, with the understanding that no parent should be required
37 to take a minimum leave.

38 5. Residency program directors should review federal and state law for guidance in
39 developing policies for parental, family, and medical leave.

40 6. Medical students and physicians who are unable to work because of pregnancy,
41 childbirth, and other related medical conditions should be entitled to such leave and
42 other benefits on the same basis as other physicians who are temporarily unable to
43 work for other medical reasons.

44 7. Residency programs should develop written policies on parental leave, family
45 leave, and medical leave for physicians. Such written policies should include the
46 following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed
47 before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental,
48 unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether
49 provision is made for continuation of insurance benefits during leave and who pays for
50 premiums; (f) whether sick leave and vacation time may be accrued from year to year
51 or used in advance; (g) extended leave for resident physicians with extraordinary and
52 long-term personal or family medical tragedies for periods of up to one year, without

1 loss of previously accepted residency positions, for devastating conditions such as
2 terminal illness, permanent disability, or complications of pregnancy that threaten
3 maternal or fetal life; (h) how time can be made up in order for a resident physician to
4 be considered board eligible; (i) what period of leave would result in a resident
5 physician being required to complete an extra or delayed year of training; (j) whether
6 time spent in making up a leave will be paid; and (k) whether schedule
7 accommodations are allowed, such as reduced hours, no night call, modified rotation
8 schedules, and permanent part-time scheduling.

9 8. Medical schools should develop written policies on parental leave, family leave,
10 and medical leave for medical students. Such written policies should include the
11 following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed
12 before and after delivery; (c) extended leave for medical students with extraordinary
13 and long-term personal or family medical tragedies, without loss of previously
14 accepted medical school seats, for devastating conditions such as terminal illness,
15 permanent disability, or complications of pregnancy that threaten maternal or fetal life;
16 (d) how time can be made up in order for a medical students to be eligible for
17 graduation without delays; (e) what period of leave would result in a medical student
18 being required to complete an extra or delayed year of training; and (f) whether
19 schedule accommodations are allowed, such as modified rotation schedules, no night
20 duties, and flexibility with academic testing schedules.

21 ~~8- 9.~~ Our AMA endorses the concept of equal parental leave for birth and adoption as
22 a benefit for resident physicians, medical students, and physicians in practice
23 regardless of gender or gender identity.

24 ~~9- 10.~~ Staffing levels and scheduling are encouraged to be flexible enough to allow for
25 coverage without creating intolerable increases in the workloads of other physicians,
26 particularly those in residency programs.

27 ~~10- 11.~~ Physicians should be able to return to their practices or training programs after
28 taking parental leave, family leave, or medical leave without the loss of status.

29 ~~11- 12.~~ Residency program directors must assist residents in identifying their specific
30 requirements (for example, the number of months to be made up) because of leave
31 for eligibility for board certification and must notify residents on leave if they are in
32 danger of falling below minimal requirements for board eligibility. Program directors
33 must give these residents a complete list of requirements to be completed in order to
34 retain board eligibility.

35 ~~12- 13.~~ Our AMA encourages flexibility in residency training programs and medical
36 schools incorporating parental leave and alternative schedules for pregnant trainees
37 house staff.

38 ~~13- 14.~~ In order to accommodate leave protected by the federal Family and Medical
39 Leave Act, our AMA encourages all specialties within the American Board of Medical
40 Specialties to allow graduating residents to extend training up to 12 weeks after the
41 traditional residency completion date while still maintaining board eligibility in that
42 year.

43 ~~14- 15.~~ These policies as above should be freely available online and in writing to all
44 current trainees and applicants to medical school, residency or fellowship. (Modify
45 Current HOD Policy)

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

Received: 09/20/22

The topic of this resolution is currently under study by the Council on Medical Education.

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2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.

3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.

4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.

Res. 215, I-16, Appended: BOT Rep. 11, A-19, Appended: Res. 403, A-22

Support for Residents and Fellows During Family and Medical Leave Time H-310.908

Our AMA encourages specialty boards, the Accreditation Council for Graduate Medical Education and residency review committees to study alternative mechanisms and pathways based on competency evaluation to ensure that individuals who have taken family and medical leave graduate as close to their original completion date as possible.

Res. 307, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 304
(I-22)

Introduced by: New York

Subject: Protecting State Medical Licensing Boards from External Political Influence

Referred to: Reference Committee C

1 Whereas, The US and world populations are in the midst of a COVID pandemic; and
2
3 Whereas, Hospitals, physicians and other healthcare workers are strained to contain the
4 outbreak and treat individuals who have contracted COVID; and
5
6 Whereas, There has been progress in prevention through means of social isolation, mask
7 wearing and vaccine prophylaxis; and
8
9 Whereas, Medical boards and other regulators across the country are scrambling to penalize
10 doctors who spread misinformation about vaccines, and promote unproven cures for COVID–
11 19; and
12
13 Whereas, In Idaho, local GOP officials appointed a pathologist who promoted unproven virus
14 treatments to a local public health board, despite complaints from his peers to state regulators;
15 and
16
17 Whereas, As of this date, Politico reports that medical boards have sanctioned eight physicians
18 since January 2021 for spreading coronavirus–related misinformation, according to the
19 Federation of State Medical Boards, which has recommended that health officials consider
20 action against medical professionals who dispense false medical claims in public forums; and
21
22 Whereas, In some cases the responses from some medical boards and state officials have
23 been stymied by political backlash, including in Tennessee and North Dakota; and
24
25 Whereas, Some state boards also lack the legal tools to discipline doctors for sharing unreliable
26 information via social media, and “With the click of a mouse button, two million people can get
27 information that's incorrect,” and legal structures developed for the 20th century are, in many
28 states, not suited to discipline doctors who broadcast misinformation on social media because
29 the physicians are not directly treating patients, Federation of State Medical Boards CEO
30 Humayun Chaudhry said; and
31
32 Whereas, Misinformation distorts the public debate over vaccines, and has helped create a
33 market for unproven drugs and treatment against COVID–19, sometimes with harmful side
34 effects; and
35
36 Whereas, Poison centers have recorded [increased numbers of calls related to ivermectin](#) and
37 [oleandrins](#), with some patients requiring hospitalizations; and

1 Whereas, A recent study in *The New England Journal of Medicine* projected nearly \$2.5 million
2 in wasteful insurance spending on ivermectin in a single week; and

3
4 Whereas, When the Medical Board of California started to crack down last year on doctors
5 spreading misinformation about the coronavirus vaccines, the head of the Board began getting
6 threats; and

7
8 Whereas, The federation said that two-thirds of their members had seen an increased number
9 of complaints related to disinformation in a December 2021 survey; therefore be it

10
11 RESOLVED, That our American Medical Association work with the Federation of State Medical
12 Boards and other interested parties to minimize external interference with the independent
13 functioning of state medical disciplinary and licensing boards. (Directive to Take Action)

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

Received: 09/20/22

REFERENCES:

[Medical boards get pushback as they try to punish doctors for Covid misinformation - POLITICO](#)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 305
(I-22)

Introduced by: Illinois

Subject: Encouraging Medical Schools to Sponsor Pipeline Programs to Medicine for Underrepresented Groups

Referred to: Reference Committee C

1 Whereas, Structural inequities and system-level biases amongst members of admission
2 committees contribute to non-inclusive environments and result in unequal opportunities for
3 potential underrepresented minority (URM) applicants to enter the field of medicine; and
4

5 Whereas, The racial injustices, social tragedies, and health care inequities particularly
6 highlighted throughout the COVID-19 pandemic reinforce the demand for the implementation of
7 strategies to support diversity, equity, and inclusion; and
8

9 Whereas, Middle and high school pipeline programs providing comprehensive educational
10 support and enrichment have improved test scores and raised school graduation and college
11 matriculation rates; and
12

13 Whereas, A study examining undergraduate students found that lower grade achievement of
14 URM students in pre-health courses may not be fully attributable to the precollege educational
15 pipeline, and can potentially be improved by academic and social supports during college; and
16

17 Whereas, Nascent pipeline programs that have connected medical students and high school
18 students in context specific and culturally relevant manner have the potential to help
19 underrepresented students with identity formation and perceived achievement goals; and
20

21 Whereas, Outreach and pipeline programs targeting students underrepresented in medicine are
22 beneficial to the participants and the community by 1) exposing underserved and
23 underrepresented youth to medicine, 2) improving their candidacy by providing opportunities for
24 research, shadowing, and volunteering, and 3) increasing diversity in healthcare; and
25

26 Whereas, Engaging with such programs provides value to the medical schools by 1) fulfilling
27 accreditation requirements, 2) granting medical students the opportunity to interact with the
28 surrounding community, and 3) serving as a source of qualified applicants who are
29 underrepresented in medicine; therefore be it
30

31 RESOLVED, That our American Medical Association urge medical schools to develop or
32 expand the reach of existing pipeline programs for underrepresented middle school, high school
33 and college aged students to motivate them to pursue and prepare them for a career in
34 medicine (New HOD Policy); and be it further
35

36 RESOLVED, That our AMA encourage collegiate programs to establish criteria by which
37 completion of such programs will secure an interview for admission to the sponsoring medical
38 school (New HOD Policy); and be it further

1 RESOLVED, That our AMA recommend that medical school pipeline programs for
2 underrepresented students be free-of-charge or provide financial support with need-based
3 scholarships and grants (New HOD Policy); and be it further
4

5 RESOLVED, That our AMA encourage all physicians to actively participate in programs and
6 mentorship opportunities that help expose underrepresented students to potential careers in
7 medicine. (New HOD Policy)

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

Received: 09/27/22

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RELEVANT AMA POLICY

Underrepresented Student Access to US Medical Schools H-350.960

Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; and (5) recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations.
Citation: Res. 908, I-08; Reaffirmed in lieu of Res. 311, A-15; Appended: CME Rep. 5, A-21

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

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

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.
5. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.
6. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.
7. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.
8. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.
9. Our AMA will recommend that medical school admissions committees 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

Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979

- Our AMA supports increasing the representation of minorities in the physician population by: (1) Supporting efforts to increase the applicant pool of qualified minority students by: (a) Encouraging state and local governments to make quality elementary and secondary education opportunities available to all; (b) Urging medical schools to strengthen or initiate programs that offer special premedical and precollegiate experiences to underrepresented minority students; (c) urging medical schools and other health training institutions to develop new and innovative measures to recruit underrepresented minority students, and (d) Supporting legislation that provides targeted financial aid to financially disadvantaged students at both the collegiate and medical school levels.
- (2) Encouraging all medical schools to reaffirm the goal of increasing representation of underrepresented minorities in their student bodies and faculties.
 - (3) Urging medical school admission committees to consider minority representation as one factor in reaching their decisions.
 - (4) Increasing the supply of minority health professionals.
 - (5) Continuing its efforts to increase the proportion of minorities in medical schools and medical school faculty.
 - (6) Facilitating communication between medical school admission committees and premedical counselors concerning the relative importance of requirements, including grade point average and Medical College Aptitude Test scores.
 - (7) Continuing to urge for state legislation that will provide funds for medical education both directly to medical schools and indirectly through financial support to students.
 - (8) Continuing to provide strong support for federal legislation that provides financial assistance for able students whose financial need is such that otherwise they would be unable to attend medical school.
- Citation: CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 306
(I-22)

Introduced by: New York

Subject: Increased Credit for Continuing Medical Education Preparation

Referred to: Reference Committee C

-
- 1 Whereas, Our American Medical Association offers a maximum of only two hours of Category 2
2 credit for the preparation and presentation of a one-hour continuing medical education (CME)
3 program for physicians; and
4
5 Whereas, A physician may need many more hours — often as many as 50 — to create a one-
6 hour CME program of acceptable quality and utility for his or her peers; and
7
8 Whereas, The small number (just two hours) of Category 2 credits dissuades many physicians
9 from taking on the task of preparing and presenting CME programs; therefore be it
10
11 RESOLVED, That our American Medical Association collaborate with the Accreditation Council
12 on Continuing Medical Education (ACCME), to allow physicians to claim an amount of Category
13 1 CME credits that more accurately reflects the hours they spend on preparing and presenting
14 CME programs to a maximum of four (4) Category 1 CME hours. (Directive to Take Action)

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

Received: 09/27/22

RELEVANT AMA POLICY

Support for Development of Continuing Education Programs for Primary Care Physicians in Non-Academic Settings H-295.926

The AMA: (1) supports development, where appropriate, of programs of education for medical students and faculty in non-academic settings, making use of telecommunications as needed; (2) encourages that medical schools provide faculty development programs that are designated for *AMA PRA Category 1 Credit*"; and (3) encourages that teaching continue to be accepted for *AMA PRA Category 2 Credit*" when not designated for *AMA PRA Category 1 Credit*" .

Citation: (CME Rep. 3, A-94; Reaffirmed: CME Rep. 2, A-05; Modified: CME Rep. 1, A-15)

Unification of Education Credits H-300.976

It is the policy of the AMA to develop, in cooperation with national specialty organizations and state medical associations, uniform nationwide standards for continuing medical education credits recognized by all medical associations and specialty societies.

Citation: Res. 102, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CME Rep. 2, A-10; Reaffirmed: CME Rep. 01, A-20;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 307
(1-22)

Introduced by: Arkansas

Subject: Fair Compensation of Residents and Fellows

Referred to: Reference Committee C

- 1 Whereas, Residents and Fellows form the backbone and the future of our healthcare system (1,
2 2); and
3
4 Whereas, Residents and Fellows are usually under heavy financial debt of student loans
5 accumulated over eight years of intense college and medical school education (3, 4); and
6
7 Whereas, Residents and Fellows, having to be employed for 3-7 years, who are dependent on
8 their salary for those years for daily living and payment of student debt (5); and
9
10 Whereas, The Centers for Medicare & Medicaid Services (CMS) provides direct and indirect
11 compensation for Residents and Fellows to cover their cost to the institution, and usually in
12 excess (6, 7, 8, 9); and
13
14 Whereas, CMS payments per resident/fellow vary widely exacerbating financial strain for some
15 training institutions (8, 9); and
16
17 Whereas, Residents and Fellows provide patient care services that are mission critical and an
18 important source of revenue for their institutions (10, 11, 12, 13); and
19
20 Whereas, Current Resident and Fellow compensation, approaching minimum wage, is
21 inadequate and unfair from all reasonable perspectives (14, 15, 16, 17); and
22
23 Whereas, The Arkansas Delegation believes that our AMA must advocate on behalf of its most
24 vulnerable and most important constituency; therefore be it
25
26 RESOLVED, That our American Medical Association advocate for increasing the Resident and
27 Fellow salary substantially (by at least 50% of current levels or better), along with all benefits
28 including retirement benefits with institutional match as available to institutional administration,
29 and peg yearly salary increase thereafter to COLA (Directive to Take Action); and be it further
30
31 RESOLVED, That our AMA advocate for enhanced and uniform payment per resident and
32 fellow for all educational and training institutions across the country (Directive to Take Action);
33 and be it further
34
35 RESOLVED, That our AMA amend the Residents and Fellows Bill of Rights: H-310.912 (last
36 modified 2022) accordingly. (Modify Current HOD Policy)

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

Received: 09/27/22

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RELEVANT AMA POLICY

Residents and Fellows' Bill of Rights H-310.912

1. Our AMA continues to advocate for improvements in the ACGME Institutional and Common Program Requirements that support AMA policies as follows: a) adequate financial support for and guaranteed leave to attend professional meetings; b) submission of training verification information to requesting agencies within 30 days of the request; c) adequate compensation with consideration to local cost-of-living factors and years of training, and to include the orientation period; d) health insurance benefits to include dental and vision services; e) paid leave for all purposes (family, educational, vacation, sick) to be no less than six weeks per year; and f) stronger due process guidelines.
2. Our AMA encourages the ACGME to ensure access to educational programs and curricula as necessary to facilitate a deeper understanding by resident physicians of the US health care system and to increase their communication skills.
3. Our AMA regularly communicates to residency and fellowship programs and other GME stakeholders this Resident/Fellows Physicians' Bill of Rights.
4. Our AMA: a) will promote residency and fellowship training programs to evaluate their own institution's process for repayment and develop a leaner approach. This includes disbursement of funds by direct deposit as opposed to a paper check and an online system of applying for funds; b) encourages a system of expedited repayment for purchases of \$200 or less (or an equivalent institutional threshold), for example through payment directly from their residency and fellowship programs (in contrast to following traditional workflow for reimbursement); and c) encourages training programs to develop a budget and strategy for planned expenses versus unplanned expenses, where planned expenses should be estimated using historical data, and should include trainee reimbursements for items such as educational materials, attendance at conferences, and entertaining applicants. Payment in advance or within one month of document submission is strongly recommended.
5. Our AMA will partner with ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing employee benefits including, but not limited to, on-call meal allowances, transportation support, relocation stipends, and childcare services.
6. Our AMA will work with the Accreditation Council for Graduate Medical Education (ACGME) and other relevant stakeholders to amend the ACGME Common Program Requirements to allow flexibility in the specialty-specific ACGME program requirements enabling specialties to require salary reimbursement or "protected time" for resident and fellow education by "core faculty," program directors, and assistant/associate program directors.
7. Our AMA encourages teaching institutions to offer retirement plan options, retirement plan matching, financial advising and personal finance education.
8. Our AMA adopts the following "Residents and Fellows' Bill of Rights" as applicable to all resident and fellow physicians in ACGME-accredited training programs:

RESIDENT/FELLOW PHYSICIANS' BILL OF RIGHTS

Residents and fellows have a right to:

A. An education that fosters professional development, takes priority over service, and leads to independent practice.

With regard to education, residents and fellows should expect: (1) A graduate medical education experience that facilitates their professional and ethical development, to include regularly scheduled didactics for which they are released from clinical duties. Service obligations should not interfere with educational opportunities and clinical education should be given priority over service obligations; (2) Faculty who devote sufficient time to the educational program to fulfill their teaching and supervisory responsibilities; (3) Adequate clerical and clinical support services that minimize the extraneous, time-consuming work that draws attention from patient care issues and offers no educational value; (4) 24-hour per day access to information resources to educate themselves further about appropriate patient care; and (5) Resources that will allow them to pursue scholarly activities to include financial support and education leave to attend professional meetings.

B. Appropriate supervision by qualified physician faculty with progressive resident responsibility toward independent practice.

With regard to supervision, residents and fellows must be ultimately supervised by physicians who are adequately qualified and allow them to assume progressive responsibility appropriate to their level of education, competence, and experience. In instances where clinical education is provided by non-physicians, there must be an identified physician supervisor providing indirect supervision, along with mechanisms for reporting inappropriate, non-physician supervision to the training program, sponsoring institution or ACGME as appropriate.

C. Regular and timely feedback and evaluation based on valid assessments of resident performance.

With regard to evaluation and assessment processes, residents and fellows should expect: (1) Timely and substantive evaluations during each rotation in which their competence is objectively assessed by faculty who have directly supervised their work; (2) To evaluate the faculty and the program confidentially and in writing at least once annually and expect that the training program will address deficiencies revealed by these evaluations in a timely fashion; (3) Access to their training file and to be made aware of the contents of their file on an annual basis; and (4) Training programs to complete primary verification/credentialing forms and recredentialing forms, apply all required signatures to the forms, and then have the forms permanently secured in their educational files at the completion of training or a period of training and, when requested by any organization involved in credentialing process, ensure the submission of those documents to the requesting organization within thirty days of the request.

D. A safe and supportive workplace with appropriate facilities.

With regard to the workplace, residents and fellows should have access to: (1) A safe workplace that enables them to fulfill their clinical duties and educational obligations; (2) Secure, clean, and comfortable on-call rooms and parking facilities which are secure and well-lit; (3) Opportunities to participate on committees whose actions may affect their education, patient care, workplace, or contract.

E. Adequate compensation and benefits that provide for resident well-being and health.

(1) With regard to contracts, residents and fellows should receive: a. Information about the interviewing residency or fellowship program including a copy of the currently used contract clearly outlining the conditions for (re)appointment, details of remuneration, specific responsibilities including call obligations, and a detailed protocol for handling any grievance; and b. At least four months advance notice of contract non-renewal and the reason for non-renewal.

(2) With regard to compensation, residents and fellows should receive: a. Compensation for time at orientation; and b. Salaries commensurate with their level of training and experience. Compensation should reflect cost of living differences based on local economic factors, such as housing, transportation, and energy costs (which affect the purchasing power of wages), and include appropriate adjustments for changes in the cost of living.

(3) With regard to benefits, residents and fellows must be fully informed of and should receive: a. Quality and affordable comprehensive medical, mental health, dental, and vision care for residents and their families, as well as retirement plan options, professional liability insurance and disability insurance to all residents for disabilities resulting from activities that are part of the educational program; b. An institutional written policy on and education in the signs of excessive fatigue, clinical depression, substance abuse and dependence, and other physician impairment issues; c. Confidential access to mental health and substance abuse services; d. A guaranteed, predetermined amount of paid vacation leave, sick leave, family and medical leave and educational/professional leave during each year in their

training program, the total amount of which should not be less than six weeks; e. Leave in compliance with the Family and Medical Leave Act; and f. The conditions under which sleeping quarters, meals and laundry or their equivalent are to be provided.

F. Clinical and educational work hours that protect patient safety and facilitate resident well-being and education.

With regard to clinical and educational work hours, residents and fellows should experience: (1) A reasonable work schedule that is in compliance with clinical and educational work hour requirements set forth by the ACGME; and (2) At-home call that is not so frequent or demanding such that rest periods are significantly diminished or that clinical and educational work hour requirements are effectively circumvented. Refer to AMA Policy H-310.907, "Resident/Fellow Clinical and Educational Work Hours," for more information.

G. Due process in cases of allegations of misconduct or poor performance.

With regard to the complaints and appeals process, residents and fellows should have the opportunity to defend themselves against any allegations presented against them by a patient, health professional, or training program in accordance with the due process guidelines established by the AMA.

H. Access to and protection by institutional and accreditation authorities when reporting violations.

With regard to reporting violations to the ACGME, residents and fellows should: (1) Be informed by their program at the beginning of their training and again at each semi-annual review of the resources and processes available within the residency program for addressing resident concerns or complaints, including the program director, Residency Training Committee, and the designated institutional official; (2) Be able to file a formal complaint with the ACGME to address program violations of residency training requirements without fear of recrimination and with the guarantee of due process; and (3) Have the opportunity to address their concerns about the training program through confidential channels, including the ACGME concern process and/or the annual ACGME Resident Survey.

9. Our AMA will work with the ACGME and other relevant stakeholders to advocate for ways to defray additional costs related to residency and fellowship training, including essential amenities and/or high cost specialty-specific equipment required to perform clinical duties.

10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation should, at minimum, reflect length of pre-training education, hours worked, and level of independence and complexity of care allowed by an individual's training program (for example when comparing physicians in training and midlevel providers at equal postgraduate training levels).

11. The Residents and Fellows' Bill of Rights will be prominently published online on the AMA website and disseminated to residency and fellowship programs.

12. Our AMA will distribute and promote the Residents and Fellows' Bill of Rights online and individually to residency and fellowship training programs and encourage changes to institutional processes that embody these principles.

Citation: CME Rep. 8, A-11; Appended: Res. 303, A-14; Reaffirmed: Res. 915, I-15; Appended: CME Rep. 04, A-16; Modified: CME Rep. 06, I-18; Appended: Res. 324, A-19; Modified: Res. 304, A-21; Modified: Res. 305, A-21; Modified: BOT Rep. 18, I-21; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 308
(1-22)

Introduced by: American College of Radiology, American Academy of Pediatrics, Maryland, Radiological Society of North America, Society of Interventional Radiology, American Society for Radiation Oncology, American Institute of Ultrasound in Medicine, American Roentgen Ray Society, American College of Radiation Oncology, Association of University Radiologists, American College of Nuclear Medicine, American Society of Neuroradiology, Society of Nuclear Medicine and Molecular Imaging, Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Paid Family/Medical Leave in Medicine

Referred to: Reference Committee C

1 Whereas, The mission of the American Medical Association is “to promote the art and science
2 of medicine and the betterment of public health...by representing physicians with a unified voice
3 in courts and legislative bodies across the nation, removing obstacles that interfere with patient
4 care...and driving the future of medicine to tackle the biggest challenges in health care.” [1]; and
5

6 Whereas, The federal Family Medical Leave Act (FMLA) of 1993 requires private employers
7 with 50 or more employees within 75 miles of the eligible employee’s worksite and all public
8 agencies to provide eligible employees* up to 12 work weeks of unpaid leave in a 12-month
9 period for the birth and care of a newborn, adopted child, or foster child, as well as for care of
10 oneself or an immediate family member with a serious health condition [2]**; and
11

12 Whereas, “The American Academy of Pediatrics has publicly endorsed 12 weeks of paid family
13 leave based upon the scientific evidence of benefits to the child.” [3]; and
14

15 Whereas, Since April 2022, the American College of Radiology (ACR) “recommends that
16 diagnostic radiology, interventional radiology, radiation oncology, medical physics, and nuclear
17 medicine practices, departments and training programs strive to provide 12 weeks of paid
18 family/medical leave in a 12-month period for its attending physicians, medical physicists, and
19 members in training as needed.” [4]; and
20

21 Whereas, The business case for paid family/medical leave is compelling, with “significant
22 rewards that outweigh the costs: improved employee retention; better talent attraction;
23 reinforced values; improved engagement, morale, and productivity; and enhanced brand
24 equity.” [5]. For instance, research has shown that the average time to fill a vacant position is 42
25 days, and the average cost of a hire is at least 21% of annual salary [6]; and
26

27 Whereas, While the most frequent argument against paid family/parental leave is “we can’t
28 afford it,” there are ways to mitigate the cost of paid leave. Some states offer a paid leave
29 program that can be used to offset the cost to a practice [7]. Short-term disability insurance for
30 all practice members can also protect a practice from unexpected medical issues. Lastly,
31 practices can consider creating an account that is funded annually for circumstances requiring
32 family/medical leave [6]; therefore be it

1 RESOLVED, That our American Medical Association policy H-405.960 "Policies for Parental
2 Family and Medical Necessity Leave" be amended by addition and deletion to read as follows:
3

4 AMA adopts as policy the following guidelines for, and encourages the
5 implementation of, Parental, Family and Medical Necessity Leave for Medical
6 Students and Physicians:

7 1. Our AMA urges medical schools, residency training programs, medical specialty
8 boards, the Accreditation Council for Graduate Medical Education, and medical group
9 practices to incorporate and/or encourage development of leave policies, including
10 parental, family, and medical leave policies, as part of the physician's standard benefit
11 agreement.

12 2. Recommended components of parental leave policies for medical students and
13 physicians include: (a) duration of leave allowed before and after delivery; (b)
14 category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision
15 is made for continuation of insurance benefits during leave, and who pays the
16 premium; (e) whether sick leave and vacation time may be accrued from year to year
17 or used in advance; (f) how much time must be made up in order to be considered
18 board eligible; (g) whether make-up time will be paid; (h) whether schedule
19 accommodations are allowed; and (i) leave policy for adoption.

20 3. AMA policy is expanded to include physicians in practice, reading as follows: (a)
21 residency program directors and group practice administrators should review federal
22 law concerning maternity leave for guidance in developing policies to assure that
23 pregnant physicians are allowed the same sick leave or disability benefits as those
24 physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged
25 to be flexible enough to allow for coverage without creating intolerable increases in
26 other physicians' workloads, particularly in residency programs; and (c) physicians
27 should be able to return to their practices or training programs after taking parental
28 leave without the loss of status.

29 4. Our AMA encourages medical schools, residency programs, specialty boards, and
30 medical group practices to incorporate into their parental, family, and medical
31 necessity leave policies a ~~six~~-twelve-week minimum leave allowance, with the
32 understanding that no ~~parent~~ individual should be required to take a minimum leave.

33 5. Our AMA recommends that medical practices, departments and training programs
34 strive to provide 12 weeks of paid parental, family and medical necessity leave in a
35 12-month period for their attending and trainee physicians as needed.

36 ~~56.~~ Residency program directors should review federal and state law for guidance in
37 developing policies for parental, family, and medical leave.

38 ~~67.~~ Medical students and physicians who are unable to work because of pregnancy,
39 childbirth, and other related medical conditions should be entitled to such leave and
40 other benefits on the same basis as other physicians who are temporarily unable to
41 work for other medical reasons.

42 ~~78.~~ Residency programs should develop written policies on parental leave, family
43 leave, and medical leave for physicians. Such written policies should include the
44 following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed
45 before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental,
46 unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether
47 provision is made for continuation of insurance benefits during leave and who pays for
48 premiums; (f) whether sick leave and vacation time may be accrued from year to year
49 or used in advance; (g) extended leave for resident physicians with extraordinary and
50 long-term personal or family medical tragedies for periods of up to one year, without
51 loss of previously accepted residency positions, for devastating conditions such as
52 terminal illness, permanent disability, or complications of pregnancy that threaten

1 maternal or fetal life; (h) how time can be made up in order for a resident physician to
2 be considered board eligible; (i) what period of leave would result in a resident
3 physician being required to complete an extra or delayed year of training; (j) whether
4 time spent in making up a leave will be paid; and (k) whether schedule
5 accommodations are allowed, such as reduced hours, no night call, modified rotation
6 schedules, and permanent part-time scheduling.

7 ~~89.~~ Our AMA endorses the concept of equal parental leave for birth and adoption as a
8 benefit for resident physicians, medical students, and physicians in practice
9 regardless of gender or gender identity.

10 ~~910.~~ Staffing levels and scheduling are encouraged to be flexible enough to allow for
11 coverage without creating intolerable increases in the workloads of other physicians,
12 particularly those in residency programs.

13 ~~4011.~~ Physicians should be able to return to their practices or training programs after
14 taking parental leave, family leave, or medical leave without the loss of status.

15 ~~4412.~~ Residency program directors must assist residents in identifying their specific
16 requirements (for example, the number of months to be made up) because of leave
17 for eligibility for board certification and must notify residents on leave if they are in
18 danger of falling below minimal requirements for board eligibility. Program directors
19 must give these residents a complete list of requirements to be completed in order to
20 retain board eligibility.

21 ~~4213.~~ Our AMA encourages flexibility in residency training programs, incorporating
22 parental leave and alternative schedules for pregnant house staff.

23 ~~4314.~~ In order to accommodate leave protected by the federal Family and Medical
24 Leave Act, our AMA encourages all specialties within the American Board of Medical
25 Specialties to allow graduating residents to extend training up to 12 weeks after the
26 traditional residency completion date while still maintaining board eligibility in that
27 year.

28 ~~4415.~~ These policies as above should be freely available online and in writing to all
29 applicants to medical school, residency or fellowship. (Modify Current HOD Policy)

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

Received: 09/30/22

The topic of this resolution is currently under study by the Council on Medical Education

REFERENCES:

- (1) American Medical Association. About. Accessed June 14, 2022. <https://www.ama-assn.org/about>
- (2) US Department of Labor. Wage and Hour Division (WHD). Family and Medical Leave Act. Accessed February 25, 2019. <https://www.dol.gov/whd/fmla/>
- (3) Riano NS, Linos E, Accurso EC, Sung D, Linos E, Simard JF, Mangurian C. Paid Family and Childbearing Leave Policies at Top US Medical Schools. *JAMA*. 2018 Feb 13;319(6):611-614. doi: 10.1001/jama.2017.19519. PMID: 29450516; PMCID: PMC5838606.
- (4) Resolution#13: Paid family/medical leave in radiology, interventional radiology and radiation oncology. Accessed May 6, 2022. [https://www.aawr.org/Portals/10/Focus/Spring%202022/AAWR.ResolutionPaidFamilyMedicalLeaveFor2022.FINAL_%20\(1\).pdf?ver=dptncUDp-LiVfKBSp7XrZw%3d%3d](https://www.aawr.org/Portals/10/Focus/Spring%202022/AAWR.ResolutionPaidFamilyMedicalLeaveFor2022.FINAL_%20(1).pdf?ver=dptncUDp-LiVfKBSp7XrZw%3d%3d)
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- (6) Arleo EK. Paid family/medical leave: That's great - What's next? *Clin Imaging*. 2020 May;61:A1-A3. doi: 10.1016/j.clinimag.2020.02.004. Epub 2020 Feb 20. PMID: 32115344.
- (7) State Paid Family and Medical Leave Insurance Laws, as of January 2021: California, New Jersey, Rhode Island, New York, District of Columbia, Washington, Massachusetts, Connecticut, Oregon. <https://www.nationalpartnership.org/our-work/resources/economic-justice/paid-leave/state-paid-family-leave-laws.pdf>. Accessed July 14, 2021.

*Defined, per FMLA, as “Employees are eligible for leave if they have worked for their employer at least 12 months, at least 1,250 hours over the past 12 months, and work at a location where the company employs 50 or more employees within 75 miles.” [3]

**Additional reasons under the FMLA include:

- any qualifying exigency arising out of the fact that the employee’s spouse, son, daughter, or parent is a covered military member on “covered active duty”; and
- to care for a covered service member with a serious injury or illness if the eligible employee is the service member’s spouse, son, daughter, parent, or next of kin (leave entitlement is up to 26 weeks in a 12-month period). [2]

***Defined, as “the problem of employees who are not fully functioning in the workplace because of an illness, injury or other condition. Even though the employee may be physically at work, he may not be able to fully perform his duties and is more likely to make mistakes on the job.” [12]

RELEVANT AMA POLICY

Policies for Parental, Family and Medical Necessity Leave H-405.960

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without

creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22

AMA Statement on Family and Medical Leave H-420.979

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy;

(2) maternity leave for the employee-mother;

(3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and

(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.

Citation: BOT Rep. A, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: CMS Rep. 03, A-16;

Parental Leave H-405.954

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.

2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.

3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.

4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.

Citation: Res. 215, I-16; Appended: BOT Rep. 11, A-19; Appended: Res. 403, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 309
(I-22)

Introduced by: Resident and Fellow Section

Subject: Bereavement Leave for Medical Students and Physicians

Referred to: Reference Committee C

- 1 Whereas, The aging of the U.S. population stands to increase the number of senior citizens
2 dying every year, and the bereavement felt by their loved ones in all sectors, including medical
3 students and physicians; and¹
4
- 5 Whereas, Medical students and physicians also suffer emotional trauma related to reproductive
6 complications such as pregnancy loss, as 10% of known pregnancies end in miscarriage or
7 stillbirth,² and many students and physicians suffer failure of assisted reproductive technology
8 and adoption; and
9
- 10 Whereas, States of mental and emotional distress have been associated with unsafe patient
11 care, as demonstrated in a 2016 systematic review that found poor wellbeing and moderate to
12 high levels of burnout in healthcare staff were associated, in the majority of studies reviewed,
13 with poor patient safety outcomes such as medical errors; and³
14
- 15 Whereas, The Fair Labor Standards Act and the Family and Medical Leave Act do not require a
16 U.S. employer to provide an employee with paid leave to attend a funeral, grieve a family
17 member, or grieve a pregnancy loss; and⁴
18
- 19 Whereas, Only 60% of private-sector workers were granted paid bereavement leave in 2012,
20 per a report from the Bureau of Labor Statistics; and⁵
21
- 22 Whereas, Other countries have instituted bereavement leave policies, such as Canada and
23 France which guarantee three to five days of bereavement leave to employees suffering the
24 loss of a close family member,⁶ and India and New Zealand which have pregnancy loss laws
25 entitling Indian women to 6 weeks of paid leave and New Zealand women and their partners to
26 3 days of paid leave; and⁷
27
- 28 Whereas, AMA policy H-405.960, "Policies for Parental, Family and Medical Necessity Leave,"
29 sets precedent for the AMA providing detailed recommendations for medical schools, residency
30 programs, medical specialty boards, the ACGME, and medical group practices to provide leave
31 benefits to their medical students and physicians; therefore be it

1 RESOLVED, That our American Medical Association support bereavement leave for medical
2 students and physicians:

- 3 1. Our AMA urges medical schools, residency and fellowship training
4 programs, medical specialty boards, the Accreditation Council for
5 Graduate Medical Education, and medical group practices to incorporate and/or
6 encourage development of bereavement leave policies as part of the physician's
7 standard benefit agreement.
- 8 2. Recommended components of bereavement leave policies for medical students and
9 physicians include:
 - 10 a. whether cases requiring extensive travel qualify for additional days of leave
11 and, if so, how many days;
 - 12 b. policy and duration of leave for an event impacting pregnancy or fertility
13 including pregnancy loss, an unsuccessful round of intrauterine insemination or of
14 an assisted reproductive technology procedure, a failed adoption arrangement, a
15 failed surrogacy arrangement, or an event that impacts pregnancy or fertility;
 - 16 c. whether leave is paid or unpaid;
 - 17 d. whether obligations and time must be made up; and
 - 18 e. whether make-up time will be paid.
- 19 3. Our AMA encourages medical schools, residency and fellowship programs,
20 specialty boards, specialty societies and medical group practices to incorporate into
21 their bereavement leave policies a three-day minimum leave, with the understanding
22 that no physician or medical student should be required to take a minimum leave.
- 23 4. Medical students and physicians who are unable to work beyond the defined
24 bereavement leave period because of physical or psychological stress, medical
25 complications of pregnancy loss, or another related reason should refer to their
26 institution's sick leave policy, family and medical leave policy, and other benefits on the
27 same basis as other physicians who are temporarily unable to work for other reasons.
- 28 5. Our AMA supports the concept of equal bereavement leave for pregnancy loss and
29 other such events impacting fertility in a physician or their partner as a benefit for
30 medical students and physicians regardless of gender or gender identity.
- 31 6. Staffing levels and scheduling are encouraged to be flexible enough to allow for
32 coverage without creating intolerable increases in the workloads of other physicians,
33 particularly those in residency programs.
- 34 7. These guidelines as above should be freely available online and in writing to all
35 applicants to medical school, residency, or fellowship. (Directive to Take Action)

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

Received: 09/30/22

The topic of this resolution is currently under study by the Council on Medical Education

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1. Jordan J. (2020, June 25). 65 and Older Population Grows Rapidly as Baby Boomers Age. United States Census Bureau. <https://www.census.gov/newsroom/press-releases/2020/65-older-population-grows.html>. Retrieved September 10, 2021.
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7. Wamsley L. New Zealand approves paid leave after a miscarriage. *NPR.* <https://www.npr.org/2021/03/25/981309826/new-zealand-approves-paid-leave-after-a-miscarriage>. Published March 25, 2021. Accessed September 17, 2021.

RELEVANT AMA POLICY

H-405.960 Policies for Parental, Family and Medical Necessity Leave

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.
8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.
13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.
14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22

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, recertification, 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

1 Whereas, A 2020 survey of 1711 medical students and 113 residents in Texas medical
2 programs indicated majority of respondents believed virtual interviews were less stressful than
3 in-person interviews, and residency programs should offer both options for interviewing⁹; and
4

5 Whereas, In May 2020, the American Association of Medical Colleges released resources and
6 protocols for residency interviewees and program directors to use in preparing for virtual
7 interviews^{10,11}; and
8

9 Whereas, Several studies from August 2020-June 2021 showed that although residency
10 interviewees expressed concerns about the limitations of virtual interviews such as ability to
11 assess the program, ability to fully demonstrate their personality, and increased emphasis on
12 exam scores and class rank, residency programs may be able to improve the virtual interview
13 experience, by developing comprehensive marketing materials, hosting a resident panel for
14 interviewees, and creating an informal virtual gathering for interviewees and residents¹²⁻¹⁴; and
15

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

20 Whereas, The National Resident Matching Program reported that 60% of surveyed program
21 directors from the 2021 MATCH intended to use virtual platforms for future recruitment seasons,
22 including two-thirds of these respondents intending to use these platforms for the interview¹⁶;
23 and
24

25 Whereas, Incorporating video conferencing into residency interviews as an adjunct to in-person
26 interviews is proposed as a means to increase efficiency and lower costs, given its perceived
27 feasibility from the 2021 MATCH¹⁷; and
28

29 Whereas, Most existing American Medical Association policy supports studying methods to
30 reduce residency interviewing cost (H-310.966, D-310.949), but does not take a stance to
31 support the incorporation of technologies, such as videoconferencing, as a method to increase
32 interview efficiency; therefore be it
33

34 RESOLVED, That our American Medical Association support incorporating virtual interviews as
35 a component to the residency and fellowship interview process as a means to increase
36 interviewing efficiency (New HOD Policy); and be it further
37

38 RESOLVED, That our AMA work with appropriate stakeholders, such as the Association of
39 American Medical Colleges and the Accreditation Council for Graduate Medical Education, to
40 study interviewee and program perspectives on incorporating videoconferencing as an adjunct
41 to residency and fellowship interviews, in order to guide the development of protocols for
42 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: 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

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 - (3) The medical profession must be integrally involved in any workforce planning efforts sponsored by federal or state governments, or by the private sector.
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 - (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;

Reference Committee F

BOT Report(s)

- 02 Further Action to Respond to the Gun Violence Public Health Crisis
- 07 Transparency of Resolution Fiscal Notes
- 08 The Resolution Committee as a Standing Committee of the House
- 09 Employed Physicians

CLRPD Report(s)

- 01 Senior Physicians Section Five-Year Review

HOD Comm on Compensation of the Officers

- 01 Report of the HOD Committee on Compensation of the Officers

Report of the Speakers

- 01 Election Committee - Interim Report

Resolution(s)

- 601 AMA Withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity
- 602 Finding Cities for Future AMA Conventions/Meetings
- 606* Patient-Centered Health Equity Strategic Plan and Sustainable Funding
- 607* Accountability for Election Rules Violations

REPORT OF THE BOARD OF TRUSTEES

B of T Report 2-I-22

Subject: Further Action to Respond to the Gun Violence Public Health Crisis
(Resolution 246-A-22)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

1 At the 2022 Annual Meeting, the House of Delegates (HOD) referred Resolution 246, “Further
2 Action to Respond to the Gun Violence Public Health Crisis,” to the Board of Trustees (Board) for
3 a report back to the HOD at 2022 Interim Meeting. Resolution 246, introduced by the Medical
4 Student Section, asked that our American Medical Association (AMA) convene a task force for the
5 purposes of: “working with advocacy groups and other relevant stakeholders to advocate for
6 federal, state, and local efforts to end the gun violence public health crisis; identifying and
7 supporting evidence-based community interventions to prevent gun injury, trauma, and death;
8 monitoring federal, state, and local legislation, regulation, and litigation relating to gun violence;
9 and reporting annually to the HOD on the AMA’s efforts to reduce gun violence.” The reference
10 committee heard mixed testimony on whether a task force was necessary to develop actionable
11 recommendations for our AMA to be a leader in responding to the firearm violence crisis; similar
12 testimony was offered during the HOD floor debate. This report therefore addresses recent AMA
13 activities on preventing firearm violence and makes a recommendation about creating a task force.
14

15 BACKGROUND

16
17 The AMA declared firearm violence a public health crisis at the 2016 Annual Meeting, which
18 convened in the aftermath of the mass shooting at the Pulse nightclub in Orlando where 49 people
19 were killed. Immediately before the 2022 Annual Meeting, two mass shootings occurred within 10
20 days at an elementary school in Uvalde, Texas and a grocery store in Buffalo, New York. In the
21 AMA’s press statement after the Uvalde shooting, then AMA President Gerald Harmon, MD,
22 stated, “The shooting yesterday at an elementary school is horrific and sadly—and unacceptably—
23 all too familiar in the United States. A week after Buffalo, 10 years after Sandy Hook, 23 years
24 after Columbine; the places and cities change, but the story is the same—too-easy access to
25 firearms, inaction on wildly popular, common-sense safety measures like background checks, and
26 countless lives lost or changed forever.” Dr. Harmon further stated, “More and more it is clear no
27 place is safe—malls, schools, movie theaters, places of worship, and grocery stores have all been
28 targeted.... We call on lawmakers, leaders, and advocates to say enough is enough. No more
29 Americans should die of firearm violence. No more people should lose loved ones.”
30

31 In remarks at the 2022 Annual Meeting, Dr. Harmon declared that “Gun violence is a plague on our
32 nation. It is a public health crisis, and much of it is preventable.” Also at the Annual Meeting, then
33 AMA Board Chair Bobby Mukkamala, MD, addressed the HOD to reaffirm that the Board is fully
34 committed to continuing to work on preventing firearm violence as a top AMA advocacy priority.
35 With over 45,000 firearm-related deaths in 2020 and a continuing string of mass shootings, the
36 Board recognizes this public health crisis needs heightened efforts and new strategies. According to
37 the Gun Violence Archive—an independent, non-profit data collection and research group that

1 provides free online public access to accurate information about gun-related violence in the U.S.—
2 there have been 393 mass shootings in 2022 (as of August 4, 2022) and a total of 26,300 deaths
3 from firearm violence from all causes. Recent data from the Centers for Disease Control and
4 Prevention (CDC) indicate that firearm deaths are increasing, and disparities are widening, with
5 young people, males, and Black people experiencing the highest firearm homicide rates. These
6 statistics are clearly unacceptable, especially since firearm injuries and deaths are preventable.
7

8 RECENT AMA ADVOCACY ACTIVITIES 9

10 During the 117th Congress, our AMA has advocated for evidence-based, commonsense legislative
11 proposals to address firearm violence. The AMA expressed support for H.R. 8, the “Bipartisan
12 Background Checks Act of 2021,” (Thompson, D-CA/Upton, R-MI), which would expand the
13 existing background check system to cover all firearm sales, including those at gun shows, over the
14 internet and through classified ads, while providing reasonable exceptions for law enforcement and
15 family and friend transfers. This bill was passed by the U.S. House of Representatives on
16 March 11, 2021, but has not been considered by the U.S. Senate. The AMA also supported
17 H.R. 7910, the “Protecting Our Kids Act,” (Nadler, D-NY), an omnibus package of eight
18 previously introduced bills focused on preventing firearm violence. This bill was passed by the
19 House of Representatives on June 22, 2022, but also was not considered by the Senate.
20

21 However, Congress succeeded in passing the first major firearm legislation in over 30 years with
22 S. 2938, the “Bipartisan Safer Communities Act” (Murphy, D-CT/Cornyn, R-TX), which the AMA
23 supported. President Biden signed this bill into law on June 25, 2022, and AMA Board Chair
24 Sandra Fryhofer, MD, attended the signing ceremony. Key provisions of the bill include:
25

- 26 • Providing grants for states to establish or strengthen extreme risk protection orders;
- 27 • Adding convicted domestic violence abusers in dating relationships to the National Instant
28 Criminal Background Check System (NICS);
- 29 • Requiring the NICS to contact authorities to see whether an individual under the age of 21 has
30 a “disqualifying” juvenile record for buying a firearm;
- 31 • Making it a federal crime to buy a firearm on behalf of an individual who is prohibited from
32 doing so; and
- 33 • Including new spending for school security and mental health treatment.
34

35 In the AMA’s statement following the Act’s enactment into law, AMA President Jack Resneck, Jr.,
36 MD, noted that this law will save lives, and stated “The measures in this law—funding for red flag
37 programs, closing the so-called ‘boyfriend loophole,’ and expanding background checks on people
38 between the ages of 18 and 21 seeking to buy a gun—will keep weapons out of the hands of people
39 wishing to do harm. This law isn’t a panacea, and more work remains to prevent firearm violence,
40 but it is an important, critical step in the right direction.” Our AMA is now focused on advocating
41 to ensure that the new funding authorized in the new law is actually appropriated, advocating for
42 states to establish or strengthen extreme risk protection orders, and ensuring that the other
43 provisions are properly and quickly implemented.
44

45 The AMA is also working to ensure that Congress appropriates increased funding for research to
46 prevent firearm violence. The AMA is working with medical specialty societies, including the
47 American Academy of Pediatrics (AAP), to support \$60 million in funding for the CDC and the
48 National Institutes of Health (NIH) to conduct public health research on firearm morbidity and
49 mortality prevention. This would double the amount of funding provided last year. Our efforts have
50 been successful so far: the House 2023 Labor-HHS Appropriations bill that passed out of the
51 Appropriations Committee on June 30 includes the \$60 million for the NIH and CDC firearm

1 injury and prevention programs funding. The Senate Appropriations Committee released the
2 Chairman’s mark of all 2023 appropriations bills on July 28; the summary document listed the
3 same \$60 million for firearm injury and mortality prevention research at NIH and CDC. Our AMA
4 will continue to monitor appropriations developments and advocate to ensure that this funding is
5 approved by Congress.

6
7 In addition, our AMA is advocating our policy through the courts. Most recently, the U.S. Supreme
8 Court in *New York State Rifle & Pistol Association Inc., et al. v. Bruen* struck down a New York
9 law limiting the concealed carrying of firearms in public to those who demonstrated proper cause
10 for needing to do so—such as documented threats of physical violence against them in a 6-3 ruling.
11 The Litigation Center of the American Medical Association and State Medical Societies, the
12 Medical Society of the State of New York, American Academy of Pediatrics and the American
13 Academy of Child and Adolescent Psychiatry had filed an amicus brief urging the Supreme Court
14 to uphold a lower-court decision and arguing that the law’s requirements do not violate the Second
15 Amendment. The amicus brief from the AMA and others argued that New York has the right to
16 “enforce its reasonable licensing requirements for individuals who wish to carry concealed
17 handguns in public spaces, including our streets, highways, stores, shopping malls, movie theaters,
18 Little League games, hospitals, subway cars, concert halls, football stadiums, outdoor festivals,
19 bars, restaurants, basketball courts, parks, political rallies, houses of worship, and other crowded
20 venues filled with children and adults alike.” The brief also noted that more than 8,800 New
21 Yorkers died of firearm-related injuries between 2010 and 2019, and that firearm violence “is a
22 grave public health crisis that must be addressed by measures such as New York’s concealed carry
23 law.” The AMA noted its deep disappointment with the Court’s “harmful and disturbing decision”
24 to rule against the law, which it described as an “appropriate and constitutional response to the
25 scourge of firearm violence” in New York communities.

26
27 In addition, our AMA will work to implement the new policies approved by the HOD at the recent
28 2022 Annual Meeting. With the rising availability of homemade “ghost guns,” the AMA called on
29 state legislatures and Congress to subject these weapons to the same regulations and licensing
30 requirements as traditional firearms (Policy H-145.967, “Regulation of Homemade Firearms”).
31 New policy was also adopted that our AMA support legislation requiring that packaging for any
32 firearm ammunition produced in, sold in, or exported from the United States carry a boxed
33 warning. At a minimum, the warning should be text-based statistics and/or graphic warning labels
34 related to the risks, harms, and mortality associated with firearm ownership and use. It also should
35 include an explicit recommendation that ammunition be stored securely and separately from
36 firearms (Policy H-145.968, “Support for Warning Labels on Firearm Ammunition Packaging”).

37
38 Another policy adopted is focused on ensuring that active-shooter and live-crisis drills consider the
39 mental health of children (Directive D-145.993, “Addressing Adverse Effects of Active-Shooter
40 and Live-Crisis Drills on Children's Health”). With school shootings continuing at a troubling pace
41 and few regulations in place to address the country’s firearm crisis, some schools prepare faculty
42 and children to respond. While well-intentioned, there are concerns that the style of drill may have
43 unintended harmful effects on children’s mental health. To address these concerns, the policy
44 adopted encourages active-shooter and live-crisis drills to be conducted in an evidence-based and
45 trauma-informed way that takes children’s physical and mental wellness into account, considers
46 prior experiences that might affect children's response to a simulation, avoids creating additional
47 traumatic experiences for children, and provides support for students who may be adversely
48 affected. Our AMA will work with relevant stakeholders to raise awareness of ways to conduct
49 active-shooter or live-crisis drills that are safe for children and developmentally appropriate. The
50 AMA will also advocate for research into the impact of live-crisis exercises and drills on the

1 physical and mental health and well-being of children, including the goals, efficacy, and potential
2 unintended consequences of crisis-preparedness activities involving children.

3
4 COLLABORATIONS

5
6 Our AMA is a partner organization of AFFIRM at The Aspen Institute, which is a non-profit
7 dedicated to ending the American firearm injury epidemic using a health-based approach. AFFIRM
8 combines health expertise with the knowledge and traditions of responsible firearm stewardship to
9 achieve consensus recommendations. AFFIRM is committed to reducing the rate of firearm injuries
10 and deaths. AFFIRM also builds partnerships with non-medical organizations that are equally
11 committed to preventing firearm injury, including groups committed to firearm safety and shooting
12 sports.

13
14 The AMA has joined the American College of Physicians (ACP), American Academy of Family
15 Physicians, AAP, American College of Surgeons (ACS), American Psychiatric Association (APA),
16 and American Public Health Association in calling for policies to help stem firearm-related injuries
17 and deaths in the United States. The organizations endorsed the article, Firearm-Related Injury and
18 Death in the United States: A Call to Action From the Nation's Leading Physician and Public
19 Health Professional Organizations, published online in *Annals of Internal Medicine* on August 7,
20 2019.

21
22 Our AMA is actively participating in monthly meetings convened by the AAP on advocacy related
23 to doubling last year's appropriations funding for research on preventing firearm violence. The
24 AMA also participated in a 2019 meeting on firearm violence organized by ACS and will be
25 actively participating in a follow-up Medical Summit on Firearm Injury Prevention being
26 sponsored by ACS in collaboration with the ACP, the American College of Emergency Physicians,
27 and the Council of Medical Specialty Societies. The objectives of the 2022 summit are to use a
28 consensus-based, non-partisan approach to selecting recommendations for executive action and/or
29 legislation at the federal, state, and municipal levels that would decrease firearm-related injuries
30 and identify elements of the most effective programs that can be implemented by physician
31 practices/clinics/hospitals/health systems in partnership with their communities to effectively lower
32 the risk of violence, with an emphasis on marginalized communities that are disproportionately
33 impacted by violence.

34
35 The AMA is also scheduling meetings with representatives of law enforcement and education
36 organizations to see where consensus might be reached on possible solutions to reducing firearm
37 violence and preventing firearm injuries and deaths. Our AMA is also planning federation calls to
38 follow-up on the Medical Summit on Firearm Injury Prevention and plans to convene an informal
39 advisory group of physicians to brainstorm additional ideas on how to prevent and reduce injuries
40 and deaths from firearm violence.

41
42 EDUCATION

43
44 In 2017, the AMA and the American Bar Association held a joint conference in Chicago,
45 "Preventing Gun Violence: Moving from Crisis to Action." This conference led the Council on
46 Science and Public Health to initiate a report on "The Physician's Role in Firearm Safety," which
47 was adopted by the House of Delegates at the 2018 Annual Meeting. At that meeting, the Council
48 also co-sponsored an educational session with the AMA's Advocacy Resource Center focused on
49 "Preventing Gun Violence: What Physicians Can do Now." The session focused on describing the
50 trends in morbidity and mortality associated with firearm violence in the U.S., identifying
51 evidenced-based strategies available to reduce firearm morbidity and mortality, and defining the

1 physician's unique role in promoting firearm safety and preventing firearm violence. Featured
2 speakers included Marian "Emmy" Betz, MD, MPH, MPH, University of Colorado School of
3 Medicine; Garen Wintemute, MD, MPH, University of California-Davis School of Medicine; and
4 Megan Ranney, MD, MPH, Warren Alpert Medical School, Brown University. Dr. Betz,
5 Dr. Wintemute and Dr. Ranney then collaborated with the AMA to develop an enduring CME
6 module, "The Physician's Role in Promoting Firearm Safety," which was published on the AMA
7 Ed Hub in December of 2018.

8
9 The AMA also recognizes the need for state-specific guidance for physicians on how to counsel
10 patients to reduce their risk for firearm-related injury or death, including when and how to ask
11 sensitive questions about firearm ownership, access and use, and clarification on the circumstances
12 under which physicians are permitted or may be required to disclose the content of such
13 conversations to family members, law enforcement, or other third parties. To inform this work the
14 AMA conducted research to: (1) understand physician's barriers and emotions related to firearm
15 safety discussion with patients; (2) co-create with physicians and partners on relevant tools or
16 methods to help improve firearm safety; and (3) recommend a path forward for the AMA to aid
17 physicians in having firearm safety conversations. Six interviews were conducted with subject
18 matter experts working in the field of firearm safety and violence prevention and four two-hour
19 co-creation groups were held exploring current barriers to firearm safety conversations, physicians'
20 emotions, and functional and emotional design needs. The four co-creation groups were convened
21 by specialty (pediatrics, primary care (adult), psychiatry, and emergency physicians). Each group
22 included four physicians.

23
24 The findings of this research have informed the development of a resource to help physicians
25 effectively screen and counsel patients at risk of firearm related injury and mortality. The resource
26 is an online tool containing guidance on when and how to ask sensitive questions about firearm
27 ownership, access, and use, as well as state-specific legal information about discrete legal topics
28 related to firearms, such as laws governing physician speech about firearms, physicians'
29 obligations to disclose confidential patient information, safe storage and child access prevention
30 laws, and laws governing the possession and transfer of firearms. The tool is expected to be
31 launched by the end of 2022.

32 33 EXISTING AMA POLICY

34
35 In addition to the newly adopted policies noted above, the AMA has developed and adopted over
36 [30 policy recommendations](#) over the past two decades to reduce firearm trauma, injury, and death.
37 These include:

- 38
- 39 • [A waiting period for firearm availability, and](#)
- 40 [Background checks for all firearm purchasers, Policy H-145.996](#)
- 41 • [Firearm safety and research and enhancing access to mental health care, Policy H-145.975](#)
- 42 • [Gun safety education and regulation of interstate traffic of guns, Policy H-145.997](#)
- 43 • [Distribution of firearm safety materials in the clinical setting, Policy D-145.996](#)
- 44 • [Limit and control the possession and storage of weapons on school property, Policy H-](#)
- 45 [145.983](#)
- 46 • [Firearm safety counseling with patients, Policy H-145.976](#)
- 47 • [Trigger locks and gun cabinets to improve firearm safety, Policy H-145.978](#)
- 48 • [Data on firearm deaths and injuries, Policy H-145.984](#)
- 49 • [Prevention of unintentional shooting deaths among children, Policy H-145.979](#)
- 50 • [Ban on handguns and automatic repeating weapons, Policy H-145.985](#)
- 51 • [Prevention of firearm accidents in children, Policy H-145.990](#)

- 1 • [Waiting period before gun purchase, Policy H-145.992](#)
- 2 • [Restriction of assault weapons, Policy H-145.993](#)
- 3 • [Mandated penalties for crimes committed with firearms, Policy H-145.999](#)
- 4 • [Public health policy approach for preventing violence in America, Policy H-515.971](#)

5
6 DISCUSSION

7
8 The Board believes that the above policies and additional policies that have been adopted by the
9 HOD provide abundant opportunity to advocate at the federal, state, and local levels and with other
10 stakeholders for evidence-based policy solutions to respond to the current public health crisis of
11 firearm violence. The challenge in achieving legislative success, especially at the federal level, is
12 not the lack of sufficient or adequate AMA policy but rather the political realities in the current
13 Congress, especially advancing specific legislation through the U.S. Senate. Congress regards the
14 passage and enactment of the Bipartisan Safer Communities Act as the high bar on what firearm
15 related laws can be achieved at the federal level in the current political environment. Therefore,
16 while seeking opportunities at the federal level to further advance comprehensive legislation,
17 including expanding background checks to all firearm purchasers or restricting assault weapons
18 and large capacity magazines, the AMA will continue to advocate for timely implementation and
19 adequate funding of the recently enacted Bipartisan Safer Communities Act, with a particular focus
20 at the state level in expanding Extreme Risk Protection Order (ERPO) laws.

21
22 The Board acknowledges the impassioned testimony expressed during reference committee and on
23 the floor of the HOD about the need to create an AMA task force to develop actionable
24 recommendations for the AMA to be a leader in responding to the gun violence crisis. As
25 summarized in this report, however, our AMA is already engaged in the advocacy, litigation, and
26 coalition activities similarly called for in Resolution 246 and in accord with existing AMA policy.
27 The Board concludes, therefore, that a task force, as called for in Resolution 246, is not necessary
28 for the AMA to remain a leader and strong advocate for state and federal legislation and
29 regulations to reduce firearm violence. Furthermore, the Board remains committed to seeking new
30 solutions (through advocacy, litigation, education, and coalition activities) to reduce firearm
31 violence, and can accomplish this in a more responsive and nimble manner than through a new task
32 force. Accordingly, the Board recommends that Resolution 246 not be adopted. However, in order
33 to keep the Federation of Medicine and the HOD up-to-date on developments in this space, the
34 AMA will make readily available on the AMA website the comprehensive summary of AMA
35 policies, activities, and progress regarding the public health crisis of firearm violence.

36
37 RECOMMENDATION

38
39 The Board of Trustees recommends that the following be adopted in lieu of Resolution 246 and
40 that the remainder of the report be filed:

41
42 Our AMA will make readily accessible on the AMA website the comprehensive summary of AMA
43 policies, plans, current activities, and progress regarding the public health crisis of firearm
44 violence. (New HOD Policy)

Fiscal note: None.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 7-I-22

Subject: Transparency of Resolution Fiscal Notes
(Resolution 608-A-22)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

1 Resolution 608 from the 2022 Annual Meeting, “Transparency of Resolution Fiscal Notes,” was
2 introduced by Resident and Fellow Section and referred. The resolution proposed amendments to
3 Policy G-600.061, “Guidelines for Drafting a Resolution or Report,” as follows:
4

5 RESOLVED, That our American Medical Association amend current Policy G-600.061,
6 “Guidelines for Drafting a Resolution or Report,” by addition and deletion to read as follows:
7

8 (d) A fiscal note setting forth the estimated resource implications (expense increase,
9 expense reduction, or change in revenue) of ~~the any~~ proposed ~~policy, program, study~~ or
10 ~~directive to take action~~ shall be generated and published by AMA staff in consultation with
11 the sponsor: prior to its acceptance as business of the AMA House of Delegates. Estimated
12 changes in expenses will include direct outlays by the AMA as well as the value of the
13 time of AMA’s elected leaders and staff. A succinct description of the assumptions used to
14 estimate the resource implications must be included in the AMA House of Delegates
15 Handbook to justify each fiscal note. ~~When the resolution or report is estimated to have a~~
16 ~~resource implication of \$50,000 or more, the AMA shall publish and distribute a document~~
17 ~~explaining the major financial components or cost centers~~ (such as travel, consulting fees,
18 meeting costs, or mailing). No resolution or report that proposes ~~policies, programs, studies~~
19 or actions that require financial support by the AMA shall be considered without a fiscal
20 note that meets the criteria set forth in this policy.
21

22 In its report, the reference committee, stated:
23

24 Your Reference Committee heard mixed testimony on Resolution 608. Testimony noted that
25 standardizing the fiscal note process will be beneficial for both the resolution author and the
26 House of Delegates. It was stated that a process for developing fiscal notes was previously
27 established through current AMA policy. Additionally, a concern was raised the proposed
28 process could hinder the timely generation of fiscal notes for emergency resolutions. Due to
29 issues raised during testimony, your Reference Committee believes that an exploration of all
30 concerns related to fiscal note development is merited and recommends referral.
31

32 The resolution was not discussed in the House, as the reference committee recommendation was
33 adopted on the consent calendar. The full text of the policy in its current form is below in
34 Appendix A. Appendix B provides the text of Resolution 608.

1 BACKGROUND

2
3 Fiscal notes have been attached to items of business, particularly resolutions for decades. In 1999,
4 (then) Policy H-545.935, “Expanded Fiscal Notes on Resolutions,” stated:

5
6 Fiscal notes estimated to be more than \$5,000 shall specify whether it is a “loss of revenue,”
7 “additional operating expense,” or “savings to the AMA.” The AMA publishes and distributes
8 a document containing explanations and/or assumptions for fiscal notes on each resolution
9 estimated to have a fiscal impact of \$50,000 or more, containing greater detail and supporting
10 documentation, including major components or cost centers (such as travel, consulting fees,
11 meeting costs, mailing).

12
13 At the 1999 Annual Meeting, Council on Long Range Planning and Development (CLRPD)
14 Report 4 altered the policy somewhat and incorporated it into (then new) Policy H-545.933,
15 “Guidelines for Drafting a Resolution,” with the new language as follows:

16
17 A fiscal note setting forth the estimated cost of the proposed policy, program, or action shall be
18 generated by AMA staff in consultation with the sponsor. Fiscal notes estimated to be more
19 than \$5,000 shall specify whether it is a “loss of revenue,” “additional operating expense,” or
20 “savings to the AMA” When the resolution is estimated to have a fiscal impact of \$50,000 or
21 more, the AMA shall publish and distribute a document explaining the major financial
22 components or cost centers (such as travel, consulting fees, meeting costs, or mailing). No
23 resolution requiring finances shall be considered without attachment of such fiscal note.

24
25 The same report created (then) Policy H-545.934, “Guidelines for Drafting a Report,” under which
26 “all reports to the HOD for action shall include a fiscal note and a designation whether or not it is
27 within the current budget.”

28
29 At the 2003 Annual Meeting, CLRPD Report 6-A-03 made the two guideline drafting policies
30 parallel, calling for a fiscal note for any “proposed policy, program, or action” whether in a
31 resolution or report. Similarly, the requirement to publish and distribute a document on the
32 financial components was extended to reports, and consideration of either a resolution or action
33 report without the requisite fiscal note was to be precluded. The fiscal note focus was changed from
34 cost to “resource implications (expense increase, expense reduction, or change in revenue).”

35
36 Except for consolidating the two policies into a single policy, other changes to the policy since
37 2003 did not address the portion on fiscal notes. The policy as it appears in the Appendix has been
38 in place since 2018.

39
40 CURRENT PRACTICE WITH FISCAL NOTES

41
42 Fiscal notes are based on a gross estimate of the AMA staff time that would be required to
43 implement the resolution or report as written along with other cost centers such as survey expenses
44 and consultant fees or foregone revenue. A fiscal note is printed on every resolution and action
45 report (i.e., informational reports are excluded), provided the information is available when the
46 document is officially released in the handbook, addendum, or tote.* Fiscal notes can only rarely be

* The tote contains items of business submitted after the on-time deadline for a meeting. Historically, this has been the “Sunday tote,” but for A-22 was the “Saturday tote,” and for the Special Meetings was a “Friday tote.”

1 calculated precisely, so current practice characterizes the fiscal note for most items within one of
2 three ranges:

- 3
4 • Minimal – less than \$1,000
5 • Modest – between \$1,000 - \$5,000
6 • Moderate – between \$5,000 - \$10,000
7

8 Items for which the fiscal note exceeds \$10,000 are addressed in the “Summary of Fiscal Notes
9 [meeting]” document, which is included in the initial handbook and is updated and included in the
10 tote distributed for the second opening.

11
12 In fact, the fiscal notes for all items of business having a fiscal note appear in the “Summary of
13 Fiscal Notes,” including those items that did not directly incorporate the figure when initially
14 released. For those items where the note exceeds \$10,000, additional information is included for
15 most, with exceptions largely from section-sponsored resolutions transmitted for immediate
16 consideration by the House of Delegates and for which only a gross figure is available, but
17 otherwise, a breakdown of the fiscal note is provided using broad categories (e.g., consultant fees).
18 For example, the document included the following fiscal notes in June:

- 19
20 • Res 242, Public Awareness and Advocacy Campaign to Reform the Medicare Physician
21 Payment System: Est btwn \$1M - \$25M to conduct a public awareness camp (incl. paid ads,
22 social and earned media, patient and phys grassroots) to prevent/mitigate further Medicare
23 payment cuts and lay the groundwork to pass fed legislation. Incl prof. fees and promotion
24 • Res 615, Anti-Harassment Training: Est cost approx. \$60K-\$65K to create 3 targeted
25 eLearning modules. Incl end to end content design & devel costs to start from scratch, subj
26 matter expert honorariums and staff time
27

28 The summary document provides this additional information for all items for which the fiscal note
29 exceeds \$10,000, not only those greater than \$50,000 as called for by existing Policy G-600.061.
30 Also worth noting is that the resolution sponsor is contacted when the fiscal note exceeds \$5,000.
31 That sometimes leads to a change in the resolution.
32

33 *Limitations in the Current Fiscal Note Process*

34

35 As noted generating reliable estimates of the “estimated resource implications (expense increase,
36 expense reduction, or change in revenue),” to use the language of the current policy, of an item of
37 business, particularly resolutions, is difficult. Resolutions are most frequently submitted on or near
38 deadlines, meaning time for processing—and preparing a fiscal note is only one facet of that
39 process—must be accomplished relatively quickly and like any estimate, cannot be calculated with
40 precision. Fiscal notes for reports are generally more reliable than those for resolutions because
41 more time is available for their development, but even so, they should be considered qualified
42 estimates rather than definitive.*
43

44 Moreover, few resolutions specify parameters sufficiently to yield reliably precise figures. While
45 estimates of foregone revenue and changes in member benefits are readily calculated simply
46 because accurate figures can be used (e.g., the number of members and the revenue or cost per
47 member are available), even those figures are subject to estimates of the number of members who
48 will take advantage of the proposal. Resolutions calling for our AMA to study an issue are

* The Report of the Speakers’ Special Advisory Committee from the 2009 Annual Meeting included a chart, characterized how business is processed for a meeting. The chart would not be substantially different today.

1 particularly prone to interpretation. Does “study” simply mean that a report be prepared, or does it
2 require more extensive effort, such as fielding a survey or soliciting members’ experiences?
3

4 Finally, it should be borne in mind that the fiscal note is prepared based on the item of business as
5 written. Changes by the reference committee and amendments in the House can significantly alter
6 the item, potentially decreasing confidence and increasing error in the fiscal note. Routine
7 informational reports to the House that are attributable to existing policy (e.g., the annual tobacco
8 report, the annual demographic report, the update on the ACA at every HOD meeting) incur costs
9 that are not captured by fiscal notes at all, even though their genesis is found in resolutions adopted
10 by the House. The expense related to reports that stem from referred resolutions is similarly not
11 captured in a fiscal note. Based on observations over multiple House meetings, it seems that
12 “small” fiscal notes—small by whatever definition—concern few people, while “large” fiscal
13 notes—probably defined as in excess of \$500,000—however accurate, seemingly cause concern
14 that the dollars are used as a barrier against doing the work, rather than acceptance that the work
15 can be and often times is costly.
16

17 Lost in the discussion of fiscal notes is the fact that every item of business incurs various expenses.
18 Those expenses begin with the sponsoring organization and extend to our AMA for processing,
19 distribution, and implementation, even if implementation is little more than recording the statement
20 in PolicyFinder. Similarly, items of business indirectly add to expenses for members of the House
21 who leave their practices to attend House of Delegates meetings. To be clear, these observations
22 are not criticisms, only an acknowledgement that fiscal notes do not cover all associated costs,
23 much as various regulatory schemes or insurance practices impose costs on physicians even if
24 unintended and unacknowledged.
25

26 RESOLUTION 608-A-22

27
28 The declared intent underlying Resolution 608-A-22 is found in the whereas clause that states,
29 “Providing the rationale behind the fiscal note to the House of Delegates would promote
30 understanding, transparency, standardization and enable the House to utilize the AMA’s resources
31 more judiciously.” (The full text of the resolution, including the whereas clauses, is found in
32 Appendix B.) The fiscal note for the resolution was just over \$5800 annually, or moderate using
33 the standard terminology, assuming the submission of 280 resolutions per year.
34

35 The resolution proposes changes to three elements of the existing policy regarding fiscal notes,
36 although the need for each change is not explicitly stated:
37

- 38 • Removes proposed “policies and programs” from the requirement for a fiscal note while
39 inserting “study or directive to take” before the word “action.”
- 40 • Requires that the fiscal note be generated and published “prior to acceptance as business.”
- 41 • Calls for including a succinct justification for each fiscal note to be included in the handbook.
42

43 The rationale for the first change is unclear. If the intent is simply to propose alternative language
44 for the existing policy, the change serves no real purpose. If the intent is to use the “directive to
45 take action” terminology to cover any resolution calling for any sort of activity, the distinction with
46 and inclusion of “study” is unnecessary. Given that the authors distinguish between “study” and
47 “directive to take action,” it would be inconsistent to remove the word “program” from the policy.
48

49 More problematic is the removal of the word “policy,” which is inconsistent with the author’s
50 suggestion that the change will “enable the House to utilize the AMA’s resources more
51 judiciously,” as it ignores the fact that every resolution incurs some cost, even if minimal. And it

1 should be reiterated that processing, distribution, and other meeting-related costs are not captured
2 by fiscal notes. In addition, even purely philosophical statements of policy may carry costs
3 associated with implementation and advocacy. For example, recent policies emphasizing the role of
4 physicians on the health care team have led to considerable activity.

5
6 Finally, the “policy, program, or action” language was developed by the Council on Long Range
7 Planning and Development after careful consideration and presentation of its 1999 report
8 mentioned above. Your Board cannot support the proposed change to this part of the policy.

9
10 The second proposed change calls for preparing and publishing the fiscal note before accepting the
11 item as business. Again the intent is unclear. Whenever possible, as noted above, fiscal notes are
12 appended to the resolution before it is distributed in the handbook, addendum, or tote, and the
13 summary of fiscal notes document appears in the handbook and in updated form in the tote. Thus it
14 would seem that this is already accomplished.

15
16 The policy already calls for the fiscal note to be developed in consultation with the authors, but
17 given the usual timing of resolution submissions and the multiple processing steps, the Speakers
18 have determined that this consultation is required only for those resolutions for which the fiscal
19 note exceeds \$5000. To consult with the sponsor for every resolution would be problematic. First,
20 it would likely add significantly to the processing time for resolutions. Most resolutions are
21 submitted by medical society staff, but the person sending the resolutions to the House Office is not
22 necessarily the best contact for the resolution. Connecting with the proper individual may take
23 time, and it is not uncommon that the most knowledgeable party is the physician who initially
24 generated the idea that then came through the society. Relatedly, section-sponsored resolutions,
25 particularly those sent for immediate consideration by the House, may require governing council
26 input if questions arise about the fiscal note, a potentially time-consuming process. Second, such
27 consultations seem largely unnecessary for resolutions that have minimal costs. The value added
28 for the time invested is virtually nil, as fiscal notes under \$5,000 essentially represent staff time,
29 meaning there is little to explicate. Finally, resolutions are technically not accepted as business
30 until the House acts (usually as part of the second opening) by which time fiscal notes have been
31 prepared and published for all items of business, with only a handful of exceptions. If the authors
32 have in mind that the fiscal note should be made available before the resolution can be included in
33 the handbook, they have effectively created an impossible task or need to suggest a workable
34 mechanism that will allow timely publication of meeting materials.

35
36 Not seeing how this change benefits the House and not seeing how this proposal could be
37 implemented without disrupting or delaying HOD meeting preparations, your Board does not
38 support this change.

39
40 The last change proposed would include a “succinct description of the assumptions used to
41 estimate the resource implications” of each resolution in the handbook. As noted, most resolutions
42 with a fiscal note under \$5,000 reflect costs associated with staff time, and the same is true for
43 fiscal notes up to \$10,000. Including assumptions on staff costs would involve adding the hours
44 and salary rates for AMA employees that would be an inappropriate public disclosure of
45 compensation in many cases. Insofar as fiscal notes over \$5000 are discussed with the sponsor and
46 the summary of fiscal notes document includes elements of the costs associated with resolutions
47 having fiscal notes in excess of \$10,000, your Board believes this change is unnecessary.

1 RECOMMENDATION

2

3 Your Board of Trustees recommends that Resolution 608 not be adopted and the remainder of the
4 report be filed.

Fiscal Note: None other than preparing this report

APPENDIX A - PolicyG-600.061, "Guidelines for Drafting a Resolution or Report"

Resolutions or reports with recommendations to the AMA House of Delegates shall meet the following guidelines:

1. When proposing new AMA policy or modification of existing policy, the resolution or report should meet the following criteria:
 - (a) The proposed policy should be stated as a broad guiding principle that sets forth the general philosophy of the Association on specific issues of concern to the medical profession;
 - (b) The proposed policy should be clearly identified at the end of the resolution or report;
 - (c) Recommendations for new or modified policy should include existing policy related to the subject as an appendix provided by the sponsor and supplemented as necessary by AMA staff. If a modification of existing policy is being proposed, the resolution or report should set out the pertinent text of the existing policy, citing the policy number from the AMA policy database, and clearly identify the proposed modification. Modifications should be indicated by underlining proposed new text and lining through any proposed text deletions. If adoption of the new or modified policy would render obsolete or supersede one or more existing policies, those existing policies as set out in the AMA policy database should be identified and recommended for rescission. Reminders of this requirement should be sent to all organizations represented in the House prior to the resolution submission deadline;
 - (d) A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of the proposed policy, program, or action shall be generated by AMA staff in consultation with the sponsor. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in each fiscal note. When the resolution or report is estimated to have a resource implication of \$50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing). No resolution or report that proposes policies, programs, or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy.
2. When proposing to reaffirm existing policy, the resolution or report should contain a clear restatement of existing policy, citing the policy number from the AMA policy database.
3. When proposing to establish a directive, the resolution or report should include all elements required for establishing new policy as well as a clear statement of existing policy, citing the policy number from the AMA policy database, underlying the directive.
4. Reports responding to a referred resolution should include the resolves of that resolution in its original form or as last amended prior to the referral. Such reports should include a recommendation specific to the referred resolution. When a report is written in response to a directive, the report should sunset the directive calling for the report.
5. The House's action is limited to recommendations, conclusions, and policy statements at the end of report. While the supporting text of reports is filed and does not become policy, the House may correct factual errors in AMA reports, reword portions of a report that are objectionable, and rewrite portions that could be misinterpreted or misconstrued, so that the "revised" or "corrected" report can be presented for House action at the same meeting whenever possible. The supporting texts of reports are filed.
6. All resolutions and reports should be written to include both "MD and DO," unless specifically applicable to one or the other.

7. Reports or resolutions should include, whenever possible or applicable, appropriate reference citations to facilitate independent review by delegates prior to policy development.
8. Each resolution resolve clause or report recommendation must be followed by a phrase, in parentheses, that indicates the nature and purpose of the resolve. These phrases are the following:
 - (a) New HOD Policy;
 - (b) Modify Current HOD Policy;
 - (c) Consolidate Existing HOD Policy;
 - (d) Modify Bylaws;
 - (e) Rescind HOD Policy;
 - (f) Reaffirm HOD Policy; or
 - (g) Directive to Take Action.
9. Our AMA's Board of Trustees, AMA councils, House of Delegates reference committees, and sponsors of resolutions will try, whenever possible, to make adjustments, additions, or elaborations of AMA policy positions by recommending modifications to existing AMA policy statements rather than creating new policy.

Policy Timeline

CLRPD Rep. 4, A-99; Modified by BOT Rep. 15, A-00; Consolidated: CLRPD Rep. 3, I-01;
Modified: CLRPD Rep. 2, A-02; Modified: CLRPD Rep. 6, A-03; Reaffirmed: BOT Rep. 19, A-04;
Appended: Res. 606, A-05; Appended: Res. 611, A-07; Modified: CCB/CLRPD Rep. 1, A-12;
Modified: Speakers Rep., A-18

APPENDIX B – Resolution 608-A-22

Whereas, AMA resolutions include a fiscal note to share the projected cost of the resolution resolved clauses, if adopted; and

Whereas, The fiscal note is often categorized minimal, modest or moderate or sometimes, more specifically states an estimated cost in dollars; and

Whereas, Little justification or detail is provided to explain fiscal notes; and

Whereas, Providing the rationale behind the fiscal note to the House of Delegates would promote understanding, transparency, standardization and enable the House to utilize the AMA's resources more judiciously; therefore be it

RESOLVED, That our American Medical Association amend current policy G-600.061, "Guidelines for Drafting a Resolution or Report," by addition and deletion to read as follows:

(d) A fiscal note setting forth the estimated resource implications (expense increase, expense reduction, or change in revenue) of ~~the any proposed policy, program, study or directive to take action~~ shall be generated and published by AMA staff in consultation with the sponsor, prior to its acceptance as business of the AMA House of Delegates. Estimated changes in expenses will include direct outlays by the AMA as well as the value of the time of AMA's elected leaders and staff. A succinct description of the assumptions used to estimate the resource implications must be included in the AMA House of Delegates Handbook to justify each fiscal note. ~~When the resolution or report is estimated to have a resource implication of \$50,000 or more, the AMA shall publish and distribute a document explaining the major financial components or cost centers (such as travel, consulting fees, meeting costs, or mailing).~~ No resolution or report that proposes ~~policies, programs, studies~~ or actions that require financial support by the AMA shall be considered without a fiscal note that meets the criteria set forth in this policy.

REPORT 8 OF THE BOARD OF TRUSTEES (I-22)
The Resolution Committee as a Standing Committee of the House
(Resolution 605-N-21 and Resolution 619-A-22)
(Reference Committee F)

EXECUTIVE SUMMARY

At the November 2021 Special Meeting of the House of Delegates, Texas introduced Resolution 605 seeking the establishment of a resolution committee to review “resolutions submitted for consideration at all meetings of the American Medical Association House of Delegates” to ensure that the resolutions meet the purpose of the meeting. At the 2022 Annual Meeting, another resolution having multiple sponsors proposed establishing a resolution committee that would be operational for all House of Delegates meetings. Both resolutions were referred to the Board of Trustees, and this report addresses both.

While the Interim Meeting is to focus on advocacy matters and ethics concerns, along with matters that require urgent action, the Annual Meeting has no expressly stated purpose beyond serving as the setting for the legislative and policymaking activities of the House of Delegates as described in the AMA Constitution. The bylaws have established a Resolution Committee for the Interim Meeting (§2.13.3).

A fundamental element of parliamentary law is that a body can determine its agenda, but only the House of Delegates can decide whether a resolution committee is the means to set the agenda for its meetings. Your Board of Trustees is not empowered to set House procedures and offers this report to determine the will of the House with respect to establishing a resolution committee.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 8-I-22

Subject: The Resolution Committee as a Standing Committee of the House
(Resolution 605-N-21 and Resolution 619-A-22)

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to: Reference Committee F

1 At the November 2021 Special Meeting of the House of Delegates (HOD) Texas introduced the
2 following resolution (605-N-21), which was referred:

3
4 RESOLVED, That the Bylaws of the American Medical Association be amended to provide
5 that the Resolution Committee be responsible for reviewing resolutions submitted for
6 consideration at all meetings of the American Medical Association House of Delegates and
7 determining compliance of the resolutions with the purpose of any such meeting; and be it
8 further

9
10 RESOLVED, That the membership of the Resolution Committee reflect the diversity of the
11 House of Delegates; and be it further

12
13 RESOLVED, That the Resolution Committee rules be written to produce impartial results and
14 appropriate changes be made to the AMA Bylaws as necessary to empower the committee.

15
16 The reference committee had recommended referral and characterized the testimony in the hearing
17 as follows:

18
19 Your Reference Committee heard robust, yet widely divided testimony on formalizing the
20 Resolution Review Committee as a standing House of Delegates committee. Testimony
21 reflected that the Resolution Review Committee was implemented as a temporary solution to
22 address an unprecedented situation.

23
24 Opposition to formalizing the Resolution Review Committee entailed concerns, such as
25 inconsistencies with evaluating resolutions, limiting discussion on ideas and emergent issues,
26 ineffective extraction process, lack of inclusivity in policy deliberations, and exclusion of the
27 minority voice in the parliamentary process.

28
29 Testimony favoring formalization of the resolution review process cited issues regarding
30 members of our AMA House of Delegates not having sufficient time to review a growing
31 volume of business and the need to triage priority items of business.

32
33 The resolution was then debated in the House and referred, and much of that debate could be
34 characterized like the testimony in the reference committee.

35
36 At the 2022 Annual Meeting, Texas, South Carolina, Florida, Mississippi, New Jersey, and
37 Pennsylvania introduced Resolution 619-A-22, which reads:

1 RESOLVED, That the Resolutions Committee be formed as a standing committee of the
2 house, the purpose of which is to review and prioritize all submitted resolutions to be acted
3 upon at the annual and interim meetings of the AMA House of Delegates; and be it further
4

5 RESOLVED, That the membership of the Resolutions Committee be composed of one Medical
6 Student Section (MSS) member, one Resident and Fellow Section (RFS) member, and one
7 Young Physicians Section (YPS) member, all appointed by the speakers through nominations
8 of the MSS, RFS, and YPS respectively; six regional members appointed by the speakers
9 through nominations from the regional caucuses; six specialty members appointed by the
10 speakers through nominations from the specialty caucuses; three section members appointed by
11 the speakers through nominations from sections other than the MSS, RFS, and YPS; and one
12 past president appointed by the speakers; and be it further
13

14 RESOLVED, That the members of the Resolutions Committee serve staggered two-year terms
15 except for the past president and the MSS and RFS members, who shall serve a one-year term;
16 and be it further
17

18 RESOLVED, That members of the Resolutions Committee cannot serve more than four years
19 consecutively; and be it further
20

21 RESOLVED, That if a Resolutions Committee member is unable or unwilling to complete his
22 or her term, the speakers will replace that member with someone from a similar member group
23 in consultation with that group the next year, and the new member will complete the unfulfilled
24 term; and be it further
25

26 RESOLVED, That each member of the Resolutions Committee confidentially rank resolutions
27 using a 0-to-5 scale (0 – not a priority to 5 – top priority) based on scope (the number of
28 physicians affected), urgency (the urgency of the resolution and the impact of not acting),
29 appropriateness (whether AMA is the appropriate organization to lead on the issue), efficacy
30 (whether an AMA stance would have a positive impact), history (whether the resolution has
31 been submitted previously and not accepted), and existing policy (whether an AMA policy
32 already effectively covers the issue). Resolutions would not have to meet all of these
33 parameters nor would these parameters have to be considered equally; and be it further
34

35 RESOLVED, That the composite (or average) score of all members of the Resolutions
36 Committee be used to numerically rank the proposed resolutions. No resolution with a
37 composite average score of less than 2 would be recommended for consideration. The
38 Resolutions Committee would further determine the cutoff score above which resolutions
39 would be considered by the house based on the available time for reference committee and
40 house discussion, and the list of resolutions ranked available for consideration would be titled
41 “Resolutions Recommended to be Heard by the HOD”; and be it further
42

43 RESOLVED, That the Resolutions Committee also make recommendations on all resolutions
44 submitted recommending reaffirmation of established AMA policy and create a list titled
45 “Resolutions Recommended for Reaffirmation,” with both lists presented to the house for
46 acceptance; and be it further
47

48 RESOLVED, That the membership of the Resolutions Committee be published on the AMA
49 website with a notice that the appointed members should not be contacted, lobbied, or coerced;
50 any such activity must be reported to the AMA Grievance Committee for investigation; and

1 should the alleged violations be valid, disciplinary action of the offending person will follow;
2 and be it further

3

4 RESOLVED, That the bylaws be amended to add the Resolution Committee as a standing
5 Committee with the defined charge, composition, and functions as defined above for all AMA
6 HOD meetings effective Interim 2022.

7

8 Reference committee testimony on June's resolution echoed the comments that had been heard at
9 the preceding November meeting and acknowledged the referral of the matter at that meeting. This
10 resolution too was referred.

11

12 At the outset your Board would note that a decision regarding a resolution committee rightly rests
13 with the House. Your Board is not empowered to establish House procedures, so this report is
14 intended to determine the will of the House in this matter.

15

16 BACKGROUND

17

18 The House has never restricted the subject matter of resolutions. No subject is foreclosed at any
19 HOD meeting, and aside from a few late resolutions, nearly all resolutions have been accepted over
20 the years. The Annual Meeting has no defined focus. The Interim Meeting, however, is to focus on
21 advocacy-related matters, and when that decision was made, a resolution committee was
22 implemented to ensure that focus. The special meetings of 2020 and 2021 employed resolutions
23 committees to limit the business to urgent or priority issues. Thus the limitations that have been
24 imposed were based not on the subject matter but on the focus (i.e., advocacy) or need for action
25 (i.e., urgency and priority).

26

27 *Resolution Committee – Interim Meetings*

28

29 A committee tasked with the review of resolutions did not originate with the special meetings. It
30 was just over twenty years ago that the House of Delegates determined that the Interim Meeting
31 should be focused on advocacy matters, and while June's annual meetings would consider any
32 business properly submitted, November's meetings should consider only resolutions that address
33 advocacy and legislation. Matters concerning ethics were later added as an appropriate topic in
34 November. It should be noted that the Interim Meetings are a full day shorter than our Annual
35 Meetings further supporting a need for a narrow focus of business to be considered.

36

37 To ensure the focus on advocacy, AMA bylaws were amended, and bylaw 2.12.1.1, "Business of
38 Interim Meeting," reads:

39

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

46

47 Determining what business is appropriate for consideration at an Interim Meeting is the province of
48 the Resolution Committee. That section of the bylaws reads:

1 2.13.3 Resolution Committee. The Resolution Committee is responsible for reviewing
2 resolutions submitted for consideration at an Interim Meeting and determining compliance of
3 the resolutions with the purpose of the Interim Meeting.
4

5 The Resolution Committee for the Interim Meeting is appointed by the Speaker with broad
6 representation from the House including members from all sections and councils. Our Bylaws
7 restrict the committee to a maximum of 31 delegates. The committee does not meet, rather each
8 member of the committee independently reviews the resolutions and sends their recommendations
9 to the Office of House of Delegates Affairs, which tallies the individual votes. A “resolution shall
10 be accepted for consideration at an Interim Meeting upon majority vote of committee members
11 voting.” Items recommended against consideration by the committee are subject to appeal to the
12 House, which can accept the resolution by majority vote as noted above. Your Board is not aware
13 of any objections to the way in which the Interim Meeting Resolution Committee has operated,
14 including the fact that its members have traditionally not been identified.
15

16 *Resolutions Committees – Special Meetings, 2020 & 2021*
17

18 Health and safety concerns as well as government-imposed restrictions stemming from the SARS-
19 CoV-19 pandemic disallowed holding in-person meetings of the House of Delegates for the 2020
20 and 2021 calendar years.¹ Under AMA bylaws, your Board of Trustees can and did call for special
21 meetings of the House of Delegates, with four such meetings in those two years.
22

23 The bylaws for special meetings state that notice of the meeting “shall specify the time and place of
24 meeting and the purpose for which it is called, and the House of Delegates shall consider no
25 business except that for which the meeting is called” (§2.12.2). Your Board declared that the
26 purposes of the special meetings included leadership transitions (for the June meetings) and the
27 consideration of urgent or priority business of the Association. Determining what proposals met the
28 defined purposes of the meetings was thought best left to the House, following the model of the
29 Resolution Committee associated with the Interim Meeting. That course was adopted for the
30 November 2020, June 2021, and November 2021 special meetings. The June 2020 special meeting
31 was much more circumscribed, with only a handful of items required by the bylaws considered in a
32 meeting that required only about three hours.
33

34 To be clear, the special meetings that were held in June 2021 and November 2020 and 2021 were
35 not annual or interim meetings and were convened under different bylaws. Following the pattern of
36 the Resolution Committee for the Interim Meeting, the Speakers appointed members for the
37 similarly named committees associated with each special meeting to address through their
38 individual assessments the priority or urgency of all resolutions.² Volunteers were solicited from
39 across the House, including the sections, regional caucuses, councils, and Specialty and Service
40 Society. The November 2020 committee included 10 delegates; both 2021 meetings included 31
41 delegates, with representation from all membership segments. (Though not technically applicable
42 to the special meetings, the special meetings resolutions committees adhered to the bylaws-
43 imposed limit of 31 members that applies to an Interim Meeting Resolution Committee.)

¹ Other meetings, including the State Advocacy Summit, National Advocacy Conference, and various RUC and CPT meetings, were also cancelled or moved to a virtual format. Your Board of Trustees did not meet in person between March 2020 and July 2021, until all had been vaccinated against COVID. Masks and other precautions were standard for the initial face-to-face meetings.

² In a similar fashion, the councils and Board limited their report submissions to those deemed most urgent or the greatest priority.

1 In addition to determining what proposals met the urgency or priority threshold, mechanisms had to
2 be developed to allow debate and voting in accord with Illinois corporate law, AMA bylaws, and
3 the House’s procedures. Although the available tools were relatively easy to use, AMA’s
4 procedures such as limiting election votes to delegates, substituting alternate delegates for their
5 delegates (and vice versa), and allowing any member to testify in a reference committee presented
6 special challenges related to use and familiarity with new technology. Consequently, concerns
7 arose about the ability of the House to address the usual volume of business in a virtual format,
8 which led to the need to pare the business to a reasonable level. The model of the Interim Meeting
9 Resolution Committee provided the best available solution. A similar mechanism is used by the
10 British Medical Association and was used by some state and specialty societies during the
11 pandemic.
12

13 Aside from a different focus for the special meetings, namely urgency or priority as noted in the
14 call to each meeting, the special meeting resolutions committees functioned like the Interim
15 Meeting Resolution Committee, with each member making independent judgments about every
16 resolution. Each resolution was rated on a five-point scale from “a top priority” to “not a priority at
17 this time,” using a priority matrix that had been developed by a subcommittee of the initial
18 committee.³ The initial priority matrix was modified slightly and approved by the subsequent
19 committees. The average score for each resolution was calculated, and every resolution that was
20 collectively rated as at least a medium priority (a “3” on the five-point scale) along with a handful
21 that scored slightly below medium priority was recommended for acceptance, with the remaining
22 items recommended against acceptance. Recommendations were based on each item’s rating—at
23 least medium priority, although a few items rated slightly less than medium priority were proposed
24 for acceptance. It was thought better to err on the side of inclusion. The committee’s
25 recommendations were presented to the House as a consent calendar from which any delegate
26 could extract an item, with the House determining whether to consider that item by a majority vote.
27

28 The votes by the House were taken without oral debate, which is not ordinary practice in the
29 House. This was intended to avoid debate about what would be debated, but the delegate requesting
30 extraction could prepare a written statement on why the item should be considered, with that
31 statement provided to the House in various ways: as part of the committee’s written report,
32 appearing on screen before and during the vote, and at the November 2021 meeting appearing on
33 screen while read aloud by the Speaker before the vote. In no case across the three meetings was a
34 committee recommendation overturned, which has led some to call foul and argue that the process
35 was unfair and dismissive of the minority view. Complying with AMA bylaws, which meant
36 considering only the business for which the meetings had been called, was the reason for using
37 resolutions committees across the special meetings.
38

39 VIEWS ON A RESOLUTION COMMITTEE

40

41 The divergent views expressed about the referred resolutions derive from different perspectives.
42 Those favoring the resolutions want to focus the work of the House of Delegates on matters that
43 our AMA can effectively address and that are deemed important and relevant to the largest number
44 of physicians. They favor in-depth discussion and debate about fewer issues over limited debate
45 about a multitude of business items.

³ Members of the Interim Meeting Resolution Committee are typically presented with a binary choice for each resolution: it is or is not advocacy, but the special meetings’ purpose being urgency or priority augured for a finer gradation.

1 Those opposed to the resolutions are generally more concerned about ensuring that all resolutions
2 are considered, with those concerns characterized in terms of fairness, member engagement and
3 process transparency.

4
5 PROCESS FOUNDATION AND OUTCOMES OF THE SPECIAL RESOLUTIONS
6 COMMITTEE

7
8 AMA-sponsored meetings, including the House of Delegates meetings, are conducted according to
9 the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*, albeit with
10 slight modifications such as the distinction between referral for report and referral for decision.
11 Noted therein is that “the purpose of parliamentary procedure is to facilitate the orderly transaction
12 of business and to promote cooperation and harmony” (p 7). Shortly thereafter is stated that “The
13 majority vote decides. The ultimate authority of an organization is, as a general matter, vested in a
14 majority of its members” (p 8).

15
16 Your Board believes that the resolutions committees employed for the special meetings were
17 implemented in good faith to allow the House to exercise its legislative and policymaking authority
18 cooperatively using tools and a format that are inherently less efficient than our AMA’s traditional
19 in-person meetings while staying true to our parliamentary processes and House practices.

20
21 A fundamental aspect of the deliberative process is that a legislative body has the right to
22 determine its agenda. A full debate, discussion and vote on every proposal is not guaranteed.
23 Indeed, House procedures provide two motions that preclude full consideration of specific items:
24 the motion to object to consideration and the motion to table. Other House procedures, the
25 reaffirmation calendar (initiated in 1991) and the Interim Meeting Resolution Committee,
26 effectively operate to the same end. Insofar as these mechanisms generally become operable on the
27 basis of a majority (or even supermajority) vote—extractions from the reaffirmation calendar being
28 an exception—they fully comport with parliamentary procedure and, by inference, represent the
29 majority’s view.

30
31 That none of the items extracted from the resolution committee reports was successfully added to
32 the agenda of one of the special meetings does not mean the process was ineffective or unfair. At
33 the November 2021 meeting, 165 resolutions were submitted. From that pool, the resolutions
34 committee had recommended that 39 be accepted, as those were of at least medium priority or
35 nearly so. Of those recommended against acceptance, 98 were not extracted, and among the 28
36 extracted items, three-fifths (i.e., 60%) or more of those voting supported the committee’s
37 recommendation against consideration for 23 items, and the smallest margin was a four-point
38 difference (52% to 48%).

39
40 OPERATION OF THE HOUSE OF DELEGATES

41
42 Commentary from both supporters and opponents of the resolutions committee noted the need for
43 efficiency in the House of Delegates, although no concrete changes for improving efficiency were
44 heard beyond the perceived pros or cons of a resolution committee. Efficiency in House of
45 Delegates meetings has long been sought, and multiple changes have been implemented by various
46 Speakers toward this goal. The previously mentioned reaffirmation calendar is one, and another is
47 treating reference committee reports as a consent calendar from which items are extracted for
48 debate in the House, which dates from the mid-1990s. The Interim Meeting Resolution Committee
49 was instituted not as an efficiency measure but as a mechanism to allow the House to ensure the
50 meeting is focused on advocacy.

1 The table below shows the number of resolutions submitted to each meeting since 2007, not
 2 including memorial resolutions and without regard to whether each resolution was considered. The
 3 four meetings in 2020 and 2021 were of course the special meetings conducted online.

Resolutions Submitted to House of Delegates Meetings, 2007-2022

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020*	2021*	2022
June	246	233	220	195	183	212	176	197	194	182	193	200	233	0	148	265
Nov.	97	112	93	109	119	82	93	117	98	103	101	107	99	100	165	-

* These were the special meetings.

4 The number of items of business is inarguably correlated with the time required for reference
 5 committee hearings and likely related to the duration of business sessions and debate in the House
 6 as well.⁴ Few would question the assertion that items considered late in a reference committee or
 7 on the last day at the House of Delegates meeting typically get a less thorough hearing than items
 8 considered earlier. Reference committees frequently rush through the last few items on their
 9 agendas, and delegates' comments and testimony are not uncommonly constricted—forced into
 10 60 second time slots—on the last day of the meeting. Prioritizing the business to be considered
 11 would be better than the somewhat random consignment of items to late in the agenda, whereby
 12 they receive foreshortened consideration.

13

14 CONCLUSION

15

16 In many ways a resolution committee would parallel efforts to focus the activities of our AMA
 17 across strategic arcs. Whether a resolution committee is viewed as a means to focus deliberations
 18 on priority issues or a cudgel to limit business, particularly business that is perceived to come from
 19 minority viewpoints or to propose possibly unpopular policies, is clearly a subjective evaluation.
 20 Also true is that the effect of a resolution committee on the proceedings of a House of Delegates
 21 meetings is unknown.

22

23 Your Board believes a process that would allow the House of Delegates to focus on key concerns
 24 of patients and our profession may merit a test. That decision, however, rests solely with the
 25 House. Your Board is not empowered to set out House procedures, and this report should be
 26 considered a vehicle to determine whether the House of Delegates wishes to implement a trial of a
 27 standing resolution committee for future meetings. Should the House favor a test, your Board will
 28 come back with a detailed proposal at the June 2023 House of Delegates Meeting (June 10-14,
 29 2023) recommending both the parameters for a resolution committee and the necessary bylaws
 30 changes.

31

32 The idea that a resolution committee would recommend which resolutions should be considered
 33 strikes some as an affront to the democratic nature of the House of Delegates. Others view it as a
 34 means to focus the work of the House on matters of greatest importance to the profession. Virtually
 35 any issue can be presented to the House for consideration, and the House has the right to choose
 36 which items should be considered or whether any limits should be imposed.

37

38 The nature of the virtual format of the special meetings limited the volume of business that could
 39 be considered. The limit was imposed, however, not primarily based on volume but on the
 40 collective evaluation of a proposal's urgency or priority. In fact, the special meetings were called
 41 by the Board to only handle urgent and priority business. For in-person meetings, the House has

⁴ Consider that the Interim Meeting is a full day shorter than the Annual Meeting and typically has only about half the number of items of business, which are handled in two fewer reference committees.

1 previously decided to focus the Interim Meeting on advocacy matters and not to restrict the
2 business considered at the Annual Meeting.

3
4 A decision whether to change the procedures of the House by implementing a resolution committee
5 for all House of Delegates meetings appropriately rests with the House of Delegates, not your
6 Board of Trustees. This report is intended to be a vehicle to determine the will of the House.

7
8 RECOMMENDATION

9 Your Board of Trustees offers the following recommendation to be adopted in lieu of Resolutions
10 605-N-21 and 619-A-22 and the remainder of the report filed.

11
12 That the Board of Trustees prepare a report for consideration at the 2023 Annual Meeting
13 recommending a trial of a resolution committee, including the make-up and operation of the
14 committee and create measures of fairness and effectiveness of the trial. (Directive to Take
15 Action)
16

Fiscal Note: Within current budget

REPORT OF THE BOARD OF TRUSTEES

B of T Report 9-I-22

Subject: Employed Physicians

Presented by: Sandra Adamson Fryhofer, MD, Chair

Referred to Reference Committee F

1 INTRODUCTION

2
3 At the November 2021 Special Meeting of the House of Delegates (HOD), Resolution 615,
4 “Employed Physicians,” was introduced by the Oklahoma, Alabama, District of Columbia,
5 Georgia, Mississippi, New Jersey, North Carolina, South Carolina, and Tennessee delegations and
6 referred for report. In brief, Resolution 615 asks the AMA to:^{*}

- 7
- 8 1. dedicate full-time staff to address employed physician issues, which would include
- 9 providing legal assistance to physicians on contractual matters;
- 10 2. increase the representation of “employed physicians” (a term that would need to be
- 11 defined) in the HOD by allocating additional representation to the Organized Medical Staff
- 12 Section; and
- 13 3. increase representation of employed physicians in AMA leadership by adding OMSS
- 14 representatives (who would be employed physicians) to the Board of Trustees and to each
- 15 AMA council and committee.
- 16

17 Testimony on Resolution 615 reflected concern with the proposed representation scheme.
18 Nevertheless, it was clear that the HOD seeks, in the words of the reference committee, “a
19 workable plan for supporting employed physicians.” This report examines how the voice of
20 employed physicians might best be heard within the organization.

21 BACKGROUND

22
23
24 The AMA supports the needs of physicians in all modes of practice, including employed
25 physicians. Moreover, the AMA has long recognized that employed physicians as a category have
26 unique needs that can and should be met by the AMA. In particular, AMA Policy G-615.105,
27 “Employed Physicians and the AMA,” states that the AMA will:

- 28 • “strive to become the lead association for physicians who maintain employment or
- 29 contractual relationships with hospitals, health systems, and other entities;”
- 30 • “provide...assistance, such as information and advice, but not legal opinions or
- 31 representation, as appropriate, to employed physicians, physicians in independent practice,
- 32 and independent physician contractors in matters pertaining to their relationships with
- 33 hospitals, health systems, and other entities...” and
- 34 • “work through the Organized Medical Staff Section and other sections and special groups
- 35 as appropriate to represent and address the unique needs of physicians who maintain
- 36 employment or contractual relationships with hospitals, health systems, and other entities.”

^{*} See Appendix A for full text of Resolution 615-N-21.

1 The AMA’s work on behalf of employed physicians has included the creation of model
2 employment contracts, offering of multiple education opportunities on employment matters,
3 development of the seminal “[AMA Principles for Physician Employment](#)” (AMA Policy H-
4 225.950), and legislative, regulatory, and judicial advocacy on employment concerns such as non-
5 compete agreements, due process rights, and so forth.

6
7 *Defining “employed physician”*

8
9 There is at present no universally acknowledged definition of what constitutes an employed
10 physician relative to one that is not employed. While employed physicians could be understood to
11 be physicians who are paid for their services by another party, the simple act of receiving a
12 paycheck is not necessarily determinative of a physician’s employment status.

13
14 For the purposes of this report, we propose the following working definition of what it means to be
15 an employed physician:

16
17 An employed physician is any non-resident, non-fellow physician who maintains a
18 contractual relationship to provide medical services with an entity from which the
19 physician receives a W-2 to report their income and in which the physician does not have a
20 controlling interest, either individually or as part of a collective.

21
22 *Trends in physician practice ownership and employment*

23
24 For many years, physicians have been moving away from private practice and toward employment
25 by health care entities. The AMA’s Physician Benchmark Survey found in 2020 that for the first
26 time fewer than half (49.1 percent) of physicians surveyed reported that they worked in physician-
27 owned private practice (as opposed to self-identifying as employees or contractors), which was
28 down from 2018 when 54 percent of physicians surveyed worked in physician-owned practices.¹
29 As of May 2022, there are just under 1.1 million active primary care and specialist physicians
30 working in the US,² implying that roughly 537,000 physicians are employed.

31
32 The benchmark survey showed that the trend toward employment varied widely across specialties.
33 Surgical subspecialties and radiology held the lowest percentages of employed physicians, both
34 under 40 percent. At the other extreme, family medicine, pediatrics, internal medicine
35 subspecialties, general surgery and emergency medicine physicians all reported that greater than 50
36 percent of physicians were employed, with family medicine and pediatrics having the lowest rates
37 of practice ownership.

38
39 The Covid-19 pandemic potentially confounds the study of trends in physician employment during
40 the last two years. During the pandemic, physician overhead costs increased while payments failed
41 to keep pace,³ which likely accelerated the trend toward physician employment and practice
42 acquisition by health care entities. Indeed, a 2021 study examining growth trends in physician
43 practice ownership and employment between January 1, 2019, and January 1, 2021, found that
44 more than 48,000 physicians left independent practice to become employees of a health care entity
45 during that time, a 12 percent increase in the number of employed physicians. At the same time,
46 hospitals and other health care entities acquired 20,900 physician practices, a 25 percent increase in
47 corporate-owned practices.⁴

1 DISCUSSION

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As the number of employed physicians continues to grow relative to the number who are in private practice, our AMA will continue to represent and otherwise meet the needs of employed physicians, as it does the needs of physicians in all practice settings. Resolution 615 proposes two key areas for AMA action, which we evaluate here before offering an alternative approach to ensure the voice of employed physicians continues to be heard within our organization.

Dedicated staffing to address employed physician issues

Resolution 615 asks the AMA to dedicate full-time staff to address issues of concern to employed physicians, with the authors going so far as to suggest in their Statement of Priority that AMA ought to establish a new stand-alone business unit (“office of the employed physicians”). We agree that employment relationships create unique challenges for physicians who choose this mode of practice and further, that AMA ought to be aware of these challenges and seek to address them. However, we do not believe that establishing a staffing entity dedicated to employed physicians is the correct approach.

The needs of employed physicians are addressed across the existing staffing entities of the AMA. For example, AMA section staff, advocacy staff, and legal counsel form a center of expertise around physician-hospital relations, including contracting and medical staff bylaws protections for employed physicians. Similarly, in tackling physician burnout, the Professional Satisfaction and Practice Sustainability unit (“PS2”) considers how systemic deficiencies in healthcare organizations drive burnout among employed physicians. This pattern is borne out across the AMA, leading us to conclude that the needs of employed physicians would be better served by encouraging the various components of our organization to continue to consider the specific needs of physicians in all practice settings, including employed physicians, as they go about their work.

Relatedly, Resolution 615 asks the AMA to provide a greater level of service to employed physicians in contracting matters—specifically, to provide legal opinions. AMA Policy G-615.105, which the resolution seeks to amend to achieve its goal, states explicitly that the AMA will not provide legal opinions or representation:

As a benefit of membership our AMA will provide, through the Sections and Special Groups, assistance, such as information and advice, but not legal opinions or representation, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.

While it is appropriate for our AMA to provide some level of guidance to physicians in contractual matters (e.g., AMA’s model annotated employment contracts for group practice employment and hospital employment, both of which are currently undergoing updates), AMA itself is not positioned to provide legal opinions or representation for individual physicians across U.S. states and territories, each with its own nuances of employment law. AMA has previously explored partnering with a third party to provide such services to physicians at a discounted rate but ultimately found such an arrangement to be cost prohibitive.

1 *Expanded representation of employed physicians across AMA governance*

2
3 Resolution 615 asks the AMA to expand the representation of employed physicians across AMA
4 governance, including in the House of Delegates, on the Board of Trustees, and on all AMA
5 councils and committees. This expansion would be accomplished by granting OMSS proportional
6 representation in the HOD and set-aside seats on the Board and councils/committees.

7
8 The resolution purports to base this proposed structure on the proportional representation granted to
9 medical students and residents/fellows in the HOD (i.e., regional and sectional delegates,
10 respectively), and on the inclusion of medical students, residents/fellows, and young physicians on
11 the Board and councils. However, the resolution misconstrues the nature of the relationship
12 between these leaders and the sections of which they are members. Medical student regional
13 delegates and resident/fellow sectional delegates do not represent the MSS or the RFS. Nor do the
14 medical student, resident/fellow, and young physician members of the Board and councils
15 represent the MSS, RFS, or YPS. Rather, they simply give voice to those particular segments of
16 AMA membership. For this reason, it is inappropriate to route increased representation of
17 employed physicians through OMSS, even if OMSS may be a logical home for employed
18 physicians.

19
20 More broadly than concerns with the proposed representation structure, we believe it is generally
21 inadvisable to create additional governance set-asides. Medical students, residents/fellows, and
22 young physicians are granted special representation because without dedicated positions, and
23 owing to their relatively short AMA tenure, it is unlikely that there would be many of them in
24 AMA leadership positions. Employed physicians, as individuals, do not face the same barrier.
25 While they might not have been elected to explicitly represent the interests of employed physicians
26 and while they might be proportionally underrepresented, there are in fact employed physicians at
27 every level of AMA leadership. We fear that an additional carve-out for any group, including
28 employed physicians, would spark an interest arms race wherein physicians in other practice
29 arrangements seek proportional representation.

30
31 *An alternative solution: employed physician caucus*

32
33 AMA Policy G-615.002, “AMA Member Component Groups,” defines a “caucus” as “an informal
34 group of physicians (from specialty and/or geographic medical groups or focused interest areas)
35 who meet at the Annual and/or Interim meetings to discuss issues, pending resolutions and reports,
36 candidates, and possible actions of the HOD.” Caucuses are a critical component of the AMA
37 governance structure, giving voice in the AMA policymaking process to many groups that are not
38 explicitly represented in the HOD. Examples of recently constituted caucuses include the obesity
39 caucus and the mobility caucus.

40
41 The creation of an employed physician caucus would validate the supposition that employed
42 physicians as a category have unique needs and interests that should be heard within our AMA. But
43 it would do so without creating problematic set-asides and while conforming to established
44 pathways for recognition of viewpoints within our AMA.

45
46 While it is beyond the scope of the Board to establish caucuses, the Board fully supports the
47 creation of an employed physician caucus. It is our understanding that OMSS leadership has begun
48 to engage other interested parties to convene an inaugural meeting of an employed physician
49 caucus at the 2022 Interim Meeting. We are eager to see how this group will amplify the voice of
50 employed physicians in our policymaking process and ultimately help our organization best meet
51 the needs of the growing ranks of employed physicians. Additionally, while it is beyond the scope

1 of the Board to recommend the establishment of a new AMA section, we note that a caucus is an
2 appropriate starting point for that level of representation, with multiple sections having originated
3 as caucuses.

4
5 RECOMMENDATIONS

6
7 Your Board of Trustees recommends that the following recommendations be adopted in lieu of
8 Resolution 615-N-21, and that the remainder of this report be filed:

9
10 1. That our AMA adopt the following definition of “employed physician”:

11
12 An employed physician is any non-resident, non-fellow physician who maintains a contractual
13 relationship to provide medical services with an entity from which the physician receives a W-
14 2 to report their income, and in which the physician does not have a controlling interest, either
15 individually or as part of a collective. (New HOD Policy)

16
17 2. That our AMA re-examine the representation of employed physicians within the organization
18 and report back at the 2024 Annual Meeting. (Directive to Take Action)

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

REFERENCES

1. Kane, C. (2021) Policy research perspectives Recent changes in physician practice arrangements: Private practice dropped to less than 50 percent of physicians in 2020; American Medical Association.
2. Kaiser Family Foundation. (2022); Professionally active physicians; State Health Facts. Accessed August 8, 2022: <https://www.kff.org/other/state-indicator/total-active-physicians/?currentTimeframe=0&sortModel=%7B%22collId%22:%22Location%22,%22sort%22:%22asc%22%7D>
3. Gillis, K. (2021); Impacts of the COVID-19 pandemic on 2020 Medicare Physician Spending; Policy Research Perspectives; American Medical Association; Accessed 7/12/2022: <https://www.ama-assn.org/practice-management/sustainability/covid-19-financial-impact-physician-practices>.
4. Avalere Health; (2021); COVID-19’s impact on acquisitions of physician practices and physician employment 2019-2021; Prepared for Physicians Advocacy Institute; June 2021.

Appendix A: Full text of resolve clauses of Resolution 615-N-22

RESOLVED, That our American Medical Association dedicate full-time staff to the Employed Physician to aggressively address relevant AMA Policy pertaining to the Employed Physician (Directive to Take Action); and be it further

RESOLVED, That our AMA study amending Policy G-615.105 to read as follows:

Employed Physicians and the AMA G-615.105

1. Our AMA will ~~strive to~~ become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.
2. As a benefit of membership our AMA will provide, ~~through the Sections and Special Groups,~~ assistance, such as information, ~~and~~ advice, ~~but not~~ and legal opinions ~~or representation,~~ as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts, contract negotiations and contract renewals, ~~including~~ medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.
3. Our AMA will also work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities. (Directive to Take Action); and be it further

RESOLVED, That the representation of the Organized Medical Staff Section (OMSS) in the AMA House of Delegates be increased from the current one Delegate to many Delegates based on AMA membership numbers of employed physicians using the mathematical model(s), to calculate the numbers of the New OMSS Delegates, currently being used at AMA for the Medical Student and Resident and Fellows Sections to calculate the numbers of Regional Medical Students and the numbers of Regional Resident/Fellows in the AMA House of Delegates. The AMA would develop a practical meaning of the phrase "Employed Physician" for the purposes of AMA membership counting, but as an editorial comment, the SED suggests starting with employed Non-Resident/Non-Fellow physicians who have no ownership interest (or, say, less than 1% ownership each) in their employer organization (New HOD Policy); and be it further

RESOLVED, That the Organized Medical Staff Section have one designated member who is a defined employed physician on all AMA Boards and Committees and Councils to match the MSS, the RFS and the YPS. (New HOD Policy)

Appendix B: Relevant AMA policy

G-615.105, Employed Physicians and the AMA

1. Our AMA will strive to become the lead association for physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.
2. As a benefit of membership our AMA will provide, through the Sections and Special Groups, assistance, such as information and advice, but not legal opinions or representation, as appropriate, to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts including medical staff bylaws, sham peer review, economic credentialing, and the denial of due process.
3. Our AMA will work through the Organized Medical Staff Section and other sections and special groups as appropriate to represent and address the unique needs of physicians who maintain employment or contractual relationships with hospitals, health systems, and other entities.

G-615.002, AMA Member Component Groups G-615.002

...

A "caucus" is an informal group of physicians (from specialty and/or geographic medical groups or focused interest areas) who meet at the Annual and/or Interim meetings to discuss issues, pending resolutions and reports, candidates, and possible actions of the HOD. With the exception of AMA Section caucuses, these groups will not have a reporting relationship or resources allocated by the AMA.

REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT

CLRPD Report 1-I-22

Subject: Senior Physicians Section Five-Year Review

Presented by: Edmond Cabbabe, MD, Chair

Referred to: Reference Committee F

1 AMA Bylaw 7.0.9 states, “A delineated section must reconfirm its qualifications for continued
2 delineated section status and associated representation in the House of Delegates by demonstrating
3 at least every 5 years that it continues to meet the criteria adopted by the House of Delegates.”
4 AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and
5 Development (CLRPD) is “to evaluate and make recommendations to the House of Delegates,
6 through the Board of Trustees, with respect to the formation and/or change in status of any section.
7 The Council will apply criteria adopted by the House of Delegates.”

8
9 The Council assessed information from the letter of application submitted by the Senior Physicians
10 Section (SPS) for renewal of delineated section status, which is presented in the discussion section
11 of this report.

12 APPLICATION OF CRITERIA TO THE SENIOR PHYSICIANS SECTION

13
14
15 Criterion 1: Issue of Concern – Focus will relate to concerns that are distinctive to the subset within
16 the broader, general issues that face medicine. A demonstrated need exists to deal with these
17 matters, as they are not currently being addressed through an existing AMA group.

18
19 The SPS identified the following priority areas of concern as focal points of the last five years:
20 healthy aging, transitioning to retirement/end-of-career practice patterns, physician re-entry,
21 grassroots advocacy, and the *JAMA* Career Center. The Council asked the Section what actions
22 have been taken on these issues, as well as the results of those activities. On the issue of healthy
23 aging, the SPS Governing Council (GC) has offered educational programs at AMA HOD meetings
24 on “how to keep your brain fit” and mindfulness workshops to help foster resiliency for senior
25 physicians, as well as developing a guide of best health practices in senior independent living
26 communities for publication on the AMA website. In 2018, the SPS assembled topics for a
27 members-only, web-based toolkit, “How to Successfully Transition out of Medicine and into
28 Retirement,” which included resources for transitioning to retirement as one leaves medical
29 practice. The SPS presented educational programs on alternate licensure tracks for reentering
30 physicians and created the State Licensure and Liability Laws grid for physicians, a state-by-state
31 reference guide of liability laws for senior physician volunteers.

32
33 The SPS has identified several issues of concern on which to focus for the coming years including
34 senior physician competency, hearing screening/hearing aids and dementia, COVID-19 and
35 seniors, advance care planning and health disparity relating to ageism.

1 Criterion 2: Consistency – Objectives and activities of the group are consistent with those of the
2 AMA. Activities make good use of available resources and are not duplicative.

3
4 For the past five years, the SPS has convened a meeting in July or August to provide GC members
5 with an introduction to the AMA Strategic Focus areas. The Section has engaged in regular
6 activities related to the AMA strategic arcs. In collaboration with key staff in the Improving Health
7 Outcomes (IHO) unit, the SPS GC promoted the Diabetes Prevention Program (DPP) shortly after
8 it was approved as a Medicare benefit. The SPS began work three years ago to expand attendance
9 at physician health care entrepreneurial events with innovation organizations with which the AMA
10 has an affiliation (MATTER and Health2047). The SPS GC invited the AMA Chief Medical
11 Information Officer to speak on electronic health record (EHR) adoption for older physicians who
12 practice in rural or underserved communities, and SPS members provided feedback on EHR
13 adoption and how it varies across practice specialty. In 2020, the SPS identified senior physicians
14 to participate as Medical Student Section (MSS)/SPS mentors and role models to broaden the
15 number of medical school campuses with an advisor. Staff worked to locate leaders at five
16 campuses to participate as coaches in communities that may not be aware of the AMA SPS and/or
17 the MSS.

18
19 Criterion 3: Appropriateness – The structure of the group will be consistent with its objectives and
20 activities.

21
22 The SPS made changes to their internal operating procedures in 2018 and 2020, which included:

- 23
24 • Clarification of continued service on the SPS GC for an Officer-at-Large member in
25 his/her second term who is elected as SPS Chair-Elect.
- 26
27 • Implementation of new criteria for the Officer-at-Large position that require demonstrated
28 experience in organized medicine to help ensure that nominees are familiar with the
29 functions of the AMA and the House of Delegates (HOD).
- 30
31 • Development of a Candidate Review Committee that verifies all nominees are eligible to
32 be placed on the general election ballot and validates election results. The SPS Immediate
33 Past Chair leads the committee comprised of a diverse mix (specialty, geographic
34 representation, gender, age and race/ethnicity) of volunteer members.
- 35
36 • Establishment of a maximum tenure of 8 years from the current 6 years for SPS GC
37 members. This is consistent with the maximum tenure for AMA Council and Board
38 members as well as the governing councils of several other sections.
- 39
40 • Expansion of criteria for the SPS delegate and alternate delegate that require attendance at
41 two HOD meetings and participation in HOD reference committees. The GC determined
42 that more specific and stringent criteria were needed given a large pool of candidates for
43 these positions and for those applying with no prior HOD experience.

44
45 SPS meetings are held in conjunction with AMA HOD meetings. Each meeting includes a SPS
46 Assembly Meeting followed by either a keynote speaker or an educational session. The SPS
47 chooses to present CME programs, as most senior physicians who attend the meeting are still in
48 active practice or wish to maintain their licensure. At the assembly meeting, most time is spent
49 reviewing HOD resolutions of interest to the SPS, with a discussion of SPS positions on HOD
50 reports and resolutions. Items are chosen in advance by the SPS delegate and alternate delegate and
51 sent to those who register by email. Outcomes from these discussions help to identify gaps in

1 resources and policy as well as discussion of future program topics. Meeting evaluations ask
2 participants to rank reasons they attend the meetings to understand what resonates most with them,
3 and that information is used by leadership to inform agendas for future meetings.

4
5 The SPS explores two signature issues with the SPS assembly at annual and interim meetings with
6 discussion time for its members. In 2020, the SPS began a policy library, an institutional repository
7 of current articles of interest to senior physicians published in major journals. Articles are posted to
8 the SPS GC listserv weekly for comment. The policy committee regularly reviews the feedback to
9 determine whether topics should become the next policy issues and to address future reports and
10 proposals as part of its “signature issue pipeline.”

11
12 Criterion 4: Representation Threshold – Members of the formal group would be based on
13 identifiable segments of the physician population and AMA membership. The formal group would
14 be a clearly identifiable segment of AMA membership and the general physician population. A
15 substantial number of members would be represented by this formal group. At minimum, this
16 group would be able to represent 1,000 AMA members.

17
18 The qualifying criterion for membership in the SPS is to be an AMA member physician 65 years or
19 above. Whether physicians are working full-time, part-time or retired, the SPS represents all
20 physician members aged 65 and over.

21
22 There are 61,895 physician AMA members aged 65 and above, according to AMA Masterfile 2020
23 YE data. The SPS, by definition, represents 100% of these members. There are an additional
24 317,181 senior physicians who are non-AMA members. Thus, SPS represented 16.3% of all senior
25 physicians in 2020.

26
27 Criterion 5: Stability – The group has a demonstrated history of continuity. This segment can
28 demonstrate an ongoing and viable group of physicians will be represented by this section and both
29 the segment and the AMA will benefit from an increased voice within the policymaking body.

30
31 According to AMA Masterfile YE data, in 2015 there were 53,720 AMA senior physician
32 members, and in 2020, there were 61,895 senior physician members. The 2020 YTD retention rate
33 for senior physicians was 91.61%, and for retired physicians, the percentage was 89.09%. The
34 retention rate for senior physicians, which includes dues exempt members, was the highest overall
35 when compared to other AMA segments. The SPS works to extend physicians’ careers in clinical
36 medicine and, in many cases, facilitate re-entry into medical practice. A 2015 retired physician
37 survey revealed that 79% of retired physicians responded that they had been a member of the AMA
38 for 20 years or longer.

39
40 Attendance at SPS educational programs has ranged from ~100 attendees to ~200 attendees during
41 each AMA HOD meeting and remained at those levels throughout the COVID-19 pandemic in
42 virtual environments. The Section’s primary communication vehicle is a newsletter that keeps
43 members apprised of SPS activities and relevant news/updates for senior physicians.
44 Communications are sent approximately once per month for physicians who have an email address
45 in the AIMS database and have opted in (~48K physicians in 2020, up from ~42K physicians in
46 2018). Over the same period, both the open rate (28.3% in 2020, up from 23.5% in 2018) and click
47 through rate (1.3% in 2020, up from 0.6% in 2018) of those communications have increased as
48 well and the Section noted that the growth in engagement exceeds both AMA and industry
49 standards.

1 The SPS described steps it has taken towards advancing membership engagement and growth:

- 2
- 3 • In 2018, the SPS participated in the AMA Members Move Medicine campaign, profiling
4 senior physician leaders in advocacy, education, patient care and practice innovation in
5 AMA marketing campaigns. Profiles were promoted in Morning Rounds, SPS newsletters
6 and in banners at both the A-18 and I-18 Meetings.
- 7
- 8 • The SPS recruits AMA Ambassadors to champion the value of AMA membership and
9 promote the work of the AMA. The Ambassador Program provides senior physicians with
10 tools to share the impact of the AMA's work and the value of AMA membership to
11 physicians at every stage of their career and life.
- 12
- 13 • SPS members serve as judges for the AMA's annual Research Symposium, which
14 promotes collaboration between senior leaders and students during the meeting and
15 facilitates mentorship opportunities.
- 16

17 Criterion 6: Accessibility - Provides opportunity for members of the constituency who are
18 otherwise under-represented to introduce issues of concern and to be able to participate in the
19 policymaking process within the AMA House of Delegates (HOD).

20

21 More than one-third of delegates (36.4%) and one-fifth of alternate delegates (19.4%) are senior
22 physicians, according to CLRPD Report 1-June-21, "Demographic Characteristics of the House of
23 Delegates and AMA Leadership." Based purely on delegate count, members of the senior physician
24 demographic are not underrepresented in the HOD. However, as discussed in previous five-year
25 reviews of the SPS, when serving on state and specialty delegations, physicians are obligated to
26 represent the interests of their respective delegations, and not specifically the interests of senior
27 physicians; the SPS, therefore, provides the appropriate structure to ensure that the concerns of
28 senior physicians are adequately represented in the HOD.

29

30 To that end, the SPS regularly submits resolutions to the HOD and provides testimony on items of
31 business that are of interest to the constituents of the SPS. The SPS implemented a resolution idea
32 form to make it easier for senior physicians to introduce resolution topics, as well as a tutorial to
33 help educate SPS members on the HOD processes and AMA PolicyFinder©. All resolution ideas
34 are reviewed by the SPS delegate and alternate delegate and presented for the GC's approval.
35 Resolutions are posted to an online member forum to allow viewing and comment. Senior
36 physicians are then invited to provide testimony on the resolutions submitted. The SPS convenes a
37 virtual teleconference twice a year to maintain open communications with SPS members across the
38 country. Members can either submit a resolution idea or testify on behalf of items of concern to
39 senior physicians. The testimony is then discussed on a virtual teleconference open to all SPS
40 members to develop consensus opinions on SPS reports and resolutions. A majority vote of those
41 present on the virtual conference call helps guide the actions of the SPS delegate when submitting
42 items of business to the HOD for annual and interim meetings.

43

44 In conjunction with each HOD meeting, the SPS holds onsite business assembly meetings that
45 generate an average of 60-150 people per meeting. This is open to all SPS members. The GC
46 develops an agenda that provides an opportunity for SPS assembly members to discuss SPS-
47 sponsored resolutions, business in the HOD Handbook relevant to the Section, educational
48 sessions, internal operating issues, and other proposed items of interest. For any action of the
49 assembly, a majority vote of those present constitutes an adopted action.

1 CLRPD DISCUSSION

2
3 AMA Policy G-615.002, “AMA Member Component Groups,” states that “Delineated Sections
4 will allow a voice in the house of medicine for large groups of physicians, who are connected
5 through a unique perspective, but may be underrepresented. These sections will often be based on
6 demographics or mode of practice.” The AMA is well positioned to represent and address the
7 specific interests and needs of defined physician groups, with benefits to those groups and the
8 Association as a whole.

9
10 In the opinion of CLRPD, the SPS has created an effective structure that allows for the
11 participation of senior physicians in the deliberations of the HOD and provides tools and
12 educational opportunities that ensure the AMA maintains an appropriate focus on issues of concern
13 to senior physicians. According to the U.S. Census Bureau, 16% of the U.S. population in 2021
14 was 65 years of age or older, and that percentage is expected to grow to 21.6% of the population by
15 2040. Additionally, according to 2018 CDC data, individuals who reach the age of 65 have an
16 average life expectancy of 19.5 years; not only will senior physicians continue to represent a
17 significant proportion of AMA membership, but that proportion is likely to grow. These data make
18 it clear that to remain responsive to and effectively address the needs of the evolving physician
19 demographics in the United States, the AMA must maintain a strong focus on the concerns and
20 needs of senior physicians. The SPS provides the AMA with a centralized structure to ensure that
21 focus, particularly in the areas of lifelong learning and healthy aging.

22
23 Educational sessions hosted by the SPS, often in conjunction with other AMA sections and
24 councils, have been consistently well-attended, including those held virtually during the COVID-19
25 pandemic. Topics of these sessions in the past five years have demonstrated the Section’s
26 commitment to addressing a variety of areas of concern relevant to senior physicians, including
27 healthy aging (mindfulness, brain fitness, the impacts of vision and hearing loss), career issues
28 (assessing competency of senior physicians, transitioning into retirement, understanding ageism
29 and its impacts), and health equity (improving health outcomes for vulnerable patient populations,
30 improving end-of-life care communication for seniors and LGBTQ elders).

31
32 To facilitate senior physician contributions to HOD deliberations, the SPS has continued to refine
33 its processes that allow any member of the constituency to submit ideas for resolutions and to
34 provide input on items of business proposed by the SPS and/or of concern to the SPS constituency.
35 Notably, the SPS provides a variety of avenues to allow any of its members to contribute insight on
36 HOD items of business, leveraging virtual teleconferencing, online forums, and onsite business
37 meetings, which are open to all SPS members. These practices demonstrate a strong commitment
38 to accessibility, which is perhaps especially important for the senior demographic group, members
39 of which may, for various reasons, find it undesirable or difficult to attend in-person AMA
40 meetings.

41
42 In the future, the Council looks forward to observing progress on newer initiatives being
43 undertaken by the SPS. Among these are the nationwide mentorship program being piloted in
44 conjunction with the MSS, as well as efforts to increase diversity of the SPS GC, which the SPS
45 undertook with assistance from the AMA Center for Health Equity to recruit more diverse
46 physicians by looking at racial and ethnic, socioeconomic, geographic, and academic/professional
47 backgrounds. Additional initiatives include the implementation of a review mechanism to increase
48 the scope and scale of resolution ideas for potential development, an improved format of its
49 assembly to review SPS and HOD resolutions, and a SPS policy development committee that meets
50 twice per year with AMA councils, sections and/or other constituencies to help educate authors
51 about SPS positions.

1 In closing, the Council thanks SPS leadership, members and staff for their thoughtful work on the
2 reapplication process, their continued contributions to ensure that the perspectives of senior
3 physicians remain prominent in the AMA policymaking process, and all their efforts on behalf of
4 senior physicians and patients in the United States.

5

6 RECOMMENDATION

7

8 The Council on Long Range Planning and Development recommends that our American Medical
9 Association renew delineated section status for the Senior Physicians Section through 2027 with
10 the next review no later than the 2027 Interim Meeting and that the remainder of this report be
11 filed. (Directive to Take Action)

Fiscal Note: Within current budget

REPORT OF THE HOUSE OF DELEGATES COMMITTEE
ON THE COMPENSATION OF THE OFFICERS

Compensation Committee Report, November 2022

Subject: Report of the House Of Delegates Committee on the Compensation of the Officers
Presented by: Ray C. Hsiao, MD, Chair
Referred to: Reference Committee F

1 This report by the committee at the November 2022 Interim Meeting includes one recommendation
2 and documents the compensation paid to Officers for the period July 1, 2021 through June 30,
3 2022, including 2021 calendar year IRS reported taxable value of benefits, perquisites, services,
4 and in-kind payments for all Officers.

5
6 BACKGROUND

7
8 At the 1998 Interim Meeting, the House of Delegates (HOD) established a House Committee on
9 Trustee Compensation, currently named the Committee on Compensation of the Officers (the
10 “Committee”). The Officers are defined in the American Medical Association’s (AMA)
11 Constitution and Bylaws. (Note: under changes to the Constitution previously approved by the
12 HOD, Article V refers simply to “Officer,” which includes all 21 members of the Board among
13 whom are the President, President-Elect, Immediate Past President, Secretary, Speaker and Vice
14 Speaker of the HOD, collectively referred to in this report as Officers.) The composition,
15 appointment, tenure, vacancy process and reporting requirements for the Committee are covered
16 under the AMA Bylaws. Bylaws 2.13.4.5 provides:

17
18 The Committee shall present an annual report to the House of Delegates recommending the
19 level of total compensation for the Officers for the following year. The recommendations of the
20 report may be adopted, not adopted, or referred back to the Committee, and may be amended
21 for clarification only with the concurrence of the Committee.

22
23 At A-00, the Committee and the Board jointly adopted the American Compensation Association’s
24 definition of total compensation which was added to the Glossary of the AMA Constitution and
25 Bylaws. Total compensation is defined as the complete reward/recognition package awarded to an
26 individual for work performance, including: (a) all forms of money or cash compensation; (b)
27 benefits; (c) perquisites; (d) services; and (e) in-kind payments.

28
29 Since the inception of this Committee, its reports document the process the Committee follows to
30 ensure that current or recommended Officer compensation is based on sound, fair, cost-effective
31 compensation practices as derived from research and use of independent external consultants,
32 expert in Board compensation. Reports beginning in December 2002 documented the principles the
33 Committee followed in creating its recommendations for Officer compensation.

34
35 At A-08, the HOD approved changes that simplified compensation practices with increased
36 transparency and consistency. At A-10, Reference Committee F requested that this Committee
37 recommend that the HOD affirm a codification of the current compensation principle, which

1 occurred at I-10. At that time, the HOD affirmed that this Committee has and will continue to base
2 its recommendations for Officer compensation on the principle of the value of work performed,
3 consistent with IRS guidelines and best practices recommended by the Committee's external
4 independent consultant, who is expert in Board compensation.

5
6 At A-11, the HOD approved the alignment of Medical Student and Resident Officer compensation
7 with that of all other Officers (excluding Presidents and Chair) because these positions perform
8 comparable work.

9
10 Immediately following A-11, the Committee retained Mr. Don Delves, founder of the Delves
11 Group, to update his 2007 research by providing the Committee with comprehensive advice and
12 counsel on Officer compensation. The updated compensation structure was presented and approved
13 by the HOD at I-11 with an effective date of July 1, 2012.

14
15 The Committee's I-13 report recommended and the HOD approved the Committee's
16 recommendation to provide a travel allowance for each President to be used for upgrades because
17 of the significant volume of travel representing our AMA.

18
19 At I-16, based on results of a comprehensive compensation review conducted by Ms. Becky Glantz
20 Huddleston, an expert in Board Compensation with Willis Towers Watson, the HOD approved the
21 Committee's recommendation of modest increases to the Governance Honorarium and Per Diems
22 for Officer Compensation, excluding the Presidents and Chair, effective July 1, 2017. At A-17 the
23 HOD approved modifying the Governance Honorarium and Per Diem definition so that Internal
24 Representation, greater than eleven days, receives a per diem.

25
26 At A-18, based on comprehensive review of Board leadership compensation, the HOD approved
27 the Committee's recommendation to increase the President, President-elect, Immediate Past-
28 President, Chair, and Chair-elect honoraria by 4% effective July 1, 2018.

29
30 At A-18 and A-19, the House approved the Committee's recommendation to provide a Health
31 Insurance Stipend to President(s) who are under Medicare eligible age when the President(s) and
32 his/her covered dependents, not Medicare eligible, lose the President's employer provided health
33 insurance during his/her term as President. Should the President(s) become Medicare eligible while
34 in office, he/she received an adjusted Stipend to provide insurance coverage to his/her dependents
35 not Medicare eligible.

36
37 The Committee's I-19 report recommended and the HOD approved the Committee's
38 recommendation to increase the Governance Honorarium and Per Diem for Officers, excluding
39 Presidents and Chair, by approximately 3% each effective July 1, 2020.

40
41 The Committee's A-22 report recommended and the House approved increasing the travel upgrade
42 allowance for President, President-Elect, and Immediate Past-President to \$5,000 and adding an
43 upgrade allowance of \$2,500 for all other Officers to use as each deems appropriate, typically when
44 traveling on an airline with non-preferred status.

45 46 CASH COMPENSATION SUMMARY

47
48 The cash compensation of the Officers shown in the following table will not be the same as
49 compensation reported annually on the AMA's IRS Form 990s because Form 990s are based on a
50 calendar year. The total cash compensation in the summary is compensation for the days these
51 officers spent away from home on AMA business approved by the Board Chair. The total cash

1 compensation in the summary includes work as defined by the Governance Honorarium, Per Diem
 2 for Representation and Telephone Per Diem for External Representation. Detailed definitions are in
 3 the Appendix.
 4
 5 The summary covers July 1, 2021 to June 30, 2022.

AMA Officers	Position	Total Compensation	Total Days
David H. Aizuss, MD	Officer	\$ 67,000	42.5
Toluwalase A. Ajayi, MD	Officer	-	2.5
Susan R Bailey, MD	Immediate Past President	\$ 284,960	62
Madelyn E. Butler, MD	Officer	\$ 67,000	39
Alex Ding, MD, MS, MBA	Officer	-	2
Willarda V. Edwards, MD, MBA	Officer	\$ 74,700	49
Lisa Bohman Egbert, MD	Vice Speaker, House of Delegates	\$ 133,500	104
Jesse M. Ehrenfeld, MD, MPH	Officer	\$ 132,800	86
Scott Ferguson, MD	Secretary	\$ 69,100	46
Sandra Adamson Fryhofer, MD	Chair-Elect	\$ 210,280	69.5
Gerald E. Harmon, MD	President	\$ 290,160	112.5
Drayton Charles Harvey	Medical Student Officer	\$ 67,000	43.5
Marilyn Heine, MD	Officer	-	2.5
Pratistha Koirala, MD	Resident/Fellow Physician Officer	\$ 67,000	34.5
Russ Kridel, MD	Immediate Past Chair	\$ 69,800	46.5
Ilse R. Levin, DO, MPH & TM	Officer	\$ 67,000	36
Thomas J. Madejski, MD	Officer	\$ 78,900	45.5
Mario E. Motta, MD	Officer	\$ 80,300	49.5
Bobby Mukkamala, MD	Chair	\$ 282,380	65
Harris Pastides, PhD, MPH	Public Member Officer	\$ 67,000	35
Jack Resneck, Jr, MD	President-Elect	\$ 291,260	88
Bruce A. Scott, MD	Speaker, House of Delegates	\$ 142,600	96
Michael Suk, MD, JD, MPH, MBA	Officer	\$ 80,300	51.5
Willie Underwood, III, MD, MSc, MPH	Officer	\$ 81,700	61

6 President, President-Elect, Immediate Past President, and Chair
 7 In 2021-2022, each of these positions received an annual Governance Honorarium which was paid
 8 in monthly increments. These four positions spent a total of 327.5 days on approved Assignment
 9 and Travel, or 81.9 days each on average.
 10
 11 Chair-Elect
 12 This position received a Governance Honorarium of approximately 75% of the Governance
 13 Honorarium provided to the Chair.
 14
 15 All other Officers
 16 All other Officers received cash compensation, which included a Governance Honorarium of
 17 \$67,000 paid in monthly installments. The remaining cash compensation is for Assignment and
 18 Travel Days that are approved by the Board Chair to externally represent the AMA and for Internal
 19 Representation days above 11. These days were compensated at a per diem rate of \$1,400.

1 *Note:* The Speaker and Vice Speaker had higher compensation than normal given how much extra
2 time they devoted to planning the virtual and in-person House meetings in November 2021 and
3 June 2022.

4
5 **Assignment and Travel Days**

6 The total Assignment and Travel Days for all Officers (excluding the President, President-Elect,
7 Immediate Past President and Chair) were 942.

8
9 **EXPENSES**

10
11 Total expenses paid for period, July 1, 2021 – June 30, 2022, was \$535,706, without use of upgrade
12 allowance of \$5,000 for Presidents and \$2,500 all other Officers per position per term. Total
13 upgrade allowances used for the period were \$10,763.95.

14
15 **BENEFITS, PERQUISITES, SERVICES, AND IN-KIND PAYMENTS**

16
17 Officers are able to request benefits, perquisites, services, and in-kind payments, as defined in the
18 “AMA Board of Trustees Standing Rules on Travel Expenses.” These non-taxable business
19 expense items are provided to assist the Officers in performing their duties.

- 20
21
 - AMA Standard laptop computer or iPad
 - American Express card (for AMA business use)
 - Combination fax/printer/scanner (reimbursable up to \$250)
 - An annual membership to the airline club of choice offered each year during the Board member’s tenure
 - Personalized AMA stationery, business cards, and biographical data for official use

22
23
24
25
26
27
28 Additionally, all Officers are eligible for \$305,000 term life insurance and are covered under the
29 AMA’s \$500,000 travel accident policy and \$10,000 individual policy for medical costs arising out
30 of any accident while traveling on official business for the AMA. Life insurance premiums paid by
31 the AMA are reported as taxable income. Also, travel assistance is available to all Officers when
32 traveling more than 100 miles from home or internationally.

33
34 Secretarial support, other than that provided by the AMA’s Board office, is available up to defined
35 annual limits as follows: President, during the Presidential year, \$15,000, and \$5,000 each for the
36 President-Elect, Chair, Chair-Elect, and Immediate Past President per year. Secretarial expenses
37 incurred by other Officers in conjunction with their official duties are paid up to \$750 per year per
38 Officer. This is reported as taxable income.

39
40 Officers are also eligible to participate in a service provided to AMA employees by Care@Work
41 through Care.com. This service offers referral services at no cost and back-up care for children and
42 adults up to 10 days a calendar year at a subsidized rate. If a Board member uses back-up care, it
43 will be reported to the IRS as taxable income.

44
45 Calendar year taxable life insurance and taxable secretarial fee reported to the IRS totaled \$48,132
46 and \$29,125 respectively for 2021. An additional \$10,500 was paid to third parties for secretarial
47 services during 2021.

1 FINDINGS

2

3 The Cash Compensation Summary, travel expenses, and the suspension of tracking telephonic
4 representation since most meetings were conducted virtually reflect the impact of the Coronavirus
5 on the Officers in representing our AMA. Our AMA leadership quickly pivoted to continue
6 representing the AMA, both internally and externally in virtual and in-person meetings. This pivot,
7 while appearing seamless, required significant flexibility and behind-the-scenes planning of our
8 Officers. As you know, the 2021 Interim Meeting was suspended.

9

10 This Committee commends and thanks our Officers for their representation of the AMA.

11

12 RECOMMENDATIONS

13

14 1. That there be no changes to the Officers' compensation for the period beginning July 1, 2022
15 through June 30, 2023. (Directive to Take Action.)

16

17 2. That the remainder of the report be filed.

Fiscal Note: \$0

APPENDIX

POSITION	GOVERNANCE HONORARIUM
President	\$290,160
Immediate Past President	\$284,960
President-Elect	\$284,960
Chair	\$280,280
Chair-Elect	\$207,480
Officers	\$67,000

Definition of Governance Honorarium Effective July 1, 2017:

The purpose of this payment is to compensate Officers for all Chair-assigned internal AMA work and related travel. This payment is intended to cover all currently scheduled Board meetings, special Board or Board Committee meetings, task forces, subcommittees, Board orientation, development and media training, Board calls, sections, councils, or other internal representation meetings or calls, and any associated review or preparatory work, and all travel days related to all meetings as noted up to eleven (11) Internal Representation days.

Definition of Per Diem for Representation effective July 1, 2017:

The purpose of this payment is to compensate for Board Chair-assigned representation day(s) and related travel. Representation is either external to the AMA, or for participation in a group or organization with which the AMA has a key role in creating/partnering/facilitating, achievement of the respective organization goals such as the AMA Foundation, PCPI, etc. or for Internal Representation days above eleven (11). The Board Chair may also approve a per diem for special circumstances that cannot be anticipated such as weather-related travel delays. Per Diem for Chair-assigned representation and related travel is \$1,400 per day.

Definition of Telephone Per Diem for External Representation effective July 1, 2017:

Officers, excluding the Board Chair and the President(s) who are assigned as the AMA representative to outside groups as one of their specific Board assignments or assigned Internal Representation days above eleven (11), receive a per diem for teleconference meetings when the total of all teleconference meetings of 30 minutes or longer during a calendar day equal 2 or more hours. Payment for those meetings would require approval of the Chair of the Board. The amount of the Telephonic Per Diem will be ½ of the full Per Diem which is \$700.

REPORT OF THE SPEAKERS

Speakers' Report 1-I-22

Subject: Election Committee - Interim Report

Presented by: Bruce A. Scott, MD, Speaker; and Lisa Bohman Egbert, MD, Vice Speaker

Referred to Reference Committee F

1 The House of Delegates voted to create an Election Committee (EC) as part of the reforms adopted
2 at the June 2021 Special Meeting. Current Policy D-610.998, paragraph 9, states, "The Election
3 Committee will review the Campaign Complaint Reporting, Validation and Resolution Process as
4 implemented and make further recommendations to the House as necessary." This report of your
5 Election Committee reviews the background of the creation of the EC, provides information
6 regarding the current processes followed by the committee, and makes recommendations to further
7 clarify and codify these processes.

8 9 BACKGROUND

10
11 At the 2019 Annual Meeting of the House of Delegates the House adopted policy calling on the
12 Speaker to appoint a task force for the purpose of recommending improvements to the AMA HOD
13 election and campaign process. The task force, known as the Election Task Force or ETF, was
14 given broad purview with a plan to report their recommendations back to the HOD for action. The
15 ETF presented a preliminary report at I-19 and held an open forum to hear concerns.

16
17 The task force presented their full report, Speakers Report 2: Report of the Election Task Force,
18 with 41 recommendations at the June 2021 Special Meeting (the relevant portion from the report
19 regarding the Election Committee is attached as Appendix A). 39 of the ETF recommendations
20 were adopted by the HOD with broad support, including Recommendations 38 - 40 recommending
21 the creation of an Election Committee (Note: A recommendation regarding interviews was
22 referred, and a recommendation calling for the members of the Council on Constitution & Bylaws
23 to be appointed was not adopted):

24
25 Recommendation 38: In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election
26 Committee of 7 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a
27 lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree
28 not to be directly involved in a campaign during their tenure and would be appointed from
29 various regions, specialties, sections, and interest groups. The primary role of the committee
30 would be to work with the Speakers to adjudicate any election complaint. Additional roles to
31 be determined by the Speaker and could include monitoring election reforms, considering
32 future campaign modifications and responding to requests from the Speaker for input on
33 election issues that arise (New Policy).

34
35 Recommendation 39: The Speaker in consultation with the Election Committee will consider a
36 more defined process for complaint reporting, validation, resolution, and potential penalties.
37 This process will be presented to the House for approval (New Policy).

1 Recommendation 40: Policy G-610.020, Rules for AMA Elections, paragraph 1 be amended by
2 addition to read as follows:

3 (1) The Speaker and Vice Speaker of the House of Delegates are responsible for overall
4 administration of our AMA elections, although balloting is conducted under the supervision of
5 the chief teller and the Committee on Rules and Credentials. The Speaker and Vice Speaker
6 will advise candidates on allowable activities and when appropriate will ensure that
7 clarification of these rules is provided to all known candidates. The Speaker, in consultation
8 with the Vice Speaker and the Election Committee, is responsible for declaring a violation of
9 the rules.

10
11 Also of note was Recommendation 41 calling for a review of the modified election processes after
12 an interval of two years (after A-23).

13
14 *The EC Report and Referral for Decision to the Board of Trustees*

15
16 Pursuant to Recommendation 38 (Policy D-610.998) the Speaker appointed the initial House of
17 Delegates Election Committee (EC) made up of 7 members of the House who volunteered to serve
18 and agreed to not participate in campaigns during their tenure on the EC. As directed by the
19 adopted policy (original recommendation 39), the EC presented a report ("Speakers' Report 2:
20 Establishing an Election Committee," here forward referred to as the "EC Report," see Appendix
21 B) at the November 2021 Special Meeting proposing a process by which the Speakers and the
22 Election Committee would handle allegations of rules violations.

23
24 The EC Report provided details regarding complaint reporting, validation, resolution, and potential
25 penalties and further proposed that the Speakers would work with but not be actual members of the
26 committee. In general, the report received positive comments, but during the HOD deliberations,
27 questions about the role of the Speakers on the committee and the Speakers' role in adjudicating
28 allegations led to the matter being referred for decision.

29
30 Testimony heard at the House favored a more active role for the Speakers. The Board concluded
31 because our policy (G-610.020) and tradition call for the Speaker to have oversight of elections, it
32 was appropriate for the Speakers (unless conflicted) to serve as full voting members of the EC.

33
34 Some testimony suggested that the Speaker should be the final arbiter of a complaint, while others
35 pointed out that situations could arise where the Speaker may be conflicted. The Board concluded
36 that no single individual, including the Speaker, should be the lone arbiter of a complaint. The
37 responsibility and authority for validation of a complaint and determination of resolution should
38 rest with the Election Committee, a cross section of the House, reflecting the fact that the House of
39 Delegates determines its procedures, among which are election-related matters.

40
41 In their review, the Board noted that while the body of the EC Report provided detailed
42 information regarding complaint reporting, validation, and resolution for possible campaign
43 violations, these details were not specified in the formal recommendations adopted by the House.
44 The EC Report detailed that when a complaint was received, the Speaker would consult with the
45 committee chair to form a subcommittee of three members to investigate the allegation. The
46 subcommittee of the EC would be selected to avoid conflicts (e.g., being part of the same
47 delegation as the alleged violator). Using necessary discretion, the subcommittee would investigate
48 the complaint and when necessary, the Office of General Counsel or the HOD Office would assist.
49 The subcommittee would report to the full EC the results of their investigation, with the final
50 determination to be made by the full committee with any potentially conflicted members recused.
51 No objections to these series of actions as presented in the EC Report were heard during testimony.

1 The Board concurred with the described process, with minor clarification, and determined that the
2 process should be codified in policy.

3
4 As discussed in the report (Appendix B), historically the only formal penalty for a campaign
5 violation was announcement of the violation to the House by the Speaker. The report went on to
6 state that this singular penalty may be excessive for some violations and thus the committee, in
7 considering mitigating circumstances and the severity of the violation, should be allowed other
8 options to resolve a validated violation. The EC also noted that an exhaustive list of potential
9 violations would be an impossible task to compile and further that a list of associated penalties
10 would be too rigid and ill advised. Consequently, the EC recommended that it be given discretion
11 to determine the appropriate sanction for a validated complaint, with the option of announcement to
12 the House remaining.

13
14 The Board agreed that in many circumstances resolution may be accomplished by corrective
15 action, short of announcement to the House, and that the EC be allowed discretion to determine the
16 appropriate resolution of a given validated complaint with announcement to the House of a
17 violation remaining an option for violations that are deemed to rise to that level. In these most
18 significant violations the House of Delegates, through their vote in the election, would remain the
19 final arbiter. In addition, a record of all filed complaints and the results of the validation and the
20 resolution processes should be maintained by the General Counsel and kept confidential within the
21 EC unless the committee determined that the violation should be reported to the House. Again, the
22 Board determined these details should be specified in policy.

23
24 No testimony was provided in the House regarding the process for reporting potential campaign
25 violations. The Board concurred that individuals to whom potential campaign violations could be
26 reported should include the Speakers who have traditionally been the recipients of such, but
27 complainants should also have an option to report to the General Counsel. This third option of
28 reporting might prevent awkward situations where one or both Speakers were potentially
29 conflicted.

30
31 *Action by the Board of Trustees*

32
33 At their February 2022 meeting the Board officially adopted the following:

- 34
35 1. That Paragraph 5 of Policy D-610.998, "Directives from the Election Task Force," be
36 amended by addition to read as follows:
37
38 5. In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7
39 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime
40 maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not
41 to be directly involved in a campaign during their tenure and would be appointed from
42 various regions, specialties, sections, and interest groups. The primary role of the
43 committee would be to work with the Speakers to adjudicate any election complaint.
44 Additional roles to be determined by the Speaker and could include monitoring election
45 reforms, considering future campaign modifications and responding to requests from the
46 Speaker for input on election issues that arise. **The Speaker and Vice Speaker shall be**
47 **full members of the Election Committee.** (*emphasis added*)
48
49 2. A Campaign Complaint Reporting, Validation and Resolution Process shall be established
50 as follows:

1 Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or the
2 AMA General Counsel and should include the following details:

- 3 • The name of the person(s) thought to have violated the rules
- 4 • The date of the alleged violation and the location if relevant
- 5 • The specific violation being alleged (i.e., the way the rules were violated)
- 6 • The materials, if any, that violate the rules; original materials are preferred over copies.
7 Where necessary, arrangements for collection of these materials will be made.

- 8
- 9 3. Campaign violation complaints will be investigated by the Election Committee or a
10 subcommittee thereof.
- 11 a. The Committee will collectively determine whether a campaign violation has occurred.
 - 12 b. For validated complaints, the Committee will determine appropriate penalties, which
13 may include an announcement of the violation by the Speaker to the House.
 - 14 c. Committee members with a conflict of interest may participate in discussions but must
15 recuse themselves from decisions regarding the merits of the complaint or penalties.
 - 16 d. Deliberations of the Election Committee shall be confidential.
 - 17 e. The Speaker shall include a summary of the Election Committee's activities in "Official
18 Candidate Notifications" sent to the House. Details may be provided at the discretion of
19 the Election Committee and must be provided when the penalty includes an
20 announcement about the violator to the House.
- 21
- 22 4. A record of all complaints and the results of the validation and the resolution processes,
23 including penalties, shall be maintained by the AMA Office of General Counsel and kept
24 confidential.
- 25
- 26 5. The Election Committee will review the Campaign Complaint Reporting, Validation and
27 Resolution Process as implemented and make further recommendations to the House as
28 necessary.
- 29

30 The final policy was recorded in PolicyFinder (see Policy [D-610.998](#)).

31

32 REVIEW OF ELECTION COMMITTEE ACTIVITY

33

34 After appointment by the Speakers, the committee met virtually to discuss their role and reviewed
35 the election rules. The committee prepared the EC Report (discussed above) and presented the
36 report to the House of Delegates at the November 2021 Special Meeting. As noted above, the
37 report was referred to the Board of Trustees for decision. Subsequently, the Board adopted the
38 process detailed above.

39

40 In early 2022 the Speakers sent communications to candidates and their campaign teams detailing
41 the campaign rules as adopted by the HOD in June 2021. These were also included in the Election
42 Manual. Note the EC did not modify any of the campaign rules adopted by the House of Delegates.

43

44 As the elections at A-22 approached the Speakers responded to multiple inquiries from candidates
45 and their campaign teams regarding the election rules. A summary of the inquiries and responses
46 was sent to all candidates and their campaign teams to ensure that all had the same information.
47 The *Speakers' Letter* also included the election rules.

48

49 The EC has now completed a single campaign and election cycle. The Speaker reappointed 6
50 members of the committee (a single member was unavailable for reappointment) and appointed a
51 new member from volunteers who submitted applications. The newly constituted committee has

1 met to review the election process as implemented and discuss possible improvements. This report
2 is the first report of the 2022-2023 Election Committee.

3
4 DISCUSSION

5
6 The EC reviewed the process for complaint reporting, validation, and resolution as established by
7 the HOD and BOT. The committee believes the process, as defined by AMA policy, provides an
8 appropriate matrix for handling reported campaign violations, and recommends additions and
9 communication of the process.

10
11 At A-22 the committee elected to involve the General Counsel and the Director of the Office of
12 HOD Affairs in investigating a complaint, as was suggested in the EC Report. The EC believes the
13 option of including the GC and Director should be added to the formal process specified in AMA
14 policy.

15
16 It has been suggested that due process demands that the accused be made aware of the accusations
17 against them and given an opportunity to respond. While not specified in current policy, this
18 suggestion comports with the process followed by the committee. The EC recommends that it be
19 made explicit in policy given its inherent reasonableness and fundamental fairness.

20
21 The EC Report from November 2021 (Appendix B) reviewed the option of specified penalties and
22 concluded that creation of a "menu" of penalties would not be possible or prudent. The report
23 discussed principles that would be applied in consideration of sanctions, including the timing of the
24 offense, the advantage sought or gained, and the culpability of the candidate themselves. Policy
25 D-610.998, paragraph 7b, codifies the role of the committee in determining appropriate penalties.
26 Allowing some discretion for the EC, which is made up of a cross section of informed delegates,
27 allows consideration of nuance and mitigating or extenuating circumstances.

28
29 Current policy and precedent provide for announcement to the HOD of validated campaign
30 violations that are deemed most serious. Neither AMA policy nor Bylaws provide for removal of a
31 candidate from an election. Announcement to the House maintains the appropriate role of the HOD
32 as the final arbiter by their vote in the associated or relevant election. The EC reviewed these issues
33 and favors the current policy, allowing the House to remain the final arbiter of serious violations.
34 The committee does not seek the authority to remove a candidate.

35
36 Anonymity of complainants and confidentiality of deliberations is a basic tenet of claims of
37 malfeasance and is specified in our rules. The desire for more information regarding serious
38 accusations is understandable, but such disclosure would be problematic. It would seem unwieldy
39 to expect complete disclosure. Any summary would invite accusations of bias or being misleading.
40 In addition, disclosure could be embarrassing or even damaging to individuals interviewed solely
41 to ensure a thorough and fair investigation. Knowing that such disclosure would be made would
42 likely cause individuals to hesitate to cooperate in providing information, particularly if
43 corroborating an allegation. While one would hope that ethics and professionalism alone would
44 support truthful cooperation, the EC has no ability to compel individuals to cooperate with an
45 investigation, and individuals do not testify under oath. Although not a jury, the EC is selected
46 from experienced colleagues within the House who have agreed not to be involved in campaigns
47 during their tenure on the committee and to recuse themselves if they have any potential conflict of
48 interest in consideration of a complaint. The EC believes that while a record of all complaints and
49 the results of the validation and the resolution processes should be maintained within the Office of
50 the General Counsel, the committee deliberations should remain confidential and therefore,
51 recommends no change to paragraph 8 of Policy D-610.998.

1 Prior to 2021 and the establishment of the Election Committee, election complaints were handled
2 by a single individual, the Speaker, without any defined process. Our recently adopted House
3 policy empowers the committee to “work with the Speakers to adjudicate any election complaint,”
4 calling this the primary role of the committee. Further, AMA policy defines the process to be
5 followed. Vesting such authority in the committee places trust that the individuals will carefully
6 and fairly adjudicate any complaint.

7
8 The policy that established the EC and our AMA campaign rules do not provide for oversight of
9 delegations or caucuses beyond the fact that candidates themselves are held responsible for the
10 actions of their campaign teams. In fact, our AMA has no clear authority over caucuses, which
11 exist as independent entities and in some cases incorporated entities. The committee has heard that
12 announcement of a violation may be perceived as damaging to a caucus or entire delegation, with
13 or without their involvement. As such, it has been suggested that the leadership of a caucus or
14 delegation be made aware whenever an allegation suggests the involvement of the group. While the
15 EC does not seek broader oversight over delegations or caucuses, this request for notification and
16 an opportunity to respond is considered reasonable and a recommended addition to policy.

17
18 Paragraph 5 of Policy D-610.998 calls for the Speaker to appoint an Election Committee of 7
19 individuals in accordance with Bylaw 2.13.7. The action of the Board in April making the speakers
20 “full members” of the committee in effect expanded the EC to 9 members. This is allowed under
21 Bylaw 2.13.7.2: “Size. Each committee shall consist of 7 members, **unless otherwise provided**”
22 (*emphasis added*). Paragraph 7c of Policy D-610.998 requires committee members with a conflict
23 of interest to recuse themselves. The EC notes that recusal of members may become a challenge,
24 particularly in campaigns with multiple candidates from differing delegations, and recommends
25 further expansion of the committee by two (2) additional members.

26
27 The EC believes the process for reporting, validation and resolution of campaign violations as
28 recommended here should be codified in policy and widely communicated. While this report will
29 raise awareness, the EC believes the formal process established should be included in future
30 editions of the Election Manual.

31 32 CONCLUSION

33
34 The Election Committee was officially established in June 2021 and has been in place for a single
35 campaign and election cycle. The EC intends this interim report to raise awareness of the current
36 processes for campaign complaint reporting, validation, and resolution as codified by action of the
37 HOD and the BOT. As per Policy D-610.998, paragraph 9, the committee will continue to review
38 the processes as implemented and make further recommendations to the House as necessary. In
39 addition, the House is reminded that a review of the entirety of the modified election processes will
40 be conducted after the upcoming elections at A-23 as per adopted recommendation 41 of the
41 Election Task Force Report. Any adopted recommendations will be subject to that review.

42 43 RECOMMENDATIONS

44
45 It is recommended that the following recommendations be adopted and the remainder of the report
46 filed.

- 47
48 1. That Policy D-610.998, Paragraph 5, be amended by addition and deletion to read as follows:

49
50 In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7
51 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum

- 1 tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly
2 involved in a campaign during their tenure and would be appointed from various regions,
3 specialties, sections, and interest groups. The primary role of the committee would be to work
4 with the Speakers to adjudicate any election complaint. Additional roles to be determined by
5 the Speaker and could include monitoring election reforms, considering future campaign
6 modifications and responding to requests from the Speaker for input on election issues that
7 arise. The Speaker and Vice Speaker shall be full members of the Election Committee. (Modify
8 Current HOD Policy)
9
- 10 2. That Policy D-610.998, Paragraph 7, be amended by addition to read as follows:
11
12 Campaign violation complaints will be investigated by the Election Committee or a
13 subcommittee thereof with the option of including the Office of General Counsel or the
14 Director of the House of Delegates. (Modify Current HOD Policy)
15
- 16 3. That Policy D-610.998, Paragraph 7(a), be amended by addition to read as follows:
17
18 7(a). The Committee will collectively determine whether a campaign violation has occurred.
19 As part of the investigation process the Election Committee or its subcommittee shall
20 inform the candidate of the complaint filed and give the candidate the opportunity to
21 respond to the allegation. (Modify Current HOD Policy)
22
- 23 4. That Paragraph 7 be amended by addition of a new sub point "b" to read as follows:
24
25 7(b) If the complaint implicates a delegation or caucus, the Election Committee or its
26 subcommittee shall inform the chair of the implicated delegation or caucus of the
27 complaint filed and give the implicated delegation or caucus chair(s) the opportunity to
28 answer to the allegation as a part of the investigative process. (Modify Current HOD
29 Policy)
30
- 31 5. That amended Policy D-610.998 be widely communicated, including being published in the
32 Election Manual. (Directive to Take Action)

Fiscal Note: Up to \$5000 annually; zero in the absence of a complaint.

APPENDIX A - Report of the Election Task Force [ETF] (June 2021)

Relevant portion copied below. To review the full report go to page 103 of the pdf at <https://www.ama-assn.org/system/files/2021-06/j21-bot-reports.pdf>, which is page 133 of the J21 Proceedings.

ELECTION COMMITTEE

At the open forum discussion at I-19 the idea of an ongoing election committee was proffered and received broad support. The concept was not to detract from the Speakers' role in overseeing the campaign and election process, but rather to provide them support. Recognizing that improvement in our elections is an iterative process, a committee could monitor the impacts of the recommendations adopted from this report and make further recommendations for the continued evolution of our election process. In addition, it was mentioned that enforcing campaign rules could create real or perceived bias for a Speaker if the complainant or the accused happened to be a friend or from their delegation. The committee working with the Speakers could adjudicate potential campaign violations. The Speakers are receptive to this proposal.

The ETF recommends establishment of an Election Committee of 7 individuals, appointed by the Speaker for 1-year terms to report to the Speaker. We proposed that these individuals be allowed to serve up to 4 consecutive terms but that the maximum tenure be 8 years. These individuals would agree to not be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups to reduce potential bias. The primary role of the committee would be to work with the Speaker to adjudicate any election complaint. The ETF envisions selection of a smaller subcommittee from the Election Committee to adjudicate each specific complaint. Additional roles could include monitoring election reforms, considering future campaign modifications, and responding to requests from the Speaker for input on election issues that arise. Our Bylaws (2.13.7) provide for the appointment of such a committee. This Bylaw specifies that the term may be directed by the House of Delegates. Therefore, the ETF recommends that such a committee be established for the terms noted.

In addition, the task force recommends a more defined complaint and violation adjudication process including the proposed Election Committee. Details can be further determined by the committee in consultation with the Speakers and presented to the House at a future date, but the ETF suggests consideration of a more formal process for reporting, validation of the complaint with investigation as needed, resolution of the concern and presentation to the HOD if a formal penalty (up to and including exclusion from the election) is deemed appropriate.

APPENDIX B - Establishing an Election Committee (November 21)

HOUSE ACTION: REFERRED FOR DECISION

At the June 2021 Special Meeting (J21), the House of Delegates (HOD) adopted the following recommendation as part of the report of the Election Task Force (Speakers' Report 2):

In accordance with Bylaw 2.13.7, the Speaker shall appoint an Election Committee of 7 individuals for 1-year terms (maximum tenure of 4 consecutive terms and a lifetime maximum tenure of 8 terms) to report to the Speaker. These individuals would agree not to be directly involved in a campaign during their tenure and would be appointed from various regions, specialties, sections, and interest groups. The primary role of the committee would be to work with the Speakers to adjudicate any election complaint. Additional roles to be determined by the Speaker and could include monitoring election reforms, considering future campaign modifications and responding to requests from the Speaker for input on election issues that arise. The recommendation is recorded as Paragraph 5 in Policy D-610.998, "Directives from the Election Task Force."

The Speakers determined that the term of each committee member should run from June to June, starting and ending with the adjournment of the HOD meeting, and initial appointments, including the chair, have been made. The seven members of the Committee are delegates or alternate delegates and have agreed to refrain from active participation in election campaigns through the following June, when their (initial) appointments will have concluded. Current members will be eligible for reappointment and other individuals willing to serve on the Committee are invited to complete the application form on the Speakers' page for positions that will begin in mid-2022.

Members of the Committee are listed in Appendix A. All were selected from among members of the House that submitted an application to serve. Appointments were made to cross the geographic regions and broad specialties represented in our House. The selected individuals have extensive experience with campaigns. Among those selected are past presidents of 4 state medical associations and 2 specialty societies, plus two past state medical association speakers in addition to past members of an AMA Council and Section Governing Councils. As part of their commitment, they have also agreed that all complaints and the ensuing discussions, deliberations, and votes will be kept confidential. Only those complaints that are verified and reported to the House will be shared, and then the Speaker will report to the House only the relevant aspects of the matter. The Committee might be likened to the peer review process. (See below for the complaint process.)

In addition, Paragraph 6 of the same policy adopted at J21 reads as follows:

The Speaker in consultation with the Election Committee will consider a more defined process for complaint reporting, validation, resolution, and potential penalties. This process will be presented to the House for approval.

This report is in response to Paragraph 6.

COMMITTEE ACTIVITIES AND PROPOSALS

The Committee convened by conference call to address the matters that had been assigned. Each is discussed below.

Complaint reporting

Long established policy (Policy G 610.020 [1]) states that the Speakers "are responsible for overall administration of our AMA elections." The Committee recommends that complaints continue to be submitted through the Speaker or Vice Speaker. Should either or both have a perceived conflict, complaints may be directed to our AMA's General Counsel. Counsel will then work with the Committee chair and/or the Speaker or Vice Speaker, depending on the nature and extent of the conflict. AMA's General Counsel can be reached through the Member Service Center or the HOD Office. Members of the Committee will not accept

complaints directly and members of the House should not bring complaints to them or attempt to discuss campaign related concerns with individual members.

Complaints should generally be based on first-hand information because the necessary information is unlikely to otherwise be available. A complaint will need to include the following details:

- The name of the person(s) thought to have violated the rules
- The date of the alleged violation and the location if relevant
- The specific violation being alleged (i.e., the way the rules were violated)
- The materials, if any, that violate the rules; original materials are preferred over copies. Where necessary, arrangements for collection of these materials will be made.

Some discussion was had regarding the development of a list of potential rules violations and associated penalties, it quickly was recognized that this list would be limitless, necessarily qualified by nuance or exceptions. Furthermore, application of rigid penalties that do not take into account such nuances, would unnecessarily constrain the committee and potentially disenfranchise members of our House with whom rests the ultimate decision regarding verified infractions. Rather, the Committee recommends that they be allowed flexibility to consider the circumstances surrounding reported violations and to determine the appropriate corrective action. To ensure consistency and fairness over time, a history of the details of each verified offense and the ensuing penalty will be retained by the Office of General Counsel.

Inquiries about rules should also be directed to the Speakers. They have long interpreted AMA's election rules, and in fact, the annual election manual further elucidates the campaign rules. In this light some complaints could prove unfounded simply because of a misunderstanding of the rules. More importantly, consistency in explaining the rules is requisite, and the Speakers are familiar with both historical issues and current practice. In addition, questions sometimes arise for which the answer should be widely disseminated, and the Speakers have the ability and tools to share the information. Even-handedness in administering the elections is a hallmark of our processes.

Validation

Upon receiving a complaint, the Speaker will consult with the Committee chair to form a subcommittee of three members to investigate the allegation. The subcommittee members will be selected to avoid conflicts (e.g., being part of the same delegation as the alleged violator). Using necessary discretion, the subcommittee shall investigate the complaint and will report to the full Committee whether the complaint is founded. When necessary, the Office of General Counsel or the HOD Office will assist.

Following the subcommittee's evaluation, the full Committee will meet as soon as practical but generally within 2 weeks, to hear the subcommittee's report, determine whether a violation has occurred, and establish appropriate next steps. Committee members with a conflict of interest will be expected to recuse themselves from the vote, although they may participate in any discussion that precedes the decision. These internal deliberations are confidential, and details will not be shared. The Speakers are ex officio members of the Committee, without vote except as necessary to break a tie within the Committee, when one of them may vote.

Resolution and potential penalties

Historically, the only formal penalty for a campaign violation was for the Speaker to announce to the House before the election that a violation had occurred by naming the violator and the violation. These announcements thankfully have been rare, but when such an announcement has been made, it is noted that the candidate subsequently lost the election.

The Committee believes the House should continue to be the final arbiter when violations are deemed to be significant; thus, the Speaker announcing a violation to the House will remain a penalty which the Committee may impose. At the same time the Committee may believe that this penalty is excessive for some violations. The Committee should consider mitigating circumstances such as inadvertent breaches and technical or

typographical errors. The Committee should also consider when during the year the violation occurs, the likely advantage sought or gained by the action in question, and who committed the violation. Consequently, the Committee recommends that it be given discretion to determine appropriate resolution of a validated complaint. In many circumstances resolution may be accomplished by corrective action, short of announcement to the House.

No exhaustive list of situations is possible, but three principles would seem to capture relevant aspects of violations:

- The more remote in time the violation occurs, the less the need to declare a violation, and conversely, the nearer the election, the greater the need for an announcement by the Speaker.

It seems likely that a violation, particularly a violation that is perceived to be serious, will become generally known if it occurs well before the election. At the same time, awareness of a violation on the eve of the election has little chance of propagating and may warrant an announcement.

- The greater the advantage sought or gained, the more the need for a public announcement.

Some subjectivity is apparent in this principle, but the Committee believes that both the motivation and the benefit of the violating activity need to be addressed. An inadvertent violation that greatly advantages a candidate is more serious than the same inadvertent violation that for some reason handicaps the candidate.

- The greater the culpability of the candidate, the greater the need for an announcement to the House.

Under AMA's election rules, the candidate is responsible for all campaign activities, including those carried out by the candidate's supporters. While it would be unwise to simply ignore a violation committed by a naïve supporter (or group), the role of the candidate her- or himself certainly needs to be considered. In the same way "plausible deniability" alone will not absolve the candidate, though it may decrease the likelihood of Speaker pronouncements.

As noted above, announcing the Committee's conclusion to the House that a violation has occurred should remain an option, but the Committee also favors availability of other options whereby relatively minor infractions may be easily and quickly remedied without being reported to the House. This may also be appropriate in those cases where the violation and corrective action is readily apparent without formal announcement. For example, Paragraph 15 of the rules (Policy G 610.020) requires candidates using electronic communications to "include a simple mechanism to allow recipients to opt out of receiving future [emails]." A candidate failing to provide the "simple mechanism" could easily correct the violation by sending another communication apologizing and adding the opt out, which would be apparent to all recipients, meaning that reporting the violation to the House would be of little need. For another example, a misstatement in an interview or on campaign materials could be subsequently corrected by the candidate by notification to those that received the misinformation.

Where a confirmed violation is deemed by the Election Committee to require a report to the House, the Speaker would report pertinent details, including any corrective action undertaken by the candidate, that are deemed appropriate for the HOD to consider. A notice to the House, separate from a meeting, could be provided when appropriate. For example, such notice could be included with the Speakers' planned announcements of candidates (see Policy G 610.020 [3]), which would allow the House to assess the gravity of the violation but also provide the violator with the opportunity to respond to concerns. Violations that occur once the Annual Meeting has convened, if determined by the Committee to be significant, would be announced during a session of the HOD.

CONCLUSION

The final recommendation of Speakers' Report 2 (Report of the Election Task Force) adopted at the J21 Special Meeting (Policy D-610.998) provides for a review of the reforms related to our election processes. The Election Committee itself and these recommendations will be subject to this review. Our tradition of

professionalism and collegiality should result in few violations of our campaign principles and rules necessitating invoking the process detailed here. The Election Committee has recommended a process that draws upon our traditions, provides appropriate flexibility without undue complexity, and yet maintains the integrity of our elections. Accordingly, your Election Committee asks that the following recommendations be approved for use in the upcoming open campaign season and that the Committee be allowed to continue to monitor our election processes with further recommendations in the future as needed.

RECOMMENDATIONS

It is recommended that the following recommendations be adopted and the remainder of the report be filed.

1. A Campaign Complaint Reporting, Validation, and Resolution Process shall be established as follows:

Campaign violation complaints should be directed to the Speaker, the Vice Speaker, or the AMA General Counsel and should include the following details:

- The name of the person(s) thought to have violated the rules
- The date of the alleged violation and the location if relevant
- The specific violation being alleged (i.e., the way the rules were violated)
- The materials, if any, that violate the rules; original materials are preferred over copies. Where necessary, arrangements for collection of these materials will be made.

Campaign violation complaints will be investigated by the Election Committee, which will determine penalties for validated complaints as appropriate. Penalties may include an announcement of the violation by the Speaker to the House.

2. The Election Committee will review the Campaign Complaint Reporting, Validation, and Resolution Process as implemented and make further recommendations to the House as necessary.
3. Policy D-610.998, Paragraph 6 be rescinded.
[Editor's note: At the time of referral, the following amended language had been adopted:
Campaign violation complaints will be investigated by the Election Committee, which will recommend penalties to the Speaker of the House, who will validate complaints and actions as appropriate. Penalties may include an announcement of the violation by the Speaker to the House.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 601
(I-22)

Introduced by: Louisiana, South Carolina

Subject: AMA Withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity

Referred to: Reference Committee F

1 Whereas, On May 11, 2021, the American Medical Association released to the public its
2 *Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity* (hereinafter
3 *the Equity Strategic Plan*), a work product developed by the AMA Center for Health Equity and
4 approved by the AMA Board of Trustees; and
5

6 Whereas, The Louisiana House of Delegates found the document to contain divisive and
7 inflammatory language, terminology and racially characterizing statements that stand in polar
8 opposition to our Louisiana State Medical Society Policies and to AMA Policies H-65.965,
9 H-65.953, H-140.900, and the AMA Code of Medical Ethics; and
10

11 Whereas, The Louisiana House of Delegates directed the Louisiana AMA Delegation to submit
12 a resolution to the AMA HOD; therefore be it
13

14 RESOLVED, That our American Medical Association withdraw its Organizational Strategic Plan
15 to Embed Racial Justice and Advance Health Equity (Equity Strategic Plan) and rewrite the
16 recommendations for correcting its past support for racially discriminating behavior with removal
17 of the inflammatory rhetoric. (Directive to Take Action)

Fiscal Note: Estimated cost of \$415,000 to implement resolution.

Received: 06/16/22

RELEVANT AMA POLICY

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

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

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

Citation: Res. 11, I-20

A Declaration of Professional Responsibility H-140.900

Our AMA adopts the Declaration of Professional Responsibility

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

Preamble

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets.

Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

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

Declaration

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

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

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

Citation: CEJA Rep. 5, I-01; Reaffirmation A-07; Reaffirmed: CEJA Rep. 04, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 602
(1-22)

Introduced by: Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, New Jersey, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Virginia, West Virginia, Texas, American College of Radiology

Subject: Finding Cities for Future AMA Conventions/Meetings

Referred to: Reference Committee F

- 1 Whereas, It appears that for at least the next five years or more the AMA Interim and Annual
2 meetings are being limited to Chicago, Illinois, Orlando, Florida (but probably no more Orlando
3 after 2026) and National Harbor, Maryland; and
4
- 5 Whereas, There is political and financial benefit to both AMA and the AMA House of Delegates
6 to move around the US as much as possible and visit in our states particularly for the Interim
7 Meeting; and
8
- 9 Whereas, There are convention centers in 47 states (see [List of convention centers in the](#)
10 [United States - Wikipedia](#)) and with 36 of these centers over 300,000 sq ft of space; and
11
- 12 Whereas, There are 19 other US cities with convention hotels with over 1500 rooms each (see
13 [US Convention Hotels | Cvent Destination Guide](#)); and
14
- 15 Whereas, About 20 US cities have over 4000 hotel rooms (from Costar: [Hotel News Now](#) and
16 [Largest Hotels in USA \(United States\) by Most Number of Rooms \(rlist.io\)](#)); and
17
- 18 Whereas, AMA Policy G-630.140 is vague and complex and has thus made AMA staff and
19 consultants fearful of “doing the wrong thing” and thus forced us to the current limit on hotels or
20 sites that AMA can “use”; and
21
- 22 Whereas, Our sole intent is to amend Policy G- 630.140 to loosen up the sites and cities
23 available to AMA meetings; therefore be it

1 RESOLVED, That our American Medical Association amend Policy G-630.140, "Lodging,
2 Meeting Venues, and Social Functions," by addition and deletion to read as follows:

3
4 AMA policy on lodging and accommodations includes the following:

5
6 1. Our AMA supports choosing hotels for its meetings, conferences, and conventions
7 based on size, service, location, cost, and similar factors.

8
9 2. Our AMA shall attempt, when allocating meeting space, to locate the Section
10 Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close
11 proximity.

12
13 3. All meetings and conferences organized and/or primarily sponsored by our AMA
14 will be held in a town, city, county, or state that ~~has regulation or enacted~~
15 ~~comprehensive~~ legislation requiring smoke-free worksites and public places (including
16 restaurants and bars), unless intended or existing contracts or special circumstances
17 justify an exception to this policy, and our AMA encourages state and local medical
18 societies, national medical specialty societies, and other health organizations to adopt
19 a similar policy.

20
21 4. It is the policy of our AMA not to ~~hold meetings organized and/or primarily~~
22 ~~sponsored by our AMA, in cities, counties, or states, or pay member, officer or~~
23 ~~employee dues in any club, restaurant, or other institution, that has exclusionary~~
24 ~~policies, including, but not limited to, policies based on, race, color, religion, national~~
25 ~~origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity~~
26 ~~and gender expression, disability, or age unless intended or existing contracts or~~
27 ~~special circumstances justify an exception to this policy.~~

28
29 5. Our AMA staff will work with facilities where AMA meetings are held to designate
30 an area for breastfeeding and breast pumping.

31
32 6. All future AMA meetings will be structured to provide accommodations for members
33 and invited attendees who are able to physically attend, but who need assistance in
34 order to meaningfully participate.

35
36 7. Our AMA will revisit our criteria for selection of hotels and other venues in order to
37 facilitate maximum participation by members and invited attendees with disabilities.

38
39 8. Our AMA will report back to the HOD by no later than the 2023 Annual Meeting
40 with a plan on how to maximize meeting participation for members and invited
41 attendees with disabilities. (Modify Current HOD Policy)

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

Received: 09/27/22

RELEVANT AMA POLICY

Lodging, Meeting Venues, and Social Functions G-630.140

AMA policy on lodging and accommodations includes the following:

1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.
2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.
3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.
4. It is the policy of our AMA not to hold meetings organized and/or primarily sponsored by our AMA, in cities, counties, or states, or pay member, officer or employee dues in any club, restaurant, or other institution, that has exclusionary policies, including, but not limited to, policies based on, race, color, religion, national origin, ethnic origin, language, creed, sex, sexual orientation, gender, gender identity and gender expression, disability, or age unless intended or existing contracts or special circumstances justify an exception to this policy.
5. Our AMA staff will work with facilities where AMA meetings are held to designate an area for breastfeeding and breast pumping.
6. All future AMA meetings will be structured to provide accommodations for members and invited attendees who are able to physically attend, but who need assistance in order to meaningfully participate.
7. Our AMA will revisit our criteria for selection of hotels and other venues in order to facilitate maximum participation by members and invited attendees with disabilities.
8. Our AMA will report back to the HOD by no later than the 2023 Annual Meeting with a plan on how to maximize meeting participation for members and invited attendees with disabilities.

Citation: Res. 2, I-87; Reaffirmed: Sunset Report, I-97; Res. 512, I-98; Consolidated: CLRPD Rep. 3, I-01; Reaffirmation A-04; Modified: CCB/CLRPD Rep. 3, A-12; Modified: CCB/CLPRD Rep. 2, A-13; Modified: BOT Rep. 17, A-17; Appended: Res. 610, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 606
(1-22)

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 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
(1-22)

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

Reference Committee J

CMS Report(s)

- 01 Incentives to Encourage Efficient Use of Emergency Departments
- 02 Corporate Practice of Medicine

Resolution(s)

- 801 Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans
- 802 FAIR Health Database
- 803 Patient Centered Medical Home – Administrative Burdens
- 804 Centers for Medicare & Medicaid Innovation Projects
- 805 COVID Vaccine Administration Fee
- 806 Healthcare Marketplace Plan Selection
- 807 Medicare Advantage Record Requests
- 808 Reinstatement of Consultation Codes
- 809 Uniformity and Enforcement of Medicare Advantage Plans and Regulations
- 810 Medicare Drug Pricing and Pharmacy Costs
- 811 Covering Vaccinations for Seniors Through Medicare Part B
- 812 Implant-Associated Anaplastic Large Cell Lymphoma
- 813 Amending Policy on a Public Option to Maximize AMA Advocacy
- 814 Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?
- 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
- 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

REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-22)
Incentives to Encourage Efficient Use of Emergency Departments
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2022 Annual Meeting, the House of Delegates adopted Policy D-130.959, “Study of Incentives to Encourage Efficient Use of Emergency Departments,” which directs the American Medical Association (AMA) to study and report on the positive and negative experiences of programs in various states that provide Medicaid beneficiaries with incentives for choosing alternate sites of care, for physical and mental health conditions, when it is appropriate to their symptoms and/or conditions instead of hospital emergency departments (EDs).

Medicaid/Children’s Health Insurance Program (CHIP) enrollees have higher rates of ED visits than Medicare, privately insured, and even uninsured individuals, thereby utilizing higher-cost services than those provided in other ambulatory care settings. To address this issue, and contain costs, states—and managed care plans that enroll Medicaid patients—have long sought ways to incentivize more efficient ED use. Financial incentives, including increased patient cost-sharing and retrospective payment denials, are among the variety of strategies that have been employed across states to try to reduce ED visits perceived to be non-emergency, nonurgent, or avoidable. Consistent with Policy D-130.959, the Council reviewed the literature on these financial incentives and finds that: 1) modest cost-sharing requirements, on their own, may not be very effective at either reducing ED services or generating significant cost-savings; and 2) diagnosis-based payment and coverage denials for non-emergency ED services may potentially harm some patients—by dissuading them from seeking emergency care when needed—as well as physicians and hospitals, when payment is denied.

The Council believes that interventions aimed at reducing ED use for services that could be provided elsewhere, and at lower cost, are worthy of ongoing monitoring and testing by the Centers for Medicare & Medicaid Services and other stakeholders. Accordingly, the Council recommends support for continued monitoring and testing of strategies and best practices for reducing non-emergency ED use, particularly among patients with the highest number of ED visits. Given the abundance of AMA policy that is relevant to this report topic, and the need for state flexibility to design strategies well suited to a state’s Medicaid population, the Council also recommends support for state efforts to encourage appropriate ED use among Medicaid/CHIP enrollees that are consistent with the standards and safeguards outlined in AMA policy on ED services. Finally, the Council recommends reaffirmation of AMA policies supporting the prudent layperson standard of determining when to seek emergency care (Policy H-130.970); criteria to be used in Medicaid managed care monitoring and oversight (Policy H-290.985); and reasonable Medicaid payment (Policy H-290.959).

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-I-22

Subject: Incentives to Encourage Efficient Use of Emergency Departments

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee J

1 At the 2022 Annual Meeting, the House of Delegates adopted Policy D-130.959, “Study of
2 Incentives to Encourage Efficient Use of Emergency Departments,” which directs the American
3 Medical Association (AMA) to study and report on the positive and negative experiences of
4 programs in various states that provide Medicaid beneficiaries with incentives for choosing
5 alternate sites of care, for physical and mental health conditions, when it is appropriate to their
6 symptoms and/or conditions instead of hospital emergency departments (EDs). The Board of
7 Trustees assigned this policy to the Council on Medical Service for a report back to the House of
8 Delegates at the 2022 Interim Meeting. This report describes the positive and negative experiences
9 of two commonly used incentives intended to reduce non-emergency ED use (increased patient
10 cost-sharing and retrospective payment denials), summarizes relevant AMA policy, and makes
11 policy recommendations.
12

13 BACKGROUND

14
15 Medicaid spending makes up an increasingly large share of most state budgets and continues to be
16 a focus of policymakers seeking ways to contain costs without compromising care quality. EDs
17 have been targeted for cost-savings in many states because, for a variety of complex reasons,
18 Medicaid/Children’s Health Insurance Program (CHIP) enrollees have higher rates of ED use than
19 Medicare, privately insured, and even uninsured individuals.^{1,2} Because services cost significantly
20 more when provided in EDs than in other ambulatory care settings (e.g., physician offices and
21 outpatient clinics), states—and managed care plans that enroll Medicaid patients—have long
22 prioritized incentivizing more efficient ED use by Medicaid enrollees. Financial incentives,
23 including increased patient cost-sharing and retrospective payment denials, are among the variety
24 of strategies employed to try to reduce ED visits perceived to be non-emergency, nonurgent, or
25 avoidable. Although there is no standard definition of what constitutes non-emergency, nonurgent,
26 avoidable ED care, it is generally described as that which can be appropriately provided in a
27 primary care or other outpatient setting at reduced cost.
28

29 Due to the lack of consensus around defining non-emergency, nonurgent, avoidable ED visits,
30 researchers have employed an array of methodologies to assess the effectiveness of strategies to
31 reduce those patient visits that could be effectively treated elsewhere. As a result, studies have
32 produced a range of estimates of ED visits classified as non-emergency, nonurgent, or avoidable,
33 depending on methodology and how these visits are defined. Importantly, a 2013 *JAMA* study
34 revealed what many physicians already knew—that non-emergency visits cannot easily be
35 discerned from patients’ presenting complaints and symptoms, since symptoms for many non-
36 emergency conditions overlap with symptoms of conditions that require emergency care.³ This
37 suggests that, in many cases, decisions about emergency versus non-emergency care are far from
38 clear-cut and may not be evident at triage. Although exact percentages are not known, most

1 estimates of non-emergency ED visits as a proportion of all ED visits are relatively small. Analyses
 2 by the Centers for Disease Control and Prevention (CDC) of ED data from the National Hospital
 3 Ambulatory Medical Care Survey found that 5.5 percent of all ED visits in 2015,⁴ 3.9 percent in
 4 2017,⁵ and 3.1 percent in 2018,⁶ were classified as nonurgent. A 2015 report of the Washington
 5 Health Alliance found that nearly 12 percent of Medicaid enrollee ED visits in the Puget Sound
 6 region could be described as avoidable, compared to 8.5 percent of ED visits by privately insured
 7 individuals.⁷

8
 9 Experts have long posited that a lack of regular access to primary care drives many patients to EDs
 10 for nonurgent reasons. Furthermore, Medicaid enrollees, and individuals dually eligible for
 11 Medicare and Medicaid, are known to experience added barriers to accessing health care, in part
 12 because they are more likely to experience inequities in social determinants of health (SDOH) that
 13 lead to complex and chronic health needs. Other factors that lower access to health care include a
 14 lack of available transportation, the distance one must travel to obtain care (especially in rural
 15 areas), an inability to get needed specialty care, difficulties taking time off to attend medical
 16 appointments, cost concerns among patients, lack of community behavioral health resources, and
 17 inadequate Medicaid physician payment rates.

18
 19 **MEDICAID PAYMENT RATES AND ENROLLEE ACCESS TO CARE**

20
 21 For decades, the AMA has highlighted the inadequacy of physician payment rates across state
 22 Medicaid programs—rates that are substantially below Medicare and private insurance fees and
 23 often do not come close to covering the cost of providing care. In enacting the equal access
 24 provision in section 1902(a)(30)(A) of the Social Security Act, Congress recognized that, “without
 25 adequate payment levels, it is simply unrealistic to expect physicians to participate in the
 26 [Medicaid] program.”⁸ While physicians have a strong sense of responsibility to provide care for
 27 Medicaid patients, physician practices cannot remain economically viable if they lose money on
 28 the care they provide. Without an adequate supply of participating physicians, Medicaid patients
 29 have coverage but may lack access to care. And without access to needed primary and specialty
 30 care, Medicaid enrollees tend to visit EDs more often for conditions that could be handled in
 31 alternate sites of service.

32
 33 Because physicians participating in Medicaid remain sparse in many areas of the country, enrollees
 34 often experience lengthy wait times, travel long distances to access care, or may go without care
 35 altogether. Medicaid payment rates have been shown to significantly impact patient access to care,
 36 with increases in payments found to improve access to care.⁹ Accordingly, the AMA has long
 37 advocated at the federal and state levels that physicians be provided fair and reasonable Medicaid
 38 payment, defined in AMA policy as a minimum of 100 percent of Medicare rates. The AMA
 39 further advocates that the Centers for Medicare & Medicaid Services (CMS) ensure that states
 40 maintain Medicaid rate structures at levels that ensure there is sufficient physician participation, so
 41 that Medicaid patients can access care in a timely manner.

42
 43 **FACTORS CONTRIBUTING TO NON-EMERGENCY ED USE**

44
 45 EDs have historically served as an essential source of care for people struggling with economic
 46 marginalization, and research has shown an association between socioeconomic variables and
 47 potentially avoidable ED use.¹⁰ Medicaid enrollees experiencing inequities in SDOH—such as
 48 housing instability, food insecurity, or lack of transportation—may be more likely to use the ED for
 49 non-emergency care.

1 As previously noted, patients who do not have an established relationship with a primary care
 2 provider may be more likely to seek care at an ED for non-emergency conditions. Moreover, across
 3 some states, and especially in rural areas, it can be difficult for some Medicaid enrollees to obtain
 4 needed specialty care; in turn, these patients may visit EDs because alternative care sites are simply
 5 not available. Lack of access to behavioral health and substance use disorder services may be an
 6 additional barrier in some areas. Physician workforce shortages in certain specialties likely
 7 compound these access barriers that contribute to higher ED use among Medicaid enrollees.

8
 9 Although some people may seek non-emergency care at EDs out of convenience, or on weekends
 10 or evenings when other outpatient care is not available, analyses have been mixed and some
 11 hospitals have found that non-emergency visits predominantly occur during regular hours when
 12 physician offices are open. A subset of Medicaid enrollees may turn to hospital EDs for services
 13 that cannot be accessed at primary care offices, while others may be motivated to have multiple
 14 health concerns addressed during a single ED visit. Patients who perceive that they cannot access
 15 timely or needed care in another setting, including individuals with mental health needs and/or
 16 substance use disorder, may also seek non-emergency ED care, as will patients who believe they
 17 are experiencing emergencies requiring immediate attention.

18
 19 Insurer prior authorization (PA) requirements are also important drivers of non-emergency ED use,
 20 especially when they preclude patients from getting timely needed care. In some cases, patients
 21 may resort to EDs for certain medically indicated services that would otherwise be delayed while
 22 approval is sought from the patient’s insurer. PA rules that impede quick access to services ranging
 23 from mental health and substance use disorder treatment to imaging may lead some patients to seek
 24 care at EDs. According to one study, a new outpatient PA process for radiologic studies may have
 25 led to an increase in ED visits for outpatient MRI scans.¹¹

26
 27 Lack of insurance, or limited insurance, also impacts ED use, although people with health
 28 insurance still experience time and access barriers to receiving regular care. Although the
 29 expansion of Medicaid under the Affordable Care Act has been found to reduce the number of
 30 uninsured individuals and increase access to primary care,¹² research findings on the association
 31 between Medicaid expansion and ED use have been mixed, in part because newly insured patients
 32 may use more health care services.

33
 34 **STRATEGIES TO REDUCE NON-EMERGENCY ED USE**

35
 36 Beyond financial incentives, strategies to reduce non-emergency ED use are numerous and varied
 37 and have produced mixed results in the literature in terms of their impact. One strategy that is
 38 central to many state efforts is care coordination designed to connect Medicaid enrollees to services
 39 that address their physical and mental health needs as well as non-medical issues such as housing,
 40 nutrition, and transportation. To improve care coordination, many states have focused on enrolling
 41 Medicaid patients in patient-centered medical homes that use a physician-led team approach to
 42 coordinating and managing care for individuals. Consistent with value-based care, care
 43 coordination and the use of patient-centered medical homes assist patients in getting the right care
 44 at the right time in the appropriate setting. Many medical home programs have successfully
 45 reduced hospitalizations and ED use including, for example, Community Care of North Carolina,
 46 which was found to decrease ED visits among individuals enrolled compared to those not
 47 enrolled.¹³ In the Medicare population, enrollees with patient-centered medical homes have also
 48 been found to have slower growth in ED use than those not treated by medical homes.¹⁴

49
 50 Additional mechanisms employed to help reduce non-emergency ED use include integrating
 51 behavioral health care into primary care and expanding access to after-hours primary care, which

1 have been implemented by some health systems along with expanded telehealth availability. In the
 2 Netherlands, linkages between primary care physician cooperatives and EDs have significantly
 3 reduced ED use.¹⁵ Rural health clinics, community health centers, and federally qualified health
 4 centers serving economically marginalized communities may also play a role in reducing non-
 5 emergency ED visits by providing accessible and timely care that would otherwise not be available.
 6 Research has shown that the availability of health centers lowers ED use, and that many centers
 7 actively work with local hospitals to further reduce ED visits.¹⁶

8
 9 Ensuring the availability of community mental health resources is also key to addressing ED use by
 10 mental health and substance use disorder patients and enabling them to access treatment outside of
 11 EDs. Crisis response services and same-day access to treatment in one’s community have also been
 12 cited as important mechanisms for reducing the use of EDs.¹⁷ Notably, some states, health plans,
 13 hospitals and health systems pursue cost-savings opportunities by targeting high-need, high-cost
 14 Medicaid patients who have the greatest number of ED visits. Case management/care management
 15 interventions of varying designs are often employed to help meet these patients’ complex physical,
 16 behavioral, and social needs, thereby reducing their use of EDs. Extensivist clinics, employed by
 17 some hospitals and health systems to coordinate and manage care for patients with multiple
 18 complex health needs, have also been found to incur cost-savings by decreasing ED utilization and
 19 hospitalizations.¹⁸ Consistent with Policy D-130.959, this report summarizes the literature on two
 20 commonly used financial incentives—increased cost-sharing for non-emergency ED use and
 21 retrospective payment denials for non-emergency diagnoses.

22
 23 **INCREASED PATIENT COST-SHARING FOR NON-EMERGENCY ED VISITS**

24
 25 Although federal law prohibits the imposition of cost-sharing for certain services in Medicaid,
 26 including “emergency services,”¹⁹ the Deficit Reduction Act of 2005 (DRA) gave states the option
 27 to impose cost-sharing for “non-emergency services.”²⁰ In 2013, CMS established through
 28 rulemaking that a maximum eight dollars in cost-sharing for non-emergency use of the ED could
 29 be imposed by states without an approved waiver.²¹ Accordingly, over the ensuing years, many
 30 states have imposed limited cost-sharing amounts of eight dollars or less. Although the Kaiser
 31 Family Foundation reported in 2020 that 21 states had mandated cost-sharing requirements for non-
 32 emergency use of EDs,²² it is unclear how many states have waived those requirements for the
 33 duration of the COVID-19 public health emergency. Notably, South Dakota’s Medicaid program
 34 informs enrollees that they will be responsible for paying the full cost of non-referred, non-
 35 emergency ED services.²³

36
 37 A handful of states have used Section 1115 demonstration waivers to establish cost-sharing
 38 amounts exceeding the eight-dollar maximum, although most of these waivers—including those
 39 from Kentucky and New Mexico—are no longer in effect. Under Georgia’s current waiver, \$30
 40 can be retroactively deducted from enrollees’ Member Rewards Accounts—used to deduct and
 41 deposit non-monetary dollar-value equivalent credits for healthy behavior activities—for non-
 42 emergency use of EDs. Because enrollees are not charged with any out-of-pocket costs, the \$30
 43 deduction in Georgia is considered an incentive but is not true cost-sharing.²⁴ Other states have
 44 provided prepaid cards to cover cost-sharing expenses that may allow enrollees to keep remaining
 45 amounts on the card at the end of the year; however, no analyses of such programs were located
 46 during the development of this report.

1 *Relevant Research*

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The landmark RAND Health Insurance Experiment, conducted between 1971 and 1982, is frequently cited as the benchmark study of cost-sharing and its effects on health care utilization, quality of care, and health. This experiment found that cost-sharing reduced utilization of almost all services, whether needed or not, and that the sickest and lowest-income people had better outcomes under free plans, suggesting that cost-sharing should not be applied to them.²⁵ Prior to enactment of the DRA, research had found that even minimal cost-sharing could lead Medicaid enrollees to use fewer health care services.²⁶

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More recent studies of cost-sharing requirements for ED visits labeled non-emergency or nonurgent have produced mixed results. A study of state ED cost-sharing requirements in the five years following DRA enactment found no differences in ED use between states with and without those cost-sharing requirements, and no increases in the use of alternative outpatient settings.²⁷ A 2010 study of data in nine states that had imposed cost-sharing for non-emergency ED visits also suggested that cost-sharing requirements did not reduce these visits and were therefore not effective.²⁸ However, a 2015 analysis of nine years of data (from 2001 to 2009) concluded that ED visits by Medicaid enrollees in states with cost-sharing requirements were less likely to be nonurgent.²⁹

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Positive and Negative Experiences

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Cost-sharing requirements are intended to incentivize appropriate health care utilization while discouraging unnecessary or inappropriate care. The DRA policy allowing limited cost-sharing requirements intended to incentivize Medicaid enrollees to reduce their reliance on EDs for services that can be provided in alternate settings at reduced costs. Cost-sharing requirements have also been touted for encouraging personal responsibility and incentivizing patients to make better health care choices, which could benefit both patients and the Medicaid program overall.

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However, increased cost-sharing in state Medicaid programs has been somewhat controversial because of the risks that imposing even limited cost-sharing amounts will dissuade economically marginalized enrollees from seeking ED care in emergency situations. Critics of these cost-sharing requirements maintain that most Medicaid enrollees use EDs for actual emergencies and, as discussed earlier in this report, a relatively small percentage of enrollees turn to EDs for non-emergency services that could be provided elsewhere. Accordingly, on their own, cost-sharing requirements may not incur much cost-savings and could lead some patients to avoid seeking or delay needed care.

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An additional drawback of cost-sharing increases for non-emergency ED visits is that it can be challenging for hospitals to administer since, in many cases, it is frequently not possible to determine at triage whether services will be considered non-emergency and thus subject to cost-sharing. Moreover, hospitals may be hesitant to request that cost-sharing be paid upfront due to potentially violating the Emergency Medical Treatment and Labor Act (EMTALA), which requires individuals to be stabilized and treated, regardless of insurance status or ability to pay. Lastly, the administrative burden on hospitals of collecting cost-sharing amounts after care is provided may be higher than any savings incurred from the minimal cost-sharing that is collected.³⁰

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48

RETROSPECTIVE PAYMENT DENIALS FOR NON-EMERGENCY ED SERVICES

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Some states and insurers have attempted to rein in Medicaid costs by reducing or denying payment and coverage for ED services when the diagnosis is retrospectively determined to be non-

1 emergency. One state using a variation of this incentive is Indiana, where the Indiana Health
 2 Coverage Program (IHCP) will pay hospitals for emergency services only if a screening determines
 3 that the patient has an emergency condition. Although the IHCP does not deny payment for non-
 4 emergency services, a site-of-service payment reduction is applied to those services so that
 5 payment is based on office visit rates.³¹

6
 7 In 2011, the Washington State Health Care Authority made headlines by announcing its intention
 8 to limit non-emergency ED visits to three per year and to deny payment to physicians and hospitals
 9 for services related to a lengthy list of diagnoses labeled non-emergent.³² Facing significant
 10 opposition from physicians and hospitals, this policy was nixed at the last minute and replaced by
 11 an alternative plan that arose from a partnership between the Washington State Medical
 12 Association, the Washington Chapter of the American College of Emergency Physicians, the
 13 Washington State Hospital Association, and the Health Care Authority. This multifaceted effort to
 14 reduce nonurgent ED visits coalesced around a series of best practices that saved nearly \$34
 15 million in the program’s first year, during which ED visits by Medicaid enrollees declined by 10
 16 percent.³³ The following “ER is for Emergencies” best practices became integral to Washington
 17 State’s efforts to reduce avoidable ED visits:

- 18
- 19 1. Adoption and use of an interoperable health information exchange;
- 20 2. Dissemination of materials intended to educate patients about appropriate care utilization
- 21 and the difference between emergencies and non-emergencies;
- 22 3. Identification by hospitals of frequent ED users;
- 23 4. Development of care management plans for frequent ED users that incorporate information
- 24 on social determinants of health;
- 25 5. Implementation of state guidelines for prescribing opioids;
- 26 6. Implementation of the state’s prescription monitoring program; and
- 27 7. Engaging ED and care management staff to track ED utilization data and provide
- 28 feedback.³⁴
- 29

30 While not specifically targeting Medicaid, large private insurers have periodically proposed
 31 coverage denials that limit payment for ED services retrospectively determined to have non-
 32 emergency ED discharge diagnoses. The AMA has advocated against such policies, as it did in
 33 2017, when Anthem implemented policies in several states that denied coverage for many ED
 34 services and shifted the cost burden onto patients.³⁵

35
 36 *Relevant Research*

37
 38 Some studies have questioned the accuracy of retrospective payment denial policies for nonurgent
 39 ED services, which are based on claims data and assume there is a clear association between
 40 presenting symptoms and discharge diagnoses. The findings from the 2013 *JAMA* study, cited
 41 earlier in this report, cast doubt on this association and further suggest that policies that deny or
 42 limit payment based on diagnosis at discharge are not appropriate and may put some patients at risk
 43 of not getting emergency care that they need. According to the *JAMA* study:

44
 45 Among ED visits with the same presenting complaint as those ultimately given a primary care-
 46 treatable diagnosis based on ED discharge diagnosis, a substantial proportion required
 47 immediate emergency care or hospital admission. The limited correspondence between
 48 presenting complaint and ED discharge diagnosis suggests that these discharge diagnoses are
 49 unable to accurately identify nonemergency ED visits.³⁶

1 Similar results were found in a 2018 study of a large private insurer’s policy to deny coverage for
 2 ED visits when the ED discharge diagnosis is determined to be nonurgent.³⁷ This analysis of ED
 3 visits of privately insured patients between 2011 and 2015 found that nearly 40 percent of the more
 4 than 15 percent of visits with non-emergency diagnoses were in fact urgent, as evidenced by the
 5 fact that patients received emergency care. Furthermore, the presenting symptoms of patients in
 6 nearly 90 percent of the ED visits were the same as symptoms of those patients with diagnoses
 7 labeled nonemergent.³⁸

8
 9 *Positive and Negative Experiences*

10
 11 Although retrospective payment denials are likely to save money, they also violate important
 12 patient protections and undercut the practice of emergency medicine. Federal law requires
 13 insurance coverage of emergency services as defined using a prudent layperson standard that is
 14 based on symptoms, not eventual diagnoses.³⁹ Retrospective payment denial policies run the risk of
 15 violating the prudent layperson standard and also disregard patients’ perceptions of their own
 16 symptoms and whether they need emergency care. Patients make care decisions based on
 17 symptoms and they should be neither encouraged to second guess their instincts that emergency
 18 care is needed nor expected to self-diagnose to determine whether, for example, chest pain is a
 19 heart attack or indigestion. Finally, the impact of policies that deny coverage and payment for
 20 emergency services based on diagnoses risks leading Medicaid patients, who may be seriously ill,
 21 to either not seek or delay seeking needed emergency medical care.

22
 23 **AMA POLICY**

24
 25 The AMA has long-standing policy supporting the prudent layperson standard (Policy H-130.970).
 26 Accordingly, this policy states that emergency services should be defined as those services
 27 provided in a hospital emergency facility after the sudden onset of a medical condition that
 28 manifests itself by symptoms of sufficient severity, including severe pain, that the absence of
 29 immediate medical attention could reasonably be expected by a prudent layperson, who possesses
 30 an average knowledge of health and medicine, to result in: (1) placing the patient’s health in
 31 serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any
 32 bodily organ or part. Policy H-130.970 also directs the AMA to work with state insurance
 33 regulators, insurance companies and other stakeholders to take action to halt the implementation of
 34 policies that violate the prudent layperson standard of determining when to seek emergency care.
 35 Policy H-290.965 supports the use of ED best practices that are evidence-based to reduce avoidable
 36 ED visits.

37
 38 Policy H-290.982 supports modest copays or income-adjusted premiums in Medicaid for non-
 39 emergent, non-preventive services. Policy H-165.855 states that children qualified for Medicaid
 40 should have no cost-sharing obligations. Under Policy H-290.985, the AMA advocates that
 41 enrollees in Medicaid managed care plans be educated about appropriate use of services, including
 42 at the emergency department, and availability of off-hours, walk-in primary care. This policy also
 43 maintains that Medicaid managed care plans should be responsive to cultural, language and
 44 transportation barriers to access, and provide intensive case management for high utilizers and
 45 realistic financial disincentives for beneficiary misuse of services.

46
 47 Policy H-450.941 supports initiatives that protect patient access and that do not contain
 48 requirements that permit third-party interference in the patient-physician relationship, and it
 49 strongly opposes attempts to steer patients towards certain physicians primarily based on cost.
 50 Policy H-450.938 states that physicians should encourage their patients to participate in making
 51 value-based health care decisions, while Policy H-155.960 supports value-based decision-making

1 and broad strategies for addressing rising health care costs. Policy H-155.960 also encourages
 2 third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are
 3 determined based on the clinical value of a health care service or treatment, and tailoring cost-
 4 sharing requirements to patient income and other factors known to impact compliance. Policy
 5 H-185.939 supports value-based insurance design (VBID), consistent with several principles
 6 including that coverage and cost-sharing policies must be transparent and that VBID should not
 7 restrict access to care. Policy D-185.979 encourages national medical specialty societies to
 8 collaborate with payers to promote alignment of patient financial incentives with utilization of
 9 high-value services.

10
 11 Under Policies H-385.921 and H-290.976, the AMA advocates for reasonable physician payments
 12 within Medicaid/CHIP, defined as a minimum of 100 percent of Medicare rates. Policy H-400.957
 13 encourages CMS to expand the extent and amount of payment for procedures performed in the
 14 physician's office, to shift more procedures from the hospital to the office setting, which is more
 15 cost effective. Policy D-240.994 advocates that third-party payers be required to assess equal or
 16 lower facility cost-sharing for lower-cost sites of service.

17
 18 The AMA has adopted principles for patient-centered medical homes, including that each patient
 19 has an ongoing relationship with a personal physician trained to provide first contact, continuous
 20 and comprehensive care (Policy H-160.919). These principles also maintain that enhanced access
 21 to care is available through systems such as open scheduling, expanded hours and new options for
 22 communication between patients, their personal physician, and practice staff. ED boarding and
 23 overcrowding are addressed by Policies H-130.940 and H-130.945. The latter policy encourages
 24 hospitals to use appropriate criteria to triage patients so those with simpler medical needs can be
 25 redirected to other appropriate ambulatory facilities. EMTALA is addressed by Policy D-130.982.

26
 27 Policy H-165.822 (1) encourages new and continued partnerships to address non-medical, yet
 28 critical health needs and the underlying social determinants of health; (2) supports continued efforts
 29 by public and private health plans to address social determinants of health in health insurance
 30 benefit designs; and (3) encourages public and private health plans to examine implicit bias and the
 31 role of racism and social determinants of health. Policy H-185.920 supports continuity of care
 32 principles for financial incentive programs, including that these programs never interfere with a
 33 patient-physician relationship, and that only treating physicians can determine whether a lower-cost
 34 care option is medically appropriate. This policy also supports objective studies of the impacts of
 35 financial incentive programs.

36
 37 Policy H-373.994 recognizes the increasing use of patient navigator and patient advocacy services
 38 to help improve access to care and help patients manage complex aspects of the health care system.
 39 Policy H-290.995 supports primary care case management programs for Medicaid enrollees: on a
 40 voluntary basis with incentives provided toward a prudent choice of care source; and on a
 41 mandatory basis only for those identified as overutilizers or mis-utilizers of services; and
 42 comparative analyses of these programs to determine their relative effectiveness regarding patient
 43 access, quality of and satisfaction with care, and cost reduction.

44
 45 **DISCUSSION**

46
 47 Policies aimed at reducing ED use for services that could be provided elsewhere, and at lower cost,
 48 have been debated for decades and are worthy of continued monitoring and testing. Since many
 49 states incorporate such policies into Section 1115 demonstration waivers and state Medicaid plan
 50 amendments, the Council recommends support for continued monitoring and pilot testing, by CMS
 51 and other stakeholders, of strategies and best practices for reducing non-emergency ED use among

1 Medicaid/CHIP enrollees, particularly among patients with the highest number of ED visits. The
 2 Council believes that ongoing study of state approaches to reducing ED use, and dissemination of
 3 study results, will greatly benefit state Medicaid programs as they strive to manage health care
 4 costs without compromising care quality.

5
 6 State Medicaid programs, hospitals and health systems have employed a variety of strategies to
 7 reduce non-emergency ED use, and the Council supports state flexibility in this regard since best
 8 practices will depend in part on the health needs of a state’s Medicaid population. Recognizing the
 9 abundance of AMA policy that is relevant to this topic, the Council recommends support for state
 10 efforts to encourage appropriate ED use among Medicaid/CHIP enrollees that are consistent with
 11 the standards and safeguards outlined in AMA policy on ED services.

12
 13 The Council understands that a complex mix of factors influences ED use and that the share of
 14 visits that are non-emergency, while difficult to discern, is relatively low. We also recognize that
 15 modest cost-sharing for non-emergency ED visits for adult Medicaid enrollees, but not for children,
 16 is consistent with AMA policy (Policies H-290.982 and H-165.855) and may incentivize some
 17 patients to make better health care choices. Although we do not recommend changes to existing
 18 policy, we conclude from the literature that modest cost-sharing requirements, on their own, may
 19 not be very effective at either reducing nonurgent ED services or generating significant cost-
 20 savings. We further question whether the cost of administering nominal cost-sharing requirements
 21 may, in some cases, be higher than any savings they generate.

22
 23 Although diagnosis-based payment and coverage denials for non-emergency ED services may
 24 effectively contain costs, the Council affirms that these policies risk violating important patient
 25 protections and may potentially harm some patients—by dissuading them from seeking emergency
 26 care when needed—as well as physicians and hospitals, when payment is denied. Accordingly, the
 27 Council recommends reaffirming Policy H-130.970, which supports the prudent layperson standard
 28 for determining the need for emergency services and directs the AMA to work with state insurance
 29 regulators, insurers, and other stakeholders to halt the implementation of policies that violate this
 30 standard.

31
 32 The Council believes that most Medicaid enrollees turn to EDs when they do not have access to
 33 primary care or needed specialty care—including mental health and substance use disorder
 34 treatment—and when few or no other care options are available. We further believe that strategies
 35 may be more effective if they specifically target individuals with the highest numbers of ED visits,
 36 generally a small percentage of enrollees who account for a disproportionately high amount of ED
 37 utilization. Facilitating these patients’ treatment for non-emergency services in alternate settings
 38 and linking them with primary care, mental health care, and other needed services, are more likely
 39 to significantly reduce ED use and incur some cost-savings. The Council emphasizes that strategies
 40 targeting frequent ED users should be comprehensive and multifaceted, addressing not only
 41 physical and mental health needs but also socioeconomic factors that could contribute to higher
 42 rates of ED utilization. Such strategies should strive to ensure access to primary, preventive and
 43 behavioral health care, as well as substance use disorder treatment, outside of EDs through the
 44 availability of community providers and resources.

45
 46 Before the COVID-19 pandemic, available state Medicaid data showed that more than 60 percent
 47 of enrollees identified as Black, Latino/a, or other individuals of color, with studies finding that
 48 enrollees of color experienced poorer outcomes and more barriers to care than whites.⁴⁰
 49 Accordingly, state Medicaid programs should consider the potential health equity implications of
 50 strategies to reduce ED visits and address SDOH. Consistent with numerous AMA site-of-service
 51 policies (i.e., Policies H-400.957 and D-240.994), state Medicaid program strategies should

1 focus—through patient education and empowerment, 24/7 telephone triage, and telehealth
2 availability, among other efforts—on ensuring that all patients receive health care services in the
3 outpatient setting most appropriate to their symptoms and needs. Accordingly, the Council
4 recommends reaffirmation of Policy H-290.985, which advocates that a long list of criteria be used
5 to monitor and oversee Medicaid managed care plans, including that enrollees are educated about
6 appropriate use of services, including ED services; plans are responsive to cultural, language and
7 transportation barriers to access; off-hours, walk-in primary care is available; there is geographic
8 dispersion and accessibility of participating physicians and other providers; intensive case
9 management is provided to high utilizers; and payment levels are realistic and based on costs of
10 care and predicted utilization levels.

11
12 Because increases in Medicaid payment rates have been found to increase enrollee access to care,
13 the Council recommends reaffirming Policy H-290.976, which affirms the AMA’s commitment to
14 advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates.
15 Finally, the Council recommends rescinding Policy D-130.959, which called for the development
16 of this report.

17
18 RECOMMENDATIONS

19
20 The Council on Medical Service recommends that the following be adopted and the remainder of
21 the report be filed:

- 22
23 1. That our American Medical Association (AMA) support continued monitoring, by the Centers
24 for Medicare & Medicaid Services and other stakeholders, of strategies and best practices for
25 reducing non-emergency emergency department (ED) use among Medicaid/Children’s Health
26 Insurance Program (CHIP) enrollees, including frequent ED users. (New HOD Policy)
27
28 2. That our AMA support state efforts to encourage appropriate emergency department (ED) use
29 among Medicaid/CHIP enrollees that are consistent with the standards and safeguards outlined
30 in AMA policy on ED services. (New HOD Policy)
31
32 3. That our AMA reaffirm Policy H-130.970, which supports the prudent layperson standard and
33 directs the AMA to work with state insurance regulators, insurers, and other stakeholders to
34 halt the implementation of policies that violate the prudent layperson standard of determining
35 when to seek emergency care. (Reaffirm HOD Policy)
36
37 4. That our AMA reaffirm Policy H-290.985, which advocates that numerous criteria be used in
38 Medicaid managed care monitoring and oversight, including that enrollees are educated about
39 appropriate use of services, including ED services; plans are responsive to cultural, language
40 and transportation barriers to access; off-hours, walk-in primary care is available; and intensive
41 case management is provided to high utilizers. (Reaffirm HOD Policy)
42
43 5. That our AMA reaffirm Policy H-290.976, which affirms the AMA’s commitment to
44 advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates.
45 (Reaffirm HOD Policy)
46
47 6. That our AMA rescind Policy D-130.959, which called for the development of this report.
48 (Rescind HOD Policy)

Fiscal Note: Less than \$500.

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Appendix
AMA Policies Recommended for Reaffirmation

Policy H-130.970, “Access to Emergency Services”

1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:

(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.

(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)

(C) All health plans should be prohibited from requiring prior authorization for emergency services.

(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.

(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an “emergency medical condition” as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.

(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third-party payer whether it is retrospectively determined that an emergency existed or not.

(G) States should be encouraged to enact legislation holding health plans and third-party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.

(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.

(I) In instances in which no private or public third-party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.

2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the “prudent layperson” standard of determining when to seek emergency care. (CMS Rep. A, A-89; Modified by CMS Rep. 6, I-95; Reaffirmation A-97; Reaffirmed by Sub. Res. 707, A-98; Reaffirmed: Res. 705, A-99; Reaffirmed: CMS Rep. 3, I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 706, I-00; Amended: Res. 229, A-01; Reaffirmation and Reaffirmed: Res. 708, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: CMS Rep. 07, A-16; Appended: Res. 128, A-17; Reaffirmation: A-18; Reaffirmed in lieu of: Res. 807, I-18)

Policy H-290.985, “Monitoring Medicaid Managed Care”

As managed care plans increasingly become the source of care for Medicaid beneficiaries, the AMA advocates the same policies for the conduct of Medicaid managed care that the AMA advocates for private sector managed care plans. In addition, the AMA advocates that the following criteria be used in federal and/or state oversight and evaluation of managed care plans serving

Medicaid beneficiaries, and insists upon their use by the Federation in monitoring the implementation of managed care for Medicaid beneficiaries:

- (1) Adequate and timely public disclosure of pending implementation of managed care under a state program, so as to allow meaningful public comment.
- (2) Phased implementation to ensure availability of an adequate, sufficiently capitalized managed care infrastructure and an orderly transition for beneficiaries and providers.
- (3) Geographic dispersion and accessibility of participating physicians and other providers.
- (4) Education of beneficiaries regarding appropriate use of services, including the emergency department.
- (5) Availability of off-hours, walk-in primary care.
- (6) Coverage for clinically effective preventive services.
- (7) Responsiveness to cultural, language and transportation barriers to access.
- (8) In programs where more than one plan is available, beneficiary freedom to choose his/her plan, enforcement of standards for marketing/enrollment practices, and clear and comparable disclosure of plan benefits and limitations including financial incentives on providers.
- (9) Beneficiary freedom to choose and retain a given primary physician within the plan, and to request a change in physicians when dissatisfied.
- (10) Significant participating physician involvement and influence in plan medical policies, including development and conduct of quality assurance, credentialing and utilization review programs.
- (11) Ability of plan participating physicians to determine how many beneficiaries and the type of medical problems they will care for under the program.
- (12) Adequate identification of plan beneficiaries and plan treatment restrictions to out-of-plan physicians and other providers.
- (13) Intensive case management for high utilizers and realistic financial disincentives for beneficiary misuse of services.
- (14) Treatment authorization requirements and referral protocols that promote continuity rather than fragment the process of care.
- (15) Preservation of private right of action for physicians and other providers and beneficiaries.
- (16) Ongoing evaluation and public reporting of patient outcomes, patient satisfaction and service utilization.
- (17) Full disclosure of plan physician and other provider selection criteria, and concerted efforts to qualify and enroll traditional community physicians and other existing providers in the plan.
- (18) Absence of gag rules.
- (19) Fairness in procedures for selection and deselection.
- (20) Realistic payment levels based on costs of care and predicted utilization levels.
- (21) Payment arrangements that do not expose practitioners to excessive financial risk for their own or referral services, and that tie any financial incentives to performance of the physician group over significant time periods rather than to individual treatment decisions.
- (22) Our AMA urges CMS to direct those state Medicaid agencies with Medicaid managed care programs to disseminate data and other relevant information to the state medical associations in their respective states on a timely and regular basis. (CMS Rep. 5 A-96; Reaffirmed and Appended: Sub. Res. 704, I-97; Reaffirmation A-00; Reaffirmation I-04; Reaffirmed: CMS Rep. 1, A-14)

Policy H-290.976, “Enhanced SCHIP Enrollment, Outreach, and Reimbursement”

1. It is the policy of our AMA that prior to or concomitant with states’ expansion of State Children’s Health Insurance Programs (SCHIP) to adult coverage, our AMA urge all states to maximize their efforts at outreach and enrollment of SCHIP eligible children, using all available state and federal funds.

2. Our AMA affirms its commitment to advocating for reasonable SCHIP and Medicaid reimbursement for its medical providers, defined as at minimum 100 percent of RBRVS Medicare allowable. (Res. 103, I-01; Reaffirmation A-07; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, I-14; Reaffirmation A-15; Reaffirmed: CMS Rep. 3, A-15; Reaffirmation: A-17; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21)

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-22

Subject: Corporate Practice of Medicine
(Resolution 721-A-22)

Presented by: Lynn Jeffers, MD, MBA, Chair

Referred to: Reference Committee J

1 At the 2022 Annual Meeting, the House of Delegates referred Resolution 721, “Amend Policy
2 H-215.981, ‘Corporate Practice of Medicine’,” which was sponsored by the Resident and Fellow
3 Section. Resolution 721-A-22 asked the American Medical Association (AMA) to “amend AMA
4 Policy H-215.981, ‘Corporate Practice of Medicine,’ by addition of a fourth clause that reads: ‘4.
5 Our AMA acknowledges that the corporate practice of medicine has led to the erosion of the
6 physician-patient relationship, erosion of physician-driven care and created a conflict of interest
7 between profit and training the next generation of physicians.’”
8

9 The referral of Resolution 721-A-22 included specific concern that the study should include the
10 impact of the corporate practice of medicine on all practice types. The Board of Trustees assigned
11 this item to the Council on Medical Service for a report back to the House of Delegates. The
12 Council notes that a related report is being presented by the Council on Medical Education at this
13 meeting (CME Report 1-I-22 “The Impact of Private Equity on Medical Training”). The Council
14 recognizes that private equity and corporate investors are becoming increasingly involved in
15 graduate medical education, residencies, fellowships, and training of non-physician practitioner.
16 We have chosen to focus this report on the general aspects of the corporate practice of medicine.
17

18 BACKGROUND

19
20 The Council recently prepared CMS Report 11 at the 2019 Annual Meeting which addressed a
21 similar topic. The corporate practice of medicine is broadly defined as non-physician investment in
22 medical practices. Two examples of corporate medicine include private equity investment funds
23 and physician management groups. Private equity funds are pooled investments used to buy
24 controlling shares of companies or other entities. After taking control, private equity funds
25 typically streamline the business (which often includes cutting costs and reducing the ability for
26 prior physician owners to make governance decisions) with the goal of selling the business for a
27 profit in three to seven years. The types of investment range from venture capital (VC) firms that
28 primarily invest in early-stage companies in exchange for minority ownership to more traditional
29 private equity firms that borrow money to take a controlling stake in mature yet undervalued or
30 underperforming companies through leveraged buyout deals.¹ Alternatively, a practice
31 management company is a privately held or publicly traded for-profit company that manages the
32 back-end administrative functions of medical practices, such as insurance contracting and billing.
33 Many practice management companies, often referred to as staffing companies, also contract with
34 hospitals and ambulatory surgical centers to provide professional staffing and management
35 services. Investments in practice management companies by private equity funds have led to an
36 increase in their utilization.²

1 While the extent of corporate investment in physician practices is not precisely known, a growing
2 number of physicians are employed by corporations including hospitals, health systems, and
3 insurers. Concerns regarding these partnerships have primarily centered on the potential for
4 subsequent increases in prices, service volume, and internal referrals, as well as the use of
5 unsupervised non-physician practitioners. An array of factors has led to these changes, including
6 changes in payment and delivery models, physician payment challenges, high costs of new
7 technology and equipment, and increased administrative and regulatory burdens.

8
9 In addition to employment by hospitals, health systems, and insurers, private equity firms and
10 publicly traded for-profit corporations may invest in physician practices. Increasingly, private
11 equity firms have acquired majority and/or controlling interests in entities that manage physician
12 practices. However, there is little peer-reviewed evidence regarding the impact of these
13 arrangements on physicians, patients or health care prices, and physician opinions vary. Hospitals,
14 health systems, academic medical centers, large multispecialty groups, and corporate buyers
15 frequently compete with private equity investors for the same physician practice targets. Corporate
16 buyers may also partner with private equity investors or form consortia of buyers to acquire highly
17 sought-after practices. Increased competition for physician groups in some specialties has led price
18 valuations of these practices to rise. Because many private equity transactions are not disclosed
19 (non-disclosure agreements are commonly used), the degree of investment in physician practices,
20 while believed to be relatively small overall, cannot be precisely determined. Incomplete data on
21 corporate transactions involving physician practices is a significant impediment to determining the
22 impact of corporate investors on physicians, patients, and the health care marketplace.³

23 24 *State-by-State Differences*

25
26 Generally, corporate practice of medicine doctrines prohibit corporations from practicing or
27 interfering with the practice of medicine. The doctrines arise from state medical practice acts and
28 are based on a number of public policy concerns, such as: (1) allowing corporations to practice
29 medicine will result in the commercialization of the practice of medicine; (2) a corporation's
30 obligation to its shareholders may not align with a physician's obligation to their patients; and
31 (3) corporate interests may interfere with the physician's independent medical judgment.⁴ It is
32 important to note that while most states have a prohibition on the corporate practice of medicine,
33 every state provides an exception for professional corporations and many states provide an
34 exception for employment of physicians by certain entities. For example, some states explicitly
35 permit hospitals to employ physicians, some states allow nonprofit hospitals to employ physicians,
36 and other states recognize an unwritten exception to the corporate practice of medicine for
37 hospitals employing physicians.⁵ Many states that allow hospitals to employ physicians specifically
38 prohibit the hospital from interfering with the independent medical judgment of the physician,
39 thereby protecting the autonomy of the physician's clinical decision-making.⁶ For example, in
40 California and Indiana, clinics and hospitals may employ physicians as long as the entity does not
41 direct or control independent medical acts, decisions or judgments of the licensed physician. On the
42 other hand, in Colorado and Arkansas, all shareholders and officers of a medical corporation must
43 be licensed physicians, consistent with each state's licensing laws. In Texas, state laws allow
44 critical access hospitals, sole community hospitals, and hospitals in counties with fewer than
45 50,000 people to employ physicians, with the requirement that physicians must "retain independent
46 medical judgment in providing care to patients at the hospital or other health care facilities owned
47 or operated by the hospital and may not be disciplined for reasonably advocating for patient care."⁷

48
49 Recently, there have been complaints filed in state courts arguing that some of these firms have
50 overstepped and are in violation of state corporate practice of medicine doctrines. One example of
51 this is a lawsuit filed in California by the American Academy of Emergency Medicine Physician

1 Group (AAEM-PG) against Envision Healthcare Corporation. In its filing, AAEM-PG alleges that
2 Envision is in violation of the state’s corporate practice of medicine doctrine, as Envision either
3 forms new medical groups with non-physician officers or “installs Envision executives or officers
4 in pre-existing medical groups.” Specifically, the lawsuit alleges that Envision: “decides how many
5 and which physicians to hire, their compensation and work schedule...controls and influences
6 advertising for physician vacancies, vetting physicians, establishing the terms of employment, the
7 physician’s rate of pay, scheduling the hours physicians will work, staffing levels, the number of
8 patient encounters and working conditions...when to terminate physicians and denies them rights
9 to appeal via traditional medical staffing mechanisms...negotiates the groups’ contracts with third-
10 party payers and health insurers and decides whether the group will agree to the terms...physicians
11 are not made aware of the terms of their contracts with third-party payers.” The lawsuit was
12 originally filed in December 2021. In May 2022, a judge for the United States District Court for the
13 Northern District of California denied Envision Healthcare’s motion to dismiss the case; therefore,
14 the case remains ongoing. The American College of Emergency Physicians and the California
15 Medical Association have both filed amicus briefs in support of AAEM-PG.⁸ Further details and
16 copies of court documents can be found on <https://www.aem.org/envision-lawsuit>.

17
18 As previously stated, there is limited data on the extent of physician practice acquisition by private
19 equity firms; however, private equity acquisition of physician practices increased from 59 deals in
20 2013 to 136 deals in 2016.⁹ In April 2022, *JAMA Health Forum* published data on the geographic
21 variations in private equity penetration of physician practices (defined as the share of physicians in
22 private equity-acquired practices) across six specialties: dermatology, gastroenterology,
23 ophthalmology, obstetrics/gynecology, orthopaedics, and urology. Private equity penetration was
24 highest in the Northeast (6.8 percent) and lowest in the Midwest (3.8 percent). Twelve states and
25 the District of Columbia (DC) have an above average share of physicians in private equity
26 practices, while eleven states have no identified acquisitions. States with the highest private equity
27 penetration are Washington, DC (18.2 percent), Arizona (17.5 percent), New Jersey (13.6 percent),
28 Maryland (13.1 percent), Connecticut (12.6 percent), and Florida (10.8 percent). By specialty,
29 private equity penetration was highest in dermatology, followed by gastroenterology,
30 ophthalmology, obstetrics/gynecology, and orthopaedics.¹⁰

31 *Risks and Benefits*

32
33
34 As with any practice type, there are risks and benefits associated with entering into corporate
35 partnerships. Risks include loss of control over the physician practice and future revenues, loss of
36 autonomy in decision-making, an emphasis on profit or meeting financial goals, potential conflicts
37 of interest, and potential uncertainties for non-owner early and mid-career physicians. Additionally,
38 after a buyout there could be added layers of bureaucracy that could add burdens to physicians.
39 Examples could be new checks and balances or updated workflows. Benefits include financially
40 lucrative deals for physicians looking to exit ownership of their practices, access to capital for
41 practice expenses or expansions (which may relieve physicians’ financial pressures), potentially
42 fewer administrative and regulatory burdens on prior practice owners, and centralized resources for
43 certain functions such as IT, marketing, and human resources.

44
45 There can also be risks to patients when physicians enter into these agreements. Recent evidence
46 has shown a 10 percent increase in short-term mortality in private equity-owned nursing homes
47 compared to non-private equity owned nursing homes. This is possibly due to decreases in nursing
48 staff and declines in compliance with federal and state standards of care.¹¹ Another study
49 evaluating private equity acquisitions of US hospitals demonstrated increased charges, increased
50 net income, and increased patient risk scores, along with fewer Medicaid patients admitted, after
51 private equity acquisition relative to control groups.¹² A third study showed that private

1 equity-owned dermatology practices were associated with 3 percent-5 percent higher prices for
 2 routine medical visits at 1.5 years after acquisition as compared with non-private equity-owned
 3 practices. Other studies have shown increased rates of surprise billing, overutilization of high-
 4 margin or low-value services, and pressure to up-code charges after private equity acquisition.¹³

5
 6 *Impact on Patient-Physician Relationship*

7
 8 Research is ongoing about the effects of corporate medicine investment on patient outcomes and
 9 cost-savings. A study of 176 hospitals acquired by private equity firms during 2005-2014 was
 10 conducted to compare financial performance to matched control hospitals.¹⁴ Private equity
 11 acquisition of short-term acute care hospitals was associated with decreased costs per discharge and
 12 increased margins. The study highlights early findings on the impact private equity investment has
 13 on the health care system. Preliminary data show that financial performance improved after
 14 acquisition; however, patient utilization of services increased, and staffing decreased. Importantly,
 15 the study found that the decline in total costs per discharge was not adjusted for total full time
 16 hospital personnel, which suggests that hospitals cut costs in other dimensions, not only labor, after
 17 private equity acquisition. The authors of the study note that although improved financial
 18 performance occurred broadly, the findings are not evidence that gains in efficacy translate to
 19 improved patient outcomes or clinical experiences in either the short or long term.¹⁵

20
 21 Under private equity investment, maintaining physician autonomy and a physician-led care team is
 22 crucial. Physicians should retain complete control of clinical decision making, as well as decisions
 23 regarding who is a member of their care team. Care provided by non-physician practitioners has
 24 been shown to be more costly than care provided by a physician-led team. An example of this is at
 25 the Hattiesburg Clinic in Mississippi. An examination of cost data for the South Mississippi
 26 system's accountable care organization (ACO) revealed that care provided by non-physician
 27 practitioners working on their own patient panels was more expensive than care delivered by
 28 physicians. The 2017-2019 Centers for Medicare & Medicaid Services (CMS) cost data on
 29 Medicare patients without end-stage renal disease and who were not in a nursing home showed that
 30 per-member, per-month spending was \$43 higher for patients whose primary health professional
 31 was a nonphysician instead of a physician. This finding could translate to \$10.3 million more in
 32 spending annually if all patients were followed by non-physician practitioners. Citing the results of
 33 the clinic's study, researchers found that "the results are consistent and clear: By allowing
 34 advanced practice providers to function with independent panels under physician supervision, we
 35 failed to meet our goals in the primary care setting of providing patients with an equivalent value-
 36 based experience." These findings underscore the importance of physician-led care teams,
 37 regardless of business model or private equity investment, both to control costs and improve patient
 38 outcomes.¹⁶

39
 40 **AMA POLICY**

41
 42 Long-standing AMA policy states that physicians are free to choose their mode of practice and
 43 enter into contractual agreements as they see fit.

44
 45 Policy H-215.981 opposes federal legislation preempting state laws prohibiting the corporate
 46 practice of medicine; states that the AMA will continue monitoring the corporate practice of
 47 medicine and its effect on the patient-physician relationship, financial conflicts of interest, and
 48 patient-centered care; and directs the AMA to provide guidance, consultation, and model
 49 legislation regarding the corporate practice of medicine, at the request of state medical associations,
 50 to ensure the autonomy of hospital medical staffs, employed physicians in non-hospital settings,
 51 and physicians contracting with corporately-owned management service organizations.

1 Policy H-285.951 states that physicians should have the right to enter into whatever contractual
2 arrangements they deem desirable and necessary but should be aware of potential conflicts of
3 interest due to the use of financial incentives in the management of care.

4
5 Policy H-215.968 supports and encourages competition between and among health facilities as a
6 means of promoting the delivery of high-quality, cost-effective care.

7
8 Policy H-225.947 encourages physicians who seek employment as their mode of practice to strive
9 for employment arrangements consistent with a series of principles, including: (a) physician
10 clinical autonomy is preserved; (b) physicians are included and actively involved in integrated
11 leadership opportunities; (c) physicians are encouraged and guaranteed the ability to organize
12 under a formal self-governance and management structure; (d) physicians are encouraged and
13 expected to work with others to deliver effective, efficient, and appropriate care; (e) a mechanism
14 is provided for the open and transparent sharing of clinical and business information by all parties
15 to improve care; and (f) a clinical information system infrastructure exists that allows capture and
16 reporting of key clinical quality and efficiency performance data for all participants accountability
17 across the system to those measures.

18
19 Policy H-160.960 states that when a private medical practice is purchased by corporate entities,
20 patients shall be informed of the ownership arrangement by the corporate entities and/or
21 physicians. Policy H-160.891 lists guidelines for physicians to consider when they are
22 contemplating corporate investor partnerships. These guidelines include: (a) how the practice's
23 current mission, vision, and long-term goals align with those of the corporate investor; (b) due
24 diligence should be conducted that includes, at minimum, review of the corporate investor's
25 business model, strategic plan, leadership and governance, and culture; (c) external legal,
26 accounting and/or business counsels should be obtained to advise during the exploration and
27 negotiation of corporate investor transactions; (d) retaining negotiators to advocate for best
28 interests of the practice and its employees should be considered; (e) whether and how corporate
29 investor partnerships may require physicians to cede varying degrees of control over practice
30 decision-making and day-to-day management; (f) the potential impact of corporate investor
31 partnerships on physician and practice employee satisfaction and future physician recruitment; (g)
32 a clear understanding of compensation agreements, mechanisms for conflict resolution, processes
33 for exiting corporate investor partnerships, and application of restrictive covenants; (h) corporate
34 investor processes for medical staff representation on the board of directors and medical staff
35 leadership selection; and (i) retain responsibility for clinical governance, patient welfare and
36 outcomes, physician clinical autonomy, and physician due process under corporate investor
37 partnerships. Additionally, Policy H-160.891 states that the AMA supports improved transparency
38 regarding corporate investment in physician practices and subsequent changes in health care prices;
39 encourages national medical specialty societies to research and develop tools and resources on the
40 impact of corporate investor partnerships on patients and the physicians practicing in that specialty;
41 and supports consideration of options for gathering information on the impact of private equity and
42 corporate investors on the practice of medicine.

43
44 **DISCUSSION**

45
46 The Council recognizes that private equity investment and the corporate practice of medicine are
47 continuing to change the health care landscape. This report describes various investment
48 opportunities and their impact on medical practice. Anecdotally, there have been challenges
49 associated with the corporate practice of medicine and evidence that some investment firms have
50 overstepped and could be in violation of state corporate practice of medicine doctrines. It is clear

1 that in order to control spending and provide optimal care for patients, care teams should be
2 physician-led.

3
4 The AMA has long-standing policy that supports a physician's right to choose their mode of
5 practice and type of employment, and we acknowledge that investor partnerships can be lucrative
6 and successful. The AMA has published several resources and ethical opinions to guide physicians
7 as they make the choice that is best for them.

8
9 The Council recommends new policy to address the concerns outlined in this report, including the
10 potential to erode the patient-physician relationship and create conflicts of interest in medical
11 education. In addition, the Council recognizes that the nature of corporate investor relationships
12 could potentially change in the future and recommends amending Policy H-160.891 regarding
13 corporate investors to strengthen the physician's role in clinical decision-making, medical
14 education, and determining the composition of the care team.

15
16 RECOMMENDATIONS

17
18 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
19 721-A-22, and the remainder of the report be filed:

- 20
21 1. That our American Medical Association (AMA) acknowledge that the corporate practice of
22 medicine has the potential to erode the patient-physician relationship. (New HOD Policy)
23
24 2. That our AMA acknowledge that the corporate practice of medicine may create a conflict of
25 interest between profit and best practices in residency and fellowship training. (New HOD
26 Policy)
27
28 3. That our AMA amend Policy H-160.891 by addition of two new clauses, as follows:
29 j. Each individual physician should have the ultimate decision for medical judgment in patient
30 care and medical care processes, including the use of mandated patient care algorithms or
31 supervision of non-physician practitioners.
32 k. Physicians should retain primary and final responsibility for structured medical education
33 inclusive of undergraduate and graduate medical education including the structure of the
34 program, program curriculum, selection of faculty and trainees, as well as educational and
35 disciplinary issues related to these programs. (Modify Current HOD Policy)

Fiscal Note: Less than \$500.

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- ³ Issue Brief: Corporate Investors. American Medical Association. 2019. Available at: <https://www.ama-assn.org/system/files/2019-12/issue-brief-corporate-investors.pdf>
- ⁴ Issue Brief: Corporate Practice of Medicine. AMA Advocacy Resource Center. American Medical Association. 2015.
- ⁵ *Ibid.*
- ⁶ *Ibid.*
- ⁷ *Ibid.*
- ⁸ American Academy of Emergency Medicine Physician Group vs. Envision Healthcare Corporation. Case No. 22-cv-00421-CRB. <https://www.aaem.org/envision-lawsuit>
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- ¹⁰ Singh, Y. “Geographic Variation in Private Equity Penetration Across Select Office-Based Physician Specialties in the US.” *JAMA Health Forum*. April 2022. Available at: <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2791722>
- ¹¹ Ikram, *Supra* note 1.
- ¹² Ikram, *Supra* note 1.
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- ¹⁴ Cerullo, M. “Financial Impacts and Operational Implications of Private Equity Acquisition of US Hospitals.” *Health Affairs*. April 2022. Available at: <https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01284>
- ¹⁵ *Ibid.*
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 801
(I-22)

Introduced by: Young Physicians Section

Subject: Parity in Military Reproductive Health Insurance Coverage for All Service Members and Veterans

Referred to: Reference Committee J

- 1 Whereas, The World Health Organization (WHO) defines infertility as “the failure to achieve a
2 pregnancy after 12 months or more of regular unprotected sexual intercourse;”¹ and
3
4 Whereas, Our AMA also recognizes infertility as a disease (AMA policy H-420.952);² and
5
6 Whereas, In an Ethics Committee Opinion, the American Society for Reproductive Medicine
7 (ASRM) states that “individuals and couples should have access to fertility services irrespective
8 of marital status, sexual orientation, or gender identity;”³ and
9
10 Whereas, This ASRM Ethics Committee Opinion also states that “results of research suggested
11 that the development, adjustment, and well-being of children are not markedly impacted by the
12 marital status, sexual orientation, or gender identity of the parents;”³ and
13
14 Whereas, This ASRM Ethics Committee Opinion also states that “programs should treat all
15 requests for assisted reproduction equally without regard to marital status, sexual orientation, or
16 gender identity;”³ and
17
18 Whereas, “Compared to the general population, military families face unique challenges that
19 can complicate family building and planning;”⁴ and
20
21 Whereas, “During military service, active duty service members may experience exposures to
22 potential chemical, physical, and environmental hazards such as jet fuel, burn pits, spent
23 uranium, nuclear power plants, and exposures associated with submarines and aviation, all of
24 which may be linked to negative effects on reproductive health;”⁴ and
25
26 Whereas, “Exposure to endocrine-disrupting chemical agents including lead, mercury, or certain
27 pesticides is shown to result in altered semen quality and sterility in men as well as menstrual
28 cycle interference in women;”⁴ and
29
30 Whereas, “Several studies demonstrate an association between military service and Post
31 Traumatic Stress Disorder, depression, toxic exposures, and their negative impact on fertility;”⁴
32 and
33
34 Whereas, “The Department of Defense (DOD) does not provide coverage for infertility services
35 for most with military insurance, including artificial (intrauterine) inseminations, costs related to
36 sperm or oocyte donation...;”⁴ and

1 Whereas, For veterans, Veterans Health Administration Directive 1334 (12 February 2018)
2 specifically excludes fertility coverage for single women or same-sex couples that would
3 otherwise be covered;^{4,5} and
4

5 Whereas, For active duty servicemembers, the Department of Defense (DoD) Policy for
6 Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or
7 III) Active Duty Service Members (ADSMs) specifically states that “Third party donations and
8 surrogacy are not covered benefits;”⁶ and
9

10 Whereas, Our AMA also “supports: (1) insurance coverage for fertility treatments regardless of
11 marital status or sexual orientation when insurance provides coverage for fertility treatments;
12 and (2) local and state efforts to promote reproductive health insurance coverage regardless of
13 marital status or sexual orientation when insurance provides coverage for fertility treatments
14 (AMA policy H-185.926);”⁷ therefore be it
15

16 RESOLVED, That our American Medical Association support expansion of reproductive health
17 insurance coverage to all active-duty service members and veterans eligible for medical care
18 regardless of marital status, gender or sexual orientation. (New HOD Policy)

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

Received: 08/19/22

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2. AMA policy H-420.952 Recognition of Infertility as a Disease, at <https://policysearch.ama-assn.org/policyfinder/detail/infertility?uri=%2FAMADoc%2FHOD.xml-H-420.952.xml>, accessed 30 April 2022.
3. Access to fertility treatment irrespective of marital status, sexual orientation, or gender identity: an Ethics Committee Opinion, at https://www.asrm.org/globalassets/asrm/asrm-content/news-and-publications/ethics-committee-opinions/access_to_fertility_treatment_by_gays_lesbians_and_unmarried_persons-pdfmembers.pdf, accessed 30 April 2022.
4. Hamai CJ, Groves SD, Kostandinis T, Girald-Berlinger S, Simon KE, Christy AY, Hsu AL. “Helping Military Families Grow”: Increasing Infertility Coverage for Active-duty Servicemembers and Veterans. *Fertil Steril Dialog*. Published online 7 Mar 2022: <https://www.fertstertdialog.com/posts/helping-military-families-grow-increasing-infertility-coverage-for-active-duty-servicemembers-and-veterans>.
5. Veterans Health Administration (VHA) Directive 1334 Assisted Reproductive Technology (ART) Services, including IN Vitro Fertilization (IVF) for the Benefit of Veterans with Service-Connected Illness or Injury Resulting in Infertility – Frequently Asked Questions (12 February 2018), accessible at: <https://www.fertstertdialog.com/documents/vha-directive-1334-bb1012b6-de5f-4626-a161-4e1a76b93f04>, accessed 30 April 2022.
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7. AMA policy H-185.926 Reproductive Health Insurance Coverage, at <https://policysearch.ama-assn.org/policyfinder/detail/fertility?uri=%2FAMADoc%2FHOD-185.926.xml>, accessed 30 April 2022.

RELEVANT AMA POLICY

Reproductive Health Insurance Coverage H-185.926

Our AMA supports: (1) insurance coverage for fertility treatments regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments; and (2) local and state efforts to promote reproductive health insurance coverage regardless of marital status or sexual orientation when insurance provides coverage for fertility treatments.

Citation: Res. 804, I-16

Recognition of Infertility as a Disease H-420.952

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

Citation: Res. 518, A-17

Health Care Disparities in Same-Sex Partner Households H-65.973

Our American Medical Association: (1) recognizes that denying civil marriage based on sexual orientation is discriminatory and imposes harmful stigma on gay and lesbian individuals and couples and their families; (2) recognizes that exclusion from civil marriage contributes to health care disparities affecting same-sex households; (3) will work to reduce health care disparities among members of same-sex households including minor children; and (4) will support measures providing same-sex households with the same rights and privileges to health care, health insurance, and survivor benefits, as afforded opposite-sex households.

Citation: CSAPH Rep. 1, I-09; BOT Action in response to referred for decision Res. 918, I-09; Reaffirmed in lieu of Res. 918, I-09; BOT Rep. 15, A-11; Reaffirmed in lieu of Res. 209, A-12; Reaffirmed: CSAPH Rep. 1, A-22

Health Disparities Among Gay, Lesbian, Bisexual, Transgender and Queer Families D-65.995

Our AMA supports reducing the health disparities suffered because of unequal treatment of minor children and same sex parents in same sex households by supporting equality in laws affecting health care of members in same sex partner households and their dependent children.

Citation: Res. 445, A-05; Modified: CSAPH Rep. 1, A-15; Res. 16, A-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

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 802
(1-22)

Introduced by: New York
Subject: FAIR Health Database
Referred to: Reference Committee J

1 Whereas, The FAIR Health database was created to bring independent accuracy and
2 transparency to medical price data; and
3
4 Whereas, This database is now widely used, not just for charge data, but also for contracted
5 rate data; and
6
7 Whereas, One important piece of information that has been included in these listings was the
8 frequency of the Current Procedural Terminology (CPT) code's usage during the past 12-month
9 period that was used to calculate the statistical data; and
10
11 Whereas, This "frequency" information was of great relevance in understanding how much data
12 FAIR Health had obtained; and
13
14 Whereas, This "frequency" data was also useful for providers when they wanted to challenge
15 the accuracy of various statistics provided by FAIR Health; and
16
17 Whereas, The FAIR Health database no longer reports the specific "frequency" of the data
18 collected; therefore be it
19
20 RESOLVED, That our American Medical Association advocate to FAIR Health to ensure the
21 continued identification of the frequency by which a particular CPT code is used. (New HOD
22 Policy)

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

Received: 09/20/22

RELEVANT AMA POLICY

Network Adequacy H-285.908

1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.
2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.
3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received.

4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.
6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician.
8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.
9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.
10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited.
11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.
12. Our AMA supports requiring that health insurers that terminate in-network providers: (a) notify providers of pending termination at least 90 days prior to removal from network; (b) give to providers, at least 60 days prior to distribution, a copy of the health insurers letter notifying patients of the providers change in network status; and (c) allow the provider 30 days to respond to and contest if necessary the letter prior to its distribution.

Citation: CMS Rep. 4, I-14; Reaffirmation I-15; Reaffirmed in lieu of Res. 808, I-15; Modified: Sub. Res. 811, I-15; Reaffirmed: CMS Rep. 03, A-17; Reaffirmed: Res. 108, A-17; Appended: Res. 809, I-17; Reaffirmed: Res. 116, A-18; Reaffirmation: A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 803
(I-22)

Introduced by: New York

Subject: Patient Centered Medical Home – Administrative Burdens

Referred to: Reference Committee J

- 1 Whereas, The “Medical Home Model” provides increased care to homebound patients but
2 increases the administrative burden on physicians and their office staff; and
3
4 Whereas, The effects of these additional administrative burdens limits physician care to other
5 patients in the office and hospital settings; and
6
7 Whereas, Administrative burdens are a leading cause of physician “burnout”; and
8
9 Whereas, The analytic data showing how the metrics which are required to be reported are
10 actually helping quality patient care is not provided; and
11
12 Whereas, Maintenance of Patient Centered Medical Home (PCMH) certification continually
13 requires additional metrics and “paper work” that takes time away from direct patient care;
14 therefore be it
15
16 RESOLVED, That our American Medical Association seek regulations which would reduce the
17 increasing strain that Patient Centered Medical Home (PCMH) metrics are placing on
18 physicians and patient care. (Directive to Take Action)

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

Received: 09/20/22

RELEVANT AMA POLICY

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

The Joint Commission Primary Care Home Initiative D-35.988

1. Our AMA Commissioners to The Joint Commission will strongly advocate that the requirements for any primary care home or medical home initiative of The Joint Commission strictly meet the requirements of the *Joint Principles of the Patient-Centered Medical Home* and more specifically that (1) each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care and (2) that a personal physician lead a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients. The *Joint Principles of the Patient-Centered Medical Home* were developed by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association and approved by the AMA.
2. Our AMA will continue to support the concept of physician-led teams within the patient centered medical home (PCMH) as outlined in the *Joint Principles of the Patient-Centered Medical Home*.
3. Our AMA will respond to The Joint Commission's interpretation of its primary care medical home certification standards addressing non-physician-led PCMHs.
4. Our AMA will oppose any interpretation by The Joint Commission, or any other entity, of primary care medical home or patient centered medical home (PCMH) as being anything other than MD/DO physician led.

Citation: (Res. 831, I-10; Reaffirmed: BOT Rep. 9, I-11; Appended: Res. 738, A-14)

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 804
(I-22)

Introduced by: New York

Subject: Centers for Medicare & Medicaid Innovation Projects

Referred to: Reference Committee J

1 Whereas, Centers for Medicare & Medicaid Services' (CMS) Center for Medicare & Medicaid
2 Innovation (CMMI), which has been developing proposals for new health care payment and
3 service delivery models, was given broad authority by the Affordable Care Act to scale up any of
4 these models for potential application to the entire Medicare program, without approval or
5 oversight by Congress; and
6

7 Whereas, Two of CMMI's models, the Direct Contracting Entities and Value-based Payment
8 Models, are designed in such a way as to incentivize the rationing and restricting of care for
9 senior patients and patients with disabilities; and
10

11 Whereas, The Direct Contracting Entities and Value-based Payment Models have not been
12 shown to improve quality of care or significantly reduce cost; therefore be it
13

14 RESOLVED, That our American Medical Association advocate against mandatory participation
15 in Centers for Medicare and Medicaid Innovation (CMMI) demonstration projects, and advocate
16 for CMMI instead to focus on the development of voluntary pilot projects (Directive to Take
17 Action); and be it further
18

19 RESOLVED, That our AMA advocate to ensure that any CMMI project that requires physician
20 and/or patient participation be required to be approved by Congress. (Directive to Take Action)

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

Received: 09/20/22

RELEVANT AMA POLICY

Medicare Physician Payment Reform D-390.961

1. Our AMA will continue to advocate for adequate investment in comparative effectiveness research that is consistent with AMA Policy H-460.909, and in effective methods of translating research findings relating to quality of care into clinical practice.
2. Our AMA will advocate for better methods of data collection, development, reporting and dissemination of practical clinical decision-making tools for patients and physicians, and rapid, confidential feedback about comparative practice patterns to physicians to enable them to make the best use of the information at the local and specialty level.
3. Our AMA urges physician organizations, including state medical associations and national medical specialty societies, to develop and recruit groups of physicians to experiment with diverse ideas for achieving Medicare savings, including the development of organizational structures that maximize participation opportunities for physician practices.

4. Our AMA will continue to advocate for changes in antitrust and other laws that would facilitate shared-savings arrangements, and enable solo and small group practices to make innovations that could enhance care coordination and increase the value of health care delivery.

5. Our AMA supports local innovation and funding of demonstration projects that allow physicians to benefit from increased efficiencies based on practice changes that best fit local needs.

6. Our AMA will work with appropriate public and private officials and advisory bodies to ensure that bundled payments, if implemented, do not lead to hospital-controlled payments to physicians.

Citation: CMS 6, A-09; Reaffirmation A-10; Reaffirmation I-13; CMS Rep. 5, I-16; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 805
(I-22)

Introduced by: Utah

Subject: COVID Vaccine Administration Fee

Referred to: Reference Committee J

- 1 Whereas, To assist the public health effort against SARS CoV2 virus in the US, health care
2 providers have contracted with the CDC to administer COVID-19 vaccines to patients and
3 community members; and
4
- 5 Whereas, Contracted COVID-19 vaccine providers are required to administer vaccine equitably
6 and to refrain from directly billing patients for the cost of administering the vaccine
7 (administration fee); and
8
- 9 Whereas, Providers previously billed the Health Resources and Services Administration (HRSA)
10 for the administration fee for uninsured patients; and
11
- 12 Whereas, Since the emergency funding appropriated by the HRSA was exhausted in April 2022,
13 HRSA ceased reimbursing the administration fee for uninsured citizens; and
14
- 15 Whereas, The US government has recently begun providing a reformulated bivalent COVID-19
16 vaccine booster to the US population; and
17
- 18 Whereas, A large portion of the US population is eligible for this bivalent COVID-19 booster; and
19
- 20 Whereas, Contracted COVID-19 vaccine providers will be expected to use their resources to
21 provide the bivalent booster; and
22
- 23 Whereas, The uninsured patients of physician offices can comprise 5 to 10% of their practice
24 and may be higher for those physician practices located in rural and underserved geographies;
25 and
26
- 27 Whereas, The lack of reimbursement from the federal government puts providers at financial
28 risk and may cause providers to no longer contract to be access points for their patients and
29 community members to receive COVID-19 vaccines; and
30
- 31 Whereas, The lack of access to providers who offer COVID-19 vaccines to uninsured patients is
32 an issue of health equity; therefore be it

1 RESOLVED, That American Medical Association policy D-440.981, “Appropriate
2 Reimbursements and Carve-outs for Vaccines,” be amended by addition to read as follows:

3
4 **Appropriate Reimbursements and Carve-outs for Vaccines D-440.981**

5 Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid
6 Services (CMS) and provide comment on the Medicare Program payment policy for
7 vaccine services; (2) continue to pursue adequate reimbursement for vaccines and
8 their administration from all public and private payers, including federal funds to
9 reimburse for administration of the COVID-19 vaccine to uninsured patients; (3)
10 encourage health plans to recognize that physicians incur costs associated with the
11 procurement, storage and administration of vaccines that may be beyond the average
12 wholesale price of any one particular vaccine; (4) seek legislation mandating that
13 health insurance companies in applicable states either adequately pay for vaccines
14 recommended by the Advisory Committee on Immunization Practices, or clearly state
15 in large bold font in their notices to patients and businesses that they do not follow the
16 federal advisory body on vaccine recommendations, the Advisory Committee on
17 Immunization Practices; and (5) advocate that a physician’s office can bill Medicare for
18 all vaccines administered to Medicare beneficiaries and that the patient shall only pay
19 the applicable copay to prevent fragmentation of care. (Modify Current HOD Policy)

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

Received: 09/23/22

RELEVANT AMA POLICY

Appropriate Reimbursements and Carve-outs for Vaccines D-440.981

Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers; (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; (4) seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on vaccine recommendations, the Advisory Committee on Immunization Practices; and (5) advocate that a physician’s office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care.

Citation: BOT Rep. 20, A-03; Reaffirmation A-07; Res. 128, A-09; Reaffirmation I-10;
Reaffirmed: Res. 807, I-11; Appended: Res. 217, A-19; Reaffirmed: CMS Rep. 3, I-20; Res.
408, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 806
(1-22)

Introduced by: Georgia

Subject: Healthcare Marketplace Plan Selection

Referred to: Reference Committee J

1 Whereas, Insurance plans purchased on the Healthcare Marketplace often have very narrow
2 networks; and

3

4 Whereas, These narrow networks often require patients to only see physicians within the county
5 in which the plan was purchased; and

6

7 Whereas, Patients are required to purchase a plan based on the county in which they reside;
8 and

9

10 Whereas, Some patients must pay for care in cash outside their plan to keep their doctor of
11 choice making their comprehensive plan more of an expensive catastrophic plan; and

12

13 Whereas, This limits patient choice by preventing patients from choosing their plan based on
14 access to their physician of choice; therefore be it

15

16 RESOLVED, That our American Medical Association advocate for patients to have expanded
17 plan options on the Healthcare Marketplace beyond the current options based solely on the zip
18 code of their primary residence or where their physician practices, including the interstate
19 portability of plans. (Directive to Take Action)

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

Received: 09/26/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 807
(I-22)

Introduced by: Georgia

Subject: Medicare Advantage Record Requests

Referred to: Reference Committee J

- 1 Whereas, Medicare Advantage rules for plans do not stipulate how record requests are handled,
2 nor any limits to number or repetitiveness of these requests; and
3
4 Whereas, Complying with these record requests can require extensive staff time and other
5 associated costs; and
6
7 Whereas, Practices are not reimbursed by Medicare Advantage companies for the staff time
8 involved in complying with these requests; and
9
10 Whereas, Each Medicare Advantage plan has different rules for record requests governed by
11 the contract between the plan and provider; therefore be it
12
13 RESOLVED, That our American Medical Association advocate for the relevant agencies and
14 stakeholders to prevent Medicare Advantage plans from requesting records from practices
15 solely to data mine for more funds and limit requests to 2% of plan participants, and otherwise
16 advocate that the plan will reimburse the practices for their efforts in obtaining additional
17 requested information. (Directive to Take Action)

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

Received: 09/26/22

RELEVANT AMA POLICY

Limiting Access to Medical Records H-315.987

Our AMA: (1) will pursue the adoption of federal legislation and regulations that will: limit third party payers' random access to patient records unrelated to required quality assurance activities; limit third party payers' access to medical records to only that portion of the record (or only an abstract of the patient's records) necessary to evaluate for reimbursement purposes; require that requests for information and completion of forms be delineated and case specific; allow a summary of pertinent information relative to any inquiry into a patient's medical record be provided in lieu of a full copy of the records (except in instances of litigation where the records would be discoverable); and provide proper compensation for the time and skill spent by physicians and others in preparing and completing forms or summaries pertaining to patient records; and (2) supports the policy that copies of medical records of service no longer be required to be sent to insurance companies, Medicaid or Medicare with medical bills. Citation: Sub. Res. 222, I-94; Appended: Res. 218, A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmed: BOT Rep. 06, A-16; Reaffirmed: BOT Rep. 16, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 808
(I-22)

Introduced by: Georgia
Subject: Reinstatement of Consultation Codes
Referred to: Reference Committee J

1 Whereas, In 2010, due to a perception of abuse or misuse of consult codes, Medicare
2 eliminated consult codes in what they calculated to be a revenue neutral manner, whereby they
3 increased the value of other evaluation and management (E+M) codes; and
4
5 Whereas, Medicare has proposed re-valuation of E+M codes, effective 2021 if finalized; and
6
7 Whereas, United Health Care (UHC) and Cigna are moving to eliminate consult codes; and
8
9 Whereas, The American Medical Association House of Delegates passed Resolution 819 in
10 2017, which passed without changes but has progressed negatively; and
11
12 Whereas, It appears cognitive care is undervalued; therefore be it
13
14 RESOLVED, That our American Medical Association proactively engage and advocate with any
15 commercial insurance company that discontinues payment for consultation codes or that is
16 proposing to or considering eliminating payment for such codes, requesting that the company
17 reconsider the policy change. (Directive to Take Action)

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

Received: 09/26/22

RELEVANT AMA POLICY

Medicare's Proposal to Eliminate Payments for Consultation Service Codes D-70.953

1. Our American Medical Association opposes all public and private payer efforts to eliminate payments for inpatient and outpatient consultation service codes, and supports legislation to overturn recent Center for Medicare & Medicaid Services' (CMS) action to eliminate consultation codes. 2. Our AMA will work with CMS and interested physician groups through the CPT Editorial Panel to address all concerns with billing consultation services either through revision or replacement of the current code sets or by some other means. 3. Our AMA will, at the conclusion of the CPT Editorial Panel's work to address concerns with billing consultation services, work with CMS and interested physician groups to engage in an extensive education campaign regarding appropriate billing for consultation services. 4. Our AMA will: (a) work with the Centers for Medicare & Medicaid Services to consider a two-year moratorium on RAC audit claims based on three-year rule violations for E/M services previously paid for as consultations; and (b) pursue Congressional action through legislation to reinstate payment for consultation codes within the Medicare Program and all other governmental programs. 5. Our AMA will petition the CMS to limit RAC reviews to less than one year from payment of claims.

Citation: Res. 807, I-09; Appended: Sub. Res. 212, I-10; Reaffirmation A-12; Appended: Res. 216, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-17

Consultation Codes and Private Payers D-385.955

1. Our AMA will proactively engage and advocate with any commercial insurance company that discontinues payment for consultation codes or that is proposing to or considering eliminating payment for such codes, requesting that the company reconsider the policy change.

2. Where a reason given by an insurance company for policy change to discontinue payment of consultation codes includes purported coding errors or abuses, our AMA will request the company carry out coding education and outreach to physicians on consultation codes rather than discontinue payment for the codes, and call for release of de-identified data from the company related to purported coding issues in order to help facilitate potential education by physician societies.

Citation: Res. 819, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 809
(I-22)

Introduced by: Senior Physicians Section

Subject: Uniformity and Enforcement of Medicare Advantage Plans and Regulations

Referred to: Reference Committee J

1 Whereas, Medicare Advantage plans must provide enrollees with coverage of all services
2 covered by Medicare Parts A and B, plus additional benefits beyond those covered by
3 Medicare; and
4

5 Whereas, Seniors are determining specifics of plans across the US, looking for uniformity to
6 compare policies in advance of enrollment; and
7

8 Whereas, Many seniors select Medicare Advantage plans because they have lower premiums
9 than Medicare; and
10

11 Whereas, When Medicare supplement plans cannot be used in Medicare Advantage, patients
12 are required to pay the copayments themselves; and
13

14 Whereas, Medicare Advantage plans often employ prior authorization and deny claims that
15 would have been paid if the patient had been in regular Medicare; and
16

17 Whereas, Many seniors have little interest in the choice of health plans and more of an interest
18 in the choice of physicians in their geographical areas; therefore be it
19

20 RESOLVED, That our American Medical Association advocate for better enforcement of
21 Medicare Advantage regulations to hold the Centers for Medicare & Medicaid Services (CMS)
22 accountable for presenting transparency of minimum standards and to determine if those
23 standards are being met for senior physicians and their patients (Reaffirm HOD Policy); and be
24 it further
25

26 RESOLVED, That our AMA advocate that Medicare Advantage plans be required to post all
27 components of Medicare covered in all plans across the US on their website along with
28 additional benefits provided (Directive to Take Action); and be it further
29

30 RESOLVED, That our AMA advocate that CMS provide an accurate, up-to-date list of
31 physicians and the plans with which they may or may not be accepting as well as if the practice
32 is no longer participating, continuing on with current patients, or taking new patients for plans
33 that they are contracted for under Medicare Advantage. (Directive to Take Action)

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

Received: 09/29/22

RELEVANT AMA POLICY

Medicare Advantage Policies H-285.913

Our AMA will:

1. pursue legislation requiring that any Medicare Advantage policy sold to a Medicare patient must include a seven-day waiting period that allows for cancellation without penalty;
2. pursue legislation to require that Medicare Advantage policies carry a separate distinct page, which the patient must sign, including the statement, "THIS COVERAGE IS NOT TRADITIONAL MEDICARE. YOU HAVE CHOSEN TO CANCEL YOUR TRADITIONAL MEDICARE COVERAGE; NOT ALL PHYSICIANS, HOSPITALS AND LABORATORIES ACCEPT THIS NEW MEDICARE ADVANTAGE POLICY AND YOU MAY PERMANENTLY LOSE THE ABILITY TO PURCHASE MEDIGAP SECONDARY INSURANCE" (or equivalent statement) and specifying the time period before they can resume their traditional Medicare coverage; and
3. petition the Centers for Medicare and Medicaid Services to implement the patient's signature page in a Medicare Advantage policy.

Citation: Res. 907, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmation: I-18

Prevent Medicare Advantage Plans from Limiting Care D-285.959

Our AMA will: (1) ask the Centers for Medicare and Medicaid Services to further regulate Medicare Advantage Plans so that the same treatment and authorization guidelines are followed for both fee-for-service Medicare and Medicare Advantage patients, including admission to inpatient rehabilitation facilities; and (2) advocate that proprietary criteria shall not supersede the professional judgment of the patient's physician when determining Medicare and Medicare Advantage patient eligibility for procedures and admissions. Citation: Res. 706, A-21;

Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans H-330.870

Our AMA will: (1) advocate for provision of transparent print and audio/video patient educational resources to patients and families in multiple languages from health care systems and from Medicare - directly accessible - by consumers and families, explaining clearly the different benefits, as well as the varied, programmatic and other out-of-pocket costs for their medications under Medicare, Medicare Supplemental and Medicare Advantage plans; (2) advocate for printed and audio/video patient educational resources regarding personal costs, changes in benefits and provider panels that may be incurred when switching (voluntarily or otherwise) between Medicare, Medical Supplemental and Medicare Advantage or other plans, including additional information regarding federal and state health insurance assistance programs that patients and consumers could access directly; and (3) advocate for increased funding for federal and state health insurance assistance programs and educate physicians, hospitals, and patients about the availability of and access to such programs.

Citation: Res. 817, I-19; Modified: Res. 125, A-22

Medicare Advantage Opt Out Rules H-330.913

Our AMA: (1) opposes managed care "bait and switch" practices, whereby a plan entices patients to enroll by advertising large physician panels and/or generous patient benefits, then reduces physician reimbursement and/or patient benefits, so that physicians leave the plan, but patients who can't must choose new doctors; (2) supports current proposals to extend the 30 day waiting period that limits when Medicare recipients may opt out of managed care plans, if such proposals can be amended to create an exemption to protect patients whenever a plan alters benefits or whenever a patient's physician leaves the plan; and (3) supports changes in CMS regulations which would require Medicare Advantage plans to immediately notify patients, whenever such a plan alters benefits or whenever a patient's physician leaves the plan, and to give affected patients a reasonable opportunity to switch plans.

Citation: Res. 707, A-99; Reaffirmed: CMS Rep. 5, A-09; Modified: CMS Rep. 01, A-19

Legislation for Assuring Equitable Participation of Physicians in Medicare Advantage H-330.916

Our AMA seeks to have the CMS, while contracting with Medicare Advantage organizations for Medicare services, require the following guarantees to assure quality patient care to medical beneficiaries: (1) a Medicare Advantage patient shall have the right to see a duly licensed physician of the appropriate training and specialty; (2) if CMS decertifies a Medicare Advantage plan, enrollees in that plan who are undergoing a course of treatment by a physician at the time of such termination shall continue to receive care from their treating physician until an appropriate transfer is accomplished; and (3) any Medicare Advantage plan deselection of participating physicians may occur only after the physician has been given the opportunity to appeal the deselection decision to an Independent Review Body.

Citation: Res. 707, I-98; Reaffirmed: BOT Rep. 23, A-09; Modified: CMS Rep. 01, A-19

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930

Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.

Citation: BOT Action in response to referred for decision Res. 711, I-06; Reaffirmation A-08; Modified: CMS Rep. 01, A-19;

Medicare Cost-Sharing D-330.951

Our AMA will urge the Centers for Medicare and Medicaid Services to require companies that participate in the Medicare Advantage program to provide enrollees and potential enrollees timely information in a comparable, standardized, and clearly-written format that details enrollment restrictions, as well as all coverage restrictions and beneficiary cost-sharing requirements for all services.

Citation: CMS Rep. 2, I-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmation: I-18

Support for Seamless Physician Continuity of Care H-390.836

Our AMA encourages physicians who encounter contractual difficulties with Medicare Advantage (MA) plans to contact their Centers for Medicare & Medicaid Services (CMS) Regional office.

Citation: BOT Action in response to referred for decision Res. 816, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 810
(I-22)

Introduced by: Senior Physicians Section
Subject: Medicare Drug Pricing and Pharmacy Costs
Referred to: Reference Committee J

1 Whereas, Many seniors look to the federal government to negotiate prices for prescription drugs
2 covered under Medicare; and
3
4 Whereas, For seniors 65 years of age and older, 40% have at least five prescription drugs,
5 compared with 23% of 50- to 64-year-olds and fewer than 10% of those under 50;¹ and
6
7 Whereas, With increased attention among policymakers towards prescription drug costs, a
8 February 2019 poll found that a majority of adults, including seniors, are in favor of policy
9 options to curb prescription drug costs;² and
10
11 Whereas, With the Inflation Reduction Act of 2022, the Centers for Medicare & Medicaid
12 Services (CMS) will be required to negotiate prices of certain prescription drugs beginning in
13 2026;³ and
14
15 Whereas, There are 510 different drugs recognized in the US, but the Inflation Reduction Act of
16 2022 requires CMS to negotiate the prices of only 10 drugs in 2026, 15 drugs in 2027 and 2028,
17 and 20 drugs in 2029 and each year after;⁴ and
18
19 Whereas, The pace of negotiating a miniscule number of prescription prices each year is not
20 beneficial to seniors or the general public; and
21
22 Whereas, The business model of making profits for pharmaceutical company's shareholders
23 should not be at the expense of generating profits; and
24
25 Whereas, Seniors should not be stretched to find funding for needed medications; therefore be
26 it
27
28 RESOLVED, That our American Medical Association advocate for immediate, timely and
29 transparent negotiations for how Medicare drug prices are set to be incorporated into law
30 (Directive to Take Action); and be it further
31
32 RESOLVED, That our AMA advocate to eliminate loopholes such as new usage for current
33 medications (commonly known as patent evergreening) (Directive to Take Action); and be it
34 further
35
36 RESOLVED, That our AMA advocate for a ban on direct-to-consumer advertising for
37 prescription drugs by no later than five years, in 2027. (Reaffirm HOD policy)

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

Received: 09/29/22

REFERENCES:

1. Kirzinger A, et al. KFF Health Tracking Poll - February 2019: Prescription Drugs. Internet Document : 1 Mar 2019. Available from: URL: <https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-february-2019-prescription-drugs/>
2. Kirzinger A, et al. KFF Health Tracking Poll - February 2019: Prescription Drugs. Internet Document : 1 Mar 2019. Available from: URL: <https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-february-2019-prescription-drugs/>
3. Congress.gov. "Text – H.R. 5376 – 117th Congress (2021-2022): Inflation Reduction Act of 2022." August 16, 2022. <http://www.congress.gov/>.
4. Congress.gov. "Text – H.R. 5376 – 117th Congress (2021-2022): Inflation Reduction Act of 2022." August 16, 2022. <http://www.congress.gov/>.

RELEVANT AMA POLICY

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

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

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.

Citation: CMS Rep. 05, A-19; Reaffirmed: CMS Rep. 6, 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.

Citation: (CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation A-14; Reaffirmed in lieu of Res. 229, I-14)

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)

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 811
(I-22)

Introduced by: Senior Physicians Section

Subject: Covering Vaccinations for Seniors through Medicare Part B

Referred to: Reference Committee J

1 Whereas, The recently passed Inflation Reduction Act of 2022 eliminates cost-sharing in
2 Medicare for vaccines; and

3

4 Whereas, Medicare coverage rules vary across vaccines as well as Parts B and D; and

5

6 Whereas, These differences can act as significant barriers to vaccination especially in different
7 socioeconomic groups of seniors; and

8

9 Whereas, It is difficult for physician practices to contract with multiple individual Medicare
10 Part D plans; therefore be it

11

12 RESOLVED, That our American Medical Association advocate that Medicare Part B cover the
13 full cost of all vaccinations administered to Medicare patients that are recommended by the
14 Advisory Committee on Immunization Practices (ACIP), the US Preventive Services Task Force
15 (USPSTF), or based on prevailing preventive clinical health guidelines. (Directive to Take
16 Action)

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

Received: 09/29/22

RELEVANT AMA POLICY

Medicare Prescription Drug and Vaccine Coverage and Payment D-330.898

Our AMA will: (1) continue to solicit input from national medical specialty societies and state medical associations for their recommendations to ensure adequate Medicare Part B drug reimbursement; (2) work with interested national medical specialty societies on alternative methods to reimburse physicians and hospitals for the cost of Part B drugs; and (3) continue working with interested stakeholders to improve the utilization rates of adult vaccines by individuals enrolled in Medicare.

Citation: CMS Rep. 3, I-20;

Reimbursement for Influenza Vaccine H-440.848

Our AMA: (1) will work with third party payers, including the Centers for Medicare and Medicaid Services, to establish a fair reimbursement price for the flu vaccine; (2) encourage the manufacturers of influenza vaccine to publish the purchase price by June 1st each year; (3) shall seek federal legislation or regulatory relief, or otherwise work with the federal government to increase Medicare reimbursement levels for flu vaccination and other vaccinations.

Citation: CSAPH Rep. 5, I-12; Reaffirmed: CSAPH Rep. 1, A-22

Financing of Adult Vaccines: Recommendations for Action H-440.860

1. Our AMA supports the concepts to improve adult immunization as advanced in the Infectious Diseases Society of America's 2007 document "Actions to Strengthen Adult and Adolescent Immunization Coverage in the United States," and support the recommendations as advanced by the National Vaccine Advisory Committee's 2008 white paper on pediatric vaccine financing.
2. Our AMA will advocate for the following actions to address the inadequate financing of adult vaccination in the United States:

Provider-related

- a. Develop a data-driven rationale for improved vaccine administration fees.
- b. Identify and explore new methods of providing financial relief for adult immunization providers through, for example, vaccine company replacement systems/deferred payment/funding for physician inventories, buyback for unused inventory, and patient assistance programs.
- c. Encourage and facilitate adult immunization at all appropriate points of patient contact; e.g., hospitals, visitors to long-term care facilities, etc.
- d. Encourage counseling of adults on the importance of immunization by creating a mechanism through which immunization counseling alone can be reimbursed, even when a vaccine is not given.

Federal-related

- a. Increase federal resources for adult immunization to: (i) Improve Section 317 funding so that the program can meet its purpose of improving adult immunizations; (ii) Provide universal coverage for adult vaccines and minimally, uninsured adults should be covered; (iii) Fund an adequate universal reimbursement rate for all federal and state immunization programs.
- b. Optimize use of existing federal resources by, for example: (i) Vaccinating eligible adolescents before they turn 19 years of age to capitalize on VFC funding; (ii) Capitalizing on public health preparedness funding.
- c. Ease federally imposed immunization burdens by, for example: (i) Providing coverage for Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B; (ii) Creating web-based billing mechanisms for physicians to assess coverage of the patient in real time and handle the claim, eliminating out-of-pocket expenses for the patient; (iii) Simplifying the reimbursement process to eliminate payment-related barriers to immunization.
- d. The Centers for Medicare & Medicaid Services should raise vaccine administration fees annually, synchronous with the increasing cost of providing vaccinations.

State-related

- a. State Medicaid programs should increase state resources for funding vaccines by, for example: (i) Raising and funding the maximum Medicaid reimbursement rate for vaccine administration fees; (ii) Establishing and requiring payment of a minimum reimbursement rate for administration fees; (iii) Increasing state contributions to vaccination costs; and (iv) Exploring the possibility of mandating immunization coverage by third party payers.
- b. Strengthen support for adult vaccination and appropriate budgets accordingly.

Insurance-related

1. Provide assistance to providers in creating efficiencies in vaccine management by: (i) Providing model vaccine coverage contracts for purchasers of health insurance; (ii) Creating simplified rules for eligibility verification, billing, and reimbursement; (iii) Providing vouchers to patients to clarify eligibility and coverage for patients and providers; and (iv) Eliminating provider/public confusion over insurance payment of vaccines by universally covering all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines.
- b. Increase resources for funding vaccines by providing first-dollar coverage for immunizations.
- c. Improve accountability by adopting performance measurements.
- d. Work with businesses that purchase private insurance to include all ACIP-recommended immunizations as part of the health plan.
- e. Provide incentives to encourage providers to begin immunizing by, for example: (i) Including start up costs (freezer, back up alarms/power supply, reminder-recall systems, etc.) in the formula for reimbursing the provision of immunizations; (ii) Simplifying payment to and encouraging immunization by nontraditional providers; (iii) Facilitating coverage of vaccines administered in complementary locations (e.g., relatives visiting a resident of a long-term care facility).

Manufacturer-related

Market stability for adult vaccines is essential. Thus: (i) Solutions to the adult vaccine financing problem should not deter research and development of new vaccines; (ii) Solutions should consider the maintenance of vibrant public and private sector adult vaccine markets; (iii) Liability protection for manufacturers should be assured by including Vaccine Injury Compensation Program coverage for all ACIP-recommended adult vaccines; (iv) Educational outreach to both providers and the public is needed to improve acceptance of adult immunization.

3. Our AMA will conduct a survey of small- and middle-sized medical practices, hospitals, and other medical facilities to identify the impact on the adult vaccine supply (including influenza vaccine) that results from the large contracts between vaccine manufacturers/distributors and large non-government purchasers, such as national retail health clinics, other medical practices, and group purchasing programs, with particular attention to patient outcomes for clinical preventive services and chronic disease management.

Citation: CSAPH Rep. 4, I-08; Reaffirmation I-10; Reaffirmation: I-12; Reaffirmation I-14; Reaffirmed: CMS Rep. 3, I-20; Reaffirmation: A-22

Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875

1. It is AMA policy that all persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as soon as possible following publication of these recommendations in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR).

2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.

3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.

4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ACIP-recommended vaccines, and the timely distribution of ACIP-recommended vaccines to providers).

5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ACIP-recommended vaccines.

6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.

7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.

8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.

9. Until compliance of AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.

10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines.

Citation: BOT Action in response to referred for decision Res. 524, A-06; Reaffirmation A-07; Appended: Res. 531, A-07; Reaffirmation A-09; Reaffirmed: Res. 501, A-09; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 422, A-11; BOT action in response to referred for decision Res. 422, A-11;

Reaffirmation: I-12; Appended: Res. 227, I-12; Appended: Res. 824, I-14; Reaffirmed: Res. 411, A-17; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 228, A-21; Reaffirmation: A-22

Appropriate Reimbursements and Carve-outs for Vaccines D-440.981

Our AMA will: (1) continue to work with the Centers for Medicare and Medicaid Services (CMS) and provide comment on the Medicare Program payment policy for vaccine services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers; (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; (4) seek legislation mandating that health insurance companies in applicable states either adequately pay for vaccines recommended by the Advisory Committee on Immunization Practices, or clearly state in large bold font in their notices to patients and businesses that they do not follow the federal advisory body on vaccine recommendations, the Advisory Committee on Immunization Practices; and (5) advocate that a physician's office can bill Medicare for all vaccines administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care. Citation: BOT Rep. 20, A-03; Reaffirmation A-07; Res. 128, A-09; Reaffirmation I-10; Reaffirmed: Res. 807, I-11; Appended: Res. 217, A-19; Reaffirmed: CMS Rep. 3, I-20; Res. 408, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 812
(I-22)

Introduced by: Resident and Fellow Section

Subject: Implant-Associated Anaplastic Large Cell Lymphoma

Referred to: Reference Committee J

- 1 Whereas, In 2016, the World Health Organization provisionally classified breast implant-
2 associated anaplastic large cell lymphoma (BIA-ALCL) as a T-cell lymphoma¹; and
3
4 Whereas, Policies concerning breast cancer treatment do not encompass BIA-ALCL given that
5 this cancer is a lymphoma; and
6
7 Whereas, The 2019 National Comprehensive Cancer Care Network consensus guidelines state
8 clearly that, “Essential to the treatment of BIA-ALCL is timely diagnosis and complete surgical
9 excision.”²; and
10
11 Whereas, Patients with BIA-ALCL suffer delays in care as they fight with their insurance
12 companies to cover surgery to remove the cancer and their breast implants, as the insurance
13 company may initially classify the surgery as cosmetic and not cover it,³ therefore be it
14
15 RESOLVED, That our American Medical Association support appropriate coverage of cancer
16 diagnosis, treating surgery and other systemic treatment options for implant-associated
17 anaplastic large cell lymphoma. (New HOD Policy)

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

Received: 09/30/22

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2. Mark W Clemens, MD, FACS, Eric D Jacobsen, MD, Steven M Horwitz, MD “2019 NCCN Consensus Guidelines on the Diagnosis and Treatment of Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL).” *Aesthetic Surgery Journal*. 2019, 39 (Supplement 1):S3–S13.
3. Denise Grady. A shocking diagnosis: breast implants 'gave me cancer.' *The New York Times*. 2017 May 14. Available at: <https://www.nytimes.com/2017/05/14/health/breast-implants-cancer.html>

RELEVANT AMA POLICY

Breast Implants H-525.984

Our AMA: (1) supports that individuals be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose; and (2) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated.

Citation: CSA Rep. M, I-91; Modified: Sunset Report, I-01; Reaffirmed: Res. 727, I-02; Modified: CSAPH Rep. 1, A-12; Modified: CSAPH Rep. 1, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 813
(I-22)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island,
Vermont, Washington

Subject: Amending Policy on a Public Option to Maximize AMA Advocacy

Referred to: Reference Committee J

- 1 Whereas, The Patient Protection and Affordable Care Act of 2010 (ACA) reduced the
2 uninsurance rate in the United States but has not achieved universal coverage^{1,2}; and
3
4 Whereas, Tens of millions of Americans are either uninsured or underinsured with insurance
5 that is too expensive to actually be used, significantly limiting their access to affordable
6 healthcare³⁻⁵; and
7
8 Whereas, Many individual insurance plans offered on the ACA's Health Insurance Marketplaces
9 (hereafter referred to as "ACA Exchanges") have high premiums, deductibles, and other out-of-
10 pocket costs that leave beneficiaries exposed to financial risk and limit their access to
11 healthcare services^{2,6-8}; and
12
13 Whereas, Some ACA Exchanges, particularly those covering rural areas, offer only a small
14 number of plans that are limited by very few insurers participating, which has been shown to
15 lead to higher costs and faster premium growth due to limited competition⁹⁻¹³; and
16
17 Whereas, Plans offered on the ACA Exchanges frequently have narrow provider networks,
18 which reduces access to care and can lead to high out-of-pocket costs if patients go out-of-
19 network¹⁴⁻¹⁶; and
20
21 Whereas, A federally-managed public insurance plan ("public option") has been proffered as a
22 mechanism to improve competition, increase access to affordable healthcare, and lower costs,
23 particularly in areas where there are few participating insurers and a commensurate lack of
24 competition between plans^{8,17-19}; and
25
26 Whereas, A recent analysis from the Urban Institute found that various public option proposals
27 with different eligibility criteria and payment rates would all decrease the uninsured rate,
28 significantly reduce premiums, and reduce the federal deficit²⁰; and
29
30 Whereas, RAND modeled four different scenarios under which a public option could be
31 implemented and found that under all scenarios, premium costs in the public option were lower
32 than in private plans, leading to more people being covered²¹; and
33
34 Whereas, A Commonwealth Fund analysis of various healthcare reform proposals found that a
35 public option would reduce the uninsured rate and significantly reduce costs to the federal
36 government, permitting the implementation of more generous premium tax credits that could
37 further reduce the uninsurance rate²²; and

1 Whereas, A public option would have significant leverage during price negotiations with
2 hospitals, pharmaceutical companies, pharmacy benefit managers, and other healthcare
3 providers due to its large size and would likely have lower administrative costs per beneficiary
4 than smaller private plans, leading to lower premiums and cost-sharing for beneficiaries and
5 lower costs to the federal government^{9,21,23,24}; and
6

7 Whereas, A 2021 CBO report on key design considerations for a public option showed that the
8 benchmark premium for insurance plans offered on the ACA Exchanges is closely correlated
9 with the number of insurers participating in the market with more insurers leading to lower
10 premiums, suggesting that the public option, as an additional insurer, would reduce premiums
11 for public and private insurers alike²⁵; and
12

13 Whereas, Though there are concerns that a public option may reduce overall physician
14 reimbursement through lower provider payment rates, CBO estimates of the impacts of
15 Medicare-for-All proposals on physician reimbursement show that lower provider payment rates
16 may be balanced by increased healthcare utilization after the expansion of public insurance
17 programs, leading to small overall changes in physician reimbursement and a net increase in
18 some scenarios^{28,29}; and
19

20 Whereas, Recent studies published by the CBO, JAMA, and AAFP have discussed the inherent
21 tradeoffs between lowering costs through reduced provider reimbursement and developing
22 provider networks attractive enough to convince prospective beneficiaries to enroll in the public
23 option, highlighting how careful design of a public option can maximize benefit to patients and
24 physicians alike³⁰⁻³²; and
25

26 Whereas, The state of Washington created a public option-like program called Cascade Care in
27 2019 that designed overall reimbursement to exceed no more than 160% of Medicare rates with
28 a minimum reimbursement of 135% of Medicare rates for primary care practices, showing how a
29 public option can be designed to reduce costs and expand coverage in ways that do not unduly
30 burden physicians^{33,34}; and
31

32 Whereas, The AMA passed Policy H-165.823 in November 2020, which lays out a variety of
33 criteria that a public option should meet, but does not go so far as to explicitly support a public
34 option; and
35

36 Whereas, H-165.823 already contains provisions to protect physicians and their practices,
37 including a requirement that the public option not tie participation to participation in other public
38 insurance programs, a requirement that contracts with physicians must be subject to meaningful
39 negotiation, and a requirement that reimbursement exceed prevailing Medicare rates and be at
40 levels sufficient to sustain the costs of medical practice; and
41

42 Whereas, Based in large part upon on this policy, the AMA recently sent a letter to Congress
43 regarding a public option, which highlighted the standards codified in H-165.823 while failing to
44 mention the potential benefits or explicitly endorse a public option³⁵; and
45

46 Whereas, multiple physician groups, including the American College of Physicians, American
47 Academy of Family Physicians, American Academy of Pediatrics, American College of
48 Obstetricians and Gynecologists, American Osteopathic Association, American Psychiatric
49 Association, and the Society of General Internal Medicine, have endorsed a public option³⁶⁻³⁸;
50 therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-165.823, “Options to
2 Maximize Coverage under the AMA Proposal for Reform”, by addition and deletion to read as
3 follows:
4

- 5 1. Our AMA will advocate ~~that any~~for a public option to expand health insurance
6 coverage ~~must that~~ meets the following standards:
7 a. The primary goals of establishing a public option are to maximize patient choice of
8 health plan and maximize health plan marketplace competition.
9 b. Eligibility for premium tax credit and cost-sharing assistance to purchase the
10 public option is restricted to individuals without access to affordable employer-
11 sponsored coverage that meets standards for minimum value of benefits.
12 c. Physician payments under the public option are established through meaningful
13 negotiations and contracts. Physician payments under the public option must be
14 higher than prevailing Medicare rates and at rates sufficient to sustain the costs of
15 medical practice.
16 d. Physicians have the freedom to choose whether to participate in the public option.
17 Public option proposals should not require provider participation and/or tie physician
18 participation in Medicare, Medicaid and/or any commercial product to participation in
19 the public option.
20 e. The public option is financially self-sustaining and has uniform solvency
21 requirements.
22 f. The public option does not receive advantageous government subsidies in
23 comparison to those provided to other health plans.
24 g. The public option shall be made available to uninsured individuals who fall into the
25 “coverage gap” in states that do not expand Medicaid – having incomes above
26 Medicaid eligibility limits but below the federal poverty level, which is the lower limit
27 for premium tax credits – at no or nominal cost. (Modify Current HOD Policy)

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

Received: 10/04/22

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RELEVANT AMA POLICY

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

1. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:

- a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
- b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
- c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
- d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
- e. The public option is financially self-sustaining and has uniform solvency requirements.
- f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
- g. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

2. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:

- a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
- b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children’s Health Insurance Program (CHIP) or zero-premium marketplace coverage.
- c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
- d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
- e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
- f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
- g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
- h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.

3. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.

Citation: CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: Res. 122, A-22

Universal Health Coverage H-165.904

Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans

Citation: Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 1, A-22

Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

- A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
- B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
- C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
- D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
- E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
- F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
- G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
- H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

Citation: Res. 118, I-91; Res. 102, I-92; BOT Rep. NN, I-92; BOT Rep. S, A-93; Reaffirmed: Res. 135, A-93; Reaffirmed: BOT Reps. 25 and 40, I-93; Reaffirmed in lieu of Res. 714, I-93; Res. 130, I-93; Res. 316, I-93; Sub. Res. 718, I-93; Reaffirmed: CMS Rep. 5, I-93; Res. 124, A-94; Reaffirmed by BOT Rep.1- I-94; CEJA Rep. 3, A-95; Reaffirmed: BOT Rep. 34, I-95; Reaffirmation A-00; Reaffirmation A-01; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CME Rep. 2, A-03; Reaffirmed and Modified: CMS Rep. 5, A-04; Reaffirmed with change in title: CEJA Rep. 2, A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation I-07; Reaffirmed in lieu of Res. 113, A-08; Reaffirmation A-09; Res. 101, A-09; Sub. Res. 110, A-09; Res. 123, A-09; Reaffirmed in lieu of Res. 120, A-12; Reaffirmation: A-17

Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
 - a. Health insurance coverage for all Americans
 - b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
 - c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
 - d. Investments and incentives for quality improvement and prevention and wellness initiatives
 - e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
 - f. Implementation of medical liability reforms to reduce the cost of defensive medicine
 - g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
 - a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
 - b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
 - c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
 - d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
 - e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
 - f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

Citation: Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 814
(I-22)

Introduced by: American College of Cardiology, American Society of Echocardiography, American Society of Nuclear Cardiology, Heart Rhythm Society, Society for Cardiovascular Angiography and Interventions, Society of Cardiovascular Computed Tomography, Texas

Subject: Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?

Referred to: Reference Committee J

- 1 Whereas, A coronary artery calcium score (CACS) measured by computed tomography is a
2 noninvasive, low-radiation diagnostic test that correlates with cardiovascular outcomes¹; and
3
4 Whereas, Screening with CACS can help guide the course of clinical management in the
5 borderline-and intermediate-risk patients with 10-year cardiovascular risk of 5% to
6 20%, particularly those with risk-enhancing factors, e.g., chronic kidney disease, metabolic
7 syndrome, an elevated high sensitivity C-reactive protein, a positive ankle-brachial index, or a
8 positive family history^{2,3} by the American College of Cardiology and American Heart Association
9 2019 Primary Prevention Guidelines; and
10
11 Whereas, CACS is not covered by insurance except in the state of Texas⁴, and the out-of-
12 pocket costs range from \$49-\$1209, which may represent a barrier for patients who may not be
13 able to afford the test, but are likely to derive benefit from the results of the test; and
14
15 Whereas, A low-cost and no-charge CACS strategy has been tested in Cleveland, Ohio⁵,
16 demonstrating a striking increase in CACS utilization in lower income patients, the black
17 population, and women; therefore be it
18
19 RESOLVED, That our American Medical Association seek national and/or state legislation
20 and/or a national coverage determination (NCD) to include coronary artery calcium scoring
21 (CACS) for patients who meet the screening criteria set forth by the American College of
22 Cardiology/American Heart Association 2019 Primary Prevention Guidelines, as a first-dollar
23 covered preventive service, consistent with the current policy in the state of Texas (Directive to
24 Take Action); and be it further
25
26 RESOLVED, That our AMA collaborate with the appropriate stakeholders to propose that
27 hospitals strongly consider a no cost/nominal cost option for CACS in appropriate patients who
28 are unable to afford this test, as a means to enhance disease detection, disease modification
29 and management. (Directive to Take Action)

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

Received: 10/04/22

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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

1 Whereas, The American Hospital Association (AHA) Patient Billing Guidelines state that health
2 care organizations have a responsibility to communicate effectively with patients and provide
3 resources for patients wishing to discuss their payments; in the event of a nonpayment, the AHA
4 guidelines recommend giving patients 30 days prior notice of any actions a hospital will take as
5 a result¹⁰; and
6

7 Whereas, The AHA Patient Billing Guidelines state that health care organizations working with
8 third-party debt collectors should ensure that the collectors adhere to the Fair Debt Collection
9 Practices Act (FDCPA), which establishes guidelines meant to prevent abusive debt practice
10 against consumers¹⁰; and
11

12 Whereas, AMA Policy H-385.963 encourages physicians to ensure no debt collection is sent to
13 a patient without the physician's knowledge and to practice compassion and discretion when
14 sending collection; and
15

16 Whereas, Our AMA currently lacks policy addressing the practice of debt litigation directly
17 conducted by health care organizations; therefore be it
18

19 RESOLVED, That our American Medical Association oppose the practice of health care
20 organizations pursuing litigation against patients due to medical debt, and encourages health
21 care organizations to consider the relative financial benefit of collecting medical debt to their
22 revenue, against the detrimental cost to a patient's well-being (New HOD Policy); and be it
23 further
24

25 RESOLVED, That our AMA encourage health care organizations to manage medical debt with
26 patients directly and consider several options, including discounts, payment plans with flexibility
27 and extensions as needed, or forgiveness of debt altogether, before resorting to third-party debt
28 collectors or any punitive actions (New HOD Policy); and be it further
29

30 RESOLVED, That our AMA encourage health care organizations to consider the American
31 Hospital Association Patient Billing Guidelines when faced with patients struggling to finance
32 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

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

3
4 Whereas, Approximately 14% of adults under 65 covered by Medicaid have a form of
5 diabetes³²; and

6
7 Whereas, Retrospective analysis of patients prescribed to a professional CGM for T2DM
8 showed no statistically significant increase in total annual costs compared to those who were
9 not prescribed a professional CGM, but did see an improvement in hemoglobin A1c (HbA1c)
10 without intensification of the current treatment regimen^{19,33}; and

11
12 Whereas, While long-term cost effectiveness studies have demonstrated CGMs' potential to
13 decrease overall costs for patients with T2DM through elimination of test strips and lancets, a
14 majority of financial benefit is due to lower HbA1c readings and mitigation of direct diabetes
15 related complications such as hospitalizations, emergency room visits, non-diabetes
16 prescription medications, and indirect costs such as hampered productivity, which collectively
17 account for 73.1% of total diabetes care cost^{17,33}; and

18
19 Whereas, The lowest-cost option among CGMs, with an out-of-pocket price of less than \$100
20 for uninsured individuals, are an alternative non-invasive glucose monitor called flash glucose
21 monitoring which provides glucose readings on demand and allows for downloadable glucose
22 data, and use has been found to decrease acute diabetes-related events and all-cause inpatient
23 hospitalizations in patients with T2DM treated with short or rapid acting insulin³⁴⁻³⁶; and

24
25 Whereas, Patients with T2DM treated with oral agents are often placed on a basal-bolus
26 regimen of insulin while admitted to the hospital for glucose control, and use of flash glucose
27 monitoring in these patients during admission demonstrated lower average daily glucose and
28 increased detection of hypoglycemia^{37,38}; and

29
30 Whereas, CGMs have been able to provide increased insight into nocturnal glucose levels,
31 glucose metabolism during exercise and feeding, and relative impact of medications on ambient
32 glucose than any form of episodic self-monitoring of blood glucose for all patients with diabetes,
33 and CGM users spent significantly less time in hypoglycemic ranges compared to their self-
34 monitoring of blood glucose counterparts^{17,39}; and

35
36 Whereas, AMA Directive D-185.983 asks our AMA Board of Trustees to consider a legal
37 challenge, if appropriate, to the authority of the Centers for Medicare & Medicaid Services
38 (CMS) and other health care insurers placing onerous barriers on diabetic patients to procure
39 medically necessary "durable medical equipment and supplies"; and

40
41 Whereas, Certain CGMs which require adjunctive therapy are deemed "non-therapeutic" and
42 thus are ineligible to be classified as durable medical equipment (DME) and supplies, despite
43 their ability to influence medical decision making⁴⁰; and

44
45 Whereas, CMS Proposal CMS-1739-P includes a section on reclassifying "therapeutic" and
46 "non-therapeutic" CGMs as DME, as access to DME has been associated with better outcomes
47 and significantly lower healthcare spending due to patients' ability to receive care at home, and
48 variations in Medicaid definitions of DME have been linked to variations in geographic
49 healthcare expenditure^{40,41}; and

1 Whereas, Increased eligibility and access to all glucose monitors, including CGM and flash
2 glucose monitoring, would provide improved, cost-effective health care outcomes for low-
3 income patients with diabetes on Medicaid and Medicare^{19,33-35,37,38}, and
4

5 Whereas, Medicaid and public state medical insurance expansions that include CGM devices
6 have been demonstrated to improve glycemic control and reduce disparities in pediatric patients
7 with type 1 diabetes^{42,43}, and
8

9 Whereas, Current AMA policy H-330.885 supports coverage of CGM for Medicare patients with
10 insulin-dependent diabetes but does not address Medicaid or CHIP; therefore be it
11

12 RESOLVED, That our American Medical Association advocate for broadening the classification
13 criteria of Durable Medical Equipment to include all clinically effective and cost-saving diabetic
14 glucose monitors (Directive to Take Action); and be it further
15

16 RESOLVED, That our AMA amend AMA Policy H-330.885, “Medicare Coverage of Continuous
17 Glucose Monitoring Devices for Patients with Insulin-Dependent Diabetes,” by addition and
18 deletion to read as follows:
19

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

22 Our AMA supports efforts to achieve ~~Medicare~~ coverage of continuous and flash
23 glucose monitoring systems for all patients with insulin-dependent diabetes by all
24 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

1 Whereas, The Cancer Drug Parity Act (originally introduced in the House of Representatives
2 and Senate in 2019, and later re-introduced in 2021) promotes equal coverage of intravenous
3 and oral medications and prohibits insurance companies from making an inequitable distinction
4 between oral and intravenous forms of chemotherapy drugs but has still not been passed in the
5 US Congress⁵; and
6

7 Whereas, Coverage requirements for private health insurance companies are regulated by the
8 federal government through the Public Health Service Act (PHSA), the Employee Retirement
9 Income Security Act of 1974 (ERISA), and the Internal Revenue Code (IRC)¹²; and
10

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

14 Whereas, Oral parity is supported by numerous organizations including the American Society of
15 Clinical Oncology (ASCO), the Leukemia and Lymphoma Society, and Susan G. Komen Breast
16 Cancer Foundation^{11,14,15}; and
17

18 Whereas, Existing AMA policy H-55.986 supports financial reimbursement of chemotherapy and
19 antibiotic drugs at home via infusion or injection, but does not extend coverage to oral therapies;
20 therefore be it
21

22 RESOLVED, That our American Medical Association amend policy H-55.986, "Home
23 Chemotherapy and Antibiotic Infusions," by addition to read as follows:
24

25 H-55.986 - HOME CHEMOTHERAPY AND ANTIBIOTIC INFUSIONS

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

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

Received: 10/12/22

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3. Doshi JA, Li P, Huo H, Pettit AR, Armstrong KA. Association of patient out-of-pocket costs with prescription abandonment and delay in fills of novel oral anticancer agents. *J Clin Oncol*. 2018;36(5):476-482.
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14. Parity in Anticancer Drugs. American Society of Clinical Oncology. Accessed April 9, 2021. <https://www.asco.org/sites/new-www.asco.org/files/content-files/about-asco/pdf/2016-oral-parity-issue-brief.pdf>
15. Cancer Drug Parity Act. Susan G. Komen Foundation. Accessed April 9, 2021. <https://komencolorado.org/wp-content/uploads/2017/12/2017-Cancer-Drug-Parity-Act-Fact-Sheet-FINAL.pdf>

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

1 Whereas, Colorectal cancer is the third leading cause of cancer death for both men and
2 women, with an estimated 52,980 persons in the US projected to die of colorectal cancer in
3 2021¹; and
4

5 Whereas, There is sufficient evidence to suggest early detection and screening of colorectal
6 cancer can reduce mortality²³⁴⁵; and
7

8 Whereas, The incidence of colorectal cancer in adults aged 40 to 49 years has increased by
9 almost 15% from 2000-2002 to 2014-2016; and
10

11 Whereas, In 2016, 25.6% of eligible adults in the US had never been screened
12 for colorectal cancer⁶; and
13

14 Whereas, The primary barriers to patients not receiving the recommended screenings at age
15 45-49: lack of physician follow-up, mistrust of medical institutions, and lack of insurance
16 coverage⁷⁸⁹¹⁰; are risk factors modifiable by way of advocacy from Our AMA; and
17

18 Whereas, Our AMA supports physician engagement with patients to share decision-making on
19 screening efforts (H-55.981, last modified 2018) and improving prevention via insurance
20 coverage for screening tests (H-330.877, last modified 2018) and encourages appropriate
21 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

Reference Committee K

CSAPH Report(s)

- 01 Drug Shortages: 2022 Update
- 02 Climate Change and Human Health

Resolution(s)

- 902 Reducing the Burden of Incarceration on Public Health
- 904 Immigration Status is a Public Health Issue
- 905 Minimal Age of Juvenile Justice Jurisdiction in the United States
- 906 Requirement for COVID-19 Vaccination in Public Schools Once Fully FDA-Authorized
- 907 A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury
- 908 Older Adults and the 988 Suicide and Crisis Timeline
- 909 Decreasing Gun Violence and Suicide in Seniors
- 910 Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use
- 911 Critical Need for National ECC System to Ensure Individualized, State-Wide, care for STEMI, CS and OHCA, and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies
- 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

* Contained in the Handbook Addendum

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-I-22

Subject: Drug Shortages: 2022 Update

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee K

1 INTRODUCTION

2

3 American Medical Association (AMA) Policy H-100.956, “National Drug Shortages,” directs the
4 Council on Science and Public Health (CSAPH) to evaluate the drug shortage issue, including the
5 impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and
6 report back at least annually to the House of Delegates (HOD) on progress made in addressing drug
7 shortages in the United States. This report provides an update on continuing trends in national drug
8 shortages and ongoing efforts to further evaluate and address this critical public health issue.

9

10 METHODS

11

12 English-language reports were selected from a PubMed and Google Scholar search from
13 September 2019 to August 2022, using the text term “drug shortages.” Additional articles were
14 identified by manual review of the references cited in these publications. Further information was
15 obtained from the internet sites of the U.S. Food and Drug Administration (FDA), National
16 Academies of Sciences, Engineering, and Medicine (NASEM), U.S. Department of Health and
17 Human Services (HHS), American Society of Health-System Pharmacists (ASHP), and Duke
18 Margolis Center for Health Policy.

19

20 BACKGROUND

21

22 CSAPH has issued twelve reports on drug shortages, with the most recent published at the
23 November 2021 Special Meeting.¹ The findings and conclusions of the first five reports are
24 summarized in CSAPH Report 2-I-15, “National Drug Shortages: Update.” The remainder of this
25 report will provide an update on drug shortages since the 2021 report was developed, including
26 specific comment on issues associated with the role of pharmacy benefit managers (PBMs).

27

28 CURRENT TRENDS IN DRUG SHORTAGES

29

30 Drug shortages remain an ongoing public health concern in the United States and the AMA
31 continues to monitor the situation and take action when appropriate. Overall, new drug shortages
32 are decreasing; however, a large number of shortages are still ongoing and pose continued
33 problems for patient care. Additionally, new shortages may occur as manufacturing capacity in the
34 pharmaceutical industry is prioritized during the continuing COVID-19 and monkeypox public
35 health emergencies, specifically for the production of vaccines and treatments.

36

37 The two primary data sources for information on drug shortages in the United States continue to be
38 the Drug Shortage Program at the FDA and the Drug Shortage Resource Center maintained by

1 ASHP in cooperation with the University of Utah Drug Information Service (see Box 1 for links to
2 these resources).^{2,3} It should be noted that FDA resources also include guidance on drugs which
3 have had their use dates extended while a known shortage is ongoing.

4
5 According to current ASHP statistics (see Appendix 1), the downward trend in new drug shortages
6 over the last few years has continued. At its peak in 2011, there were 267 new drug shortages
7 reported; in 2021, there were 114. For the first 6 months of 2022, there have been 81 newly
8 reported shortages. However, while the number of new shortages may be decreasing each year, the
9 number of active drug shortages has stayed relatively steady (282 active shortages in Q2 2019, 264
10 shortages in Q2 2022), indicating that individual shortages are taking longer to resolve. For the first
11 two quarters of 2022, the five classes of drugs with the most ongoing shortages include: central
12 nervous system drugs (40 total), fluids and electrolytes (36), antimicrobials (30), cardiovascular
13 (27), and hormones (19). Fluids and electrolytes were not present in last year's top five classes of
14 drug shortages, indicating a surge in products currently facing shortage.

15
16 In addition, the number of manufacturers reporting the underlying cause of the drug shortage as
17 "unknown" has continued to decrease, from 82 percent in 2019 to 42 percent in 2021. Compared to
18 2020, "business decision" has decreased as well from 14 percent to 4 percent in 2021. Behind
19 "unknown," "supply/demand" was listed as the second most common reason (27 percent) for drug
20 shortages by manufacturers in 2021. Beyond issues with manufacturing, ASHP has also reported
21 that hospitals are having difficulty staffing their pharmacies with experienced staff to proactively
22 identify, prevent and alleviate gaps in supply.⁴

23 24 *The Food and Drug Administration*

25
26 The FDA continues to utilize a mobile app to provide up-to-date access to information about drugs
27 in shortage as well as notifications about new and resolved drug shortages. This mobile app also
28 gives physicians the ability to report a drug shortage. The FDA Drug Shortages webpage includes a
29 current shortages list, a link to the mobile app, and additional information (Box 1).

30
31 The ninth annual report on drug shortages from the FDA to Congress published in early 2022
32 summarizes the major actions the FDA took in calendar year 2021 related to drug shortages.⁵
33 During the COVID-19 public health emergency, the FDA continued to closely monitor the medical
34 product supply chain and as expected, the supply chain was impacted by the pandemic, leading to
35 supply disruptions or shortages of drug products in the United States. Appendix 2 includes a
36 breakdown of the FDA's calendar year 2021 metrics, including the number of expedited reviews
37 (274) and expedited inspections (29).

38 39 *The Essential Medicines Report*

40
41 In May 2022, HHS and the Assistant Secretary for Preparedness and Response (ASPR) released the
42 first Essential Medicines Supply Chain and Manufacturing Resilience Assessment.⁶ A critical
43 function of this report was to prioritize drugs for increased scrutiny from a previously developed
44 list of essential medicines.⁷ In their report, a group of stakeholders identified 86 medications as
45 critical or important for minimum acute patient care with no other alternative available. Of the
46 drugs identified, 56 drugs (65 percent) at the time of publication were in shortage as described by
47 the ASHP database. Within their report, the group outlines six challenges for addressing drug
48 shortages: market structure, global competition, labor/workforce, manufacturing processes, supply
49 chain/distribution, and regulatory barriers.

1 *The Drug Enforcement Administration*

2
3 Outside of the FDA, HHS and ASPR, the Drug Enforcement Administration (DEA) is another
4 critical federal agency that impacts drug shortages. As part of its regulatory authority under the
5 Controlled Substances Act, the DEA maintains a closed system around the manufacturing of
6 Schedule I and II drugs, as well as List I chemicals (ephedrine, pseudoephedrine and
7 phenylpropanolamine). This closed system means that the DEA requires the registration and
8 continuous oversight of any entity involved in the manufacturing and distribution supply chain of
9 these drugs, including a strict quota on the volume and quantity of a controlled substance that can
10 be manufactured at a given time. Per the DEA, this quota is intended “prevent, detect, and
11 investigate the diversion of controlled pharmaceuticals and listed chemicals from legitimate
12 sources while ensuring an adequate and uninterrupted supply for legitimate medical, commercial,
13 and scientific needs.”⁸ The FDA and DEA have an ongoing memorandum of understanding to
14 share information regarding information that may impact drug shortages.⁹

15
16 However, there have been several instances where DEA quotas have either directly or indirectly
17 caused a drug shortage of a critically necessary medication. For example, in 2019 the DEA
18 proposed a 53 percent decrease to the overall quota of Schedule II opioids that could be
19 manufactured in 2020.¹⁰ However, by the spring of 2020, there was a surge in demand for
20 injectable opioids to help patients on ventilators fighting COVID-19.

21
22 In response to a 2020 joint letter from AMA, ASHP and other stakeholders,¹¹ the DEA increased
23 the manufacturing quota by 15 percent, yet injectable fentanyl, hydromorphone, and morphine are
24 all still classified as active shortages by ASHP in 2022.¹² Other drugs, such as mixed amphetamine
25 salts for the treatment of attention deficit hyperactivity disorder, are similarly facing decreases in
26 DEA manufacturing quotas while under an active drug shortage.

27
28 In light of the opioid crisis, in which medications that help prevent overdose are underprescribed
29 nationwide, supply restrictions may have significant unintended consequences. The potential
30 benefit of supply reduction is that it may discourage the diversion of controlled substances. The
31 potential harm of supply reduction is that patients may suffer serious harm when needed
32 medications are unavailable for any reason. Your Council on Science and Public Health is currently
33 unaware of any evidence that the overall benefits of supply reductions outweigh the overall harms.

34
35 *Pharmacy Benefit Managers*

36
37 At the AMA 2022 Annual Meeting, the topic of PBMs and their role in driving drug shortages was
38 specifically raised. PBMs, which serve as an intermediary between health insurers and
39 pharmaceutical companies, have long been a source of scrutiny by our AMA, with a multitude of
40 policies directly calling for oversight or reform of PBM activities.

41
42 Concern around PBMs and drug shortages is the potential for manipulating price and access to
43 medications. However, these claims cannot be tested as PBM pricing information has historically
44 been opaque, but that may be changing. On June 7, 2022, the Federal Trade Commission (FTC)
45 announced that it has launched an investigation into vertically integrated PBMs and has specifically
46 cited issues around PBM-owned pharmacies and prior authorizations.¹³ In April 2022, prior to the
47 FTC’s decision, the AMA sent a letter urging the FTC to take action and increase PBM
48 transparency.¹⁴ Additional bipartisan legislation, the Pharmacy Benefit Manager Transparency Act
49 of 2022, was introduced on May 24, 2022, and at the time of writing is pending review by the
50 Senate Commerce, Science and Transportation committee. In its current form, the PBM

1 Transparency Act would require, among other things, for PBMs to file annual reports with the FTC
2 on many of their practices.¹⁵

3
4 Beyond possible manipulations of cost and access, other PBM practices may exacerbate drug
5 shortages or otherwise impact the ability of a practice to mitigate shortages. For example, PBMs
6 may utilize techniques known as “brown bagging,” in which a health plan requires a patient to
7 obtain a medication from a PBM-owned specialty pharmacy and then bring it to the clinic for the
8 practitioner to administer. Previously, the Council on Medical Service has investigated the issue of
9 brown bagging medications in the context of patient care.¹⁶ In the context of drug shortages, brown
10 bagging decreases visibility of the supply chain for hospitals and practices; they are unable to
11 predict which medications are to be needed when, and as such may be unable to procure or
12 adequately plan for future demand.

13 14 *Monkeypox Vaccines*

15
16 Amidst the monkeypox public health emergency, there is currently a shortage of vaccinations
17 available in the United States. Two vaccines may be used for the prevention of monkeypox
18 disease.¹⁷ The JYNNEOS vaccine, a third-generation vaccine produced by a small European
19 biotech company, Bavarian Nordic, is approved for the prevention of monkeypox and smallpox
20 disease and the ACAM2000 vaccine, produced by Baxter, is approved for immunization against
21 smallpox disease and made available for use against monkeypox under an Expanded Access
22 Investigational New Drug (EA-IND) protocol. In the United States, there is a large supply of
23 ACAM2000, but this vaccine has more known side effects and contraindications.¹⁸ JYNNEOS is
24 the primary vaccine being used in the U.S monkeypox outbreak.

25
26 After its FDA approval in 2019, the Strategic National Stockpile (SNS) was reportedly supposed to
27 procure 120 million doses of JYNNEOS, enough to immunize sixty million people as one element
28 of the U.S. government’s smallpox preparedness efforts.¹⁹ However, as with other supplies in the
29 national stockpile, JYNNEOS inventory was not maintained to an appropriate level due to chronic
30 underfunding as well as the redirection of funds to other purposes, such as shelter for 20 thousand
31 unhoused migrant children at the southern border.^{20,21} With a shelf-life of 3 years, millions of doses
32 of JYNNEOS in the SNS had expired.²² Only 2,400 doses of the JYNNEOS vaccine were available
33 in the immediate holdings of the SNS at the onset of the current monkeypox outbreak.²³ More than
34 1.1 million doses of the vaccine purchased by the U.S. government were at Bavarian Nordic’s
35 facility in Denmark and required authorization from an on-site FDA inspection before they could
36 be shipped to the U.S.²⁴

37
38 To help alleviate the shortage, the FDA granted emergency use authorization for intradermal
39 administration of JYNNEOS, which utilizes approximately one-fifth of the total volume of vaccine
40 compared to currently approved subcutaneous administration.²⁵ In addition, the administration has
41 increased efforts to boost domestic manufacturing, including partnerships with Michigan-based
42 facilities to perform filling and finishing to expedite the distribution of previously ordered
43 vaccines.²⁶

44 45 CURRENT AMA DRUG SHORTAGE ACTIVITIES

46
47 AMA staff continue to remain engaged in drug shortage activities. Staff are involved in a multi-
48 stakeholder effort to remain current on policies, drug shortage and supply chain issues, and to
49 develop group recommendations on the topics. The effort includes our AMA, the ASHP, the
50 American Hospital Association (AHA), the United States Pharmacopeia (USP), the American
51 Society of Anesthesiologists (ASA), and the American Society of Clinical Oncology (ASCO).

1 Earlier this year, our AMA additionally sent a letter to leadership of the Senate Committee on
2 Health, Education, Labor and Pensions to advocate for legislation modernizing the medical supply
3 chain.²⁷ In the letter, the AMA called upon Congress to, among other things:

- 4
- 5 • Incentivize advanced manufacturing technology and develop new continuous
- 6 manufacturing technology for critical drugs and active pharmaceutical ingredients;
- 7 • Improve the function and composition of the Strategic National Stockpile;
- 8 • Improve multinational cooperation on supply chain resilience;
- 9 • Incentivize quality and resilience; and
- 10 • Replicate asks for critical drug manufacturing transparency and oversight for medical
- 11 devices and ancillary supplies (e.g., PPE).

12

13 CONCLUSION

14

15 The rate of new medical product shortages is decreasing, but individual shortages are lasting
16 longer. Due to the ongoing COVID-19 and monkeypox public health emergencies, the medical
17 supply chain has been under intense, increased scrutiny. The AMA's drug shortage policy is timely
18 and already addresses a variety of issues that are under consideration by the White House, FDA,
19 and other stakeholders. Additional policy modifications have been recommended to reflect ongoing
20 efforts by other organizations interacting with the drug manufacturing space, such as the DEA and
21 FTC.

22

23 RECOMMENDATIONS

24

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

27

28 1. Policy H-100.956, "National Drug Shortages" be amended by addition to read as follows:

- 29
- 30 1. Our AMA considers drug shortages to be an urgent public health crisis, and recent
- 31 shortages have had a dramatic and negative impact on the delivery and safety of
- 32 appropriate health care to patients.
- 33
- 34 2. Our AMA supports recommendations that have been developed by multiple stakeholders to
- 35 improve manufacturing quality systems, identify efficiencies in regulatory review that can
- 36 mitigate drug shortages, and explore measures designed to drive greater investment in
- 37 production capacity for products that are in short supply, and will work in a collaborative
- 38 fashion with these and other stakeholders to implement these recommendations in an
- 39 urgent fashion.
- 40
- 41 3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human
- 42 Services (DHHS) to expedite facility inspections and the review of manufacturing changes,
- 43 drug applications and supplements that would help mitigate or prevent a drug shortage.
- 44
- 45 4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or
- 46 Congress require drug manufacturers to establish a plan for continuity of supply of vital
- 47 and life-sustaining medications and vaccines to avoid production shortages whenever
- 48 possible. This plan should include establishing the necessary resiliency and redundancy in
- 49 manufacturing capability to minimize disruptions of supplies in foreseeable circumstances
- 50 including the possibility of a disaster affecting a plant.

- 1 5. The Council on Science and Public Health shall continue to evaluate the drug shortage
2 issue, including the impact of group purchasing organizations and pharmacy benefit
3 managers on drug shortages, and report back at least annually to the House of Delegates on
4 progress made in addressing drug shortages.
5
- 6 6. Our AMA urges continued analysis of the root causes of drug shortages that includes
7 consideration of federal actions, evaluation of manufacturer, Group Purchasing
8 Organization (GPO), pharmacy benefit managers, and distributor practices, contracting
9 practices by market participants on competition, access to drugs, pricing, and analysis of
10 economic drivers, and supports efforts by the Federal Trade Commission to oversee and
11 regulate such forces.
12
- 13 7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs
14 by ensuring that such products are not removed from the market or caused to stop
15 production due to compliance issues unless such removal is clearly required for significant
16 and obvious safety reasons.
17
- 18 8. Our AMA supports the view that wholesalers should routinely institute an allocation
19 system that attempts to fairly distribute drugs in short supply based on remaining inventory
20 and considering the customer's purchase history.
21
- 22 9. Our AMA will collaborate with medical specialty society partners and other stakeholders
23 in identifying and supporting legislative remedies to allow for more reasonable and
24 sustainable payment rates for prescription drugs.
25
- 26 10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving
27 pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to
28 determine whether such an activity has the potential to worsen drug shortages.
29
- 30 11. Our AMA urges the FDA to require manufacturers to provide greater transparency
31 regarding the pharmaceutical product supply chain, including production locations of
32 drugs, and provide more detailed information regarding the causes and anticipated duration
33 of drug shortages.
34
- 35 12. Our AMA supports the collection and standardization of pharmaceutical supply chain data
36 in order to determine the data indicators to identify potential supply chain issues, such as
37 drug shortages.
38
- 39 13. Our AMA encourages global implementation of guidelines related to pharmaceutical
40 product supply chains, quality systems, and management of product lifecycles, as well as
41 expansion of global reporting requirements for indicators of drug shortages.
42
- 43 14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing
44 technologies such as continuous pharmaceutical manufacturing.
45
- 46 15. Our AMA supports the concept of creating a rating system to provide information about
47 the quality management maturity, resiliency and redundancy, and shortage mitigation
48 plans, of pharmaceutical manufacturing facilities to increase visibility and transparency
49 and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and

- 1 purchasers to contractually require manufacturers to disclose their quality rating, when
2 available, on product labeling.
3
- 4 16. Our AMA encourages electronic health records (EHR) vendors to make changes to their
5 systems to ease the burden of making drug product changes.
6
- 7 17. Our AMA urges the FDA to evaluate and provide current information regarding the quality
8 of outsourcer compounding facilities.
9
- 10 18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine
11 and consider drug shortages as a national security initiative and include vital drug
12 production sites in the critical infrastructure plan.
13
- 14 19. Our AMA urges the Drug Enforcement Administration and other federal agencies to
15 regularly communicate and consult with the FDA regarding regulatory actions which may
16 impact the manufacturing, sourcing, and distribution of drugs and their ingredients.
17 (Modify Current HOD Policy)
18
- 19 2. That Policy H-440.847, "Pandemic Preparedness," which addresses the adequacy of the
20 Strategic National Stockpile, be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Less than \$1,000

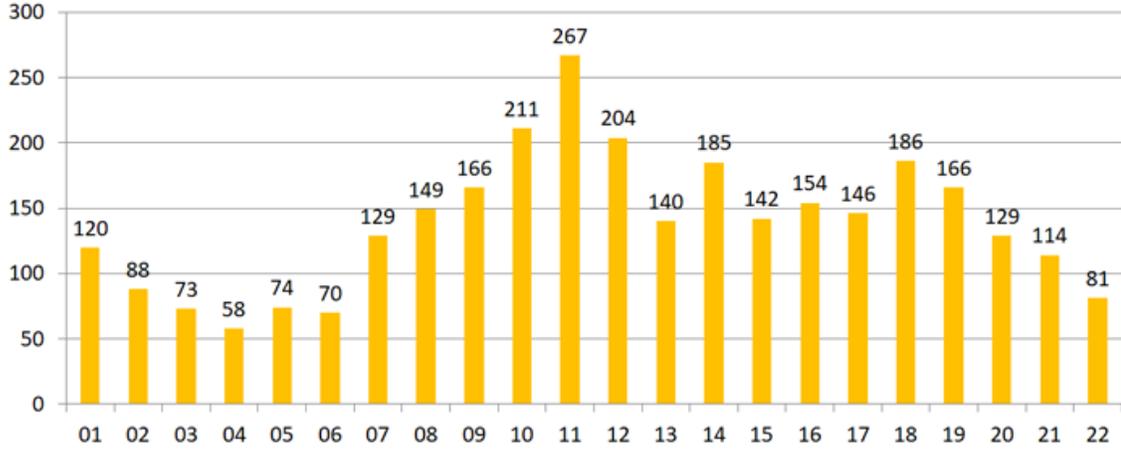
Box 1. Resources available to assist in mitigation of drug shortages.

1. [ASHP Resource Center](#)
2. ASHP [list](#) of current shortages
3. [FDA Drug Shortages Page](#) (includes current shortages list, extended use dates, mobile app, and additional information)

APPENDIX 1

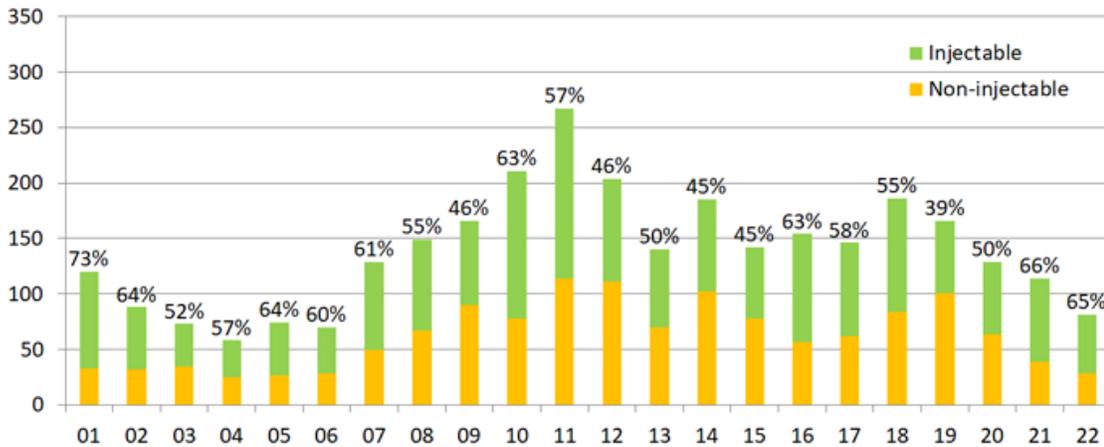
ASHP/University of Utah Drug Information Service Drug Shortage Data

Figure 1. National Drug Shortages: New Shortages by Year: January 2001 to June 30, 2022



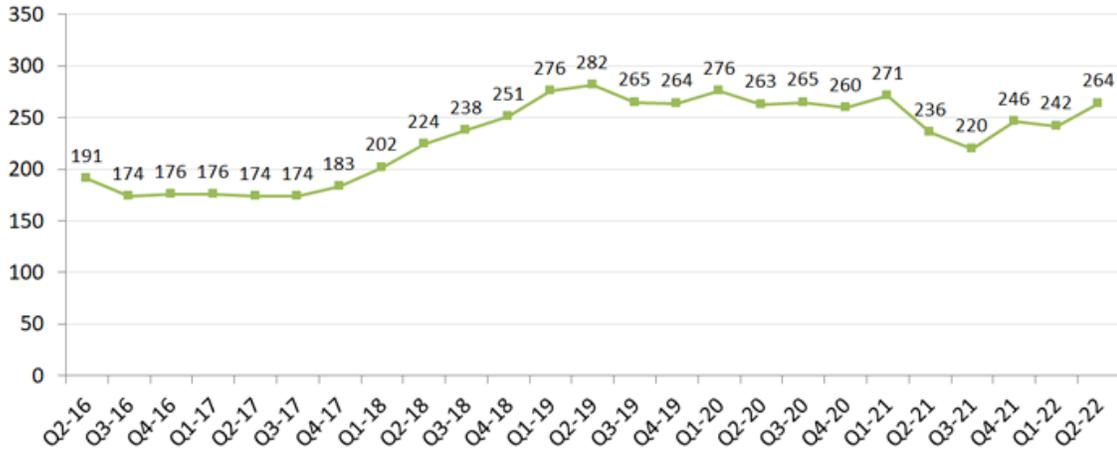
Note: Each column represents the number of new shortages identified during that year.
 University of Utah Drug Information Service
 Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

Figure 2. National Drug Shortages: New Shortages by Year - Percent Injectable: January 2001 to June 30, 2022, % Injectable



Note: Each column represents the number of new shortages identified during that year.
 University of Utah Drug Information Service
 Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

Figure 3. National Drug Shortages: Active Shortages by Quarter: 5 Year Trend

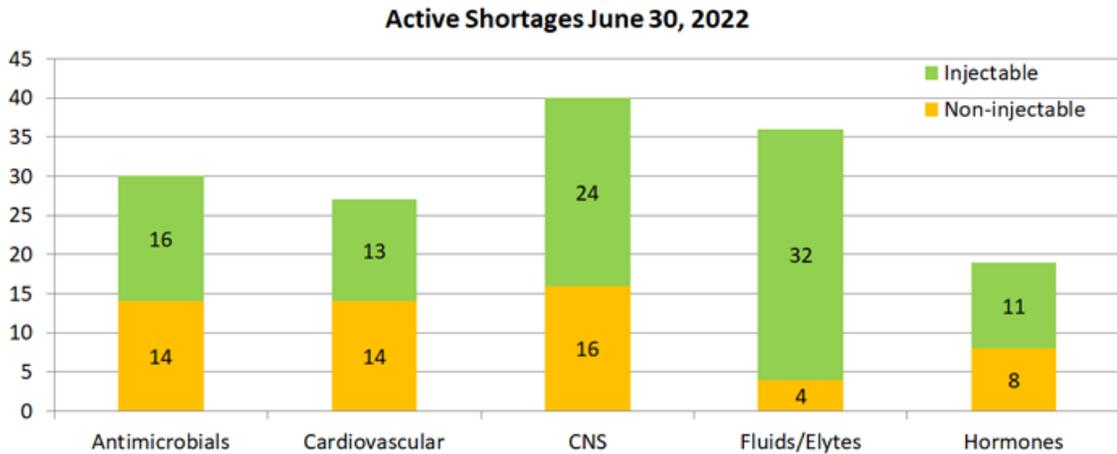


Note: Each point represents the number of active shortages at the end of each quarter.

University of Utah Drug Information Service

Contact: Erin.Fox@hsc.utah.edu, @foxeirinr for more information.

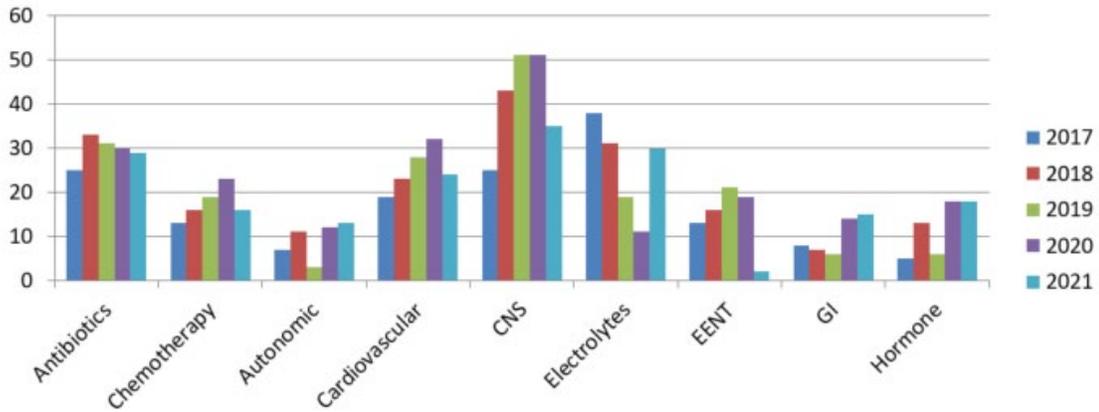
Figure 4. National Drug Shortages: Active Shortages Top 5 Drug Classes



University of Utah Drug Information Service

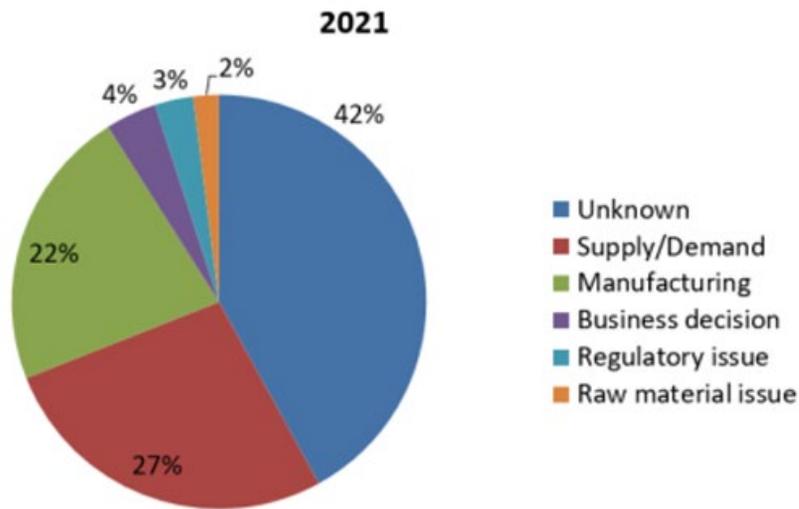
Contact: Erin.Fox@hsc.utah.edu, @foxeirinr for more information.

Figure 5. National Drug Shortages: Common Drug Classes in Short Supply: 5 Year Trend



University of Utah Drug Information Service
 Contact: Erin.Fox@hsc.utah.edu, @foxeinr for more information.

Figure 6. National Drug Shortages: Reasons for Shortages as Reported by Manufacturers During UUDIS Investigation — 2021



University of Utah Drug Information Service
 Contact: Erin.Fox@hsc.utah.edu, @foxeinr for more information.

APPENDIX 2

Breakdown of CDER's and CBER's Shortage Numbers, CY 2021

	CDER	CBER
New Shortages	38	3
Prevented Shortages	303	14
Ongoing Shortages	79	4
Notifications	744	33
No. of Manufacturers Notifying	98	23
ACTIONS TAKEN TO MITIGATE SHORTAGES		
Regulatory Flexibility and Discretion	97	0
Expedited Reviews	260	14*
Expedited Inspections	29	0

* This number includes expedited reviews for eight biologics license application (BLA)/BLA supplements and six lot-release submissions for CBER-regulated products.

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REPORT 02 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-22)
Climate Change and Human Health
(Reference Committee K)

EXECUTIVE SUMMARY

Objective. The Council on Science and Public Health initiated this report due to the significant public health threat that climate change represents and the impact on the health of patients, with marginalized populations expected to be disproportionately impacted. The Council’s last update on climate change was CSAPH Report 3-I-08, “Global Climate Change and Human Health.”

Methods. Sentinel reports on climate, global climate change, and human health were reviewed including the Intergovernmental Panel on Climate Change (IPCC) assessment reports, *Lancet* Countdown on Health and Climate Change reports, reports from the World Health Organization (WHO), the Environmental Protection Agency (EPA), and the National Oceanic and Atmospheric Administration (NOAA). English language articles were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from January 2012 to June 2022 using the search terms: “climate change and health,” “climate crisis and health,” “decarbonization and health,” and “climate change and equity.” Additional articles were also identified by manual review of the reference lists of pertinent publications. Websites managed by federal agencies, applicable professional organizations, and foundations were reviewed for relevant information

Results. It is unequivocal that human influence has warmed the atmosphere, ocean and land. The scale of recent changes across the climate system are unprecedented over many centuries. Human-induced climate change is affecting weather and climate extremes in every region across the globe. The extent and magnitude of climate change impacts are larger than previously estimated and they are causing severe and widespread disruption in nature and in society; reducing our ability to grow nutritious food or provide enough clean drinking water, thus affecting people's health and well-being and damaging livelihoods. Limiting global warming to 1.5 degrees Celsius would require “rapid and far-reaching” transitions in land, energy, industry, buildings, transport, and cities.

Conclusion. Impacts from climate change on extreme weather, air quality, and the transmission of disease increasingly threaten the health and well-being of people in the U.S., and it is widely recognized that many of the impacts of warming will disproportionately impact the most vulnerable. The health effects of climate change include increased allergies, asthma, respiratory and cardiovascular disease; injuries and premature deaths related to extreme weather events; heat-related deaths due to continued warming; changes in the prevalence and geographical distribution of food- and water-borne illnesses and other infectious diseases, and threats to mental health.

To meet the Paris Agreement goals and prevent catastrophic levels of global warming, global GHG emissions must decline by half within a decade. Emissions are declining too slowly or heading in the wrong direction in the highest emitting sectors. This delay in progress is contributing to millions of deaths each year. The U.S. health care sector is responsible for an estimated 8.5 percent of national carbon emissions. These emissions stem from the operations of health care facilities (scope 1), from both purchased sources of energy, heating, and cooling (scope 2) and from the supply chain of health care goods and services (scope 3). The U.S. health sector accounts for 25 percent of global health sector emissions—the highest proportion attributable to any individual country’s health sector. Physician’s pledge to do no harm, it’s time for the health sector to do the same by addressing the climate crisis and protecting public health

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-I-22

Subject: Climate Change and Human Health

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee K

1 The Council on Science and Public Health initiated this report due to the significant public health
2 threat that climate change represents and the impact on the health of patients, with marginalized
3 populations expected to be disproportionately impacted. The Council’s last update on climate
4 change was CSAPH Report 3-I-08, “Global Climate Change and Human Health.”
5

6 The Council’s 2008 report recognized that ongoing adverse global climate change is widely
7 accepted by the majority of scientists, climatologists, and meteorologists, and human activity is
8 influencing the rate and extent of this process. The report noted that the extent of climate change
9 will depend on many factors, most notably, changes in global greenhouse gas (GHG) emissions.
10 Anthropogenic contributions to global climate change exist, and the International Panel on Climate
11 Change (IPCC), as well as many other reports, make a compelling case for linkage between these
12 events. The report concluded the potential exists for devastating events with serious health
13 implications, including extreme heat and cold events, flooding and droughts, increases in vectors
14 carrying infectious diseases, and greater air pollution. Furthermore, the report noted the health
15 effects from these events should be of concern to the medical community and require action. The
16 report called on the health care community to advocate for public health policies that recognize and
17 mitigate climate risk and strengthen health services, as well as improve communication and
18 coordination at regional and international levels.
19

20 While the American Medical Association (AMA) House of Delegates (HOD) has adopted
21 numerous policies on climate changes since 2008, the Council initiated this report with
22 acknowledgement that an update on this topic is long overdue. There is growing recognition of the
23 impacts of climate change on health, with record-breaking heat waves, wildfires, droughts, and
24 devastating floods impacting our patients and our communities and a limited window to act. We
25 acknowledge that additional reports on the topics of climate mitigation and adaptation will be
26 necessary but have decided to focus this report on the health effects of climate change and
27 decarbonization. We also want to recognize that the AMA Board of Trustees (BOT) is working on
28 a strategic plan on climate change, which will be presented to the HOD at the 2023 Annual
29 Meeting. The BOT will also consider Resolution 605-A-22, which called for the AMA to establish
30 a climate crisis campaign, determine high-yield advocacy and leadership opportunities, and
31 centralize our AMA’s efforts towards environmental justice and an equitable transition to a net-
32 zero carbon neutral society. We hope that this report informs the strategy being developed by the
33 BOT.
34

35 EXISTING AMA POLICY

36
37 In June 2022, the AMA declared climate change a public health crisis that threatens the health and
38 well-being of all individuals and called on the AMA to protect patients by advocating for policies

1 that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas
2 emissions aimed at carbon neutrality by 2050, and (c) support rapid implementation and
3 incentivization of clean energy solutions and significant investments in climate resilience through a
4 climate justice lens. The policy also called on the AMA to develop a strategic plan for how we will
5 enact our climate change policies including advocacy priorities and strategies to decarbonize
6 physician practices and the health sector with report back to the House of Delegates at the 2023
7 Annual Meeting. (D-135.966, “Declaring Climate Change a Public Health Crisis”)

8
9 AMA policy supports scientific findings that the Earth is undergoing adverse climate change which
10 will create conditions that affect public health and will have a disproportionate impact on
11 vulnerable populations, including children, the elderly, and the poor (H-135.938, “Global Climate
12 Change and Human Health”). Accordingly, our AMA supports increased climate change education
13 so physicians may understand the health risks that climate change poses and counsel patients on
14 how to protect themselves from those health risks (H-135.919, “Climate Change Education Across
15 the Medical Education Continuum”). It is the policy of the AMA to encourage physicians to
16 implement programs in their practices that promote environmental sustainability and communicate
17 these practices to their patients and their community (H-135.923, “AMA Advocacy for
18 Environmental Sustainability and Climate”). Additionally, the AMA will urge physicians to
19 become spokespersons for environmental stewardship (H-135.969, “Environmental Health
20 Programs”).

21
22 With respect to air pollution and GHG reduction, the AMA urges the enactment of comprehensive
23 legislation to address adverse health effects that are the product of air pollution (H-135.984,
24 “Federal Clean Air Legislation”). The AMA encourages the US EPA to use its authority to regulate
25 GHG emissions and limit carbon dioxide emissions. The AMA believes the coordinated efforts of
26 the government along with industry and the public is the best way to minimize air pollution
27 (H-135.999, “Federal Programs”).

28 29 METHODS

30
31 Sentinel reports on climate, global climate change, and human health were reviewed including the
32 Intergovernmental Panel on Climate Change (IPCC) assessment reports, *Lancet* Countdown on
33 Health and Climate Change reports, reports from the World Health Organization (WHO), the
34 Environmental Protection Agency (EPA), and the National Oceanic and Atmospheric
35 Administration (NOAA).

36
37 English language articles were selected from searches of the PubMed, Google Scholar, and
38 Cochrane Library databases from January 2012 to June 2022 using the search terms: “climate
39 change and health,” “climate crisis and health,” “decarbonization and health,” and “climate change
40 and equity.” Additional articles were also identified by manual review of the reference lists of
41 pertinent publications. Websites managed by federal agencies, applicable professional
42 organizations, and foundations were reviewed for relevant information.

43 44 DEFINITIONS

45
46 Adaptation is “taking action to prepare for and adjust to both the current and projected impacts of
47 climate change.”¹

48
49 Climate change is “a long-term change in the average weather patterns that have come to define
50 Earth’s local, regional and global climates.”²

1 Decarbonization means “switching from the use of fossil fuels such as coal, natural gas or oil to
2 carbon-free and renewable energy sources.”
3

4 Global warming is “the long-term heating of Earth’s surface observed since the pre-industrial
5 period (between 1850 and 1900) due to human activities, primarily fossil fuel burning, which
6 increases heat-trapping greenhouse gas levels in Earth’s atmosphere. This term is not
7 interchangeable with the term “climate change.”³
8

9 Greenhouse gases (GHGs) are gases that trap heat in the atmosphere.⁴ GHGs emitted in the US
10 include carbon dioxide (79 percent), methane (11 percent), nitrous oxide (7 percent), and
11 fluorinated gases (3 percent).⁵
12

13 THE INTERGOVERNMENTAL PANEL ON CLIMATE CHANGE (IPCC)

14

15 The IPCC is the United Nations body for assessing the science related to climate change. Limiting
16 global warming to no more than 2 degrees Celsius above pre-industrial levels was the *de facto*
17 target for global policymakers at the UN’s 2010 climate conference in Cancun, Mexico. In 2015,
18 scientists warned that the 2 degrees Celsius limit was not adequate for avoiding some of the more
19 severe impacts of climate change and reducing the limit to 1.5 degrees Celsius would be
20 preferable.⁶
21

22 *The Paris Agreement*

23

24 The Paris Agreement is a legally binding international treaty on climate change. It was adopted by
25 196 Parties at the UN Climate Change Conference of the Parties (COP) 21, on December 12, 2015,
26 and entered into force on November 4, 2016.⁷ Its goal is to limit global warming to well below 2,
27 preferably to 1.5 degrees Celsius, compared to pre-industrial levels. To achieve this goal, countries
28 aim to reach global peaking of greenhouse gas emissions as soon as possible to achieve a climate
29 neutral world by mid-century. The Paris Agreement is important because for the first time, a
30 binding agreement brings all nations into a common cause to undertake ambitious efforts to combat
31 climate change and adapt to its effects.
32

33 *Special Report on Global Warming of 1.5°C*

34

35 In 2018, the IPCC issued a special report on the impacts of global warming of 1.5 degrees Celsius
36 above pre-industrial levels and related GHG emission pathways contained in the Paris Agreement.⁸
37 The report concluded the global climate has changed relative to the pre-industrial period, and there
38 is evidence that these changes have had impacts on organisms and ecosystems, as well as on human
39 systems and well-being.⁹ Human activities are estimated to have caused approximately 1.0 degree
40 Celsius of global warming above pre-industrial levels, with a likely range of 0.8 to 1.2 degrees
41 Celsius.¹⁰ Risks to natural and human systems are expected to be lower at 1.5 degrees Celsius than
42 at 2 degrees Celsius of global warming. This is true for heat-related morbidity and mortality and for
43 ozone-related mortality if emissions needed for ozone formation remain high. Global warming is
44 likely to reach 1.5 degree Celsius between 2030 and 2052 if it continues to increase at the current
45 rate.¹¹ The report finds that limiting global warming to 1.5 degrees Celsius would require “rapid
46 and far-reaching” transitions in land, energy, industry, buildings, transport, and cities.¹² Global net
47 human-caused emissions of carbon dioxide would need to fall by about 45 percent from 2010
48 levels by 2030, reaching ‘net zero’ around 2050. The report also recognized that many of the
49 impacts of warming will fall disproportionately on the poor and vulnerable.

1 *The Sixth Assessment Cycle*

2
3 To date the IPCC has released three reports during this cycle. The Synthesis Report for this cycle is
4 scheduled to be released in late 2022 or early 2023. Below are the high-level findings from the
5 Sixth Assessment reports.

6
7 The Physical Science Basis¹³ (2021). It is unequivocal that human influence has warmed the
8 atmosphere, ocean and land. The scale of recent changes across the climate system as a whole are
9 unprecedented over many centuries to many thousands of years. Human-induced climate change is
10 already affecting many weather and climate extremes in every region across the globe. Evidence of
11 observed changes in extremes such as heatwaves, heavy precipitation, droughts, and tropical
12 cyclones, and their attribution to human influence, has strengthened. Global warming of 1.5 and 2
13 degrees Celsius will be exceeded during the 21st century unless deep reductions in GHG emissions
14 occur in the coming decades.

15
16 Mitigation of Climate Change¹⁴ (2022). Total net anthropogenic GHG emissions have continued to
17 rise during the period 2010–2019, and average annual GHG emissions during 2010–2019 were
18 higher than in any previous decade, but the rate of growth between 2010 and 2019 was lower than
19 that between 2000 and 2009. Net anthropogenic GHG emissions have increased since 2010 across
20 all major sectors globally. An increasing share of emissions can be attributed to urban areas. The
21 unit costs of several low-emission technologies (solar energy, wind energy, and lithium-ion
22 batteries) have decreased, but innovation has lagged in developing countries due to weaker
23 enabling conditions.

24
25 Global GHG emissions are projected to peak between 2020 and 2025 in global modelled pathways
26 that limit warming to 1.5 degrees Celsius with no or limited overshoot and in those that limit
27 warming to 2 degrees Celsius. Global net zero CO₂ emissions are reached in the early 2050s in
28 modelled pathways that limit warming to 1.5°C (>50%) with no or limited overshoot, and around
29 the early 2070s in modelled pathways that limit warming to 2°C (>67%). Reaching and sustaining
30 global net zero GHG emissions results in a gradual decline in warming. Reducing GHG emissions
31 across the full energy sector requires major transitions, including a substantial reduction in overall
32 fossil fuel use, the deployment of low-emission energy sources, switching to alternative energy
33 carriers, and energy efficiency and conservation. The deployment of carbon dioxide removal
34 (CDR) to counterbalance hard-to-abate residual emissions is unavoidable if net zero CO₂ or GHG
35 emissions are to be achieved.

36
37 Impacts, Adaptation, and Vulnerability¹⁵ (2022). Climate change is affecting nature, people's lives
38 and infrastructure and its dangerous and pervasive impacts are increasingly evident in every region
39 of the world. These impacts are hindering efforts to meet basic human needs and they threaten
40 sustainable development. This report found that the extent and magnitude of climate change
41 impacts are larger than estimated in previous assessments. They are causing severe and widespread
42 disruption in nature and in society; reducing our ability to grow nutritious food or provide enough
43 clean drinking water, thus affecting people's health and well-being and damaging livelihoods.

44
45 Many species are reaching limits in their ability to adapt to climate change, and those that cannot
46 adjust or move fast enough are at risk of extinction. We see a lengthening wildfire season and
47 increases in the area burned. Roughly half of the world's population experiences severe water
48 shortages at some point during the year, in part due to climate change and extreme events such as
49 flooding and droughts. Drought conditions have become more frequent in many regions, negatively
50 affecting agriculture and energy production from hydroelectric power plants. Globally, climate
51 change is increasingly causing injuries, illness, malnutrition, threats to physical and mental health

1 and well-being, and even deaths. Climate change impacts are expected to intensify with additional
2 warming.

3
4 Climate change risks and impacts can be reduced, within limits, if humans and nature adapt to the
5 changing conditions. The scale and scope of actions to reduce climate risks have increased
6 worldwide. However, there are large gaps between ongoing efforts and adaptation needed to cope
7 with current levels of warming. Poverty and inequality present significant adaptation limits,
8 resulting in unavoidable impacts for vulnerable groups, including women, young people, the
9 elderly, ethnic and religious minorities, indigenous people, and refugees.

10 11 HEALTH EFFECTS OF CLIMATE CHANGE

12
13 Impacts from climate change on extreme weather, air quality, and the transmission of disease
14 increasingly threaten the health and well-being of people in the U.S., particularly populations that
15 at increased risk.¹⁶ The health effects of climate change include increased allergies, asthma,
16 respiratory and cardiovascular disease; injuries and premature deaths related to extreme weather
17 events; heat-related deaths due to continued warming; changes in the prevalence and geographical
18 distribution of food- and water-borne illnesses and other infectious diseases, and threats to mental
19 health.¹ (See Figure 1.) While not discussed in detail in this report, it is important to recognize that
20 climate change can cause or exacerbate resource scarcity, which may result in conflict or migration
21 of populations.¹⁷ Individuals most at risk are typically the least able to relocate.¹⁸ The health effects
22 of climate change are outlined in the Council's 2008 report, but as the IPCC reports indicate, the
23 frequency and intensity of extreme weather events will likely increase.

24
25 Allergies and Respiratory Health. The combustion of fossil fuels is a major source of air pollution
26 and cause of climate change. Fossil fuels release airborne fine particulate matter and ground-level
27 ozone. Poor air quality contributes to a range of non-communicable diseases, including
28 cardiovascular and respiratory disease.¹⁹ It is estimated that more than 8 million people died in
29 2018 from fossil fuel pollution, significantly higher than previous estimates—meaning that air
30 pollution from burning fossil fuels was responsible for about 1 in 5 deaths worldwide.²⁰
31 Furthermore, hotter temperatures and lack of rainfall increase the risk of drought and wildfires,
32 both of which create particle pollution.²¹ As temperatures rise, plants produce more pollen,
33 increasing ragweed and other allergens. Warmer temperatures allow allergens to thrive in new
34 regions and for allergy seasons to last longer.^{22,23}

35
36 Cardiovascular Disease. Air pollution can exacerbate cardiovascular disease and contribute to the
37 development of the disease. The evidence is particularly strong for outdoor particle pollution
38 exposure. Exposure to PM <2.5 µm in diameter (PM_{2.5}) over a few hours to weeks can trigger
39 cardiovascular disease-related mortality and nonfatal events; longer-term exposure (increases the
40 risk for cardiovascular mortality to an even greater extent and reduces life expectancy within more
41 highly exposed segments of the population by several months to a few years; reductions in PM
42 levels are associated with decreases in cardiovascular mortality within a time frame as short as a
43 few years.²⁴ Short -and long-term exposure to increased concentrations of PM_{2.5} has been shown to
44 increase hospitalizations for serious cardiovascular events such as coronary syndrome, arrhythmia,
45 heart failure, stroke, and sudden cardiac death, particularly in people with established heart
46 disease.²⁵ Numerous studies have shown that exposure to higher concentrations of PM_{2.5} and some
47 gaseous air pollutants (nitrogen oxides, sulfur dioxide, and ozone) can also result in arterial
48 hypertension and increased blood pressure.²⁶ Extreme heat also impacts heart health. A recent
49 study showed 600-700 additional deaths from cardiovascular disease annually over a decade-long
50 period in the U.S.²⁷ The spike in deaths during heat waves was most pronounced in men and non-
51 Hispanic Black adults.²⁸

1 Agriculture and Food Security. The agriculture sector is responsible for 11 percent of U.S. GHG
2 emissions, which come from livestock, agricultural soils, and rice production.²⁹ GHG emissions
3 from agriculture have increased by 6 percent since 1990, largely driven by a 62 percent growth in
4 combined CH₄ and N₂O emissions from livestock manure management systems.³⁰ Research
5 indicates that shifts towards sustainable diets could lead to co-benefits, such as minimizing GHG
6 emissions and land use, reducing the environmental footprint, aiding in climate change mitigation,
7 and improving population health.³¹ This is possible by reducing reliance on red meat consumption
8 and prioritizing plant-based foods and other healthier alternatives, which can reduce chronic
9 disease risk. Climate change is also expected to threaten food production, food prices, and
10 distribution systems. Crop yields are predicted to decline due to changes in rainfall, severe weather
11 events, and increasing competition from weeds and pests.³² Prices are expected to rise in response
12 to declining food production leading to food insecurity and a reliance on foods of poor nutrient
13 quality.

14
15 Vector-borne diseases. Climatic hazards have enhanced specific aspects of pathogens, including
16 improved climate suitability for reproduction, acceleration of the life cycle, increasing
17 seasons/length of likely exposure, enhancing pathogen-vector interactions (for example, by
18 shortening incubations) and increasing virulence. Between 2004 and 2018, the number of reported
19 illnesses from mosquito, tick, and flea bites more than doubled, with more than 760,000 cases
20 reported in the United States^{33,36} Nine new germs spread by mosquitoes and ticks were discovered
21 or introduced into the United States during this period.³⁴ Warming had positive effects on mosquito
22 population development, survival, biting rates and viral replication, increasing the transmission
23 efficiency of West Nile virus.³⁵ Global mobility, urbanization and climate change is also major
24 driver of the increase in the number of dengue virus infections, which have doubled every decade
25 since 1990.^{36,37} Further, the geographic ranges where ticks spread Lyme disease, anaplasmosis,
26 ehrlichiosis, and spotted fever rickettsiosis have expanded, and experts predict that tickborne
27 diseases will continue to increase and perhaps worsen.³⁸

28
29 Fungi. Rising temperatures have allowed certain disease-causing fungi to spread into new areas
30 that previously were too cold for them to survive. For example, Valley fever, caused by a fungus
31 that lives in the soil in hot and dry areas, has already spread into the Pacific Northwest.³⁹

32
33 Water-borne diseases. Ocean warming has accelerated the growth of harmful algal blooms and
34 diseases caused by *Pseudo-nitzschia sp.*, blue green cyano-bacteria, and dinoflagellates.⁴⁰ Ocean
35 warming and heavy precipitation, which reduces coastal water salinity, is predicted to also provide
36 fertile conditions for *Vibrio vulnificus* and *Vibrio cholerae*, this being a leading explanation for
37 Vibriosis outbreaks in areas where this disease is rare.^{41,42} Further, floods and storms are associated
38 with wastewater overflow, leading to the direct and foodborne transmission of noroviruses,
39 hantavirus, hepatitis and *Cryptosporidium*.^{43,44,45}

40
41 Zoonotic diseases. Patterns of contact between human and wildlife reservoirs have increased as
42 human populations move into previously unoccupied regions. Changing environmental conditions
43 can also alter species range and density, leading to novel interactions between species, and increase
44 the risk of zoonotic emergence.⁴⁶ Further, habitat disruptions caused by warming, drought,
45 heatwaves, wildfires, storms, floods and land cover change were also associated with bringing
46 pathogens closer to people. Spillovers from viruses (Nipah virus and Ebola), for instance, were
47 associated with wildlife (bats, rodents, and primates) moving over larger areas foraging for limited
48 food resources caused by drought or finding new habitats following wildfires.⁴⁷

1 Mental Health. The connections between climate change and mental health have been mostly
 2 discussed in relation to emergency preparedness and disaster response, particularly in the context
 3 of extreme weather events. The mental health effects of disasters may include trauma and shock,
 4 post-traumatic stress disorder (PTSD), feelings of abandonment, and anxiety and depression that
 5 can lead to suicidal ideation and risky behavior.⁴⁸ Rising temperatures can lead to mood and
 6 anxiety disorders, schizophrenia and vascular dementia, and can increase emergency department
 7 usage and suicide rates.⁴⁹ Concern about climate change coupled with worry about the future can
 8 lead to fear, anger, feelings of powerlessness, exhaustion, stress and sadness, which is being
 9 referred to as “eco-anxiety” or “climate anxiety.” Climate anxiety and dissatisfaction with
 10 government responses are widespread in children and young people and can impact their daily
 11 functioning.⁵⁰ Distress about climate change in young people is associated with perceiving that they
 12 have no future, that humanity is doomed, and that governments are failing to respond adequately,
 13 and with feelings of betrayal and abandonment by governments and adults.⁵¹

14
 15 **DECARBONIZATION**

16
 17 In 2021, President Biden announced the U.S. target was to achieve a 50-52 percent reduction from
 18 2005 levels in economy-wide net GHG pollution by 2030.⁵² Since 1990, gross U.S. GHG
 19 emissions have decreased by 7 percent.⁵³ In 2020, U.S. GHG emissions decreased 11 percent
 20 compared to 2019 levels primarily from CO₂ emissions from fossil fuel combustion largely due to
 21 the COVID-19 pandemic and reductions in travel and economic activity.⁵⁴ However, it is estimated
 22 that in 2021 U.S. GHG emissions increased by 6 percent above 2020 levels, returning to pre-
 23 pandemic levels.⁵⁵

24
 25 In efforts to reach the U.S. commitments under the Paris Agreement, the administration signed
 26 Executive Order (EO) 14057, “Catalyzing Clean Energy Industries and Jobs Through Federal
 27 Sustainability”, a multi-faceted approach to addressing climate change.⁵⁶ EO 14057’s stated goals
 28 include:

- 29 • 100 percent carbon emission free electricity by 2030,
- 30 • 100 percent of government acquired vehicles to be zero emission vehicles by 2035,
- 31 • a net-zero emission federal building portfolio by 2032,
- 32 • a 65 percent reduction in overall greenhouse gas emissions by 2030

33
 34 Other goals without explicit time frames include net-zero emissions of federal procurements,
 35 climate resilient infrastructure and a climate focused federal workforce.

36
 37 *The Lancet Countdown on Health and Climate Change*

38
 39 Published annually, the *Lancet Countdown* is an international, multidisciplinary collaboration,
 40 dedicated to monitoring the health profile of climate change, and independently assessing the
 41 delivery of commitments made by governments under the Paris Agreement. In 2021, the report
 42 indicated that the current global decarbonization commitments are “insufficient to meet Paris
 43 Agreement ambitions and would lead to a roughly 2.4 degrees Celsius average global temperature
 44 increase by the end of the century.”⁵⁷ To meet the Paris Agreement goals and prevent catastrophic
 45 levels of global warming, global GHG emissions must reduce by half within a decade. Emissions
 46 are declining too slowly or heading in the wrong direction in the highest emitting sectors. This
 47 delay in progress is contributing to millions of deaths each year. At the current pace of reduction, it
 48 would take more than 150 years for the energy system to fully decarbonize, and the unequal
 49 response between countries is resulting in an uneven realization of the health benefits of a low-
 50 carbon transition.⁵⁸ The use of public funds to subsidize fossil fuels is partly responsible for the

1 slow decarbonization rate, with 65 out of 84 countries reviewed still providing an overall subsidy
2 to fossil fuels in 2018.⁵⁹ Despite years of scientific reporting on the impacts of climate change,
3 efforts to build resilience have been slow and unequal, with countries with low levels of human
4 development index being the least prepared to respond to the changing health profile of climate
5 change and funding remaining a consistent challenge. Even with overwhelming evidence on the
6 health impacts of climate change, countries are not delivering an adaptation response proportionate
7 to the rising risks their populations face.⁶⁰

8 9 *Role of the Health Sector*

10
11 The U.S. health care sector is responsible for an estimated 8.5 percent of national carbon emissions.
12 These emissions stem from the operations of health care facilities (scope 1), from both purchased
13 sources of energy, heating, and cooling (scope 2) and from the supply chain of health care goods
14 and services (scope 3). The U.S. health sector accounts for 25 percent of global health sector
15 emissions—the highest proportion attributable to any individual country’s health sector.⁶¹ In 2021,
16 as part of the United Nations Climate Change Conference (COP26), 60 countries, including the
17 United States, committed to creating climate-resilient, low-carbon, sustainable health systems, with
18 20 countries committing to net-zero health care system emissions by 2050. However, while more
19 than 90 percent of Standard & Poor’s 500 Companies annually publish sustainability reports, as do
20 many private and nongovernmental entities, the same cannot be said of U.S. health care
21 organizations, despite their commitment to improving health.⁶²

22 23 *HHS Health Sector Climate Pledge*

24
25 In 2022, the US Department of Health & Human Services announced a pledge initiative, calling
26 upon the private health care sector to publicly commit to reducing and reversing their carbon
27 footprint.⁶³ The voluntary pledge calls upon signees to reduce emissions by 50 percent by 2030,
28 become net-zero emitters by 2050, complete an inventory of supply chain emissions and to develop
29 climate resilience plans for their facilities and communities. The pledge has been signed by more
30 than 60 major hospital groups, pharmaceutical companies, insurers, and medical associations.⁶⁴

31 32 *National Academy of Medicine: Action Collaborative on Decarbonizing the U.S. Health Sector*

33
34 NAM has launched an Action Collaborative on Decarbonizing the U.S. Health Sector. This public–
35 private partnership includes leadership from the federal government, the biomedical and
36 pharmaceutical industries, hospital systems, private payers, and health professions, including the
37 AMA, with the aim to develop and implement a shared action plan for decarbonizing the health
38 sector and strengthening its sustainability and resiliency.⁶⁵

39
40 The collaborative is focusing its decarbonization efforts in four areas: (1) working with industry to
41 reduce scope 3 emissions, as well as facilitate coordination with the federal government to
42 accelerate and better enable low-carbon innovations; (2) accelerating climate-sensitive health care
43 delivery and practice, including reducing scope 1 and scope 2 emissions and identifying
44 opportunities for linking performance on sustainability metrics to value-based payment and
45 reimbursement; (3) expanding health professionals’ curricula and programming on climate change;
46 and (4) developing sustainability metrics and indicators for industry and health systems, along with
47 shared plans for public reporting.⁶⁶

48 49 *Resources on Health System Decarbonization*

50

1 Health Care Without Harm has released a Road Map that provides a plan to get health care toward
2 zero emissions. By implementing this set of seven high-impact actions, health care can put itself
3 firmly on the road to zero emissions, while helping provide leadership for the rest of the world to
4 travel in the same direction.⁶⁷ The Road Map identifies seven high-impact actions as key to health
5 care decarbonization:

- 6
- 7 1. Power health care with 100 percent clean, renewable electricity.
- 8 2. Invest in zero emissions buildings and infrastructure.
- 9 3. Transition to zero emissions, sustainable travel, and transport.
- 10 4. Provide healthy, sustainably grown food and support climate resilient agriculture.
- 11 5. Incentivize and produce low-carbon pharmaceuticals.
- 12 6. Implement circular health care and sustainable health care waste management.
- 13 7. Establish greater health system effectiveness.
- 14

15 The UK's National Health Service (NHS) is the world's first health care system to commit to
16 achieve net-zero carbon emissions. Its Greener NHS plan contains critical lessons for the U.S.
17 health system.⁶⁸ The NHS has taken action in the following areas:

- 18
- 19 • Developing a framework to evaluate the carbon reduction associated with new models of
20 care under consideration.
- 21 • Working with suppliers to ensure they meet or exceed the NHS commitment on net-zero
22 emissions before the end of the decade, with new procurement from April 2022 onward
23 required to consider net zero as part of the purchasing process.
- 24 • Shifting to using zero-emission vehicles, including production of the world's first zero-
25 emission ambulance.
- 26 • Ensuring that digital transformation of health care aligns with the goal of becoming a net-
27 zero health service, investing in innovations to support that goal, and setting up a scanning
28 mechanism to identify future pipeline innovations.
- 29 • Supporting the construction of 40 new net-zero hospitals as part of the government's health
30 infrastructure plan, which includes a new net-zero carbon hospital standard.
- 31 • Completing a \$60 million LED lighting replacement program that will improve patient
32 comfort and save money.
- 33 • Making health care systems more resilient to enable them to withstand or adapt to the
34 demands of future climate events, such as floods and extreme temperatures.
- 35 • Appointing a new chief sustainability officer to lead the national program and report
36 regularly to the national board; ensuring that every NHS organization has a board-level
37 net-zero lead and a green plan; and supporting an update to the NHS constitution to include
38 the response to climate change as a core principle.
- 39

40 To support healthcare organizations in advancing toward their decarbonization commitments, the
41 Agency for Healthcare Research and Quality (AHRQ) contracted with the Institute for Healthcare
42 Improvement to develop a primer that offers guidance on high-priority measures and strategies for
43 health care organizations to reduce their carbon footprint.⁶⁹ The recommendations are intended to
44 inform organizations beginning their journey in measuring and reducing GHG emissions. The
45 primer describes six domains contributing to GHG emissions in health care: building energy,
46 transportation, anesthetic gas, pharmaceuticals and chemicals, medical devices and supplies, and
47 food. To meaningfully track and reduce GHG emissions, the primer recommends health care
48 organizations should use the Greenhouse Gas Protocol (GHGP) framework, a globally recognized
49 standard for quantifying and reporting on emissions.

1 *U.S. Securities and Exchange Commission (SEC) and Decarbonization*

2
3 The SEC is expected to finalize a rule requiring publicly traded companies to disclose climate-
4 related risks.⁷⁰ The proposed rules also would require a registrant to disclose information about its
5 direct GHG emissions (Scope 1) and indirect emissions from purchased electricity or other forms
6 of energy (Scope 2). In addition, a registrant would be required to disclose GHG emissions from
7 upstream and downstream activities in its value chain (Scope 3), if material or if the registrant has
8 set a GHG emissions target or goal that includes Scope 3 emissions. These proposals for GHG
9 emissions disclosures would provide investors with decision-useful information to assess a
10 registrant's exposure to, and management of, climate-related risks, and in particular transition risks.
11

12 EPA AUTHORITY

13
14 The Clean Air Act is the law that defines the EPA's authority and responsibility to regulate air
15 pollutants. In 2015, the Obama Administration's Clean Power Plan (CPP) established guidelines
16 for to cut power-plant emissions and instructed the states to submit their plans by 2018 and then
17 gave them until 2030 to meet their goals. The CPP relied on section 7411 of the Clean Air Act to
18 enforce guidelines on power plants. In 2019, the Trump Administration issued its Affordable Clean
19 Energy (ACE) Rule which eliminated the guidelines set by the Clean Power Plan. However, the
20 ACE rule was vacated by the U.S. Court of Appeals. As a result, petitioners challenged the EPA's
21 authority to broadly regulate GHG emissions. In a recent Supreme Court decision, *West Virginia v.*
22 *EPA*, the Court held Congress did not grant the EPA, under the Clean Air Act, the authority to
23 devise emissions caps based on the generation shifting approach the agency took in the Clean
24 Power Plan (CPP). This decision limited the EPA's ability to reduce pollution from power plants.
25

26 FEDERAL LEGISLATION

27
28 In August 2022, Congress passed H.R. 5376, also known as the Inflation Reduction Act of 2022
29 (IRA). The IRA authorized spending of \$369 billion over the next ten years, with much targeted
30 towards environmental policies. According to the Department of Energy, these policies are
31 anticipated to cut domestic greenhouse gas emissions by up to 40 percent by 2030.⁷¹ Several of the
32 programs contained in the IRA are targeted at reducing or reimbursing the upfront investments
33 required to convert to more environmentally friendly technology. For example, the IRA contains
34 tax credits or reimbursements for electric vehicle purchases, households that install rooftop solar
35 panels or heat pumps, and a new Advanced Industrial Facilities Deployment Program to provide
36 financial assistance for facilities looking to modernize. Other key elements are investments in the
37 domestic manufacturing workforce to promote green technology production within the United
38 States.
39

40 In addition to monetary investments, the IRA also contains important policy changes, particularly
41 around the powers conferred to the EPA. While the IRA does not abrogate the holdings of *West*
42 *Virginia v. EPA*, it does provide direct funding to the EPA for seven programs to reduce GHG, and
43 it explicitly defines GHG as carbon dioxide, hydrofluorocarbons, methane, nitrous oxide,
44 perfluorocarbons, and sulfur hexafluoride.⁷² These changes are expected to strengthen the agency's
45 ability to mount a legal defense against challenges similar to those levied in *West Virginia v. EPA*.
46

47 The bill also includes tax credits for carbon capture and sequestration, which could extend the life
48 of coal plants and make it harder to reach critical targets for clean power. The bill requires the
49 federal government to offer parts of the Gulf of Mexico and Alaska's Cook Inlet for oil and gas
50 development. It also requires additional oil and gas leasing for new wind and solar projects to be
51 approved. As a part of the compromise, negotiators are expected to put forth a separate bill on oil

1 and gas “permitting reform” that could weaken environmental protections under the National
 2 Environmental Policy Act.

3
 4 STATE AND LOCAL ACTIONS

5
 6 At the state level, many of the most impactful state policies are enacted by coalitions of multiple
 7 states. For example, California has been allowed to institute stricter tailpipe emission standards
 8 since obtaining a Clean Air Act waiver in 1970, and other states are allowed to adopt California’s
 9 standards. As of 2019, 17 states and the District of Columbia, representing approximately 40
 10 percent of light duty vehicle sales in the United States, utilize California’s low-emission vehicle
 11 emission regulations.⁷³ As such, this informal coalition of states places significant market pressure
 12 on car manufacturers to simply have *all* new vehicles meet California emission standards rather
 13 than dealing with the logistical complexity of having two markets with two different sets of
 14 regulations in the United States.⁷⁴

15
 16 Similarly, when the United States initially withdrew from the Paris Agreement, 24 states and 2
 17 territories representing approximately 50 percent of the United States population formed the United
 18 States Climate Alliance pledging to meet the US’s Paris Agreement goals under the Clean Power
 19 Plan. Other important state coalitions include the Regional Greenhouse Gas Initiative, the Western
 20 Climate Initiative, Inc., and the Midwestern Greenhouse Gas Reduction Accord which serve as
 21 major “cap-and-trade” markets for their respective regions.

22
 23 Other notable state-level actions in recent years include California’s Plastic Pollution Prevention
 24 and Packaging Producer Responsibility Act (requiring all packaging in the state to be recyclable or
 25 compostable by 2032), Illinois’ Climate and Equitable Jobs Act (requiring 100% renewable energy
 26 by 2050), and Wisconsin’s Office of Sustainability and Clean Energy (100% carbon-free electricity
 27 by 2050).

28
 29 As of writing, 35 of the 50 largest cities in the United States have published local climate action
 30 plans.⁷⁵ Similar to states, local governments and cities often tackle climate change through
 31 coalitions such as Climate Mayors, a collection of 470 mayors representing approximately 74
 32 million Americans committed to building political will for climate change policy. Many municipal
 33 climate plans echo those seen at the federal and state levels aiming to reduce greenhouse gas
 34 emissions, but they also provide insight into the unique issues facing different geographies. For
 35 example, the city of Miami has invested \$400 million into the Miami Forever bond to fund projects
 36 addressing sea-level rise and flood prevention,⁷⁶ and the city of Ann Arbor implemented the 10,000
 37 Trees Initiative to give away free trees and rebuild the city’s canopy.⁷⁷

38
 39 AMA ACTIONS

40
 41 *Medical Society Consortium on Climate and Health (MSCCH)*

42
 43 The AMA is a member of the MSCCH. The Consortium works to facilitate the medical
 44 community’s awareness-raising efforts, by bringing together associations representing over
 45 600,000 clinical practitioners to carry three simple messages:

- 46 • Climate change is harming Americans today and these harms will increase unless we act;
- 47 • The way to slow or stop these harms is to decrease the use of fossil fuels and increase
 48 energy efficiency and use of clean energy sources; and
- 49 • These changes in energy choices will improve the quality of our air and water and bring
 50 immediate health benefits.

1 In 2019, the AMA signed on to the “Climate, Health, and Equity: A Policy Action Agenda,” which
2 recognizes climate change is a public health emergency and outlines ten policy recommendations
3 to provide a roadmap to develop coordinated strategies for simultaneously tackling climate change,
4 health, and equity.³ The agenda calls out 10 specific policy priorities, including the following:
5

- 6 1. Meeting and strengthening greenhouse gas emission reduction commitments and
7 supporting the Paris Agreement.
- 8 2. Transitioning rapidly away from the use of coal, oil and natural gas to clean, safe, and
9 renewable energy and energy efficiency.
- 10 3. Emphasizing active transportation in the transition to zero-carbon transportation
11 systems.
- 12 4. Promoting healthy, sustainable and resilient farms and food systems, forests, and
13 natural lands.
- 14 5. Ensuring that all U.S. residents have access to safe and affordable drinking water and a
15 sustainable water supply.
- 16 6. Investing in policies that support a just transition for workers and communities
17 adversely impacted by climate change and the transition to a low-carbon economy.
- 18 7. Engaging the health sector voice in the call for climate action.
- 19 8. Incorporating climate solutions into all health care and public health system.
- 20 9. Building resilient communities in the face of climate change.
- 21 10. Investing in climate in a way that benefits health, and health in a way that doesn’t harm
22 the climate.

23
24 In January of 2020, the AMA joined the MSCCH in calling on President Trump to stop our
25 withdrawal from the Paris Climate Agreement. The letter recognizes that climate change is a public
26 health emergency. Rejoining the Paris Climate Agreement is not just about preventing the worst of
27 the devastating health harms climate change will bring. It is also about seizing this public health
28 crisis and turning it into a major public health opportunity.
29

30 *NAM Action Collaborative on Decarbonizing the Health Sector*

31
32 The AMA is also a member of the National Academy of Medicine Action Collaborative on
33 Decarbonizing the Health Sector as a member of the Steering Committee and co-lead of the Health
34 Care Delivery Workgroup, which is working toward the following four goals:
35

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

43 44 *AMA Litigation Center*

45
46 The AMA has long advocated for upholding the Clean Power Plan through amicus briefs and most
47 recently filed such a brief with the American Thoracic Society and dozens of leading medical
48 organizations and public health leaders in *West Virginia v. EPA*. The AMA brief stated the
49 importance of the EPA's authority to regulate carbon dioxide emissions from power plants in order
50 to mitigate the health effects of climate pollutants and help address climate change as a threat to
51 public health.

1 CONCLUSION

2
3 It is now unequivocal that human influence has warmed the atmosphere, ocean and land. The scale
4 of recent changes across the climate system are unprecedented over many centuries to thousands of
5 years. Human-induced climate change is affecting weather and climate extremes in every region
6 across the globe. The extent and magnitude of climate change impacts are larger than previously
7 estimated and they are causing severe and widespread disruption in nature and in society; reducing
8 our ability to grow nutritious food or provide enough clean drinking water, thus affecting people's
9 health and well-being and damaging livelihoods. Limiting global warming to 1.5 degrees Celsius
10 would require "rapid and far-reaching" transitions in land, energy, industry, buildings, transport,
11 and cities.⁷⁸

12
13 Impacts from climate change on extreme weather, air quality, and the transmission of disease
14 increasingly threaten the health and well-being of people in the U.S., and it is widely recognized
15 that many of the impacts of warming will disproportionately impact the most vulnerable. The
16 health effects of climate change include increased allergies, asthma, respiratory and cardiovascular
17 disease; injuries and premature deaths related to extreme weather events; heat-related deaths due to
18 continued warming; changes in the prevalence and geographical distribution of food- and water-
19 borne illnesses and other infectious diseases, and threats to mental health.

20
21 To meet the Paris Agreement goals and prevent catastrophic levels of global warming, global GHG
22 emissions must be reduced by half within a decade. Emissions are declining too slowly or heading
23 in the wrong direction in the highest emitting sectors. This delay in progress is contributing to
24 millions of deaths each year. The U.S. health care sector is responsible for an estimated 8.5 percent
25 of national carbon emissions. These emissions stem from the operations of health care facilities
26 (scope 1), from both purchased sources of energy, heating, and cooling (scope 2) and from the
27 supply chain of health care goods and services (scope 3). The U.S. health sector accounts for 25
28 percent of global health sector emissions, the highest proportion attributable to any individual
29 country's health sector. Physicians pledge to do no harm; it is time for the health sector to do the
30 same by addressing the climate crisis and protecting public health.

31
32 RECOMMENDATIONS

33
34 The Council on Science and Public Health recommends that the following be adopted and the
35 remainder of the report be filed.

36
37 1. That Policy D-135.966, "Declaring Climate Change a Public Health Crisis" be amended by
38 addition to read as follows:

39
40 1. Our AMA declares climate change a public health crisis that threatens the health and well-being
41 of all individuals. 2. Our AMA will protect patients by advocating for policies that: (a) limit global
42 warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a
43 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid
44 implementation and incentivization of clean energy solutions and significant investments in climate
45 resilience through a climate justice lens. 3. Our AMA consider signing on to the Department of
46 Health and Human Services Health Care Pledge or making a similar commitment to lower its own
47 greenhouse gas emissions. 4. Our AMA encourages the health sector to lead by example in
48 committing to carbon neutrality by 2050. 5. Our AMA will develop a strategic plan for how we
49 will enact our climate change policies including advocacy priorities and strategies to decarbonize

1 physician practices and the health sector with report back to the House of Delegates at the 2023
2 Annual Meeting. (Modify Current HOD Policy)

3
4 2. That Policy H-135.938, "Global Climate Change and Human Health" be amended by addition
5 and deletion to read as follows:

6
7 Our AMA: 1. Supports ~~the findings of the Intergovernmental Panel on Climate Change's fourth~~
8 ~~assessment report and concurs with the~~ scientific consensus that the Earth is undergoing adverse
9 global climate change and that anthropogenic contributions are significant. These climate changes
10 have adversely affected the physical and mental health of people. will create conditions that affect
11 public health, with We recognize that minoritized and marginalized populations, children, the
12 elderly, rural communities, and those who are economically disadvantaged will suffer
13 disproportionate impacts harms from of climate change on vulnerable populations, including
14 children, the elderly, and the poor.

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

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

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

27 5. Encourages physicians to work with ~~local and state~~ health departments to strengthen the public
28 health infrastructure to ensure that the ~~global~~ health effects of climate change can be anticipated
29 and responded to more efficiently, and that adaptation interventions are equitable and prioritize the
30 needs of the populations most at risk, and that the AMA's Center for Public Health Preparedness
31 and Disaster Response assist in this effort.

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

34 7. Encourages physicians to assess for environmental determinants of health in patient history-
35 taking and encourages the incorporation of assessment for environmental determinants of health in
36 patient history-taking into physician training. (Modify Current HOD Policy)

37
38 3. That Policy D-150.978, "Sustainable Food" be reaffirmed.

39
40 Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care
41 facilities that support and model a healthy and ecologically sustainable food system, which
42 provides food and beverages of naturally high nutritional quality; (2) encourages the development
43 of a healthier food system through tax incentive programs, community-level initiatives and federal
44 legislation; and (3) will consider working with other health care and public health organizations to
45 educate the health care community and the public about the importance of healthy and ecologically
46 sustainable food systems. (Reaffirm HOD Policy)

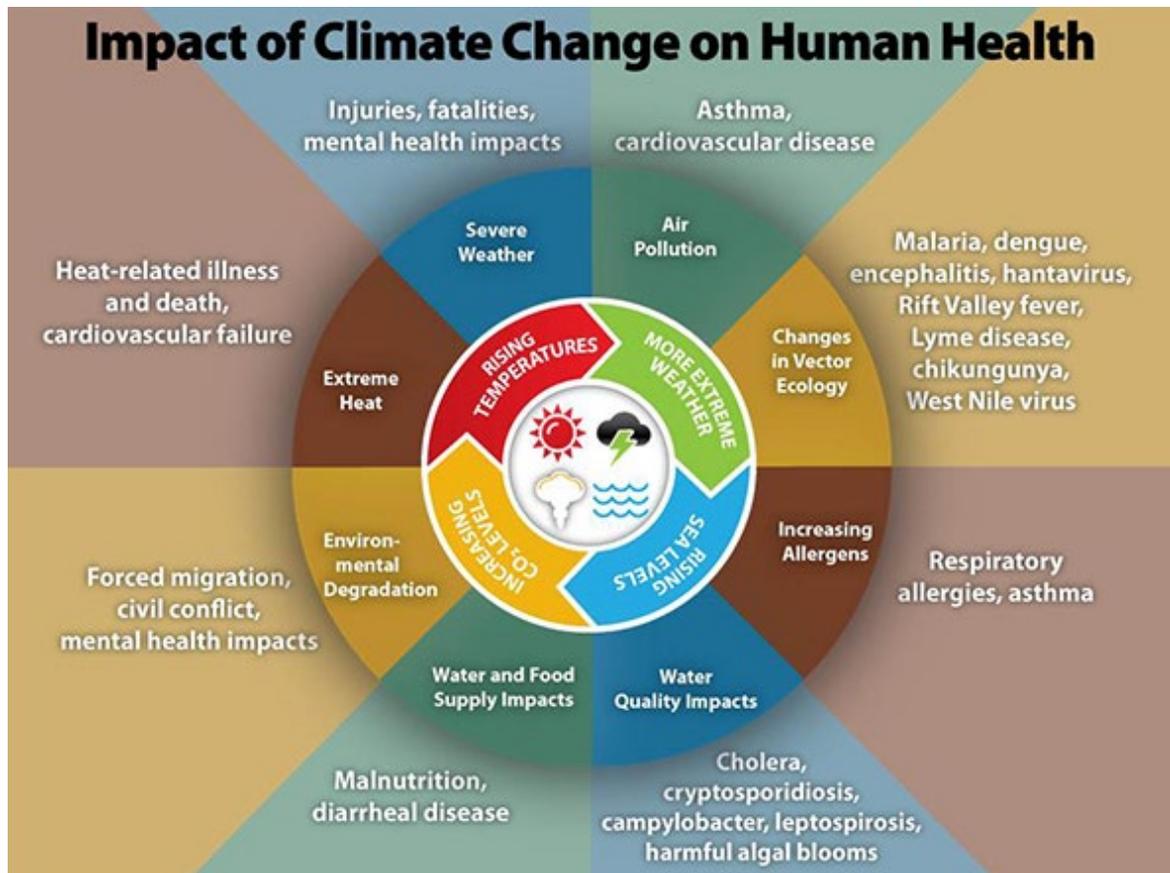
47
48 4. That Policy H-135.977, "Global Climate Change - The "Greenhouse Effect"" be rescinded.

49
50 Our AMA: (1) ~~endorses the need for additional research on atmospheric monitoring and climate~~
51 ~~simulation models as a means of reducing some of the present uncertainties in climate forecasting;~~

- 1 ~~(2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization~~
- 2 ~~policy that will promote more efficient fuel use and energy production;~~
- 3 ~~(3) endorses increased recognition of the importance of nuclear energy's role in the production of~~
- 4 ~~electricity;~~
- 5 ~~(4) encourages research and development programs for improving the utilization efficiency and~~
- 6 ~~reducing the pollution of fossil fuels; and~~
- 7 ~~(5) encourages humanitarian measures to limit the burgeoning increase in world population.~~
- 8 (Rescind HOD Policy)

Fiscal Note: less than \$1,000

FIGURE 1



Source: Centers for Disease Control and Prevention

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 902
(1-22)

Introduced by: Medical Student Section

Subject: Reducing the Burden of Incarceration on Public Health

Referred to: Reference Committee K

- 1 Whereas, The United States has the highest incarceration rate in the world¹; and
2
3 Whereas, Incarcerated individuals disproportionately have lower incomes and are more likely to
4 be Black, male, and live in urban settings²; and
5
6 Whereas, In 2018, Black Americans represented 33% of the sentenced prison population,
7 whites 30%, and Hispanic 23%, whereas these groups made up 12%, 63%, and 16% of the
8 U.S. adult population, respectively³; and
9
10 Whereas, A 2009 study found that incarcerated people have higher rates of hypertension,
11 arthritis, cervical cancer, and hepatitis than non-incarcerated individuals⁵; and
12
13 Whereas, Incarcerated individuals may also experience heightened challenges in transitions of
14 care relative to the non-incarcerated population, including poor transfer of medical, laboratory
15 and pharmacy records, poor communication among providers, variable access to care, limited
16 family involvement, and inability to afford treatment^{6,7}; and
17
18 Whereas, Many states have rules wherein Medicaid beneficiaries who are incarcerated are de-
19 enrolled and must re-enroll in Medicaid upon release, which can have a significant lag time that
20 frequently lasts up to several months^{8,9}; and
21
22 Whereas, As of 2019, 43 states had implemented suspension of benefits rather than termination
23 for certain prisons, and 42 had done this for certain jails, allowing inmates to immediately
24 reinstate their Medicaid eligibility upon release¹⁰; and
25
26 Whereas, Federal rules prohibit Medical matching funds for being used for inmate health
27 expenses with the exception of costs incurred due to inpatient hospitalization, creating
28 additional coverage issues for the incarcerated population separate from eligibility¹¹; and
29
30 Whereas, Federal Medicaid rules include a coverage exclusion “related to services for patients
31 in Institutions for Mental Diseases, which include residential treatment facilities of over sixteen
32 beds that are primarily engaged in the diagnosis, treatment, or care of persons with mental
33 diseases”¹²; and
34
35 Whereas, The Medicaid Reentry Act of 2021 was introduced into the US House of
36 Representatives and would allow for Medicaid payment for medical services rendered to
37 incarcerated individuals during the 30-day period before the individual’s release¹³; and
38
39 Whereas, The Bureau of Justice Assistance awards grants for projects that create strategic,
40 sustainable plans to facilitate successful reentry, ensure collaboration with the criminal justice

1 system and social services, and collect data to measure performance outcomes related to
2 recidivism and service provision¹⁴; and

3
4 Whereas, Individuals released from prison may legally be barred from pursuing opportunities in
5 employment, social programs, and voting¹⁵⁻¹⁷; and

6
7 Whereas, Pursuant to a report mandated by the Fair Chance to Compete for Jobs Act, the
8 Bureau of Justice Statistics in the US Department of Justice found that 33% of persons did not
9 find employment at any point during the 16 quarters after their release from prison from 2010 to
10 2014¹⁸; and

11
12 Whereas, Because the predominant source of insurance in the United States is through
13 employment, lack of employment opportunities for formerly incarcerated individuals leads to a
14 concomitant lack of access to health insurance, particularly in states that have not expanded
15 Medicaid¹⁹; and

16
17 Whereas, Homelessness and residential instability has been identified as one of the greatest
18 challenges confronting ex-offenders and their chance to achieve successful reintegration, with
19 some studies finding that formerly incarcerated individuals were 10 times more likely to be
20 homeless than the general public^{20,21}; and

21
22 Whereas, Periods of homelessness have been shown to significantly increase the risk of
23 recidivism for new convictions, revocations, and readmission to prison, suggesting the presence
24 of a vicious cycle wherein incarceration increases the risk of homelessness which further
25 increases the risk of subsequent incarceration²⁰; and

26
27 Whereas, The increased risk of homelessness among the formerly incarcerated population
28 increases with the number of times an individual has been incarcerated, with people who have
29 been to prison once experiencing homelessness at a rate 7 times greater than that of the
30 general public and people who have been incarcerated more than once experiencing
31 homelessness at a rate 13 times higher than the general public²¹; and

32
33 Whereas, The AMA has extensive policy on reducing the poor health outcomes associated with
34 incarceration (H-430.986 Health Care While Incarcerated), on the health impacts of
35 homelessness (H-160.903 Eradicating Homelessness), on support for standard ongoing
36 medical, psychiatric, and substance misuse care for inmates upon release from correctional
37 facilities in order to prevent recidivism (H-430.997 Standards of Care for Inmates of Correctional
38 Facilities), and on support for the National Commission on Correctional Health Care Standards
39 and its efforts to improve the quality of health care services for incarcerated persons (D-430.997
40 Support for Healthcare Services for Incarcerated Persons), but has no policy supporting or
41 promoting access to stable employment and housing for former inmates; therefore be it

42
43 RESOLVED, That our American Medical Association support efforts to reduce the negative
44 health impacts of incarceration, such as: (1) implementation and incentivization of adequate
45 funding and resources towards indigent defense systems; (2) implementation of practices that
46 promote access to stable employment and laws that ensure employment non-discrimination for
47 workers with previous non-felony criminal records; and (3) housing support for formerly
48 incarcerated people, including programs that facilitate access to immediate housing after
49 release from carceral settings (New HOD Policy); and be it further

1 RESOLVED, That our AMA partner with the American Public Health Association and other
2 stakeholders to urge Congress, the Department of Justice, and the Department of Health
3 and Human Services to minimize the negative health effects of incarceration by supporting
4 programs that facilitate employment and housing opportunities for formerly incarcerated
5 individuals as well as research into alternatives to incarceration. (Directive to Take Action)

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

Received: 09/20/22

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RELEVANT AMA POLICY

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.

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

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

Standards of Care for Inmates of Correctional Facilities H-430.997

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

Res. 60, A-84, Reaffirmed by CLRPD Rep. 3 - I-94, Amended: Res. 416, I-99, Reaffirmed: CEJA Rep. 8, A-09, Reaffirmation I-09, Modified in lieu of Res. 502, A-12, Reaffirmation: I-12, Modified: CSAPH Rep. 1, A-22

Disease Prevention and Health Promotion in Correctional Institutions H-430.989

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, hepatitis, and other infectious diseases. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

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

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:

- (1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
- (2) encourage all correctional systems to support NCCHC accreditation;
- (3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;

- (4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
- (5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
- (6) support an incarcerated person's right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.

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

Compassionate Release for Incarcerated Patients H-430.980

Our AMA supports policies that facilitate compassionate release for incarcerated patients on the basis of serious medical conditions and advanced age; will collaborate with appropriate stakeholders to develop clear, evidence-based eligibility criteria for timely compassionate release; and promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.

BOT Rep. 10, I-20

Dietary Intake of Incarcerated Populations D-430.995

Our AMA: 1) urges the National Commission on Correctional Health Care, the American Correctional Association, and individual states to mandate adherence to the current Dietary Reference Intakes and Dietary Guidelines for Americans (with adjustments, as needed, for special populations) as a criterion for accreditation and/or standards compliance, until national dietary guidelines specific for adolescent and adult incarcerated populations becomes available; and 2) urges the Food and Nutrition Board of the Institute of Medicine to examine the nutrient status and dietary requirements of incarcerated populations and issue guidelines on menu planning for adolescent and adult incarcerated populations.

CSAPH Rep. 4, A-11, Reaffirmed: Res. 904, I-19

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

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

Res. 404, A-17

Increased Oversight of Suicide Prevention Training for Correctional Facility Staff H-430.984

1. Our AMA strongly encourages all state and local adult and juvenile correctional facilities to develop a suicide prevention plan that meets current National Commission on Correctional Health Care standards for accreditation.

2. Our AMA strongly encourages all state and local adult and juvenile correctional facility officers to undergo suicide prevention training annually.

Res. 408, A-17

Medications for Opioid Use Disorder in Correctional Facilities H-430.987

1. Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated; and (b) medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.

2. Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.

3. Our AMA advocates for legislation, standards, policies, and funding that require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case

managers, social workers, and pharmacies in the communities where patients, including individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment.

4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.

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

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

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

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

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

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

5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 904
(I-22)

Introduced by: International Medical Graduates Section

Subject: Immigration Status Is a Public Health Issue

Referred to: Reference Committee K

- 1 Whereas, There are 47 million foreign-born residents in the U.S. in 2022 (14.3% of the
2 population) being the largest number ever recorded; and
3
4 Whereas, The Census Bureau projects the foreign-born share of the U.S. population to continue
5 to increase reaching 69 million by 2060; and
6
7 Whereas, Immigration status is being increasingly recognized as a social determinant of health
8 identifying the immigrant population as a vulnerable population that is at increased risk for poor
9 physical, psychological and social health outcomes, and inadequate healthcare; and
10
11 Whereas, Poor health outcomes among immigrants are not only dependent on socioeconomic
12 characteristics, but often determined by factors that are unique for this population – language
13 barriers, difficulty navigating the healthcare system, stigmatization, marginalization, and
14 discrimination within the healthcare system, inability to have medical coverage, poor
15 understanding of specific immigrants' health challenges by health professionals; and
16
17 Whereas, Healthcare inequities among immigrants include not only personal medical services
18 but also public health services and programs; for example, immunizations, often due to
19 institutional, structural, and systemic factors; therefore be it
20
21 RESOLVED, That our American Medical Association declare that immigration status is a public
22 health issue that requires a comprehensive public health response and solution (Directive to
23 Take Action); and be it further
24
25 RESOLVED, That our AMA recognize interpersonal, institutional, structural, and systemic
26 factors that negatively affect immigrants' health (New HOD Policy); and be it
27
28 RESOLVED, That our AMA promote the development and implementation of educational
29 resources for healthcare professionals to better understand health and healthcare challenges
30 specific for the immigrant population (Directive to Take Action); and be it further
31
32 RESOLVED, That our AMA support the development and implementation of public health
33 policies and programs that aim to improve access to healthcare and minimize systemic health
34 barriers for immigrant communities. (New HOD Policy)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 09/27/22

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 905
(I-22)

Introduced by: Illinois

Subject: Minimal Age of Juvenile Justice Jurisdiction in the United States

Referred to: Reference Committee K

- 1 Whereas, 27 states have no minimum age of juvenile adjudication; and
2
3 Whereas, Without a minimal age law, children of any age can be arrested; and
4
5 Whereas, Without minimal age law, children of any age can be charged with a juvenile violation;
6 and
7
8 Whereas, Without minimal age law, children of any age can be potentially incarcerated; and
9
10 Whereas, Without minimal age law, racial injustice and health inequalities take place; and
11
12 Whereas, Without minimal age law, families and individuals suffer economic burden, social
13 disgrace and stigmatization impacting future life and employment; and
14
15 Whereas, Evidence supports decriminalizing young children – providing them with appropriate
16 support and avoiding handcuffs and cages – as a humane and productive approach with
17 positive mental and physical health outcomes for the very young of society; and
18
19 Whereas, The United Nations Standard Minimum Rules for the Administration of Juvenile
20 Justice (The Beijing Rules) Rules do not set a minimum age, however, they set forth the
21 considerations when setting a minimum age, such as the emotional, mental and intellectual
22 maturity of the child; and
23
24 Whereas, Research by the National Governors Association identifies 15 states that have set the
25 minimum age at 10 years old for juvenile adjudication; therefore be it
26
27 RESOLVED, That our American Medical Association create a policy to establish minimal age of
28 10 years for juvenile justice jurisdiction in the United States (New HOD Policy); and be it further
29
30 RESOLVED, That our AMA introduce legislation to establish minimal age of 10 for juvenile
31 justice jurisdiction in the United States. (Directive to Take Action)

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

Received: 09/27/22

REFERENCES:

<https://www.nga.org/center/publications/age-boundaries-in-juvenile-justice-systems/>

<https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/beijingrules.pdf>

RELEVANT AMA POLICY

Juvenile Justice System Reform H-60.919

Our AMA:

1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance" policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.
5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.
6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.
7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.
8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development and local public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.

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

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;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 906
(I-22)

Introduced by: New York

Subject: Requirement for COVID-19 Vaccination in Public Schools Once Fully
FDA-Authorized

Referred to: Reference Committee K

- 1 Whereas, COVID-19 vaccination has demonstrated safety effectiveness in preventing
2 hospitalization and death for children and adolescents;¹ and
3
4 Whereas, The risks of cardiac and thromboembolic complications from COVID-19 disease,
5 including MIS-C, is far higher than the risk of myocarditis from vaccination;^{1,3} and
6
7 Whereas, COVID-19 vaccines reduce the risk of significant morbidity, including “long COVID”
8 and missed days from school and work;¹ and
9
10 Whereas, Children can serve as a pool for ongoing community spread of COVID-19 clusters
11 and outbreaks;² and
12
13 Whereas, Vaccination has been demonstrated to reduce overall community transmission of
14 COVID-19;¹⁻³ and
15
16 Whereas, Risk of exposure to COVID-19 poses significant concern for children with chronic
17 medical conditions such as asthma, diabetes and developmental disorders;^{1,2} therefore be it
18
19 RESOLVED, That our American Medical Association encourage states to make COVID-19
20 vaccination a requirement for school attendance for children and college/university students
21 once the FDA grants full approval for COVID-19 vaccination for all relevant age groups. (New
22 HOD Policy)

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

Received: 09/27/22

REFERENCES:

https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/children-teens.html?s_cid=11368:age%20limit%20for%20covid%20vaccine.sem.ga:p:RG:GM:gen:PTN:FY21
<https://www.cdc.gov/coronavirus/2019-ncov/groups/families-children.html>
<https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html>

RELEVANT AMA POLICY

Education and Public Awareness on Vaccine Safety and Efficacy H-440.830

1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; (f) supports state policies allowing minors to override their parent's refusal for vaccinations; and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.

2. Our AMA: (a) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (c) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.

Citation: Res. 9, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 411, A-17; Modified: Res. 011, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 907
(I-22)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury

Referred to: Reference Committee K

- 1 Whereas, The AMA declared gun violence in the United States a national public health crisis (PHC)
2 in 2016; and
- 3 Whereas, From January 1, 2022, through September 27, 2022, there were 32,944 gun violence
4 deaths in the United States¹, including 15,124 homicides, murders, and unintentional deaths; and
- 5 Whereas, At least 13% of mass shootings involve the use of illegally purchased weapons²; and
- 6 Whereas, Over 80% of individuals who engage in K-12 school shootings stole firearms from family
7 members², and
- 8 Whereas, From January 1, 2022, through September 27, 2022, there were 29,518 gun violence
9 survivors¹ that were injured; and
- 10 Whereas, The economic cost of firearm injury in the United States is estimated to be \$557 billion per
11 year³, including immediate costs such as hospital treatment, ambulances, and the police response;
12 subsequent costs such as long-term physical and mental health care, rehabilitation care, institutional
13 care, forgone earnings from disability or death, and criminal justice costs; and quality-of-life costs for
14 pain and suffering over a victim's life span⁴; and
- 15 Whereas, The AMA has extensive policy calling for expansion of national research and mitigation
16 strategies from entities such as the Centers for Disease Control and Prevention, the National
17 Institutes of Health, and the United States Surgeon General to address our national firearm injury
18 PHC; and
- 19 Whereas, These entities have failed to produce timely research, recommendations, and mitigation
20 strategies to address the national firearm injury PHC; and
- 21 Whereas, The US Congress has struggled to develop non-partisan conversations around firearm
22 safety strategies, but has recently taken the first step by passing the *S.2938: Bipartisan Safer
23 Communities Act*⁵; and
- 24 Whereas, The majority of community gun violence⁶ and firearm related crime in the United States
25 occurs through the use of and access to illegal firearms⁷⁻¹⁸; and
- 26 Whereas, The AMA can help reorient the public and the national conversation about the national
27 firearm injury PHC around public health in a solutions-oriented, unbiased, and non-partisan manner;
28 therefore be it
- 29 RESOLVED, That our American Medical Association support research looking at the major sources
30 of illegal gun supply, as well as possible methods of decreasing the proliferation of illegal firearms in
31 the United States (New HOD Policy); and be it further

- 1 RESOLVED, That our AMA work with key stakeholders including, but not limited to, firearm
 2 manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm
 3 injury victims advocacy groups, healthcare providers, and state and federal government agencies to
 4 study and develop evidence-informed public health recommendations to mitigate the effects of
 5 violence committed with illegal firearms (Directive to Take Action); and be it further
- 6 RESOLVED, That our AMA convene national public forums including, but not limited to, online
 7 venues, national radio, and televised/streamed in-person town halls, that bring together key
 8 stakeholders and members of the general public to focus on finding common ground, non-partisan
 9 measures to mitigate the effects of illegal firearms in our firearm injury public health crisis (Directive
 10 to Take Action); and be it further
- 11 RESOLVED, That our AMA reaffirm House policies H-145.975, H-145.984, H-145.997, D-145.994,
 12 and D-145.999 calling for increased funding for national firearm violence research. (Reaffirm HOD
 13 Policy)

Fiscal Note: Not yet determined

Received: 09/28/22

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RELEVANT AMA POLICY

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

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
 2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
 3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
- Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 3, A-21

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

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.
Therefore, the AMA:
 - (A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
 - (B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
 - (C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
 - (D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
 - (E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
 - (F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
 - (G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
 2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.
- Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19

Data on Firearm Deaths and Injuries H-145.984

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

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

Epidemiology of Firearm Injuries D-145.999

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; and (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms.

Citation: Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13; Reaffirmation: A-18

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

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

Citation: Res. 214, I-16

Removing Restrictions on Federal Funding for Firearm Violence Research D-145.994

Our AMA will provide an informational report on recent and current organizational actions taken on our existing AMA policies (e.g. H-145.997) regarding removing the restrictions on federal funding for firearms violence research, with additional recommendations on any ongoing or proposed upcoming actions.

Citation: Res. 201, I-16

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

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

Citation: (Res. 410, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 908
(I-22)

Introduced by: Senior Physicians Section

Subject: Older Adults and the 988 Suicide and Crisis Lifeline

Referred to: Reference Committee K

- 1 Whereas, Suicide is the 12th leading cause of death in the United States (2020), and is a public
2 health issue for individuals and for the communities they live in;¹ and
3
4 Whereas, While older adults comprise just 12% of the population, they make up approximately
5 18% of all suicide deaths;² and
6
7 Whereas, Among people who attempt suicide, one in four seniors will succeed, compared to 1
8 in 200 youths;³ and
9
10 Whereas, The new mental health line, known as the 988 Suicide and Crisis Lifeline, was
11 launched nationally on July 1, 2022; and
12
13 Whereas, The Department of Health and Human Services (HHS) through its Substance Abuse
14 and Mental Health Services Administration, has awarded nearly \$105 million in grant funding,
15 provided by the American Rescue Plan, to 54 states and territories in advance of the transition
16 of the National Suicide Prevention Lifeline;⁴ and
17
18 Whereas, With States having varying degrees of operational readiness, the success of 988 now
19 is important to get activated; and
20
21 Whereas, The 988 number currently does not designate priority by age group; and
22
23 Whereas, Seniors who are homebound may lack the social connections they need and call
24 centers are expected to be appropriately funded and staffed with properly trained operators to
25 handle suicide risk; therefore be it
26
27 RESOLVED, That our American Medical Association, with other interested organizations,
28 develop model legislation for use by states who wish to pursue funding for the 988 Suicide and
29 Crisis Lifeline (Directive to Take Action); and be it further
30
31 RESOLVED, That our AMA advocate that the Department of Health and Human Services (HHS)
32 prioritize education and outreach activities for use of the 988 Suicide and Crisis Lifeline to those
who are at highest risk for suicide completion with a special emphasis on those over age 65.
(Directive to Take Action)

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

Received: 09/29/22

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RELEVANT AMA POLICY

Awareness Campaign for 988 National Suicide Prevention Lifeline D-345.974

Our AMA will: (1) utilize their existing communications channels to educate the physician community and the public on the new 9-8-8 National Suicide Prevention Lifeline program; (2) work with the Federation and other stakeholders to advocate for adequate federal and state funding for the 9-8-8 system; and (3) collaborate with the Substance Abuse and Mental Health Services Administration and the 9-8-8 partner community to strengthen suicide prevention and mental health crisis services.

Citation: Res. 423, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 909
(I-22)

Introduced by: Senior Physicians Section
Subject: Decreasing Gun Violence and Suicide in Seniors
Referred to: Reference Committee K

- 1 Whereas, Our AMA has recognized that gun violence is an urgent public health crisis; and
2
3 Whereas, While most media attention focuses on mass shootings, the majority (60%) of gun
4 related deaths are in fact due to suicide;¹ and
5
6 Whereas, The prototypical gun related suicide happens in older, rural, white males;² and
7
8 Whereas, Suicide is often an impulsive act amenable to intervention; and
9
10 Whereas, New federal legislation facilitates universal adoption of Extreme Risk Protection
11 Orders (Red Flag laws);³ and
12
13 Whereas, One of the barriers to addressing this crisis is that clinicians are often hesitant to
14 discuss and counsel about firearm safety;⁴ therefore be it
15
16 RESOLVED, That our American Medical Association and other organizations develop and
17 disseminate a formal educational program to enable clinicians to effectively and efficiently
18 address suicides with an emphasis on seniors and firearms (Directive to Take Action); and be it
19 further
20
21 RESOLVED, That our AMA develop with other interested organizations a toolkit for clinicians to
22 use addressing Extreme Risk Protection Orders in their individual states (Directive to Take
23 Action); and be it further
24
25 RESOLVED, That our AMA partner with other groups interested in firearm safety to raise public
26 awareness of magnitude and interventions available regarding senior suicides and firearms.
27 (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 09/29/22

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RELEVANT AMA POLICY

Firearms and High-Risk Individuals H-145.972

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

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

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

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

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

Ban on Handguns and Automatic Repeating Weapons H-145.985

It is the policy of the AMA to:

(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:

(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;

(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;

(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);

(d) the imposition of significant licensing fees for firearms dealers;

(e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and

(f) mandatory destruction of any weapons obtained in local buy-back programs.

(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.

(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.

(4) Oppose concealed carry reciprocity federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.

(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.

Citation: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14; Appended: Res. 427, A-18; Reaffirmation: A-18; Modified: Res. 244, A-18;

Gun Violence as a Public Health Crisis D-145.995

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and

(2) will actively lobby Congress to lift the gun violence research ban.

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

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 910
(1-22)

Introduced by: Resident and Fellow Section

Subject: Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use

Referred to: Reference Committee K

- 1 Whereas, Led by the Society of Pediatric Radiology (SPR), the Image Gently Alliance was
2 formed in late 2006 with the goal of “changing practice by raising awareness of the opportunities
3 to lower radiation dose in the imaging of children” (1); and
4
- 5 Whereas, The SPR recruited other organizations/members of the imaging team into the alliance
6 in 2007 including the American College of Radiology (ACR), American Association of Physicists
7 in Medicine (AAPM), and American Society of Radiologic Technologists (ASRT) (1); and
8
- 9 Whereas, The practice of shielding reproductive organs and in utero fetuses began in the 1950s
10 given concerns about the long-term effects of radiation and the potential for passing on genetic
11 mutations through genetic inheritance (2,3); and
12
- 13 Whereas, In response to these concerns, state and federal laws and regulations have been
14 created requiring the use of gonad shields in medical imaging studies (4,5); and
15
- 16 Whereas, Through technological advances, medical physicists estimate the dose from routine
17 diagnostic imaging to reproductive organs has been reduced by 95% without compromising
18 diagnostic quality (2,3); and
19
- 20 Whereas, Technological advances and optimization have resulted in marginal hereditary risk
21 reduction from gonad shielding ranging from 1×10^{-6} in women and 5×10^{-6} in men (6); and
22
- 23 Whereas, Research on radiation dosing has shown that routine diagnostic imaging does not
24 produce harmful levels of radiation to patients and fetuses (2,3); and
25
- 26 Whereas, Modern mechanisms to optimize imaging parameters such as automatic exposure
27 control (AEC) are negatively affected by shielding (7); and
28
- 29 Whereas, The gonad shield results in decreased activity on the detector, triggering AEC to
30 increase radiation output, which results in increased exposure and patient dose along with the
31 degradation of image quality (7); and
32
- 33 Whereas, The gonad shield produces artifacts and can obscure relevant anatomy and
34 diagnostic information (7); and
35
- 36 Whereas, Non-diagnostic or obscured images may need to be repeated increasing patient dose
37 when shields are used (7); and
38
- 39 Whereas, The gonad surface shield is ineffective at reducing internal scatter (7); and

1 Whereas, Studies have shown that gonad shields are incorrectly placed for females in 91% of
2 radiographs and for males in 66% of radiographs, rendering them ineffective (8,9); and
3

4 Whereas, On January 12th, 2021, the National Council on Radiation Protection and
5 Measurements (NCRP) issued a statement that the risks of utilizing gonad shields far outweigh
6 the negligible benefits to reproductive organs and therefore they should not be routinely used
7 (10); and
8

9 Whereas, Similar statements opposing routine or mandatory use of gonadal shields were
10 released by the ACR and the AAPM in 2019 and by the ASRT in 2021 (11,12); therefore be it
11

12 RESOLVED, That our American Medical Association oppose mandatory use of gonad shields in
13 medical imaging considering the risks far outweigh the benefits (New HOD Policy); and be it
14 further
15

16 RESOLVED, That our AMA advocate that the U.S. Food and Drug Administration amend the
17 code of federal regulations to oppose the routine use of gonad shields in medical imaging
18 (Directive to Take Action); and be it further
19

20 RESOLVED, That our AMA, in conjunction with state medical societies, support model state and
21 national legislation to oppose or repeal mandatory use of gonad shields in medical imaging
22 (New HOD Policy)

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

Received: 09/30/22

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 911
(I-22)

Introduced by: Society for Cardiovascular Angiography & Interventions

Subject: Critical Need for National Emergency Cardiac Care (ECC) System to Ensure Individualized, State-Wide, Care for ST Segment Elevation Myocardial Infarction (STEMI), Cardiogenic Shock (CS) and Out-of-Hospital Cardiac Arrest (OHCA), and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies

Referred to: Reference Committee K

- 1 Whereas, Cardiovascular Disease is the number one cause of death for men and women in the
2 United States¹, and
3
4 Whereas, The Acute Coronary Syndromes of unstable angina pectoris (USAP), Non-ST
5 segment Elevation MI (NSTEMI) and STEMI are major causes of death and disability^{1,4,8}, and
6
7 Whereas, Survival for uncomplicated STEMI patients has dramatically improved over the last 6
8 decades (> 97% survival rate) with the implementation of systems of Emergency Cardiac Care
9 (ECC), survival for STEMI with cardiogenic shock (CS) is unacceptably high^{2,3,4,8}, and
10
11 Whereas, STEMI patients with cardiogenic shock (STEMI-CS) have mortality rates near 50%,
12 except in some U.S. localities where the survival rates may be as high as 70% because of
13 specialized medical centers that provide care teams and therapeutic modalities, like early use of
14 Mechanical Circulatory Support (MCS), shock teams and coronary revascularization, through
15 organized systems of ECC^{2,3,8}, and
16
17 Whereas, Out-of-Hospital Cardiac Arrest (OHCA) is the fifth most common cause of death in the
18 United States, accounting for more deaths than colon cancer, breast cancer, prostate cancer,
19 influenza, pneumonia, HIV, firearms and house fires combined^{5,6,7}, and
20
21 Whereas, 90% of OHCA occur in the home or workplace and these patients require intense and
22 precisely orchestrated ECC on site, during transportation by Emergency Medical
23 Technicians/Paramedics, and subsequent ECC as inpatients⁶, and
24
25 Whereas, Survival for patients with OHCA and refractory ventricular fibrillation is markedly
26 improved, from less than 10% to over 40%, when systems of ECC include uniquely applied
27 invasive procedures like emergent Extracorporeal Membrane Oxygenation (ECMO/ECPR)⁸, and
28
29 Whereas, Specialized systems of ECC, designed for coordinating and escalating cardiovascular
30 care for patients with STEMI, STEMI-CS and OHCA, in some States, have produced significant
31 improvements in survival for these catastrophic cardiovascular disorders^{4,8,14,17}, and
32
33 Whereas, STEMI and STEMI-CS care is provided in a disparate manner to sociodemographic
34 groups like the elderly, women, Black and Hispanic patients^{9,10} with Black and Hispanic women
35 having the highest mortality (29% and 46%, respectively), and

1 Whereas, Hospitals of different sizes, in diverse geographic and socioeconomic locations with
2 varying clinical capabilities, provide different levels of ECC, and pre-hospital care can be quite
3 variable^{11,12}, there is a need to systematize ECC in the United States because standardization
4 of systems of ECC^{13,14}, results in improved treatment times and survival for patients with STEMI,
5 STEMI-CS and OHCA^{4,5,7,8,13,14,15,17}, and
6

7 Whereas, The implementation of systems of care for ECC, with strict protocol adherence,
8 diminishes treatment disparities between sociodemographic groups^{15,16}, and
9

10 Whereas, States that have addressed ECC solutions, unique to their State, some with laws¹⁸
11 and others with State-wide clinical agreements between health systems and physicians¹⁹,
12 therefore be it
13

14 RESOLVED, That our American Medical Association encourage each state to standardize pre-
15 hospital and inpatient care for cardiac emergencies, with individualized systems of Emergency
16 Cardiac Care (ECC), specific for each state, to improve care and enhance survival for all
17 patients, especially for those citizens who receive sociodemographically disparate care, when
18 they present with cardiac emergencies (STEMI, STEMI-CS and OHCA) (New HOD Policy); and
19 be it therefore,
20

21 RESOLVED, That our AMA encourage states to designate hospitals as ECC Centers based on
22 their individual capabilities to provide ECC, much like the designations and systems of care for
23 Stroke and Trauma Centers. (New HOD Policy)

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

Received: 09/30/22

Abbreviations:

Acute Coronary Syndrome – ACS

Cardiogenic Shock – CS

Emergency Cardiac Care – ECC

Extracorporeal Membrane Oxygenation – ECMO

Extracorporeal Membrane Oxygenation facilitated Cardio-Pulmonary Resuscitation - ECPR

Mechanical Circulatory Support – MCS

Myocardial Infarction – MI

Out of Hospital Cardiac Arrest – OHCA

ST segment Elevation Myocardial Infarction – STEMI

ST segment Elevation Myocardial Infarction with Cardiogenic Shock – STEMI-CS

Unstable Angina Pectoris – USAP

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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

1 Whereas, Despite the overwhelming empirical data on the abuse of the FDA citizen petition
2 process, there is minimal official data on the true cost to society¹⁵; and
3

4 Whereas, The FDA is not obligated to nor does it actively report to Congress which petitions
5 have been filed fraudulently or the nature of generic entry market delay¹⁷; and
6

7 Whereas, Increasing the transparency of the citizen petition process would facilitate more
8 thorough research and analysis of petitions and lower unnecessary resource expenditure by the
9 FDA¹⁷; therefore be it
10

11 RESOLVED, That our American Medical Association support the research of anti-competitive
12 practices on the Food and Drug Administration's (FDA) citizen petitions process (New HOD
13 Policy); and be it further
14

15 RESOLVED, That our AMA advocate for further public transparency by the FDA in the content
16 of each petition, the relationship between citizen petitions and decisions to delay generic
17 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: 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

1 Whereas, In regions of the world where the alcohol industry has self-regulated marketing codes,
2 youth have consistently higher exposure to alcohol marketing¹⁰; and
3

4 Whereas, The youth population is considered a cohort particularly susceptible to socialization-
5 based advertising techniques frequently employed by the alcohol industry, wherein products are
6 intentionally paired with agents of socialization in order to create favorable associations
7 between the two in consumers' minds, including through product placement near to or usage by
8 popular television characters, social media campaigns, and the sponsorship of sporting teams,
9 events, and celebrities¹¹⁻¹³; and
10

11 Whereas, The Master Settlement Agreement (MSA) was reached in 1999 between 46 state
12 attorneys general and 4 tobacco manufacturers to resolve the largest class action lawsuit in
13 American history; among its provisions, the MSA: forced the tobacco industry to make
14 concessions/admissions of guilt regarding the ways in which their advertising practices
15 disproportionately targeted the youth population, placed restrictions on advertising venues for
16 the tobacco industry, and mandated that the industry pay out 206 billion dollars in
17 reparations^{14,15}; and
18

19 Whereas, Prior to the MSA, the tobacco industry had self-regulatory standards for advertising
20 practices, identical in nature to the current status of the alcohol industry^{14,15}; and
21

22 Whereas, Following the MSA, youth cigarette usage has now dropped to the lowest levels seen
23 in decades¹⁶; and
24

25 Whereas, A WHO Global Status Report on international alcohol policy demonstrated that up to
26 56% of countries worldwide have alcohol marketing regulations to protect youth and other
27 vulnerable populations from the harmful effects of alcohol marketing¹⁷; and
28

29 Whereas, The United Nations Convention on the Rights of the Child declares it the responsibility
30 of sovereign nations to create appropriate guidelines to protect children from information and
31 material injurious to their wellbeing¹⁸; and
32

33 Whereas, A 2017 study demonstrated that there is no effective system currently in place to
34 remove- or enforce punitive measures for production of- advertisements deemed "non-
35 compliant" to the American alcohol industry's self-imposed 'youth-protective' advertising
36 regulations^{9,10}; therefore be it
37

38 RESOLVED, That our American Medical Association amend policy H-30.940, "Labeling
39 Advertising, and Promotion of Alcoholic Beverages," by addition and deletion to read as follows:
40

41 **H-30.940, Labeling, Advertising, and Promotion of Alcoholic Beverages**

42 (1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all
43 beverages, including so-called "nonalcoholic" beer and other substances as well,
44 including over-the-counter and prescription medications, with removal of "nonalcoholic"
45 from the label of any substance containing any alcohol; (b) supports efforts to educate
46 the public and consumers about the alcohol content of so-called "nonalcoholic"
47 beverages and other substances, including medications, especially as related to
48 consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and
49 Explosives (ATF) and other appropriate federal regulatory agencies to continue to
50 reject proposals by the alcoholic beverage industry for authorization to place beneficial
51 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; ~~(c)~~(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

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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

1 Whereas, Proximity to and exposure to hazards from the oil and gas, plastics, animal
2 production, chemical manufacturing, endocrine-disrupting chemicals, and metal industries have
3 been strongly linked to at least one of the following: neural tube defects, preterm birth, low-birth
4 weight, diffuse interstitial lung fibrosis, chronic bronchitis, asthma exacerbation, diabetes,
5 hypertension secondary to chronic inflammation, pneumonia, reduced child cognition from
6 heavy metal exposure, neurologic diseases, cancers, hyperlipidemia, and thyroid disease¹⁹⁻²⁸;
7 and

8
9 Whereas, Closures of industrial sites and reductions in pollution have been linked to improved
10 fertility and reduced preterm births and respiratory hospitalizations²⁹⁻³¹; and

11
12 Whereas, Recent natural disasters such as hurricanes, the over 1,500 oil spills from the Dakota
13 Access Pipeline and the Keystone Pipeline in the last decade alone, the Texas freeze, and
14 states' responses to these natural disasters perpetuate environmental injustice by
15 disproportionately affecting predominantly minoritized and low-income communities³²⁻³⁷; and

16
17 Whereas, The health of American Indian tribes depends on essential natural resources that
18 have either been depleted and/or contaminated by mining and oil corporations, leading to
19 adverse health outcomes³⁸⁻⁴¹; and

20
21 Whereas, Government agencies have failed to act on current policy and integrate current
22 environmental science research or expertise into ongoing environmental regulations and public
23 health initiatives, resulting in continued and amplified environmental hazards and failing to
24 protect people, especially in Black and American Indian communities, from known and
25 predictable environmental health dangers⁴²⁻⁴⁹; and

26
27 Whereas, Climate change represents an important tenet of environmental health that can
28 significantly impact public and community health⁵⁰; and

29
30 Whereas, The United States healthcare system alone is responsible for 10% of national
31 greenhouse gas emissions and, if it were its own country, it would be the 13th largest producer
32 of greenhouse gas emissions in the world^{50,51}; and

33
34 Whereas, Extreme weather and climate events have significantly increased healthcare spending
35 in the United States, with \$14 billion in additional spending through 760,000 additional patient
36 encounters and 1,689 premature deaths between 2000 and 2009⁵²⁻⁵³; and

37
38 Whereas, The Intergovernmental Panel on Climate Change (IPCC) has determined it is possible
39 to avoid warming past 1.5°C above pre-industrial levels by 2100 if extreme measures are taken
40 to curtail anthropogenic emissions⁵⁴; and

41
42 Whereas, If global warming exceeds 1.5°C, the estimated global effects include 92,207
43 additional heat-related deaths per year by 2030, 350 million more humans exposed to severe
44 heat by 2050, and 31 to 69 million humans exposed to flooding from sea level rise by 2100⁵⁴;
45 and

46
47 Whereas, Compared to no action, limiting global warming to less than 1.5°C would result in
48 ~50% lower annual health-related costs and prevention of ~50% of infectious disease cases in
49 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
(1-22)

Introduced by: Association for Clinical Oncology

Subject: Domestic Production of Personal Protective Equipment

Referred to: Reference Committee K

1 Whereas, The Biden Administration on January 21, 2021, issued an Executive Order on a
2 Sustainable Public Health Supply Chain, directing the development of a strategy to design,
3 build, and sustain a long-term capability in the United States to manufacture supplies for future
4 pandemics and biological threats¹; and

5
6 Whereas, This strategy shall include an approach to develop a multi-year implementation plan
7 for domestic production of pandemic supplies; and

8
9 Whereas, The Biden Administration on February 24, 2021, issued an Executive Order² on
10 America's Supply Chains, ordering an examination of several critical supply chains and the
11 issuance within 100 days of a report³ with recommendations to the White House; and

12
13 Whereas, The Centers for Medicare and Medicaid Services in July, 2022, proposed policy⁴ to
14 enable and encourage hospitals to purchase and utilize domestically-produced N95 respirators
15 via a payment adjustment to compensate hospitals for the additional resource costs of acquiring
16 domestically-made NIOSH-approved surgical N95 respirators for cost reporting periods
17 beginning on or after January 1, 2023; and

18
19 Whereas, The Association for Clinical Oncology has previously recommended⁵ that the
20 Executive Branch identify raw materials, components, parts or accessories of critical devices
21 that should have domestic manufacturing capacity to improve the resilience of the U.S. device
22 supply chain and incentivize their production without limiting access to foreign sources of
23 devices; therefore be it

24
25 RESOLVED, That our American Medical Association support state and federal incentives to
26 locate the manufacturing of goods used in healthcare and healthcare facilities in the United
27 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: 926
(1-22)

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
(1-22)

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

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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
(1-22)

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

1 Whereas, Though the Federal Bureau of Prisons has released guidance for securing the lowest-
2 cost medications ethically, these guidelines are not followed universally²¹; and

3
4 Whereas, Pharmaceutical companies may exert influence over these decision makers and even
5 offer free samples or rebates to incentivize their products being preferred on formulary²²; and

6
7 Whereas, While some may advocate for accepting these reduced-cost drugs as a cost-saving
8 measure, it can be a source of bias and compromises medical necessity being a driver of
9 formulary creation, particularly for inmates who have no choice or agency in where they access
10 their healthcare²³; and

11
12 Whereas, While existing American Medical Association policy expresses strong support for the
13 ethical provision of medical care to incarcerated individuals (see: D-430.997, Item 9.7.2 of the
14 AMA Code of Medical Ethics), opposes direct-to-consumer (H-105.988) and EHR-facilitated
15 direct-to-provider (D-478.961) prescription drug advertising, and endorses principles for sound
16 formulary design (H-125.985), but has no policy explicitly recognizing the unique protections
17 that must be afforded to vulnerable, captive populations like incarcerated individuals with
18 respect to formulary design and medication procurement; therefore be it

19
20 RESOLVED, That our American Medical Association oppose the practice of pharmaceutical
21 marketing towards those who make decisions for captive populations, including, but not limited
22 to, doctors working in a correctional capacity, judges, wardens, sheriffs, correctional officers,
23 Immigration and Customs Enforcement, and other detention administrators (New HOD Policy);
24 and be it further

25
26 RESOLVED, That our AMA advocate for the inclusion of physicians in the selection of
27 medications available to vulnerable populations such as incarcerated individuals (Directive to
28 Take Action); and be it further

29
30 RESOLVED, That our AMA support and work with state medical societies to support measures
31 to increase transparency in medication procurement, including but not limited to: (1) requiring
32 those responsible for medical procurement to report gifts from pharmaceutical companies over a
33 minimum amount; and (2) centralizing formulary choices in a physician-led office, agency, or
34 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
(1-22)

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

1 Whereas, No existing AMA policy addresses longitudinal continuity of care needs of children in
2 foster care which remain unaddressed in spite of legal access to medical care for foster
3 children^{30,31}; therefore be it
4

5 RESOLVED, That our American Medical Association support the construction of computerized
6 health information systems to enhance information exchange between both tribal and non-tribal
7 child welfare agencies and healthcare professionals (New HOD Policy); and be it further
8

9 RESOLVED, That our AMA promote existing pediatric medical homes which provide continuity
10 of care to children in foster care (Directive to Take Action); and be it further
11

12 RESOLVED, That our AMA advocate for the designation of medical providers, teams, and/or
13 committees to longitudinally follow children in foster care (Directive to Take Action); and be it
14 further
15

16 RESOLVED, That our AMA support the appointment of a pediatrician in each state with
17 experience in child welfare to the position of state medical director of foster care health case
18 management in accordance with AAP guidelines to ensure standards of care are met (New
19 HOD Policy); and be it further
20

21 RESOLVED, That the AMA support the longitudinal stability and care of American Indian and
22 Alaska Native children in foster care by promoting the Indian Child Welfare Act. (New HOD
23 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

- 1 Whereas, "Street medicine" is the practice of providing medical care to unsheltered people
2 experiencing homelessness in locations like encampments, parks, and under bridges¹; and
3
- 4 Whereas, Street medicine is an evidence-based health provision model that effectively bridges
5 the unique barriers and gaps in care seen in populations experiencing unsheltered
6 homelessness by bringing medicine to the streets and connecting individuals to the existing
7 resources they need and have difficulty accessing^{2,3}; and
8
- 9 Whereas, Approximately one third of the estimated 580,466 persons experiencing
10 homelessness in 2020 were unsheltered according to reports from the United States
11 Department of Housing and Development and the Urban Institute⁴; and
12
- 13 Whereas, The National Healthcare for the Homeless Council reports up to 46,500 persons
14 experiencing homelessness die each year in the United States, and this number is climbing⁵;
15 and
16
- 17 Whereas, Life expectancy for people living on the streets is estimated to be twelve years shorter
18 than the national average, and chronic diseases and disabilities are abundant and exacerbated
19 by life on the street^{5,6}; and
20
- 21 Whereas, The COVID-19 pandemic resulted in an increased rate of persons experiencing
22 homelessness, increased criminalization of homelessness, and increased death rates amongst
23 people experiencing homelessness^{5,7,8}; and
24
- 25 Whereas, 1.4 million unsheltered people access emergency shelter or transitional housing each
26 year, placing them in congregative settings which pose tremendous risk for the spread of
27 communicable diseases like COVID-19, with the New York City Department of Emergency
28 Services reporting that COVID-19 mortality rates are 49 percent higher for sheltered homeless
29 individuals⁹; and
30
- 31 Whereas, Lack of access to health care services, limited autopsies, and the absence of housing
32 status on death certificates and hospital records leads to a severe undercount of COVID-related
33 cases and deaths among unsheltered individuals^{10,11}; and
34
- 35 Whereas, Rent prices have risen dramatically in recent years, placing undue burden upon lower
36 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

1 Whereas, H-160.903 specifically asks that the AMA “recognizes adaptive strategies based on
2 regional variations, community characteristics and state and local resources are necessary to
3 address [homelessness] on a long-term basis”, and as such has set precedence for feasibly
4 supporting such measures; therefore be it

5
6 RESOLVED, That our American Medical Association encourage medical schools to implement
7 Street Medicine programs and/or promote student-led Street Medicine programs (New HOD
8 Policy); and be it further

9
10 RESOLVED, That our AMA recognizes and supports the use of Street Medicine programs by
11 amending policy H-160.903 Eradicating Homelessness by addition and deletion to read as
12 follows:

13
14 **Eradicating Homelessness, H-160.903**

15 Our AMA:

16 (1) supports improving the health outcomes and decreasing the health care costs of
17 treating the chronically homeless through clinically proven, high quality, and cost
18 effective approaches which recognize the positive impact of stable and affordable
19 housing coupled with social services;

20 (2) recognizes that stable, affordable housing as a first priority, without mandated
21 therapy or services compliance, is effective in improving housing stability and quality of
22 life among individuals who are chronically-homeless;

23 (3) recognizes adaptive strategies based on regional variations, community
24 characteristics and state and local resources are necessary to address this societal
25 problem on a long-term basis;

26 (4) supports the use of street medicine programs, which travel to individuals who are
27 unhoused or unsheltered and provide healthcare and social services, as well as funds,
28 including Medicaid and other public insurance reimbursement, for their maintenance;

29 ~~(45)~~ recognizes the need for an effective, evidence-based national plan to eradicate
30 homelessness;

31 ~~(56)~~ encourages the National Health Care for the Homeless Council to study the funding,
32 implementation, and standardized evaluation of Medical Respite Care for homeless
33 persons;

34 ~~(67)~~ will partner with relevant stakeholders to educate physicians about the unique
35 healthcare and social needs of homeless patients and the importance of holistic, cost-
36 effective, evidence-based discharge planning, and physicians’ role therein, in addressing
37 these needs;

38 ~~(78)~~ encourages the development of holistic, cost-effective, evidence-based discharge
39 plans for homeless patients who present to the emergency department but are not
40 admitted to the hospital;

41 ~~(89)~~ encourages the collaborative efforts of communities, physicians, hospitals, health
42 systems, insurers, social service organizations, government, and other stakeholders to
43 develop comprehensive homelessness policies and plans that address the healthcare
44 and social needs of homeless patients;

45 ~~(910)~~ (a) supports laws protecting the civil and human rights of individuals experiencing
46 homelessness, and (b) opposes laws and policies that criminalize individuals
47 experiencing homelessness for carrying out life-sustaining activities conducted in public
48 spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or
49 sleeping) when there is no alternative private space available; and

50 ~~(1011)~~ recognizes that stable, affordable housing is essential to the health of individuals,
51 families, and communities, and supports policies that preserve and expand affordable
52 housing across all neighborhoods; and

1 (4412) (a) supports training to understand the needs of housing insecure individuals for
2 those who encounter this vulnerable population through their professional duties; (b)
3 supports the establishment of multidisciplinary mobile homeless outreach teams trained
4 in issues specific to housing insecure individuals; and (c) will make available existing
5 educational resources from federal agencies and other stakeholders related to the needs
6 of housing-insecure individuals; and
7 (13) supports federal and state efforts to enact just cause eviction statutes and examine
8 and restructure punitive eviction practices; instate inflation-based rent control; guarantee
9 tenants' right to counsel in housing disputes and improve affordability of legal fees; and
10 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: 933
(1-22)

Introduced by: Medical Student Section

Subject: Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV

Referred to: Reference Committee K

- 1 Whereas, Sexual identity is fluid and can be defined on a spectrum, ranging from exclusively
2 homosexual behavior to exclusively heterosexual behavior¹; and
3
4 Whereas, According to the U.S. National Survey of Family Growth, 17.4% of women and 6.2%
5 of men aged 18-44 report any same-sex sexual behavior at any time in their life, despite only
6 6.8% of women and 3.9% of men aged 18-44 report being homosexual, gay, lesbian, or
7 bisexual²; and
8
9 Whereas, Patients' reported sexual behavior and orientation is not always consistent with actual
10 sexual behavior as patients may not be willing to report their sexual histories accurately²; and
11
12 Whereas, In 2017, 30% of new HIV diagnoses in the United States were not attributed to the
13 men who have sex with men (MSM) demographic³; and
14
15 Whereas, From 2010-2016, African American heterosexual women accounted for the second
16 highest incidence of HIV infection after MSM⁴; and
17
18 Whereas, Black men who have sex with men and women (MSMW) have been hypothesized to
19 be the "bridge" through which HIV has been transmitted to black heterosexual men and women⁵⁻⁶;
20 and
21
22 Whereas, Several studies have shown that African American MSMW may challenge targeted
23 HIV prevention approaches that focus explicitly on sexual orientation since this population may
24 not identify as gay or bisexual and is therefore unlikely to participate in programs that prioritize
25 gay community affiliation as foundations for HIV prevention⁵⁻⁶; and
26
27 Whereas, In 2017, the African American population and Hispanic population collectively
28 accounted for 69% of HIV diagnoses, despite comprising only 31% of the U.S. population³; and
29
30 Whereas, A report from the CDC concluded that increasing HIV prevention services among
31 heterosexuals at increased risk is important, especially among racial and ethnic groups
32 disproportionately affected by HIV infection, such as blacks and Hispanics/Latinos⁷; and
33
34 Whereas, In 2019, the United States Preventive Services Task Force (USPSTF) recommended
35 with an "A" rating that clinicians offer HIV pre-exposure prophylaxis (PrEP) to persons who are
36 at high risk of HIV acquisition as an evidence-based primary prevention because PrEP reduces
37 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

1 RESOLVED, That our American Medical Association amend Policy H-20.895 “Pre-Exposure
2 Prophylaxis (PrEP) for HIV” by addition to read as follows:
3

4 **Pre-Exposure Prophylaxis (PrEP) for HIV, H-20.895**

- 5 1. Our AMA will educate physicians, physicians-in-training, and the public about the
6 effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical
7 Practice Guidelines.
8 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
9 3. Our AMA supports the removal of insurance barriers for PrEP such as prior
10 authorization, mandatory consultation with an infectious disease specialist and
11 other barriers that are not clinically relevant.
12 4. Our AMA advocates that individuals not be denied any insurance on the basis of
13 PrEP use.
14 5. Our AMA encourages the discussion of and education about PrEP during routine
15 sexual health counseling, regardless of a patient’s current reported sexual
16 behaviors. (Modify Current HOD Policy)

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

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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: 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

1 Whereas, A federal non-profit government manufacturer would be able to focus production of
2 generic version of prescription drugs on circumstances in which market failures occur, as in
3 scenarios where there are no generic manufacturers within a market or there are two or fewer
4 manufacturers and a significant price increase or a drug shortage^{18,22,23}; therefore be it
5

6 RESOLVED, That our American Medical Association support the formation of a non-profit
7 government manufacturer of pharmaceuticals to produce small-market generic drugs. (New
8 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

Not for consideration

Resolutions not for consideration

- 001 Updating Physician Job Description for Disability Insurance
- 004 Supporting Intimate Partner and Sexual Violence Safe Leave
- 010* Amending AMA Bylaw 2.12.2, Special Meetings of the House of Delegates
- 014* Gender-Neutral Language in AMA Policy
- 204 Elimination of Seasonal Time Change
- 210 Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time
- 212 SNAP Expansion for DACA Recipients
- 221* Development and Implementation of Recommendations for Responsible Media Coverage of Opioid Overdoses
- 225* Drug Policy Reform
- 226* Support for Mental Health Courts
- 301 Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education through Inclusion of Osteopathic Manual Therapy Education
- 312* Reporting of Residency Demographic Data
- 603 AMA House of Delegates Resolution Process Review
- 604 Solicitation Using the AMA Brand
- 605* Decreasing Political Advantage Within AMA Elections
- 608* Encouraging Collaboration Between Physicians and Industry in AI (Augmented Intelligence) Development
- 901 Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies
- 903 Supporting Further Study of Kratom
- 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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(I-22)

Introduced by: Young Physicians Section
Subject: Updating Physician Job Description for Disability Insurance
Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Many disability insurance products contain language and provisions such as “own
2 occupation” and “own specialty” that may not be consistently defined and whose definitions are
3 not readily available in marketing and policy paperwork; and
4
5 Whereas, The Department of Labor (DOL) developed the Dictionary of Occupational Titles
6 (DOT), the main source of occupational information, in 1938; however, the DOL stopped
7 updating the DOT in 1991;¹ and
8
9 Whereas, The DOL and Social Security Administration (SSA) are developing a new
10 Occupational Information System (OIS),² which will replace the DOT as the primary source of
11 occupational information that SSA staff and private insurers commonly use in the disability
12 adjudication process; and
13
14 Whereas, This pandemic has led to many physicians contracting COVID-19 with health care
15 workers and their families, representing up to one-sixth of hospitalized COVID-19 patients³; and
16
17 Whereas, Up to one-third of those infected with COVID-19 will develop Long COVID,^{4,5} which
18 can last for a year or more;⁶ and
19
20 Whereas, Many with Long COVID cannot return to work on a full time basis⁷ requiring reliance
21 on long-term disability insurance to supplement income; and
22
23 Whereas, While the DOT contains discrete and well-established descriptions of the physical
24 demands of occupations, it does not provide sufficiently specific information on associated
25 mental and cognitive requirements; and
26
27 Whereas, Working with the US Bureau of Labor Statistics allows the SSA the unique opportunity
28 to consider including descriptions of the mental and cognitive requirements of work in the new
29 OIS; and
30
31 Whereas, In the absence of more specific definitions in the disability insurance application,
32 many long-term disability insurers use a “national economy” standard to establish a job
33 description; and
34
35 Whereas, Application of such a national standard may lead to long-term disability denials and
36 financial hardship for physicians; therefore be it

1 RESOLVED, That our American Medical Association study the most effective approach to
2 developing specialty-specific job descriptions that reflect the true physical and cognitive
3 demands of each given specialty for use in the Occupational Information System under
4 development by the Social Security Administration so as to ensure that physician disability
5 policies are robust and protective if a coverage trigger occurs. (Directive to Take Action)

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

Received: 08/19/22

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(1-22)

Introduced by: Medical Student Section

Subject: Supporting Intimate Partner and Sexual Violence Safe Leave

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Intimate partner violence (IPV) is defined as any preventable form of physical, sexual, or
2 psychological aggression committed by current or former partners, including but not limited to
3 stalking, sexual harassment, or sexual coercion^{1,2}; and
4

5 Whereas, 1 in 3 women and 1 in 4 men in the United States (U.S.) have experienced some form of
6 IPV, with increased rates of injury and rape reported in sexual and ethnic minority populations^{3,4};
7 and
8

9 Whereas, Up to 61.1% of lesbian and bisexual cisgender women and 37.3% of gay and bisexual
10 cisgender men report experiencing IPV compared to 35% and 29% of heterosexual cisgender
11 women and men, respectively⁵; and
12

13 Whereas, Transgender individuals disclose instances of physical and sexual IPV at 2.5 and 3.4
14 times more frequently than individuals who do not self-identify with a sexual minority group⁵; and
15

16 Whereas, National survey data from the Centers for Disease Control state that 53.8% of multiracial
17 women, 46% of American Indian women, and 43.7% of Black women have experienced IPV,
18 compared to 34.6% of non-Hispanic white women⁶; and
19

20 Whereas, Individuals who experience IPV are also more likely to become victims of other forms of
21 sexual violence and abuse such as stalking, workplace harassment, rape, and trafficking^{7,8}; and
22

23 Whereas, A surge in case numbers of IPV has been recorded, largely due to increased levels of
24 societal stress, panic, and financial and emotional strain resulting from the COVID-19 pandemic⁹;
25 and
26

27 Whereas, IPV has acute effects on physical and mental health, including injury, unintended
28 pregnancy, low fetal birth weight, preterm birth, disorders secondary to trauma, development of
29 substance use disorders, and death by homicide^{10,11}; and
30

31 Whereas, Individuals who experience IPV have a 60% increased risk for asthma, 70% increased
32 risk for heart disease, and 80% increased risk for stroke¹²; and
33

34 Whereas, The healthcare-related costs due to IPV are estimated to be \$104,000 per female victim
35 and \$23,000 per male victim, totaling to \$5.8 billion annually^{13,14}; and
36

37 Whereas, Lifetime economic burden from IPV for all survivors in the U.S. totals nearly \$3.6 trillion,
38 which includes the financing of criminal justice proceedings and replacement of lost or damaged
39 property¹³; and

1 Whereas, Survivors of IPV require sufficient funds to pay for frequent hospital and clinic visits,
2 long-term treatment of physical and emotional injuries, mental health conditions, and substance
3 use disorders, legal proceedings, childcare, and finding safety¹⁵; and
4

5 Whereas, Job loss in the setting of IPV can propagate the cycle of violence, precipitating further
6 reliance on the abuser for living expenses, childcare, and additional resources^{3,9,16}; and
7

8 Whereas, Close to 60% of IPV survivors report employment instability and job loss due to violence-
9 related reasons, including but not limited to stigma, workplace discrimination due to the negative
10 physical and mental effects of IPV, abuse recurrence, decreased productivity, and frequent
11 absences^{3,16}; and
12

13 Whereas, 67% of those who have experienced or are experiencing IPV state that interactions with
14 an abusive partner limited their ability to complete education or job training for future career
15 growth, resulting in over 17% leaving the workforce³; and
16

17 Whereas, On average, IPV survivors experience on average at least 7.2 days of lost productivity
18 per year at work, leading to the loss of over 8 million days of paid work each year across all IPV
19 survivors, thereby decreasing their chances of earning raises or promotions^{3,14}; and
20

21 Whereas, This loss in productivity and workforce attrition translates to an annual cost of over \$9.3
22 billion to the United States¹⁴; and
23

24 Whereas, 55% of companies do not have, publicize, or provide training for a workplace violence
25 prevention policy offering protections in the event of IPV¹⁷; and
26

27 Whereas, 33% of private sector jobs do not offer paid sick leave, and only 13% of jobs have paid
28 family and medical leave¹⁸; and
29

30 Whereas, A lack of access to paid leave causes employers and workers to lose \$22.5 billion
31 annually in wages and profits²⁰; and
32

33 Whereas, Those who have experienced IPV remain more vulnerable to the detrimental
34 consequences of lost wages from limited opportunities for paid leave, due to inability to afford daily
35 costs of living and medical expenses^{18,20}; and
36

37 Whereas, Eleven states, including the District of Columbia, have enacted legislation offering “safe
38 time provisions” that protect employees who are victims of IPV^{21,22}; and
39

40 Whereas, “Safe time provisions” encompass a list of employee rights emerging in the context of
41 experienced violence, including but not limited to safe leave, protection from wrongful termination,
42 and legal assistance stipends in the event of court proceedings²¹; and
43

44 Whereas, Safe leave is defined as a period of paid or unpaid time allotted for physical, mental, and
45 social healing from trauma relating to any form of violence, particularly IPV, stalking, and sexual
46 harassment by non-partners²²; and
47

48 Whereas, Violence-related safe leave is distinct from personal medical or family leave in that it
49 includes extended time for ensuring personal and familial safety from threat of abuse, protection
50 from premature or wrongful termination of employment, stipends for legal aid, and connection to
51 social work or supportive agencies that facilitate physical, mental, and social recovery^{22,23}; and

1 Whereas, States, districts, and cities that have instituted paid or unpaid safe leave or paid family
2 and medical leave policies inclusive of safe time provisions, including Sonoma, Seattle, New York,
3 and Philadelphia, have not found negative economic effects, subsequent decreases in pay for
4 other employees, or increases in unemployment^{18,21,22}; and
5

6 Whereas, Over \$1.1 billion could be saved in emergency department visits through paid safe
7 leave, as its implementation increases the job and financial security of those experiencing IPV
8 while decreasing dependence on the abuser²⁰; and
9

10 Whereas, The implementation of paid safe leave decreases the turnover of employees and
11 healthcare costs for preventable conditions, simultaneously improving productivity and economic
12 growth^{20,24}; and
13

14 Whereas, Survivors of IPV who had access to paid leave were better able to connect to family
15 court, had increased job security, and retained greater protection against the recurrence of any
16 harassment or abuse by current, former, or non-partners^{1,25}; and
17

18 Whereas, The AMA has policy (H-515.965) encouraging physicians to campaign against IPV and
19 violence in all forms; and
20

21 Whereas, The AMA has individual policies on family, medical, and sick leave (H-420.979, H-
22 440.823), though they fall short of providing adequate time for the physical, emotional, and
23 psychiatric healing required following an experience of IPV or non-partner sexual violence;
24 therefore be it
25

26 RESOLVED, That our American Medical Association recognize the positive impact of paid safe
27 leave on public health outcomes and support legislation that offers paid and unpaid safe leave
28 (New HOD Policy); and be it further
29

30 RESOLVED, That our AMA amend policy H-420.979, "AMA Statement on Family and Medical
31 Leave," to promote inclusivity by addition to read as follows:
32

33 **AMA Statement on Family and Medical Leave, H-420.979**

34 Our AMA supports policies that provide employees with reasonable job security and
35 continued availability of health plan benefits in the event leave by an employee becomes
36 necessary due to documented medical conditions and/or concerns for safety. Such
37 policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the
38 employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if
39 medically appropriate to care for a member of the employee's immediate family, i.e., a
40 spouse or children; ~~and~~ (4) leave for adoption or for foster care leading to adoption; and
41 (5) safe leave provisions for those experiencing any instances of violence, including but
42 not limited to intimate partner violence, sexual violence or coercion, and stalking. Such
43 periods of leave may differ with respect to each of the foregoing classifications, and may
44 vary with reasonable categories of employers. Such policies should encourage voluntary
45 programs by employers and may provide for appropriate legislation (with or without
46 financial assistance from government). Any legislative proposals will be reviewed through
47 the Association's normal legislative process for appropriateness, taking into consideration
48 all elements therein, including classifications of employees and employers, reasons for the
49 leave, periods of leave recognized (whether paid or unpaid), obligations on return from
50 leave, and other factors involved in order to achieve reasonable objectives recognizing the
51 legitimate needs of employees and employers. (Modify Current HOD Policy)

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

Received: 09/20/22

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RELEVANT AMA POLICY

Family and Intimate Partner Violence H-515.965

1. Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.

2. Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

3. The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

4. Within the larger community, our AMA:

(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.

(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.

(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

5. With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required;

(c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

6. Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:

(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.

(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.

(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.

(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.

(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence. CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep. 2, I-09; Modified: CSAPH Rep. 01, A-19

AMA Statement on Family and Medical Leave H-420.979

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

Paid Sick Leave H-440.823

Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome. CMS Rep. 03, A-16; Reaffirmed: BOT Rep. 11, A-19

Parental Leave H-405.954

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.

2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.

3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to

care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.

4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.

Citation: Res. 215, I-16; Appended: BOT Rep. 11, A-19; Appended: Res. 403, A-22;

Policies for Parental, Family and Medical Necessity Leave H-405.960

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.

2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.

3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.

5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.

6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave,

family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22

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

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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) Through 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: 014
(1-22)

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

1 Whereas, AMA policy D-65.990, which calls on the AMA to standardize existing and future
2 language relating to LGBTQ people, establishes precedent for this timely action; therefore be it
3
4 RESOLVED, That our American Medical Association (1) revise all relevant policies to utilize
5 gender-neutral pronouns and other non-gendered language in place of gendered language
6 where such text inappropriately appears, and (2) utilize gender-neutral pronouns and other non-
7 gendered language in future policies where gendered language does not specifically need to be
8 used. (Directive to Take Action)

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

Received: 10/13/22

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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: 204
(I-22)

Introduced by: Missouri
Subject: Elimination of Seasonal Time Change
Referred to: Reference Committee B

- 1 Whereas, Multiple studies have demonstrated an increased risk for heart attacks, strokes, and
2 fatal car crashes as negative health consequences of moving the clock forward in Spring for
3 Daylight Savings Time; and
4
5 Whereas, The American Academy of Sleep Medicine officially recognizes Daylight Savings
6 Time as a public health problem; and
7
8 Whereas, A survey of 2,000 adults found that 63% of people supported or strongly supported
9 the elimination of a seasonal time change in favor of a national, fixed, year-round time, and only
10 11% opposed; and
11
12 Whereas, Thirteen states in the past two years have written or enacted legislation to stay on
13 one year-round time zone; therefore be it
14
15 RESOLVED, That our American Medical Association work with state medical associations to
16 enact state legislation in support of remaining in the Standard Time Zone year-round (Directive
17 to Take Action); and be it further
18
19 RESOLVED, That our AMA urge Congress to repeal the federal law establishing the annual
20 advancement of time known as "Daylight Saving Time" and leave the U.S. on standard time
21 year-round. (Directive to Take Action)

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

Received: 09/07/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(I-22)

Introduced by: Resident and Fellow Section

Subject: Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time

Referred to: Reference Committee B

- 1 Whereas, Originally conceived to conserve fuel and reduce power utilization, the annual switch
2 to Daylight Savings Time (DST) has been practiced in the United States since 1918¹; and
3
4 Whereas, For states that use DST, clocks typically “spring forward” one hour in March and then
5 “fall back” one hour in November²; and
6
7 Whereas, The Uniform Time Act of 1966 established a system of uniform DST throughout the
8 United States³; and
9
10 Whereas, Under federal law, states must currently obtain approval to adopt year-round DST¹;
11 and
12
13 Whereas, States choosing to observe year-round standard time, as Arizona and Hawaii do, are
14 not subject to federal approval¹; and
15
16 Whereas, In a response to an oil embargo, the US enacted a trial period of permanent DST
17 from 1974-1975 in an attempt to conserve energy¹; and
18
19 Whereas, Permanent DST proved unpopular in the 1970’s and was not ineffective in conserving
20 oil, and federal law was changed to disallow permanent use of DST^{4,5}; and
21
22 Whereas, The merits of using DST to reduce energy use are debatable^{2,4}; and
23
24 Whereas, The controversy regarding DST has gained increasing notoriety and press coverage
25 over the past several years with 18 states enacting legislation or passing resolutions to provide
26 for permanent DST, should Congress eventually allow for such a change⁵; and
27
28 Whereas, On March 15, 2022, the US Senate passed the Sunshine Protection Act, which would
29 move forward by one hour what is considered standard time within the US, effectively
30 establishing the permanent use of Daylight Savings Time in November 2023⁶; and
31
32 Whereas, Under the Sunshine Protection Act, states would be forced to choose whether to
33 operate either on standard or DST year-round⁵; and
34
35 Whereas, Studies have shown that the acute time change from standard time to DST has risks
36 to the public health and safety, including increased risk of cardiovascular events, hospital
37 admission, traffic fatalities, and medical errors⁸; and

1 Whereas, Most experts believe that standard time is more suited to the circadian rhythms of the
2 human body than permanent DST⁷; and
3

4 Whereas, Circadian misalignment has been associated with risks of depression, cardiovascular
5 disease, metabolic syndrome⁸; and
6

7 Whereas, The American Academy of Sleep Medicine has published a position statement in
8 support of eliminating seasonal time changes and establishing year-round standard time⁷; and
9

10 Whereas, A 2020 AASM survey found that 63% of adults support the elimination of seasonal
11 time changes⁸; and
12

13 Whereas, Our AMA has multiple policies related to fatigue and sleep, including H-15.958, H-
14 135.932, and H-60.930; and
15

16 Whereas, The stance of our AMA on this subject matter may prove influential in public policy
17 deliberations; therefore be it
18

19 RESOLVED, That our American Medical Association support the elimination of seasonal time
20 changes (New HOD Policy); and be it further
21

22 RESOLVED, That our AMA support the adoption of year-round standard time. (New HOD
23 Policy)

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

Received: 09/14/22

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RELEVANT AMA POLICY

Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958

Our AMA: (1) recognizes sleepiness behind the wheel as a major public health issue and continues to encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups;

(2) recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions;

(3) recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep;

- (4) encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness- testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment;
 - (5) urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology;
 - (6) recommends that physicians: (a) become knowledgeable about the diagnosis and management of sleep-related disorders; (b) investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories; (c) inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries; (d) advise patients about possible medication-related effects that may impair their ability to safely operate a motor vehicle or other machinery; (e) inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries; and (f) become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice;
 - (7) encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state.
 - (8) recommends that states adopt regulations for the licensing of commercial and private drivers with sleep-related and other medical disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries;
 - (9) reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.
- Citation: CSA Rep. 1, A-96; Appended: Res. 418, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19; Reaffirmation: A-22

Light Pollution: Adverse Health Effects of Nighttime Lighting H-135.932

Our AMA:

1. Supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency.
2. Recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment.
3. Supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night.
4. That work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place.

Citation: CSAPH Rep. 4, A-12; Reaffirmation: A-22; Reaffirmed: CSAPH Rep. 1, A-2

Insufficient Sleep in Adolescents H-60.930

1. Our AMA identifies adolescent insufficient sleep and sleepiness as a public health issue and supports education about sleep health as a standard component of care for adolescent patients.
2. Our AMA: (a) encourages school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep; (b) encourages physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the biologic sleep needs of adolescents; and (c) encourages continued research on the impact of sleep on adolescent health and academic performance.

Citation: Res. 503, A-10; Appended: CSAPH Rep. 06, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(I-22)

Introduced by: Medical Student Section

Subject: SNAP Expansion for DACA Recipients

Referred to: Reference Committee B

- 1 Whereas, The policy known as Deferred Action for Childhood Arrivals (DACA) has allowed
2 undocumented immigrants brought to the US as minors to remain in this country, receive work
3 authorization, and participate in the Social Security Program¹; and
4
- 5 Whereas, As of 2021 there were 649,070 active DACA recipients in the US¹; and
6
- 7 Whereas, The Department of Homeland Security considers more than 200,000 DACA recipients
8 as “essential critical infrastructure workers” contributing to the fields of health care, education,
9 and food-related industries²; and
10
- 11 Whereas, Data provided by the Department of Homeland Security showed an estimated 96% of
12 DACA recipients were born in the Caribbean and Latin American countries³; and
13
- 14 Whereas, An estimated range of 30 to 60% of immigrants in the US report food insecurity, and
15 the largest and fastest growing subgroup is foreign-born Latinxs as compared to US-born non-
16 Latinx Whites⁴; and
17
- 18 Whereas, Food insecurity is defined by the US Department of Agriculture (USDA) as a
19 household-level economic and social condition of limited or uncertain access to adequate food⁵;
20 and
21
- 22 Whereas, DACA recipients’ ineligibility for federal aid increases risk for food insecurity while
23 complicating budgeting and meal preparation⁶; and
24
- 25 Whereas, DACA recipients viewed affordable food as unhealthy and limited their intake in order
26 to obtain healthier food⁶; and
27
- 28 Whereas, Children of immigrant Latinx mothers are at the greatest risk for food insecurity and
29 this population comprises much of the DACA program⁷; and
30
- 31 Whereas, The expansion of immigration enforcement has been associated with increased food
32 insecurity among Latinx immigrant families⁸; and
33
- 34 Whereas, The percentage of families reporting very low food security has increased by 20%
35 since the COVID-19 pandemic began⁹; and
36
- 37 Whereas, A 2019 study estimated that the median county-level cost of healthcare associated
38 with food insecurity was \$4,433,000 per year¹⁰; and

1 Whereas, Undocumented immigrants in the United States contribute an estimated \$11.6 billion
2 taxes annually, but they remain largely ineligible for public benefits including social security and
3 SNAP¹¹; and
4

5 Whereas, The Supplemental Nutrition Assistance Program (SNAP) is the most important tool
6 used in the US to alleviate food insecurity and its subsequent negative health consequences¹²;
7 and
8

9 Whereas, SNAP participation is associated with economic benefits including lower healthcare
10 costs¹³; and
11

12 Whereas, US Citizenship and Immigration services reports that California has a DACA
13 population of 183,460, as of March 2020¹⁴; and
14

15 Whereas, In 2021, California state legislators proposed opening the state-funded food stamp
16 program to all income-eligible Californians, regardless of immigration status, which would cost
17 about \$550 million a year¹⁵; and
18

19 Whereas, The food pantry system was initially designed to serve only during emergency
20 scenarios to address starvation¹⁶; and
21

22 Whereas, People with very low food security who rely on food pantries have a significantly
23 higher incidence of obesity often attributed to acquired foods that are high in sodium and sugar,
24 while low in fiber, vitamins, and minerals¹⁷; and
25

26 Whereas, food pantry recipients are shown to have insufficient intake of up to 16 different key
27 nutrients such as calcium, potassium, and fiber¹⁸; and
28

29 Whereas, Those with food insecurity incur greater health care expenditures resulting in an
30 additional \$77.5 billion in healthcare spending annually¹⁹; therefore be it
31

32 RESOLVED, That our American Medical Association actively support expansion of SNAP to
33 Deferred Action Childhood Arrivals (DACA) recipients who would otherwise qualify. (Directive to
34 Take Action)

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

Received: 09/20/22

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RELEVANT AMA POLICY

Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services D-440.927

Our AMA will, upon the release of a proposed rule, regulations, or policy that would deter immigrants and/or their dependents from utilizing non-cash public benefits including but not limited to Medicaid, CHIP, WIC, and SNAP, issue a formal comment expressing its opposition.

Res. 254, A-18

Improvements to Supplemental Nutrition Programs H-150.937

(1)Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.(2) Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC. (3) Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.

Res. 414, A-10, Reaffirmation A-12, Reaffirmation A-13, [Appended: CSAPH Rep. 1, I-13](#), Reaffirmation A-14, Reaffirmation I-14, Reaffirmation A-15, [Appended: Res. 407, A-17](#), [Appended: Res. 233, A-18](#)

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

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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: 225
(1-22)

Introduced by: Medical Student Section

Subject: Drug Policy Reform

Referred to: Reference Committee B

1 Drug Use in the US

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

8
9 Whereas, In 2019, 20.4 million Americans (9.7% of those who used a substance in the past
10 year) aged 12 and over met substance use disorder (SUD) criteria, including 14.5 million
11 Americans with alcohol use disorder and 8.3 million with an SUD involving an illicit drug¹; and

12
13 Incarceration for Drug Possession in the US

14
15 Whereas, The US classifies controlled substances into five schedules, but significant
16 controversy exists over the schedules of certain drugs deemed to have “no medical use,”
17 despite research showing that these drugs may have therapeutic potential²⁻⁵; and

18
19 Whereas, Sentences and penalties for federal and state drug offenses vary depending on the
20 drug’s schedule, amount of drug, circumstances of arrest, and previous drug convictions and
21 criminal record⁶⁻⁸; and

22
23 Whereas, Drug possession is defined as being found with an amount of a drug small enough for
24 personal use (as determined by the government) without legal justification⁶⁻⁸; and

25
26 Whereas, Under federal statute, drug possession is classified as a criminal misdemeanor and
27 can be punishable by up to 1 year imprisonment and/or at least \$1,000 in fines for a first-time
28 offense and up to 3 years imprisonment and/or \$5,000 in fines for repeat offenses, with greater
29 sentences and penalties depending on amount of drug, previous drug convictions, and criminal
30 record⁷⁻⁸; and

31
32 Whereas, State statutes are most commonly used to charge people with drug possession and
33 these statutes vary significantly, with many states (including Indiana, Kentucky, and Oklahoma)
34 reclassifying possession from felonies to misdemeanors over the last decade, lowering
35 mandatory minimums, and using savings from reduced incarceration to fund social services,
36 while many other states (such as Idaho, Missouri, and Nebraska) continue to charge possession
37 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

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

6 Whereas, Research shows that incarceration is ineffective and does not significantly reduce
7 recidivism, drug use, drug overdose deaths, or drug arrests, with a 2013 Washington state study
8 finding that overdose was the leading cause of death for people previously incarcerated³⁴⁻³⁶; and
9

10 Whereas, Drug criminalization is associated with increased stigma and discrimination against
11 people who use drugs, impairing their mental and physical health and hindering treatment
12 efforts; has fueled the growth of illegal markets, organized crime, and violent injuries; and
13 detrimentally affected public health by increasing overdose deaths due to drug contamination
14 and spreading HIV and hepatitis C³⁷⁻⁴¹; and
15

16 Whereas, Previous incarceration of people who use drugs is associated with lack of access to
17 health insurance, even after the implementation of the Affordable Care Act, while possession
18 arrests, regardless of conviction, can negatively impact employment, housing, and student loan
19 eligibility, leading to widespread and multifactorial health consequences⁴²⁻⁴⁴; and
20

21 Whereas, Drug felony convictions can lead to lifelong bans from receiving government
22 assistance (such as SNAP and TANF), employment and housing discrimination, and loss of the
23 right to vote or serve on a jury^{7,45-48}; and
24

25 Whereas, People who are incarcerated are at higher risk of chronic conditions such as
26 cardiovascular disease, hypertension, and cancer compared to the general population, with an
27 important 2013 New York state study finding that each year spent in prison corresponded with a
28 two-year decline in life expectancy⁴⁹⁻⁵⁰; and
29

30 Outcomes of Drug Decriminalization

31

32 Whereas, Drug criminalization is costly, ineffective, and stigmatizing, exposing people to
33 incarceration, encouraging more dangerous drug consumption methods, and discouraging
34 people from receiving health services⁵¹⁻⁵³; and
35

36 Whereas, 83% of Americans believe that the “War on Drugs” has failed, 66% support
37 “eliminating criminal penalties for drug possession,” and 61% of voters support reducing
38 sentences of people currently incarcerated for drug offenses, with similar findings replicated
39 across multiple states⁵⁴⁻⁵⁸; and
40

41 Whereas, California reclassified drug possession from a felony to misdemeanor in 2014 by
42 passing ballot initiative Proposition 47, “The Safe Neighborhoods and Schools Act,” leading to
43 the release or resentencing of 3,000 people and saving the state \$156 million, with a later study
44 finding no associated increase in crime⁵⁹⁻⁶³; and
45

46 Whereas, A 2018 study on cannabis decriminalization in five U.S. states did not find an increase
47 in the prevalence of youth cannabis use as a result of decriminalization⁶⁴; and
48

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

1 Whereas, Drug decriminalization in Portugal resulted in a decrease in heroin- and cocaine-
2 related seizures, HIV and drug-related deaths, and decreased societal costs related to drug
3 use⁶⁷⁻⁶⁸; and
4

5 Whereas, In 2019 the United Nations Chief Executives Board for Coordination issued a
6 statement calling for the “promot[ion of] alternatives to conviction and punishment in appropriate
7 cases, including the decriminalization of drug possession for personal use”^{18,69}; and
8

9 Whereas, Decriminalization of personal use and possession of drugs is supported by the World
10 Health Organization, American Public Health Association, Human Rights Watch, Global
11 Commission on Drug Policy, International Federation of Red Cross and Red Crescent Societies,
12 NAACP, and National Latino Congreso⁷⁰⁻⁷⁶; therefore be it
13

14 RESOLVED, That our American Medical Association advocate for federal and state
15 reclassification of drug possession offenses as civil infractions and the corresponding reduction
16 of sentences and penalties for individuals currently incarcerated, monitored, or penalized for
17 previous drug-related felonies (Directive to Take Action); and be it further
18

19 RESOLVED, That our AMA support federal and state efforts to expunge criminal records for
20 drug possession upon completion of a sentence or penalty at no cost to the individual (New
21 HOD Policy); and be it further
22

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

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

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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 of 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

1 Whereas, Because mental health courts are dependent on participation from national, state, and
2 local governmental agencies, justice systems, and mental health service organizations and on
3 the appropriation of public funds, including federal monies for MIOTCRA programs and grants
4 administered by SAMHSA and BJA¹⁰⁻¹², the American Medical Association can play a role in
5 advocating for the continued support and funding of mental health courts by policymakers; and
6

7 Whereas, Courts that connect individuals with mental illness to treatment as an alternative to
8 incarceration exist under many different names, with each focused on different types of mental
9 illness, including “mental health courts” (for mental illness in general), “drug courts” (for
10 substance use disorders), and “sobriety” or “sober courts” (for alcohol use disorder and
11 sometimes certain other substance use disorders)³²⁻³⁵; and AMA policy should be inclusive of all
12 these different types; and
13

14 Whereas, Existing AMA Policy H-100.955 (passed at A-12) established support for drug courts,
15 which are similar in function to mental health courts but narrower in scope, “for individuals with
16 addictive disease who are convicted of nonviolent crimes”; and
17

18 Whereas, Existing AMA Policy H-510.979 (passed at I-19) established support for veteran
19 courts, which are similar in function to mental health courts but narrower in scope, “for veterans
20 who commit criminal offenses that may be related to a neurological or psychiatric disorder”; and
21

22 Whereas, At I-19, House of Delegates Reference Committee B originally recommended
23 amending Resolution 202 on veteran courts to limit their use to only nonviolent offenses, to be
24 consistent with previous Policy H-100.955 on drug courts³⁶⁻³⁷; and
25

26 Whereas, At I-19, despite the Reference Committee B recommendation, Resolution 202 was
27 extracted in our HOD to remove the restriction on only using veteran courts for nonviolent
28 offenses, and our HOD ultimately passed Policy H-510.979 such that veteran courts could
29 potentially be used for criminal offenses in general and not only for nonviolent offenses³⁶; and
30

31 Whereas, To be consistent with our HOD’s most recent debate on this matter, Policy H-100.955
32 on drug courts and any future AMA policy on alternatives to incarceration for individuals with
33 mental illness should not be limited to only nonviolent offenses; therefore be it
34

35 RESOLVED, That AMA Policy H-100.955, Support for Drug Courts, be amended by addition
36 and deletion to read as follows:
37

38 **Support for Mental Health Drug Courts, H-100.955**

39 Our AMA: (1) supports the establishment and use of mental health drug courts,
40 including drug courts and sobriety courts, as an effective method of intervention for
41 individuals with mental illness involved in the justice system within a comprehensive
42 system of community-based services and supports ~~addictive disease who are convicted~~
43 ~~of nonviolent crimes~~; (2) encourages legislators to establish mental health drug courts
44 at the state and local level in the United States; and (3) encourages mental health drug
45 courts to rely upon evidence-based models of care for those who the judge or court
46 determine would benefit from intervention rather than incarceration. (Modify Current
47 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: 301
(I-22)

Introduced by: Resident and Fellow Section

Subject: Increasing Musculoskeletal Education in Primary Care Specialties and
Medical School Education Through Inclusion of Osteopathic Manual Therapy
Education

Referred to: Reference Committee C

1 Whereas, According to the American Osteopathic Association, osteopathic manipulative
2 medicine/treatment (OMM/OMT) is special training for the musculoskeletal system that doctors
3 of osteopathy receive to provide care that involves using the hands to diagnose, treat, and
4 prevent illness or injury; and

5
6 Whereas, The evidence basis for OMT is quite broad and spans many disease processes and
7 organ systems and supports its use as an adjunct treatment in a variety of conditions; and

8
9 Whereas, In order to train residents in osteopathic practice and principles (OPP) and
10 osteopathic manipulative treatment (OMT), faculty must be available and qualified; and

11
12 Whereas, Osteopathic Recognition (OR) is a “designation conferred by the ACGME’s
13 Osteopathic Principles Committee upon ACGME-accredited programs that demonstrate,
14 through a formal application process, the commitment to teaching and assessing Osteopathic
15 Principles and Practice (OPP) at the graduate medical education level”; and

16
17 Whereas, Programs must meet criteria laid out by that committee and apply for recognition¹;
18 and

19
20 Whereas, Residents in a recognized program must be assessed for OPP knowledge and “skill
21 proficiency in OMT as applicable to [their] specialty”²; and

22
23 Whereas, As of the 2021-2022 academic year there are approximately 250 PGY-1 GME
24 programs with osteopathic recognition out of the 4,780 available programs (roughly 5%)¹¹;
25 therefore be it

26
27 RESOLVED, That our American Medical Association continue to support equal treatment of
28 osteopathic students, trainees and physicians in the residency application cycle and workplace
29 through continued education on the training of osteopathic physicians (New HOD Policy); and
30 be it further

31
32 RESOLVED, That our AMA encourage education on the benefits of evidence-based
33 Osteopathic Manual Therapy for musculoskeletal conditions in medical education of allopathic
34 students and in primary care residencies. (New HOD Policy)

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

Received: 09/14/22

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RELEVANT AMA POLICY

Definition of a Physician H-405.969

1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine. 2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree. 3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign. Citation: CME Rep. 4-A-94; Reaffirmed by Sub. Res. 712, I-94; Reaffirmed and Modified: CME Rep. 2, A-04; Res. 846, I-08; Reaffirmed in lieu of Res. 235, A-09; Reaffirmed: Res. 821, I-09; Appended: BOT Rep. 9, I-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-13; Reaffirmation A-15; Reaffirmed in lieu of: Res. 225, A-17; Reaffirmed: Res. 228, A-19

Definition and Use of the Term Physician H-405.951

Our AMA: 1. Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency. 2. Will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above: a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician; b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician; and c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician. 3. Urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care. 4. Ensure that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider. 5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree. 6. Will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (JAMA) Editorial Governance Plan, which protects the editorial independence of JAMA. 7. Actively supports the Scope of Practice Partnership in the Truth in Advertising campaign
Citation: Res. 214, A-19

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

1 Whereas, Forty-two percent of the studied residency programs offered paid parental leave in
2 some capacity, and twenty-two percent of the study's programs referred residents to state-
3 funded paid family leave programs¹²; and
4

5 Whereas, No mention was made of adherence to the additional parental leave guidelines
6 imposed by professional specialty societies¹⁴; and
7

8 Whereas, It is of note that these family leave policies were not necessarily published on each
9 program's website, and the authors of this study conducted a web search to find publicly
10 available information, then contacted schools directly for this data¹²; and
11

12 Whereas, Even after these efforts, there was one school that did not publish family leave
13 information on their website and did not respond to inquiries, indicating this information may not
14 be readily accessible to prospective residency applicants and current residents¹²; and
15

16 Whereas, In addition to gathering and publishing information on the items identified in FREIDA,
17 ACGME surveys, and internal residency program surveys should consider collecting information
18 on ability, religion, and immigration status to identify additional resources necessary to support
19 current residents¹⁵; and
20

21 Whereas, To date, there is a scarcity of information on the demographic and parenthood of
22 residents, and existing surveys from FREIDA, ACGME, and internal residency programs could
23 be used to gather this information, as well as data on factors such as incoming and current
24 residents' ability, religion, and immigration status; and
25

26 Whereas, Gathering this robust array of data on the background of residents has the potential to
27 elucidate the path to equity, diversity, and inclusion in medicine; therefore be it
28

29 RESOLVED, That our American Medical Association work with appropriate stakeholders to
30 encourage that residency programs annually publish and share with FREIDA and other
31 appropriate stakeholders, (a) demographic data, including but not limited to the composition of
32 their program over the last 5 years by age, gender identity, URM status, and LGBTQIA+ status;
33 (b) parental and family leave policies; and (c) the number and/or proportion of residents who
34 have utilized parental or family leave in the past 5 years (Directive to Take Action); and be it
35 further
36

37 RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical
38 Education and other relevant stakeholders to annually collect data on pregnancy, childbirth, and
39 parenthood from all accredited US residency programs and publish this data with
40 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: 603
(1-22)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: AMA House of Delegates Resolution Process Review

Referred to: Reference Committee F

1 Whereas, Submission of resolutions as items of business is an important process at our AMA
2 House of Delegates (HOD); and
3
4 Whereas, The number of resolutions submitted has increased over time; and
5
6 Whereas, The rules for submission of resolutions have not been changed in many years
7 including definitions for on time, late and emergency resolutions; and
8
9 Whereas, There are multiple exceptions to the “on time” resolution definition including
10 resolutions from AMA sections and societies who meet after the “on time” deadline; and
11
12 Whereas, The Saturday/Sunday tote contains a significant amount of new resolutions each
13 year; and
14
15 Whereas, The resolutions in the Saturday/Sunday tote cannot be adequately reviewed and
16 vetted by all delegations and delegation staff; and
17
18 Whereas, For the past 2 years, all delegations and sections have met virtually and have been
19 able to work asynchronously to discuss and vote on potential resolutions to submit to the AMA
20 HOD; and
21
22 Whereas, According to Bylaws 2.11.3.1, “To be considered as regular business, each resolution
23 must be introduced by a delegate or organization represented in the House of Delegates and
24 must have been submitted to the AMA not later than 30 days prior to the commencement of the
25 meeting at which it is to be considered”; and
26
27 Whereas, According to Bylaws 2.11.3.1.3, “Late resolutions may be presented by a delegate
28 prior to the recess of the opening session of the House of Delegates, and will be accepted as
29 business of the House of Delegates only upon two-thirds vote of delegates present and voting”;
30 and
31
32 Whereas, According to Bylaws 2.11.3.1.4 Emergency Resolutions, “resolutions of an
33 emergency nature may be presented by a delegate any time after the opening session of the
34 House of Delegates is recessed. Emergency resolutions will be accepted as business only upon
35 a three-fourths vote of delegates present and voting, and if accepted shall be presented to the
36 House of Delegates without consideration by a reference committee. A simple majority vote of
37 the delegates present and voting shall be required for adoption”; and

- 1 Whereas, The ability to meet virtually and work asynchronously has been enhanced during the
2 pandemic to the point where it is potentially more efficient and convenient for delegations and
3 sections; therefore be it
4
- 5 RESOLVED, That our American Medical Association review the entire process of resolution
6 submission including re-evaluating the definitions of “on time,” late, and emergency resolutions
7 and current exceptions with a report back at the Interim 2023 meeting (Directive to Take Action);
8 and be it further
9
- 10 RESOLVED, That the review committee consider changing the policy so that all on time
11 resolutions must be submitted to the HOD by the same deadlines so that the only resolutions in
12 the Saturday/Sunday tote would be emergency and late resolutions to be voted on for
13 acceptance by the HOD (Directive to Take Action); and be it further
14
- 15 RESOLVED, That the review committee consider changing the rule so that all sections of the
16 AMA will submit their “on time” resolutions by the same deadlines as the rest of the HOD, with
17 only emergency resolutions to be submitted after Section meetings during the week before the
18 annual or interim meetings (Directive to Take Action); and be it further
19
- 20 RESOLVED, That our AMA facilitate virtual meetings of the sections prior to the resolution
21 deadline so that all resolutions can be submitted, reviewed, and discussed prior to the deadline.
22 (Directive to Take Action)

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

Received: 09/28/22

References:

AMA Constitution and Bylaws: <https://www.ama-assn.org/system/files/ama-constitution-and-bylaws.pdf>

RELEVANT AMA POLICY

House of Delegates

Procedure. B-2.11

2.11.1 Order of Business. The Order of Business will be proposed by the Speaker and approved by the House of Delegates.

At any meeting, the House of Delegates, by majority vote, may change the order of business.

2.11.2 Privilege of the Floor. The House of Delegates, by a two-thirds vote of delegates present and voting, may extend to any person an invitation to address the House.

2.11.3 Introduction of Business.

2.11.3.1 Resolutions. To be considered as regular business, each resolution must be introduced by a delegate or organization represented in the House of Delegates and must have been submitted to the AMA not later than 30 days prior to the commencement of the meeting at which it is to be considered, with the following exceptions.

2.11.3.1.1 Exempted Resolutions. If any member organization's house of delegates or primary policy making body, as defined by the organization, adjourns during the 5-week period preceding commencement of an AMA House of Delegates meeting, the organization is allowed 7 days after the close of its meeting to submit resolutions to the AMA. All such resolutions must be received by noon of the day before the commencement of the AMA House of Delegates meeting. The presiding officer of the organization shall certify that the resolution was adopted at its just concluded meeting and that the body directed that the resolution be submitted to the AMA House of Delegates.

2.11.3.1.2 AMA Sections. Resolutions presented from the business meetings of the AMA Sections may be presented for consideration by the House of Delegates no later than the recess of the House of Delegates opening session to be accepted as regular business.

Resolutions presented after the recess of the opening session of the House of Delegates will be accepted in accordance with Bylaw 2.11.3.1.4.

2.11.3.1.3 Late Resolutions. Late resolutions may be presented by a delegate prior to the recess of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.

2.11.3.1.4 Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates is recessed. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee. A simple majority vote of the delegates present and voting shall be required for adoption.

2.11.3.1.5 Withdrawal of Resolutions. A resolution may be withdrawn by its sponsor at any time prior to its acceptance as business by the House of Delegates.

2.11.3.1.6 Resolutions not Accepted. Late resolutions and emergency resolutions not accepted as business by the House of Delegates may be submitted for consideration at a future meeting in accordance with the procedure in Bylaw 2.11.3.

2.11.3.2 Business from the Board of Trustees. Reports, recommendations, resolutions or other new business, may be presented by the Board of Trustees at any time during a meeting. Items of business presented before the recess of the opening session of the House of Delegates will be accepted as regular business. Items of business presented after the recess of the opening session of the House of Delegates will be accepted as emergency business and shall be presented to the House of Delegates without consideration by a reference committee. A two-thirds vote of the delegates present and voting shall be required for adoption.

2.11.3.3 Business from the Councils. Reports, opinions or recommendations from a council of the AMA or a special committee of the House of Delegates may be presented at any time during a meeting. Items of business presented before the recess of the opening session of the House of Delegates will be accepted as regular business. Items of business presented after the recess of the opening session of the House of Delegates will be accepted as emergency business and shall be presented to the House of Delegates without consideration by a reference committee. A two-thirds vote of the delegates present and voting shall be required for adoption.

2.11.3.4 Informational Reports of Sections. Informational reports may be presented by the AMA Sections on an annual basis.

2.11.4 Referral to Reference Committee. Reports, recommendations, resolutions or other new business presented prior to the recess of the opening session of the House of Delegates shall be referred to an appropriate reference committee for hearings and report, subject to acceptance as business of the House of Delegates. Items of business presented after the recess of the opening session are not referred to reference committee, but rather heard by the House of Delegates as a whole, subject to acceptance as business of the House of Delegates. Informational items are not referred to a reference committee.

2.11.6 Quorum. A majority of the voting members of the House of Delegates Official Call shall constitute a quorum.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(I-22)

Introduced by: Resident and Fellow Section

Subject: Solicitation Using the AMA Brand

Referred to: Reference Committee F

1 Whereas, Some physicians are turned off by third party solicitation material mailed with the
2 AMA brand, such as regarding disability insurance or student loan refinancing, potentially
3 harming the AMA's reputation and costing physician membership; and
4

5 Whereas, Financial literacy websites such as White Coat Investor detail the flaws in the AMA
6 branded third party disability insurance plan¹; and
7

8 Whereas, There is a financial and environmental cost to printed solicitation; and
9

10 Whereas, Associating the AMA brand to specific third-party products may or may not be in the
11 best interest of the AMA or current and potential AMA members; therefore be it
12

13 RESOLVED, That our American Medical Association study the use of AMA branded solicitation
14 material mailed to physicians, the impact it has on the perception of our AMA by current and
15 potential physician members, and the merits of continuing to use these materials in future
16 communications (Directive to Take Action); and be it further
17

18 RESOLVED, That our AMA study our membership on the preferred method to receive third
19 party solicitation material (mail, phone, email, social media) and provide a method to opt-out of
20 certain methods if not desired. (Directive to Take Action)

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

Received: 09/30/22

References:

1. [AMA's Disability Insurance: You Get What You Pay For - White Coat Investor](#)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(1-22)

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: 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

1 Whereas, Our AMA has supported physician innovation, especially in the field of AI, through the
2 Physician Innovation Network (PIN), an online forum board for entrepreneurs to seek medical
3 specialists to “connect the health care innovation ecosystems to improve the development of
4 emerging healthcare technology solutions”⁷; and
5

6 Whereas, Early analysis of the PIN has identified that early engagement of physicians and
7 respecting a physician’s time and expertise contribute to more meaningful connections between
8 physicians and entrepreneurs⁸; and
9

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

- 11 (1) Interviews with current physicians on the PIN suggest that the PIN only appeals to a
12 small subset of physicians who have already realized early in their careers that they
13 wish to pursue a nontraditional path in medicine and innovation⁹,
- 14 (2) As of 2018, only 2,600 physicians were reported to be on the network, or about 1%
15 of our AMA’s physician membership base¹⁰; and
16

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

- 19 (1) Leverage medical expertise to ensure clinical validation and assessment of clinical
20 applications of AI systems by practicing physicians,
- 21 (2) Outline a new professional role to aid and guide health care AI systems; therefore be
22 it
23

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

- 28 (1) Expanding recruitment among AMA physician members,
- 29 (2) Advising AMA physician members who are interested in healthcare innovation/AI
30 without knowledge of proper channels to pursue their ideas,
- 31 (3) Increasing outreach from AMA to industry leaders and companies to both further
32 promote the PIN and to understand the needs of specific companies,
- 33 (4) Facilitating communication between companies and physicians with similar interests,
- 34 (5) Matching physicians to projects early in their design and testing stages,
- 35 (6) Decreasing the time and workload spent by individual physicians on finding projects
36 themselves,
- 37 (7) Above all, boosting physician-centered innovation in the field of AI research and
38 development (Directive to Take Action); and be it further
39

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

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

Received: 10/11/22

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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: 901
(I-22)

Introduced by: Medical Student Section

Subject: Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies

Referred to: Reference Committee K

1 Whereas, While imprisoned, able-bodied incarcerated people are often required to work and
2 assigned duties if they have not already identified a job for themselves¹; and
3

4 Whereas, Incarcerated people can work in a variety of positions⁴; and
5

6 Whereas, Refusal to perform involuntary prison labor can be punished through various means,
7 including solitary confinement, revocation of family visitation, loss of earned “good behavior”
8 time^{2,3}; and
9

10 Whereas, Work programs operate in 88% of prisons in the United States and employ
11 approximately 775,000 prisoners⁵; and
12

13 Whereas, The prison system was hit especially hard during the initial waves of the COVID-19
14 pandemic in 2020 and since the primary defense against infection is vaccines, which did not
15 reach incarcerated people until 2021, and given prisons’ notoriously crowded environments,
16 COVID-19 rates in prisons soared⁶; and
17

18 Whereas, Staff shortages during this time meant that there were also fewer nurses and guards
19 to ensure the incarcerated people’s health and physical well-being⁷; and
20

21 Whereas, Despite the infection rates, many prison systems did not follow protocols to prevent
22 the spread of COVID-19 and still expected incarcerated workers to work in similar conditions to
23 those prior to the pandemic⁸; and
24

25 Whereas, For example, in the Washington Department of Corrections (WDOC), the prison
26 managers did not enforce post-exposure isolation and did not provide adequate hand sanitizer
27 or social distancing measures⁸; and
28

29 Whereas, California also kept their prison factories running through the pandemic, even as
30 infection rates rose, and incarcerated people report being threatened that their chances for
31 release from prison would be put into jeopardy if they refused to attend work because of
32 COVID-19 safety concerns because although prison representatives report that adequate
33 measures to address COVID-19 were put into place, interviews from across the United States
34 show otherwise^{9,10}; and
35

36 Whereas, As of February 10th, 2022, more than 476,000 people incarcerated in prisons have
37 had confirmed cases of COVID-19 and over 2,900 people have died from COVID-19 behind
38 bars¹¹; and

1 Whereas, During the COVID-19 pandemic, prison labor was used to assist front line workers in
2 a national response¹²; and
3

4 Whereas, States such as New York, Missouri, Louisiana, and others, made use of this prison
5 labor to quickly and cheaply make needed products and prisoners were forced to make
6 products used by front-line workers such as hand sanitizer, gowns, masks and even products
7 such as toilet paper, which did not benefit first responders directly, were produced by these
8 workers and wages for this work were far below minimum wage, but many were not paid at all;
9 and
10

11 Whereas, The prison-workplaces did not implement social distancing measures on par with
12 equivalent workplaces in non-carceral settings; and
13

14 Whereas, The Occupational Safety and Health Act of 1970 (OSH Act) requires that employers
15 provide employees with safe working conditions that are free of serious recognized hazards and
16 in compliance with Occupational Safety and Health Administration (OSHA)'s safety and health
17 standards¹³; and
18

19 Whereas, In addition to an employer's "general duty" to provide a safe workplace, OSHA sets in
20 place specific safety standards for certain workplaces, such as providing personal protective
21 equipment (PPE) and limiting exposure to toxic substances such as lead and asbestos and
22 OSHA can inspect private workplaces and workers can file complaints with OSHA regarding
23 unsafe working conditions with protection against retaliation; and
24

25 Whereas, However, the definition of "employer" in the OSH Act specifically excludes States and
26 political subdivisions of States - meaning that federal and state prisons employing prisoners are
27 exempted from the OSH Act¹⁴; and
28

29 Whereas, In federal prisons, the Bureau of Prisons [provides](#) health and safety requirements for
30 incarcerated workers through its occupational health and safety program¹⁵; and
31

32 Whereas, This policy [includes](#) annual safety [training](#) for incarcerated workers, [investigations](#) into
33 work-related injuries, and [compensation](#) for lost wages due to workplace injuries while injury
34 compensation, is [restricted](#) to individuals working through the [Federal Prison Industries](#) and
35 work assignments related to the maintenance of the facility; and
36

37 Whereas, For state prison workers, safety standards are left to the discretion of the state, with
38 some states not granting many protections at all^{14,16}; and
39

40 Whereas, For example, Pennsylvania provides compensation for lost wages for inmate workers
41 who suffer work-related injuries, while Texas explicitly [excludes](#) incarcerated workers from
42 receiving work-related injury compensation in their statute while in another example, the
43 California Prison Industry Authority (CALPIA) is a state agency that oversees the prison work
44 programs in the country's second largest prison system¹⁷; and
45

46 Whereas, In California, inmate workers cannot receive workers' compensation while still
47 incarcerated. Furthermore, the shortage of federal regulations has led to a lack of data related
48 to workplace conditions and injuries in corrections facilities and for policymakers to understand
49 the full extent of existing workplace safety standards in prisons, there must be a standard of
50 reporting¹⁸; and

1 Whereas, The issue of prison labor is an ethically nuanced topic with multiple points to consider.
2 There are benefits to providing incarcerated people with jobs, such as providing them a sense of
3 community and purpose because participating in meaningful work can help develop professional
4 skills that can benefit them once released and these jobs also potentially help incarcerated
5 people earn money to support themselves while incarcerated and after release; and
6

7 Whereas, Prison labor can be ethically appropriate when done in the best interest of the
8 prisoner without coercion or influence from exploitative purposes and incarcerated people must
9 be fairly compensated for their work to avoid said exploitation and provide them meaningful
10 resources as a result; and
11

12 Whereas, While it has been the policy to have imprisoned individuals do dangerous tasks, such
13 as working in crowded environments during the COVID-19 pandemic, at times it has been done
14 with inadequate protection and in the case of a pandemic, decreased protection due to
15 inadequate PPE and work conditions inconsistent with guidelines from the CDC and NIH would
16 constitute exploitative labor in addition to prisoners working in prisons where there was a
17 statistically higher level of COVID cases throughout the course of the pandemic, leading to a
18 five-fold greater risk of infection and 30% greater risk of death from infection compared to the
19 general population¹⁹; and
20

21 Whereas, Further, incarcerated people are often not protected by regulatory health and safety
22 standards, such as OSHA, practiced in the non-incarcerated context and without these
23 regulatory mechanisms, it is difficult to ascertain the extent of dangerous working conditions in
24 prisons and offer avenues for recourse for unsafe working conditions; and
25

26 Whereas, If the work being done by prisoners could be considered “essential” then they too
27 would be owed increased compensation²⁰; and
28

29 Whereas, Whether wildfires or a pandemic, no emergency justifies labor exploitation of a
30 population made vulnerable by the state, and any need for labor must also offer fair
31 compensation, preferential benefits (such as official certification and paths to further job
32 opportunities), and of course safety guarantees that are satisfactory with standard workplace
33 safety laws and regulatory bodies^{21,22}; and
34

35 Whereas, Current AMA policy sets a strong precedent for protecting incarcerated populations
36 from communicable diseases and has advocated for stronger protections for incarcerated
37 populations against COVID-19 during the early stages of the pandemic when outbreaks in
38 prisons were commonplace; and
39

40 Whereas, The AMA advocates for safe working conditions for all people through OSHA
41 regulation (D-135.935, D-135.974, H-135.935, H-490.413) and acknowledges that people who
42 are incarcerated are a vulnerable population (H-430.986); and
43

44 Whereas, The AMA supports access to healthcare while incarcerated, programs to help
45 incarcerated people transition to care once released, and promotes acceptable living conditions
46 (H-430.986, H-430.997); and
47

48 Whereas, While current policy addresses the need for healthcare and acknowledges exposure
49 risks related to incarceration itself, there is not a clear policy advocating for protection against
50 work-related exposures while incarcerated because clear gap in policy exists and AMA
51 advocacy could meaningfully improve prison workplace conditions to prevent further exploitation
52 of incarcerated peoples; therefore be it

- 1 RESOLVED, That our American Medical Association oppose the use of forced or coercive labor
2 practices for incarcerated populations (New HOD Policy); and be it further
3
4 RESOLVED, That our AMA support that any labor performed by incarcerated individuals or
5 other captive populations should include adequate workplace safety and fairness standards
6 similar to those outside of carceral institutions and support their reintegration into the workforce
7 after incarceration. (New HOD Policy)

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

Received: 09/20/22

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RELEVANT AMA POLICY

Support Stricter OSHA Silica Permissible Exposure Limit Standard D-135.974

Our AMA: (1) supports the Department of Labor's Occupational Safety and Health Administration's (OSHA's) proposed rule to establish a stricter permissible exposure limit (PEL) for respirable crystalline silica; (2) supports OSHA's proposed rule to establish a stricter standard of exposure assessment and medical surveillance requirements to identify adverse health effects in exposed populations of workers; and (3) will submit comments, in collaboration with respiratory and occupational health medical societies, in support of a stricter silica PEL.

Res. 916, I-13

Advocating for Heat Exposure Protections for All Workers D-135.967

Our AMA: (1) will advocate for all workers to have access to preventive cool-down rest periods in shaded, ventilated, and/or cooled areas for prevention of injury from sun exposure and heat injury as well as appropriate access to emergency services when signs and symptoms of heat exposure injury; (2) will advocate for legislation that creates federal standards for protections against heat stress and sun exposure specific to the hazards of the workplace; (3) supports policy change at the federal level via legislation or administrative rule changes by the Occupational Safety and Health Administration (OSHA) that would require that workers receive health educational materials about prevention and recognition of heat exhaustion and heat exposure injury that is in the worker's primary language; (4) will work with the United States Department of Labor, OSHA, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for workers independent of legal status; and (5) recognizes there are particular medical conditions and medications, including but not limited to psychotropics, which increase an individual's vulnerability to the negative impacts of heat and sun exposure and advocate for recognition of this, as well as additional protections as part of any guidelines, legislation or other policies.

Res. 502, I-21

OSHA Standards for Lead H-135.935

Our AMA will advocate with American College of Occupational and Environmental Medicine and other professional organizations to change the Occupational Safety & Health Administration legal standard for temporary medical removal from all lead work environments, regardless of the airborne lead concentrations, which result in workers' blood lead levels exceeding 20 mcg/dL on any two consecutive blood tests, or any single value exceeding 30 mcg/dL, as recommended by a subgroup of an expert panel convened by the Association of Occupational and Environmental Clinics (2007) and by Cal/OSHA (2009).

Res. 423, A-10, Reaffirmed: CSAPH Rep. 01, A-20

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

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

the visitor; (d) that all people inside a correctional facility or detention center wear an appropriate mask at all times, except while eating or drinking or at a 6 ft. distance from anyone else if local transmission rate is above low risk as determined by the CDC; and (e) that correctional facilities or detention centers be able to request and receive all necessary funding for COVID-19 vaccination and testing, according to CDC or local public health guidelines.

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

Health Care While Incarcerated H-430.986

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

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

Standards of Care for Inmates of Correctional Facilities H-430.997

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

Res. 60, A-84, Reaffirmed by CLRPD Rep. 3 - I-94, Amended: Res. 416, I-99, Reaffirmed: CEJA Rep. 8, A-09, Reaffirmation I-09, Modified in lieu of Res. 502, A-12, Reaffirmation: I-12, Modified: CSAPH Rep. 1, A-22

Smoke-Free and Vape-Free Environments and Workplaces H-490.913

On the issue of the health effects of environmental tobacco smoke (ETS), passive smoke, and vape aerosol exposure in the workplace and other public facilities, our AMA: (1) (a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free and vape-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking and vaping in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws; (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free and vape-free schools and eliminating smoking and vaping in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking and anti-vaping campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children; (d) encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe and cigar smoking and vaping in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking inhalation; (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking or non-vaping ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia; (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and (7) collaborates with local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues.

CSA Rep. 3, A-04, Appended: Sub. Res. 426, A-04, Modified: CSAPH Rep. 1, I-07, Reaffirmation I-14, Reaffirmation I-15, Modified: Res. 902, I-19, Modified: Res. 417, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 903
(1-22)

Introduced by: Medical Student Section

Subject: Supporting Further Study of Kratom

Referred to: Reference Committee K

1 Whereas, *Mitragyna speciosa* is a plant species commonly known as “Kratom” which is
2 characterized by analgesic, anxiolytic, and stimulatory properties depending on the strain and
3 dose, and is commonly used in Southeast Asia as a remedy for common ailments such as fever
4 and cough, as a stimulant to combat fatigue, and as a social drink¹⁻³; and

5
6 Whereas, Kratom acts on mu-opioid receptors to produce analgesia and euphoria⁴; and

7
8 Whereas, Millions of Americans currently use Kratom as an alternative to opioids for its pain-
9 relieving and mood-altering effects⁵; and

10
11 Whereas, A cross-sectional survey of 59,714 U.S. adults found an estimated 0.8% past-year
12 prevalence, with Kratom users having an above-average substance abuse profile⁶; and

13
14 Whereas, A systematic review on the mental health effects of Kratom found that Kratom
15 withdrawal is relatively mild compared to opioids while still significant enough that some users
16 found difficulty maintaining abstinence⁷; and

17
18 Whereas, One study surveyed 500 patients with substance use disorder and found that 68.9%
19 of the respondents were using Kratom to reduce or replace opioid use, suggesting that Kratom
20 may have potential as a harm-reducing agent for substance use disorder¹; and

21
22 Whereas, One study found that the risk of mortality from Kratom overdose is over 1,000 times
23 less than the risk of mortality from overdose with other opioids, and found that other substances
24 like heroin and methamphetamine were usually present in Kratom users who had experienced
25 significant adverse side effects⁸; and

26
27 Whereas, Between 2011 and 2017, there were 11 deaths associated with Kratom exposure,
28 including two deaths associated with Kratom use alone, and 7 reported neonatal exposures with
29 5 neonates experiencing withdrawal symptoms⁹; and

30
31 Whereas, A retrospective review identified 2,312 Kratom exposures reported to the National
32 Poison Control Centers between 2011 and 2018, with 935 cases involving Kratom alone, with
33 serious side effects reported including seizure (6.1%), withdrawal (6.1%), hallucinations (4.8%),
34 respiratory depression (2.8%), coma (2.3%), and cardiac or respiratory arrest (0.6%)¹⁰; and

35
36 Whereas, Research has shown that Kratom can lead to various organ toxicities, including acute
37 liver failure, acute kidney failure, seizure, brain injury, and cardiovascular toxicities^{11,12}; and

38
39 Whereas, Kratom can be purchased on the internet from vendors, often without age
40 verification¹³; and

1 Whereas, As of 2022, Kratom is legal in 44 states and explicitly banned in six states¹⁴; and
2
3 Whereas, Several states are considering banning or regulating Kratom to various degrees¹⁴;
4 and
5
6 Whereas, The Controlled Substance Act (CSA) established five tiers of drugs based upon eight
7 distinct criteria, determined primarily by the Drug Enforcement Administration¹⁵; and
8
9 Whereas, The first tier, “Schedule 1”, is defined to include “drugs with no currently accepted
10 medical use, has a high potential for abuse, and that there is a lack of accepted safety for the
11 use of the drug under medical supervision”¹⁶; and
12
13 Whereas, Prescriptions may only be written for Schedule II through V drugs, with Schedule I
14 drugs only available for research purposes^{17,18}; and
15
16 Whereas, Drug Enforcement Administration (DEA) scheduling of Kratom could impact
17 physicians’ prescribing habits and limit patient access to Kratom, should it be determined to
18 have medical utility, as evidenced by scheduling adjustments of other substances^{19,20}; and
19
20 Whereas, One study found that within six months of rescheduling hydrocodone, a 20% decline
21 in prescribing and dispensing was observed in the U.S and Australia²⁰; and
22
23 Whereas, In the UK, scheduling of mephedrone in 2011 led to a 49% of mephedrone users
24 increasing MDMA use, a 40% increase in purchasing of mephedrone from illicit sources, and an
25 increase in mephedrone-related deaths from 2011-2015^{20,21}; and
26
27 Whereas, Research on Schedule I drugs requires completing an application and registration
28 with the DEA²²; and
29
30 Whereas, Schedule I drugs may be difficult to obtain for research as manufacturers and custom
31 synthesis companies are sparse or prohibitively expensive²³; and
32
33 Whereas, Funding for the study of Schedule I drugs is limited, with a significant portion of the
34 research focused on potential harms rather than potential clinical applications²³; and
35
36 Whereas, LSD was extensively studied for potential in psychotherapy before classification as a
37 Schedule I drug; however, following the scheduling of LSD, research declined sharply²³; and
38
39 Whereas, Research into whether the positive characteristics of Kratom use outweigh the
40 potential adverse effects is currently insufficient to draw general conclusions²⁴; and
41
42 Whereas, Scheduling Kratom prior to robust research showing that the harms outweigh the
43 potential benefits would limit the conduct of future studies that might identify novel therapies for
44 substance use disorder^{1,2,7,8,23,24}; therefore be it

1 RESOLVED, That our American Medical Association amend policy H-95.934, "Kratom and its
2 Growing Use Within the United States," by addition and deletion to read as follows:
3

4 Kratom and its Growing Use Within the United States, H-95.934
5 Our AMA: supports legislative or regulatory efforts to prohibit the sale or distribution of
6 Kratom in the United States which do not inhibit proper scientific research efforts to
7 further study the clinical uses, benefits, and potential harms of Kratom, and oppose
8 efforts that may restrict research. (Modify Current HOD Policy)

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

Received: 09/20/22

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RELEVANT AMA POLICY

Kratom and its Growing Use Within the United States H-95.934

Our AMA supports legislative or regulatory efforts to prohibit the sale or distribution of Kratom in the United States which do not inhibit proper scientific research.

Res. 509, A-16

Cannabis and Cannabinoid Research H-95.952

1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.
2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.
3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.
4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.
5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.
6. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.
7. Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.

CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01; Modified: CSAPH Rep. 3, I-09; Modified in lieu of Res. 902, I-10; Reaffirmed in lieu of Res. 523, A-11; Reaffirmed in lieu of Res. 202, I-12; Reaffirmed: CSAPH Rep. 2, I-13; Modified: CSAPH Rep. 05, I-17; Reaffirmed in lieu of: Res. 434, A-19; Appended: Res. 913, I-19; Appended: Res. 913, I-19; Reaffirmation: A-22

FDA H-100.992

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

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

Drugs of Choice H-100.997

Our AMA opposes any proposal that would establish a classification of drugs of choice for any specific clinical entity through governmental regulation.

Res. 117, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Dietary Supplements and Herbal Remedies H-150.954

- (1) Our AMA supports efforts to enhance U.S. Food and Drug Administration (FDA) resources, particularly to the Office of Dietary Supplement Programs, to appropriately oversee the growing dietary supplement sector and adequately increase inspections of dietary supplement manufacturing facilities.
- (2) Our AMA supports the FDA having appropriate enforcement tools and policies related to dietary supplements, which may include mandatory recall and related authorities over products that are marketed as dietary supplements but contain drugs or drug analogues, the utilization of risk-based inspections for dietary supplement manufacturing facilities, and the strengthening of adverse event reporting systems.
- (3) Our AMA supports continued research related to the efficacy, safety, and long-term effects of dietary supplement products.
- (4) Our AMA will work with the FDA to educate physicians and the public about FDA's Safety Reporting Portal (SRP) and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.
- (5) Our AMA strongly urges physicians to inquire about patients' use of dietary supplements and engage in risk-based conversations with them about dietary supplement product use.
- (6) Our AMA continues to strongly urge Congress to modify and modernize the Dietary Supplement Health and Education Act to require that:
 - (a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy;
 - (b) dietary supplements meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling;
 - (c) FDA establish a mandatory product listing regime that includes a unique identifier for each product (such as a QR code), the ability to identify and track all products produced by manufacturers who have received warning letters from the FDA, and FDA authorities to decline to add labels to the database if the label lists a prohibited ingredient or new dietary ingredient for which no evidence of safety exists or for products which have reports of undisclosed ingredients; and
 - (d) regulations related to new dietary ingredients (NDI) are clarified to foster the timely submission of NDI notifications and compliance regarding NDIs by manufacturers.
- (7) Our AMA supports FDA postmarketing requirements for manufacturers to report adverse events, including drug interactions; and legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement
- (8) Our AMA will work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements and supports adequate funding and resources for FTC enforcement of violations of the FTC Act.
- (9) Our AMA strongly urges that criteria for the rigor of scientific evidence needed to support a structure/function claim on a dietary supplement be established by the FDA and minimally include requirements for robust human studies supporting the claim.
- (10) Our AMA strongly urges dietary supplement manufacturers and distributors to clearly label all products with truthful and not misleading information and for the product labeling to:
 - (a) not include structure/function claims that are not supported by evidence from robust human studies;
 - (b) not contain prohibited disease claims;
 - (c) eliminate "proprietary blends" and list and accurately quantify all ingredients contained in the product;
 - (d) require advisory statements regarding potential supplement-drug and supplement-laboratory interactions and risks associated with overuse and special populations; and
 - (e) include accurate and useful disclosure of ingredient measurement.
- (11) Our AMA supports and encourages the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies.
- (12) Our AMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.
- (13) Our AMA will continue its efforts to educate patients and physicians about the risks associated with the use of dietary supplements and herbal remedies and supports efforts to increase patient, healthcare

practitioner, and retailer awareness of resources to help patients select quality supplements, including educational efforts to build label literacy.

Res. 513, I-98; Reaffirmed: Res. 515, A-99; Amended: Res. 501 & Reaffirmation I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 516, I-00; Modified: Sub. Res. 516, I-00; Reaffirmed: Sub. Res. 518, A-04; Reaffirmed: Sub. Res. 504, A-05; Reaffirmation A-05; Reaffirmed in lieu of Res. 520, A-05; Reaffirmation I-09; Reaffirmed in lieu of Res. 501, A-10; Reaffirmation A-11; Reaffirmation I-14; Modified: Res. 511, A-16; Reaffirmation: A-17; Reaffirmation: A-19; Modified: CSAPH Rep. 3, I-20

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

Global Climate Change and Human Health H-135.938

Our AMA:

1. Supports 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: 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

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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: 932
(1-22)

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

1 Whereas, Lack of funding has been increasingly detrimental during the COVID-19 pandemic,
2 with community programs through WIOA reporting over 30% of employment service
3 programming closed due to COVID-19¹²; and
4

5 Whereas, The Arc, an organization that trains and employs thousands of individuals with
6 disabilities nationally, reported that employment programs have struggled during the COVID-19
7 pandemic due to funding concerns, and 44% of agencies through The Arc had to lay-off or
8 furlough staff^{13,14}; and
9

10 Whereas, Section 188 of WIOA requires that employment services provide equal opportunities
11 for individuals with disabilities to participate in services and receive appropriate
12 accommodations; however, the COVID-19 pandemic has created disparities in receiving these
13 accommodations¹⁵; and
14

15 Whereas, Our AMA Policy H-90.967 and MSS Policy 25.002 encourage government agencies
16 and other organizations to provide psychosocial support for people with disabilities, but do not
17 include employment benefits; and
18

19 Whereas, As employment and socioeconomic status are social determinants of health closely
20 linked to health outcomes, increased resources for employment support programs would
21 provide equitable solutions for the drastic disparities that the COVID-19 pandemic has created
22 for people with disabilities¹⁶; therefore be it
23

24 RESOLVED, That our American Medical Association support increased resources for
25 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: 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

1 RESOLVED, That our American Medical Association policy H-430.983, “Reducing the Use of
2 Restrictive Housing in Prisoners with Mental Illness,” be amended by addition and deletion to
3 read as follows:
4

5 **Reducing ~~Opposing~~ the Use of Restrictive Housing in for Prisoners with Mental**
6 **Illness H-430.983**

7 Our AMA will: (1) ~~support limiting~~ oppose the use of solitary confinement of any length,
8 ~~with rare exceptions,~~ for incarcerated persons ~~with mental illness,~~ in adult correctional
9 facilities and detention centers, except for medical isolation or to protect individuals
10 who are actively being harmed or will be immediately harmed by a physically violent
11 individual, in which cases confinement may be used for as short a time as possible;
12 and (2) while solitary confinement practices are still in place, support efforts to ensure
13 that the mental and physical health of all individuals placed in solitary confinement are
14 regularly monitored by health professionals; and (3) encourage appropriate
15 stakeholders to develop and implement safe, humane, and ethical alternatives to
16 solitary confinement for incarcerated persons in all correctional facilities; ~~and (3)~~
17 ~~encourage appropriate stakeholders to develop and implement alternatives to solitary~~
18 ~~confinement for incarcerated persons in all correctional facilities.~~ (Modify Current HOD
19 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;

Informational Reports

BOT Report(s)

- 06 Informal Inter-Member Mentoring
- 10 Redefining the AMA's Position on ACA and Healthcare Reform
- 11 2022 AMA Advocacy Efforts

CEJA Opinion(s)

- 01 Amendment to E-9.3.2, "Physician Responsibilities to Colleagues with Illness, Disability or Impairment"

CEJA Report(s)

- 04 Research Handling of De-Identified Patient Information

CMS Report(s)

- 03 Health System Consolidation

REPORT OF THE BOARD OF TRUSTEES

B of T Report 6-I-22

Subject: Informal Inter-Member Mentoring

Presented by: Sandra Adamson Fryhofer, MD, Chair

1 At the November 2021 Special Meeting of the House of Delegates (HOD), Policy D-635.980,
2 “Informal Inter-Member Mentoring,” was adopted.

3
4 To implement the policy, our AMA has convened a Mentorship Steering Committee consisting of
5 representatives from each of the AMA sections (see appendix). Given the sections’ role as the
6 place for members to become more actively involved in the AMA and their focus on leadership
7 development, the sections are a natural home for this initiative. As the work of the Steering
8 Committee and organization continues, we will continue to be broadly inclusive of the diversity of
9 experiences and needs across our membership.

10
11 The Mentorship Steering Committee has been charged with identifying mentorship opportunities
12 and best practices within individual sections and more broadly across the organization. The
13 Committee has discussed the importance of creating informal, organic opportunities for mentors
14 and mentees to identify one another and connect, as opposed to establishing more formal programs
15 with assigned mentors/mentees.

16
17 Discussions about the most appropriate format for such interaction continue and will guide
18 management in its exploration of scalable mechanisms to achieve the aim of the policy. Your
19 Board will provide a progress report at the 2023 Annual Meeting.

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

Appendix: Inaugural Membership of the Mentorship Steering Committee

Neel Shah, MD, Academic Physicians Section
Kamalika Roy, MD, International Medical Graduates Section
Donna Smith, MD, Integrated Physician Practice Section
Carl Streed, MD, Advisory Committee on LGBTQ Issues
Samantha Lopez, MD, Minority Affairs Section
Danielle Rivera, Medical Student Section
Nancy Mueller, MD, Organized Medical Staff Section
Carolyn Francavilla, MD, Private Practice Physicians Section
Breyen Coffin, MD, Resident and Fellow Section
Louise Andrew, MD, Senior Physicians Section
Aleesha Shaik, MD, Women Physicians Section
Laura Gephart, MD, Young Physicians Section

REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-I-22

Subject: Redefining AMA’s Position on ACA and Healthcare Reform

Presented by: Sandra Adamson Fryhofer, MD, Chair

1 At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy
2 D-165.938, “Redefining AMA’s Position on ACA and Healthcare Reform,” which calls on our
3 American Medical Association (AMA) to “develop a policy statement clearly outlining this
4 organization’s policies” on several specific issues related to the Affordable Care Act (ACA) as well
5 as repealing the SGR and the Independent Payment Advisory Board (IPAB). The adopted policy
6 also calls for our AMA to report back at each meeting of the HOD. Board of Trustees Report
7 6-I-13, “Redefining AMA’s Position on ACA and Healthcare Reform,” accomplished the original
8 intent of the policy. This report serves as an update on the issues and related developments
9 occurring since the most recent meeting of the HOD.

10

11 IMPROVING THE AFFORDABLE CARE ACT

12

13 Our AMA continues to engage policymakers and advocate for meaningful, affordable health care
14 for all Americans to improve the health of our nation. Our AMA remains committed to the goal of
15 universal coverage, which includes protecting coverage for the 20 million Americans who acquired
16 it through the ACA. Our AMA has been working to fix the current system by advancing solutions
17 that make coverage more affordable and expanding the system’s reach to Americans who fall
18 within its gaps. Our AMA also remains committed to improving health care access so that patients
19 receive timely, high-quality care, preventive services, medications, and other necessary treatments.
20

21

22 Our AMA continues to advocate for policies that would allow patients and physicians to be able to
23 choose from a range of public and private coverage options with the goal of providing coverage to
24 all Americans. Specifically, our AMA has been working with Congress, the Administration, and
25 states to advance our plan to cover the uninsured and improve affordability as included in the
26 “2022 and Beyond: AMA’s Plan to Cover the Uninsured.” The COVID-19 pandemic initially led
27 to many people losing their employer-based health insurance. This only increased the need for
28 significant improvements to the Affordable Care Act. Recent data indicate that the uninsured rate
29 has decreased during the COVID-19 pandemic, due to the temporary ACA improvements included
30 in the American Rescue Plan Act, continuous Medicaid enrollment, state Medicaid expansions, and
31 the 2021 special enrollment period for ACA marketplaces.

32

33 We also continue to examine the pros and cons of a broad array of approaches to achieve universal
34 coverage as the policy debate evolves.

35

36 Our AMA has been advocating for the following policy provisions:

37

38 Cover Uninsured Eligible for ACA’s Premium Tax Credits

39

- Our AMA advocates for increasing the generosity of premium tax credits to improve premium
40 affordability and incentivize tax credit eligible individuals to get covered. Currently, eligible

1 individuals and families with incomes between 100 and 400 percent federal poverty level
2 (FPL) (133 and 400 percent in Medicaid expansion states) are being provided with refundable
3 and advanceable premium tax credits to purchase coverage on health insurance exchanges.

- 4 • Our AMA has been advocating for enhanced premium tax credits to young adults. In order to
5 improve insurance take-up rates among young adults and help balance the individual health
6 insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium
7 tax credits could be provided with “enhanced” premium tax credits—such as an additional \$50
8 per month—while maintaining the current premium tax credit structure which is inversely
9 related to income, as well as the current 3:1 age rating ratio.
- 10 • Our AMA also is advocating for an expansion of the eligibility for and increasing the size of
11 cost-sharing reductions. Currently, individuals and families with incomes between 100 and 250
12 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for
13 cost-sharing subsidies if they select a silver plan, which leads to lower deductibles, out-of-
14 pocket maximums, copayments, and other cost-sharing amounts. Extending eligibility for cost-
15 sharing reductions beyond 250 percent FPL, and increasing the size of cost-sharing reductions,
16 would lessen the cost-sharing burdens many individuals face, which impact their ability to
17 access and afford the care they need.

18 19 Cover Uninsured Eligible for Medicaid or Children’s Health Insurance Program

20
21 Before the COVID-19 pandemic, in 2018, 6.7 million of the nonelderly uninsured were eligible for
22 Medicaid or the Children’s Health Insurance Program (CHIP). Reasons for this population
23 remaining uninsured include lack of awareness of eligibility or assistance in enrollment.

- 24
25 • Our AMA has been advocating for increasing and improving Medicaid/CHIP outreach and
26 enrollment, including auto enrollment.
- 27 • Our AMA has been opposing efforts to establish Medicaid work requirements. The AMA
28 believes that Medicaid work requirements would negatively affect access to care and lead to
29 significant negative consequences for individuals’ health and well-being.

30 31 Make Coverage More Affordable for People Not Eligible for ACA’s Premium Tax Credits

32
33 Before the COVID-19 pandemic, in 2018, 5.7 million of the nonelderly uninsured were ineligible
34 for financial assistance under the ACA, either due to their income, or because they have an offer of
35 “affordable” employer-sponsored health insurance coverage. Without the assistance provided by
36 ACA’s premium tax credits, this population can continue to face unaffordable premiums and
37 remain uninsured.

- 38
39 • Our AMA advocates for eliminating the subsidy “cliff,” thereby expanding eligibility for
40 premium tax credits beyond 400 percent FPL.
- 41 • Our AMA has been advocating for the establishment of a permanent federal reinsurance
42 program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance
43 plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher
44 premiums across the board in anticipation of higher-risk people enrolling in coverage. Section
45 1332 waivers have also been approved to provide funding for state reinsurance programs.
- 46 • Our AMA also is advocating for lowering the threshold that determines whether an employee’s
47 premium contribution is “affordable,” allowing more employees to become eligible for
48 premium tax credits to purchase marketplace coverage.
- 49 • Our AMA has been strongly advocating for the Internal Revenue Service (IRS) proposed
50 regulation on April 7, 2022 that would fix the so-called “family glitch” under the ACA,

1 whereby families of workers remain ineligible for subsidized ACA marketplace coverage even
2 though they face unaffordable premiums for health insurance coverage offered through
3 employers. The proposed regulation would fix the family glitch by extending eligibility for
4 ACA financial assistance to only the family members of workers who are not offered
5 affordable job-based family coverage. Our AMA is urging the Biden Administration to finalize
6 the proposed rule as soon as possible.

7 8 EXPAND MEDICAID TO COVER MORE PEOPLE

9
10 Before the COVID-19 pandemic, in 2018, 2.3 million of the nonelderly uninsured found
11 themselves in the coverage gap—not eligible for Medicaid, and not eligible for tax credits because
12 they reside in states that did not expand Medicaid. Without access to Medicaid, these individuals
13 do not have a pathway to affordable coverage.

- 14
15 • Our AMA has been encouraging all states to expand Medicaid eligibility to 133 percent FPL.

16
17 New policy adopted by the AMA HOD during the November 2021 Special Meeting seeks to assist
18 more than 2 million nonelderly uninsured individuals who fall into the “coverage gap” in states that
19 have not expanded Medicaid—those with incomes above Medicaid eligibility limits but below the
20 FPL, which is the lower limit for premium tax credit eligibility. The new AMA policy maintains
21 that coverage should be extended to these individuals at little or no cost, and further specifies that
22 states that have already expanded Medicaid coverage should receive additional incentives to
23 maintain that status going forward.

24 25 AMERICAN RESCUE PLAN OF 2021

26
27 On March 11, 2021, President Biden signed into law the American Rescue Plan (ARPA) of 2021.
28 This legislation included the following ACA-related provisions that will:

- 29
30 • Provide a temporary (two-year) 5 percent increase in the Federal Medical Assistance
31 Percentage (FMAP) for Medicaid to states that enact the Affordable Care Act’s Medicaid
32 expansion and covers the new enrollment period per requirements of the ACA.
- 33 • Invest nearly \$35 billion in premium subsidy increases for those who buy coverage on the
34 ACA marketplace.
- 35 • Expand the availability of ACA advanced premium tax credits (APTCs) to individuals whose
36 income is above 400 percent of the FPL for 2021 and 2022.
- 37 • Give an option for states to provide 12-month postpartum coverage under State Medicaid and
38 CHIP.

39
40 ARPA represents the largest coverage expansion since the Affordable Care Act. Under the ACA,
41 eligible individuals, and families with incomes between 100 and 400 percent of the FPL (between
42 133 and 400 percent FPL in Medicaid expansion states) have been provided with refundable and
43 advanceable premium credits that are inversely related to income to purchase coverage on health
44 insurance exchanges. However, consistent with Policy H-165.824, “Improving Affordability in the
45 Health Insurance Exchanges,” ARPA eliminated ACA’s subsidy “cliff” for 2021 and 2022. As a
46 result, individuals and families with incomes above 400 percent FPL (\$51,520 for an individual
47 and \$106,000 for a family of four based on 2021 federal poverty guidelines) are eligible for
48 premium tax credit assistance. Individuals eligible for premium tax credits include individuals who
49 are offered an employer plan that does not have an actuarial value of at least 60 percent or if the
50 employee share of the premium exceeds 9.83 percent of income in 2021.

1 Consistent with Policy H-165.824, ARPA also increased the generosity of premium tax credits for
2 two years, lowering the cap on the percentage of income individuals are required to pay for
3 premiums of the benchmark (second lowest-cost silver) plan. Premiums of the second lowest-cost
4 silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of
5 their income. Notably, resulting from the changes, eligible individuals and families with incomes
6 between 100 and 150 percent of the FPL (133 percent and 150 percent FPL in Medicaid expansion
7 states) now qualify for zero-premium silver plans, effective until the end of 2022.

8
9 In addition, individuals and families with incomes between 100 and 250 percent FPL (between 133
10 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they
11 select a silver plan, which reduces their deductibles, out-of-pocket maximums, copayments, and
12 other cost-sharing amounts.

13 14 LEGISLATIVE EXTENSION OF ARPA PROVISIONS

15
16 On August 16, President Biden signed into law the Inflation Reduction Act of 2022 through the
17 highly partisan budget reconciliation process, which allows both the House and Senate to pass the
18 bill with limits on procedural delays. Most significantly, reconciliation allows the Senate to bypass
19 the filibuster and pass legislation with a 50-vote threshold so long as it meets a series of budgetary
20 requirements. The Inflation Reduction Act includes provisions that would extend for three years to
21 2025 the aforementioned ACA premium subsidies authorized in ARPA.

22
23 The Inflation Reduction Act does not include provisions to close the Medicaid “coverage gap” in
24 the states that have not chosen to expand.

25 26 ACA ENROLLMENT

27
28 According to the U.S. Department of Health and Human Services (HHS), 14.5 million Americans
29 have signed up for or were automatically re-enrolled in the 2022 individual market health insurance
30 coverage through the marketplaces since the start of the 2022 Marketplace Open Enrollment Period
31 (OEP) on November 1, 2021, through January 15, 2022. That record-high figure includes nearly 2
32 million new enrollees, many of whom qualified for reduced premiums granted under ARPA. In
33 August, the Department of Health and Human Services issued a report noting that the uninsured
34 rate in the U.S. had dropped to an all-time low of 8 percent.

35 36 *TEXAS VS. AZAR* SUPREME COURT CASE

37
38 The Supreme Court agreed on March 2, 2020, to address the constitutionality of the ACA for the
39 third time, granting the petitions for certiorari from Democratic Attorneys General and the House
40 of Representatives. Oral arguments were presented on November 10, 2020, and a decision was
41 expected before June 2021. The AMA filed an amicus brief in support of the Act and the
42 petitioners in this case.

43
44 On February 10, 2021, the U.S. Department of Justice under the new Biden Administration
45 submitted a letter to the Supreme Court arguing that the ACA’s individual mandate remains valid,
46 and, even if the court determines it is not, the rest of the law can remain intact.

47
48 This action reversed the Trump Administration’s brief it filed with the Court asking the justices to
49 overturn the ACA in its entirety. The Trump Administration had clarified that the Court could
50 choose to leave some ACA provisions in place if they do not harm the plaintiffs, but as legal
51 experts pointed out, the entire ACA would be struck down if the Court rules that the law is

1 inseparable from the individual mandate—meaning that there would be no provisions left to
2 selectively enforce.

3
4 On June 17, 2021, the Supreme Court in a 7-2 decision ruled that neither the states nor the
5 individuals challenging the law have a legal standing to sue. The Court did not touch the larger
6 issue in the case: whether the entirety of the ACA was rendered unconstitutional when Congress
7 eliminated the penalty for failing to obtain health insurance.

8
9 With its legal status now affirmed by three Supreme Court decisions, and provisions such as
10 coverage for preventive services and pre-existing conditions woven into the fabric of U.S. health
11 care, the risk of future lawsuits succeeding in overturning the ACA is significantly diminished.

12 13 *KELLEY VS. BECERRA* FEDERAL COURT CASE

14
15 A case before a federal district court judge in the Northern District of Texas, *Kelley v. Becerra*,
16 would eliminate the ACA requirement that most health insurance plans cover preventive services
17 without copayments. Those filing the case object to paying for coverage that they do not want or
18 need, particularly for those items or services that violate their religious beliefs, such as
19 contraception or PrEP drugs. If the case is successful, health plan enrollees will also lose access to
20 full coverage for more than 100 preventive health services, including vaccinations and screenings
21 for breast cancer, colorectal cancer, cervical cancer, heart disease, and other diseases and medical
22 conditions.

23
24 The AMA and 61 national physician specialty organizations issued a joint statement on July 25,
25 sounding the alarm about the millions of privately insured patients who would be affected by an
26 adverse ruling.

27 28 SGR REPEAL

29
30 The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 repealing and replacing
31 the SGR was signed into law by President Obama on April 16, 2015.

32
33 The AMA is now working on unrelated new Medicare payment reduction threats and is currently
34 advocating for a sustainable, inflation-based, automatic positive update system for physicians.

35 36 INDEPENDENT PAYMENT ADVISORY BOARD REPEAL

37
38 The Bipartisan Budget Act of 2018 signed into law by President Trump on February 9, 2018,
39 included provisions repealing IPAB. Currently, there are not any legislative efforts in Congress to
40 replace the IPAB.

41 42 CONCLUSION

43
44 Our American Medical Association will remain engaged in efforts to improve the health care
45 system through policies outlined in Policy D-165. 938 and other directives of the House of
46 Delegates.

REPORT 11 OF THE BOARD OF TRUSTEES (I-22)
2022 AMA Advocacy Efforts
(Informational)

EXECUTIVE SUMMARY

Numerous advocacy challenges emerged in 2022, but once again, our AMA rose to the moment and achieved significant progress on the issues most important to America's physicians and patients. While the COVID-19 public health emergency (PHE) has subsided to a certain degree, it persists. The AMA has stood by America's physicians and patients throughout the pandemic, securing billions in relief to protect private practices; reducing reporting burdens and penalties; advancing telehealth; enabling investments in therapeutics and vaccines to end the pandemic; standing up for health equity to achieve optimal health for all; and strongly advocating for science in the halls of power. At the same time, the AMA has been advocating extensively on other issues critical to physicians and patients.

At the 2022 Annual Meeting, the AMA launched a Recovery Plan for America's Physicians targeting some of the toughest issues physicians face today—on both professional and personal levels. Components of the plan include:

- Reforming Medicare payment to promote thriving physician practices and innovation;
- Stopping scope creep that threatens patient safety;
- Fixing prior authorization to reduce the burden on practices and minimize patient care delays;
- Supporting telehealth to maintain coverage and payment; and
- Reducing physician burnout and addressing the stigma around mental health.

Success on these issues will be key to helping physicians get back on track after the practice interruptions and shutdowns they have faced in the last two years.

While the AMA is focusing on tackling the issues contained in the recovery plan, other issues have arisen that need heightened advocacy efforts too. The mass shootings in Buffalo, NY, and Uvalde, TX, forced policymakers to finally come to the table and consider some initial steps to halt such massacres. Further, the *Dobbs v. Jackson Women's Health Organization* decision to overturn *Roe v. Wade* allows lawmakers to invade the exam room in ways not seen in decades and has created a whirlwind of clinical questions facing physicians trying to provide the best care while avoiding legal liability.

The AMA is fighting to advance our policy on these issues and many more that are updated in this report.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-I-22

Subject: 2022 AMA Advocacy Efforts

Presented by: Sandra Adamson Fryhofer, MD, Chair

1 BACKGROUND

2
3 Policy G-640.005, “AMA Advocacy Analysis,” calls on the Board of Trustees (the Board) to
4 provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year’s
5 advocacy activities and should include efforts, successes, challenges, and recommendations/actions
6 to further optimize advocacy efforts. The Board has prepared the following report to provide an
7 update on American Medical Association (AMA) advocacy activities for the year. (Note: This
8 report was prepared in August based on approval deadlines, so more recent developments may not
9 be reflected in it.)

10
11 DISCUSSION OF 2022 ADVOCACY EFFORTS

12
13 Numerous advocacy challenges emerged in 2022, but once again, our AMA rose to the moment
14 and achieved significant progress on the issues most important to America’s physicians and
15 patients. While the COVID-19 public health emergency (PHE) has subsided to a certain degree, it
16 persists. The AMA has stood by America’s physicians and patients throughout the pandemic,
17 securing billions in relief to protect private practices; reducing reporting burdens and penalties;
18 advancing telehealth; enabling investments in therapeutics and vaccines to end the pandemic;
19 standing up for health equity to achieve optimal health for all; and strongly advocating for science
20 in the halls of power. At the same time, the AMA has been advocating extensively on other issues
21 critical to physicians and patients.

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24 targeting some of the toughest issues physicians face today—on both professional and personal
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34 interruptions and shutdowns they have faced in the last two years.

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36 While the AMA is focusing on tackling the issues contained in the recovery plan, other issues have
37 arisen that need heightened advocacy efforts, too. The mass shootings in Buffalo, NY, and Uvalde,
38 TX, forced policymakers to finally come to the table and consider some initial steps to halt such
39 massacres. Further, the *Dobbs v. Jackson Women’s Health Organization* (hereafter *Dobbs*)
40 decision to overturn *Roe v. Wade* (hereafter *Roe*) allows lawmakers to invade the exam room in

1 ways not seen in decades and has created a whirlwind of clinical questions facing physicians trying
2 to provide the best care while avoiding legal liability.

3
4 The AMA is fighting to advance AMA policy on these issues and many more that are updated in
5 this report.

6 7 *Medicare Payment Reform*

8
9 The AMA is focused on reforming our nation's Medicare physician payment system. The Medicare
10 Access and CHIP Reauthorization Act of 2015 (MACRA) made needed improvements to the
11 system including eliminating the Sustainable Growth Rate (SGR), but time has revealed significant
12 statutory flaws. The promise of a viable glide path to voluntary participation in alternative payment
13 models (APMs) never materialized, with 30 physician-proposed models being rejected for
14 implementation. Meanwhile, the increasingly aggressive financial incentives to participate in
15 APMs continue. The quality and reporting programs for physicians in the Merit-based Incentive
16 Payment System (MIPS) are burdensome and lack clinical relevance. The Medicare fee schedule is
17 chronically underfunded. No annual updates will be provided for physician services for several
18 years, and those received over the past two decades have collectively fallen well below the rising
19 costs of medical practice.
20

21 The 2023 Medicare payment schedule proposed rule released in July fails to account for inflation in
22 practice costs and COVID-related challenges to practice sustainability and also includes a
23 significant and damaging across-the-board reduction in payment rates. Such a move would create
24 long-term financial instability in the Medicare physician payment system and threaten patient
25 access to Medicare-participating physicians. The AMA is working with Congress to prevent this
26 harmful outcome in the short term and to advance more comprehensive reform in coming sessions.
27

28 To achieve the needed level of reform, the AMA and 120 Federation groups have agreed on the
29 following ["Characteristics of a Rational Medicare Payment System"](#) and will be advocating to see
30 these principles implemented by Congress and the Administration.
31

32 Simplicity, relevance, alignment, and predictability, for physician practices and the Centers for 33 Medicare & Medicaid Services.

- 34
- 35 • Ensuring financial stability and predictability
 - 36 ○ Provide financial stability through a baseline positive annual update reflecting inflation in
 - 37 practice costs, and eliminate, replace, or revise budget neutrality requirements to allow for
 - 38 appropriate changes in spending growth.
 - 39 ○ Recognize fiscal responsibility. Payment models should invest in and recognize
 - 40 physicians' contributions in providing high-value care and the associated savings and
 - 41 quality improvements across all parts of Medicare and the health care system (e.g.,
 - 42 preventing hospitalizations).
 - 43 ○ Encourage collaboration, competition, and patient choice rather than consolidation through
 - 44 innovation, stability, and reduced complexity by eliminating the need for physicians to
 - 45 choose between retirement, selling their practices or suffering continued burnout.
 - 46 • Promoting value-based care
 - 47 ○ Reward the value of care provided to patients, rather than administrative activities, such as
 - 48 data entry, that may not be relevant to the service being provided or the patient receiving
 - 49 care.
 - 50 ○ Encourage innovation, so that practices and systems can be redesigned and continuously
 - 51 refined to provide high-value care and include historically non-covered services that

- 1 improve care for all or a specific subset of patients (e.g., COPD, Crohn’s Disease), as well
2 as for higher risk and higher cost populations.
- 3 ○ Offer a variety of payment models and incentives tailored to the distinct characteristics of
4 different specialties and practice settings. Participation in new models must be voluntary
5 and continue to be incentivized. A fee-for-service payment model must also remain a
6 financially viable option.
 - 7 ○ Provide timely, actionable data. Physicians need timely access to analyses of their claims
8 data, so they can identify and reduce avoidable costs. Though Congress took action to give
9 physicians access to their data, they still do not receive timely, actionable feedback on their
10 resource use and attributed costs in Medicare. Physicians should be held accountable only
11 for the costs that they control or direct.
 - 12 ○ Recognize the value of clinical data registries as a tool for improving quality of care, with
13 their outcome measures and prompt feedback on performance.
 - 14 ● Safeguarding access to high-quality care
 - 15 ○ Advance health equity and reduce disparities. Payment model innovations should be risk-
16 adjusted and recognize physicians’ contributions to reducing health disparities, addressing
17 social drivers of care, and tackling health inequities; physicians need support as they care
18 for historically marginalized, higher risk, hard to reach or sicker populations.
 - 19 ○ Support practices where they are by recognizing that high-value care is provided by both
20 small practices and large systems, and in both rural and urban settings.

21
22 For the near term, AMA and the Federation are asking Congress to take the following steps before
23 the end of the year to address cuts that are scheduled to take effect in 2023:

- 24
- 25 ● Replace the 0% payment schedule conversion factor update scheduled for next year with one
26 that is based on inflation;
 - 27 ● Stop the 4.5% combined budget neutrality adjustments that offset the costs of improved
28 payments for office-based (-3%) and facility-based (-1.5%) E/M services;
 - 29 ● Waive the 4% PAYGO sequestration requirement that was triggered by the infrastructure and
30 COVID relief bills passed last year;
 - 31 ● Extend the \$500 million exceptional MIPS performance fund; and
 - 32 ● Extend current APM policies related to incentive bonuses and qualifying revenue thresholds.

33
34 *Scope of Practice*

35
36 The AMA defends the practice of medicine against inappropriate scope of practice expansions,
37 supports physician-led team care, and ensures patients have access to physicians for their health
38 care. All health care professionals play a critical role in caring for patients and are important
39 members of the care team; however, their skillsets are not interchangeable with that of a fully
40 trained physician. At the state level, the AMA works in strong collaboration and coordination with
41 the state medical associations and national medical specialty societies. This includes sharing
42 resources, reviewing, and advising on legislative language/strategy, testifying before state
43 legislatures, submitting letters of opposition to lawmakers, and amplifying calls to action. The
44 AMA also has a comprehensive library of resources to support our scope of practice campaign,
45 including GEOMAPS, education and training modules, patient surveys, media toolkit, and one-
46 pagers. These provide data and talking points to address the most common arguments to preserve
47 physician-led care and refute assertions made by non-physicians. Since 2007 the AMA’s Scope of
48 Practice Partnership (SOPP) has played a key role in bringing organized medicine together on this
49 issue, including by providing grants to SOPP members to support state efforts. There are currently
50 108 members of the SOPP and more than \$2.7 million in grants have been awarded to date.

1 In 2022, the AMA has collaborated with more than 25 state medical associations on hundreds of
2 bills to defeat scope expansions or encourage states to adopt truth in advertising legislation.

3 Highlights to date include:

- 4
- 5 • In Colorado, Louisiana and South Dakota, physician assistant bills were defeated;
 - 6 • Truth in advertising legislation was enacted in Indiana;
 - 7 • Kentucky and Tennessee rejected efforts to expand nurse practitioner prescriptive authority;
 - 8 • Louisiana, Mississippi, Missouri, and Wisconsin defeated efforts to pass advanced practice
9 registered nurse (APRN) expansion bills; and
 - 10 • Alabama and Missouri defeated legislation that would have expanded pharmacist scope of
11 practice.
- 12

13 In 2021, the Department of Veterans Affairs (VA) created the Federal Supremacy Project which is
14 establishing National Standards of Practice (NSP), irrespective of state scope of practice laws, for
15 approximately 50 categories of health professionals. The AMA established a specialty workgroup
16 that we have been working with since the VA started this effort. Initially the VA was fast tracking
17 the project, but the efforts of the AMA and the specialty societies have greatly slowed the pace. We
18 were also able to secure a much more transparent process. The VA has committed to publishing the
19 NSPs in the Federal Register and allowing for a 60-day comment period. In addition, the VA
20 agreed to stagger the publication of the NSPs so stakeholders would have a better ability to
21 comment. To date, the VA has published 3 NSPs. The AMA will continue to inform the Federation
22 and work with the specialty society workgroup as the VA publishes the NSPs.

23

24 *Prior Authorization*

25

26 Payers continue to overuse prior authorization and do so on far too wide a basis despite agreeing to
27 a consensus statement with the AMA in 2018 aimed at alleviating many of the concerns with this
28 practice. For patients, prior authorization delays or denies access to care, often resulting in harm
29 (e.g., hospitalization, permanent impairment, or death) and/or negative clinical outcomes—also,
30 less value for premiums paid. For physicians, prior authorization wastes resources (time and
31 money) and is related to burnout. For employers, restrictive prior authorization requirements will
32 reduce the health of their workforce and provide less value for premiums. The AMA is advocating
33 to right-size and streamline the prior authorization process through state, federal and private sector
34 advocacy to provide patients, physicians, and employers relief.

35

36 To further illustrate the problems with indiscriminate prior authorization use, the AMA published
37 its annual survey on the topic, which found:

38

- 39 • 93% of physicians report care delays;
 - 40 • 82% percent of physicians report that prior authorization can sometimes lead to treatment
41 abandonment;
 - 42 • 34% of respondents report that prior authorization has led to a serious adverse event for a
43 patient (including hospitalization, life-threatening event, or disability);
 - 44 • On average, practices complete 41 prior authorizations per physician per week;
 - 45 • Physicians/staff spend approximately 13 hours each week completing prior authorizations; and
 - 46 • 40% of physicians have staff dedicated to working exclusively on prior authorization.
- 47

48 To address these issues at the federal level, the AMA strongly supports:

49

- 50 • The “Improving Seniors’ Timely Access to Care Act of 2021” (H.R. 8487/S. 3018), which
51 would require Medicare Advantage (MA) plans to implement a streamlined electronic prior

1 authorization (PA) process; increase transparency for beneficiaries and providers; enhance
2 oversight by the Centers for Medicare & Medicaid Services (CMS) on the processes used for
3 PA; ensure that care and treatments that routinely receive PA approvals are not subjected to
4 unnecessary delays through real-time decisions by MA plans; and mandate that MA plans meet
5 certain beneficiary protection standards. This legislation passed the House Ways and Means
6 Committee in July.

- 7 • The “Getting Over Lengthy Delays in Care as Required by Doctors” (GOLD CARD) Act (H.R.
8 7995) of 2022, which would exempt physicians from MA plan prior authorization requirements
9 so long as 90% of a physician’s prior authorization requests were approved in the preceding 12
10 months. The MA plan-issued gold cards would only be applicable to items and services
11 (excluding drugs) and remain in effect for at least a year. The federal legislation is based on a
12 similar law enacted in Texas that took effect in 2021.

13
14 The AMA is also continuing to advocate at the state level where several states have enacted
15 comprehensive reform legislation while others are at earlier stages in the legislative process. In
16 2022, strong legislation has been enacted in Georgia, Iowa, Louisiana, and Michigan. The AMA
17 also worked with members of the Federation to push Aetna to stop requiring prior authorization for
18 cataract surgery. Aetna recently changed this policy with the exceptions of Florida and Georgia
19 Medicare Advantage patients.

20 21 *Telehealth*

22
23 The AMA has long supported making telehealth services widely available to patients, but prior to
24 the COVID-19 pandemic and the resulting loss of access to in-person medical care, most patients
25 could not access telehealth services from their regular physicians. Due to restrictions in the
26 Medicare statute, the Medicare program only covered telehealth services for patients in rural areas
27 and, even then, the patient had to go to a medical facility to receive the telehealth services from a
28 physician at another site. While private plans may not have had the same geographic restrictions,
29 they often had limitations on coverage and payment of services provided via telehealth, as well as
30 acceptable modalities. Many plans also often limited or incentivized patients to receive telehealth
31 only from a separate telehealth company, not their regular physicians. Early in the pandemic, with
32 strong support from the AMA, the restrictions on coverage for telehealth services were lifted by
33 Medicare and other health plans. State laws and state Medicaid policies were also modified to
34 permit widespread use of telehealth during the pandemic.

35
36 The AMA has prioritized making the telehealth expansion permanent. As an intermediate step, the
37 AMA successfully urged Congress to extend the telehealth expansion through five months after the
38 public health emergency ends. Further, CMS has also proposed to extend payment for a number of
39 services that were added to the Medicare Telehealth List for an additional 5 months after the public
40 health emergency ends.

41
42 And in July, the full House passed H.R. 4040, a bill that would extend telehealth payment and
43 regulatory flexibilities for an additional two years, through the end of 2024, on a bipartisan vote of
44 416-12.

45
46 At the state level, the AMA has updated its model state telehealth legislation and continues to
47 support state efforts to advance telehealth legislation and policy to ensure patient access to high
48 quality care.

1 *Physician Wellness*

2
3 Prior to the COVID-19 pandemic, physician burnout, depression and suicide already were major
4 challenges for the U.S. health care system, impacting nearly every aspect of clinical care as well as
5 being a heavy burden for physicians and their families. Physicians are very resilient, but the
6 environments in which physicians work drive these high levels of burnout. Compounding the
7 problems are medical licensing applications, employment and credentialing applications, and
8 professional liability insurance applications. The problem is when these contain questions that
9 include problematic and potentially illegal questions requiring disclosure of whether a potential
10 licensee or applicant has ever been diagnosed or received treatment for a mental illness or
11 substance use disorder (SUD) or even sought counseling for a mental health or wellness issue.
12 These questions about past diagnosis or treatment are strongly opposed by the AMA, Federation of
13 State Medical Boards, The Joint Commission, the Federation of State Physician Health Programs,
14 and The Dr. Lorna Breen Heroes' Foundation.

15
16 At the federal level, the AMA strongly advocated for the Dr. Lorna Breen Health Care Provider
17 Protection Act (H.R. 1667), named for a physician who died by suicide in 2020. The bill provides
18 grants to help create evidence-based strategies to reduce burnout and the associated secondary
19 mental health conditions related to job stress. It includes a national campaign to encourage health
20 professionals to prioritize their mental health and to use available mental and behavioral health
21 services. It also establishes grants for employee education and peer-support programming.

22
23 AMA advocacy and partnership with state medical associations has also helped enact state laws in
24 Arizona, Indiana, South Dakota, and Virginia to provide strong confidentiality protections for
25 physicians and medical students who seek care for burnout and wellness-related issues. The AMA
26 is also continuing to urge state medical boards to remove stigmatizing questions that
27 inappropriately ask about past diagnoses. In addition, the AMA is working with key stakeholders to
28 bolster state physician health programs as well as identify health systems and others who can play a
29 powerful role in removing stigma and supporting physicians' health and wellness.

30
31 *Surprise Billing*

32
33 The AMA is taking a two-pronged approach to the No Surprises Act of 2021 (NSA). The AMA is
34 educating physicians on how to comply with the NSA while also advocating for implementation of
35 the law as Congress intended. Specifically, the AMA has:

- 36
37 • Initiated litigation (along with the American Hospital Association) arguing that the
38 government's interim final rule is contrary to the law and exceeds statutory authority by
39 creating a rebuttable presumption that the arbiter in the Independent Dispute Resolution (IDR)
40 process considers the "qualifying payment amount" (essentially the median in-network rate) as
41 the appropriate out-of-network payment amount. (The Texas Medical Association has also
42 filed litigation and secured a positive initial ruling.);
- 43 • Released an [initial toolkit](#) (PDF) on the implementation of the No Surprises Act and a [second](#)
44 [toolkit](#) (PDF) on implementation of the billing process for certain out-of-network care under
45 the No Surprises Act. We have also [compiled](#) a number of other resources, including regulatory
46 summaries and comment letters;
- 47 • Held two national webinars on the No Surprises Act, the [first](#) on its implementation and the
48 [second](#) on the payment process for physicians and other providers in surprise medical billing
49 situations;

- 1 • Continues to advocate for a fair IDR process, recently arguing in a letter to the Administration
2 that a balanced IDR process is not anti-patient, pushing back on payer and employer efforts to
3 undermine the process;
- 4 • Working with other stakeholders to develop recommendations on the good faith estimate and
5 advanced EOB requirements, to highlight administrative burdens and ensure minimal
6 workflow disruption;
- 7 • Working directly with CMS to address operational challenges with additional physician and
8 provider resources—CMS has already held two physician-focused webinars on the good faith
9 estimate provisions and notice and consent and enforcement. A webinar on the payment
10 process is expected soon; and
- 11 • Calling on CMS to conduct more physician outreach and education which CMS has agreed to
12 do.

13 14 *COVID-19 Response and Monkeypox Outbreak*

15
16 As mentioned above, the AMA continues to mount a multi-pronged effort advocating for a
17 comprehensive response to the COVID-19 public health emergency (PHE) as the virus continues to
18 evolve and different variants continue to thwart recovery efforts. The AMA steadfastly supports
19 financial relief for physician practices still negatively affected by the pandemic; robust testing to
20 limit spread; vaccination in line with U.S. Centers for Disease Control and Prevention
21 recommendations including for children; and permanent implementation of the telehealth
22 expansion granted during the PHE. For a full list of AMA activities on this topic please visit this
23 [website](#). More specifically the AMA produces a [regular video segment](#) update on recent
24 developments with COVID-19 and other public health issues.

25
26 One recent development is that the Health Resources and Services Administration (HRSA) has
27 announced that it will set up a process for physicians who received funds from the Provider Relief
28 Fund to contest recoupment of the relief funds. Physicians receiving \$10,000 or more from the
29 program are required to spend the funds within a year and report how the relief funds were spent.
30 These requirements have been difficult for many practices to fulfill during the continued instability
31 caused by the pandemic. The AMA pressed HRSA for this decision and is pleased that HRSA will
32 work with physicians to ensure the intent of the relief program is achieved.

33
34 The AMA is also active in the courts defending the authority of public health agencies. The
35 Litigation Center of the American Medical Association and State Medical Societies and Wisconsin
36 Medical Society filed an amicus brief supporting state and local officials and their authority to
37 issue emergency orders during a public health crisis. The Wisconsin Supreme Court sided with
38 public health officials in a [4-3 vote](#) which was a win for organized medicine.

39
40 Finally, the AMA is closely monitoring monkeypox and its progression throughout the U.S. and is
41 ready to respond as needed. The AMA is [posting clinical information](#) for physicians as the virus
42 spreads and has established a new CPT code for monkeypox vaccines.

43 44 *Reproductive Health*

45
46 When the Supreme Court of the United States issued its ruling in the *Dobbs* case overturning *Roe*,
47 AMA President Jack Resneck Jr., MD, stated “The American Medical Association is deeply
48 disturbed by the U.S. Supreme Court’s decision to overturn nearly a half century of precedent
49 protecting patients’ right to critical reproductive health care—representing an egregious allowance
50 of government intrusion into the medical examination room, a direct attack on the practice of
51 medicine and the patient-physician relationship, and a brazen violation of patients’ rights to

1 evidence-based reproductive health services. States that end legal abortion will not end abortion—
2 they will end safe abortion, risking devastating consequences, including patients’ lives.” The AMA
3 filed an amicus brief in the case when it first came before the Supreme Court stating our opposition
4 to overturning this established right.

5
6 In a post-*Roe* landscape, the AMA is pursuing multiple strategies to address the broad spectrum of
7 issues that the *Dobbs* decision created. At the federal level, the AMA immediately called for
8 greater digital privacy for patients out of concern that minimal oversight of data use by digital apps
9 could place women in jeopardy in states seeking to enforce abortion restrictions. The AMA in
10 conjunction with the American College of Obstetricians and Gynecologists (ACOG) also called for
11 the removal or revision of the Risk Evaluation and Mitigation Strategies (REMS) and Elements to
12 Assure Safe Use (ETASU) requirements for mifepristone, to eliminate medically unsupported and
13 unnecessary barriers for physicians, patients, and pharmacies. The Biden Administration also
14 reminded hospitals and health care providers of their obligation to comply with the provisions of
15 the Emergency Medical Treatment and Labor Act (EMTALA) that preempt any state laws that
16 restrict access to stabilizing medical treatment, including abortion procedures and other treatments
17 that may result in the termination of a pregnancy. Dr. Resneck also testified to the Subcommittee
18 on Oversight and Investigations for the House Committee on Energy and Commerce at a hearing
19 titled, “*Roe* Reversal: The Impacts of Taking Away the Constitutional Right to an Abortion” and
20 discussed the impact that the *Dobbs* case is having on patients and physicians.

21
22 At the state level, the AMA is working with the Federation to determine how to best protect
23 patients and physicians from aggressive legislative intrusions into the exam room. Some states are
24 seeking to create new protections for patients while others are pressing for tougher abortion bans
25 and other restrictions. The legal situation for physicians and their practices is very muddled in
26 many states. The AMA is collecting information and conducting legislative analyses to help states
27 sort through their best paths forward. We are also preparing to be very active on both the legislative
28 and litigation fronts as the country works through this new set of legislative realities.

29 *Firearm Violence*

30
31
32 “Gun violence is a plague on our nation. It’s a public health crisis, and much of it is preventable,”
33 then-AMA President Gerald E. Harmon, MD, said in remarks to the House of Delegates at the
34 2022 AMA Annual Meeting. With over 45,000 firearm-related deaths in 2020 and a continuing
35 string of mass shootings, this public health crisis needs heightened efforts and new strategies.
36 Congress did take a positive step by passing the first piece of major firearm legislation in over 30
37 years with the Bipartisan Safer Communities Act, which the AMA supported and President Biden
38 signed on June 25. Key provisions of the bill include:

- 39
40
- 41 • Providing grants for states to establish or strengthen extreme risk protection orders;
 - 42 • Adding convicted domestic violence abusers in dating relationships to the National Instant
43 Criminal Background Check System (NICS);
 - 44 • Requiring the Federal Bureau of Investigation National Instant Criminal Background Check
45 System to contact authorities to see whether an individual under the age of 21 has a
46 “disqualifying” juvenile record for buying a firearm;
 - 47 • Making it a federal crime to buy a firearm on behalf of an individual who is prohibited from
48 doing so; and
 - Including new spending for school security and mental health treatment.

1 However, significant work still needs to be done to avoid more senseless tragedies as witnessed in
2 Buffalo, Uvalde, and Highland Park, among other cities. Besides seeking further legislative
3 options, AMA strategies include encouraging intervention by physicians and nurses when patients
4 demonstrate risk factors for firearm violence; amplifying AMA work with other organizations
5 related to firearm safety and violence prevention; and reaching out to law enforcement and
6 educators to explore how collaborative progress can be made. Further, the AMA adopted several
7 new policies in June calling for active-shooter and live-crisis drills to consider the mental health of
8 children; regulating ghost guns; and advocating for warning labels on ammunition packages.

9
10 *Maternal Mortality*

11
12 The AMA continues to be very active advocating for improved maternal health in 2022 with a
13 particular focus on the inequitable impact seen by Black women. The AMA has lobbied the
14 Congressional Healthy Future Task Force Security Subcommittee to focus on this issue; called on
15 Congress to increase funding in fiscal year 2023 for federal programs at the Health Resources
16 Services Administration (HRSA), the U.S. Centers for Disease Control and Prevention (CDC), and
17 the National Institutes of Health; and focused our comments on maternal health equity issues in the
18 Hospital Inpatient Prospective Payment Systems (IPPS) Rule. Additionally, the House of
19 Representatives passed the TRIUMPH for New Moms Act as part of the Restoring Hope for
20 Mental Health and Well-Being Act of 2022, a bipartisan mental health and substance abuse
21 package that would reauthorize key programs within the Substance Abuse and Mental Health
22 Services Administration. The AMA previously wrote letters to the House of Representatives and
23 Senate encouraging the passage of TRIUMPH, which would create a Task Force on Maternal
24 Mental Health to identify, evaluate and make recommendations to coordinate and improve federal
25 responses to maternal mental health conditions, as well as create a national strategic plan for
26 addressing maternal mental health disorders.

27
28 At the state level, CMS approved California, Florida, Kentucky, and Oregon actions to expand
29 Medicaid and Children's Health Insurance Program coverage to 12 months postpartum. This
30 extension provides over 120,000 more families with guaranteed coverage as they navigate this
31 critical postpartum period. The AMA supports the extension of Medicaid coverage to 12 months
32 postpartum and has provided comments on the importance of the matter.

33
34 *Drug Overdose*

35
36 Ending the nation's drug-related overdose and death epidemic—as well as improving care for
37 patients with pain, mental illness or substance use disorder—requires partnership, collaboration,
38 and commitment to individualized patient care decision-making to implement impactful changes.
39 Due to AMA and Federation advocacy, there were several positive steps in 2022:

- 40
41
- 42 • CDC proposed removing arbitrary prescribing thresholds from its 2022 revised guideline—per
43 AMA recommendations to CDC;
 - 44 • Arizona, New Mexico, and Wisconsin are three of the states that AMA has helped enact
45 legislation to decriminalize fentanyl test strips; several other states have passed bills in one
46 house and are continuing to consider these bills;
 - 47 • More than a dozen states have enacted legislation or other policies to help ensure that opioid
48 litigation settlement funds are focused on public health efforts;
 - 49 • AMA worked closely with the Rhode Island Medical Society to help develop regulations
implementing the nation's first legally authorized harm reduction center;

- 1 • The National Association of Insurance Commissioners (NAIC) continues to develop [tools and](#)
2 [resources](#) to help state departments of insurance and the U.S. Department of Labor better
3 enforce state and federal parity laws—at the urging of the AMA and our partner medical
4 societies; and
- 5 • The AMA continues to work closely with the Administration on policies to increase access to
6 harm reduction efforts and reduce barriers to medications for opioid use disorder (MOUD),
7 including support for federal funding for states to purchase fentanyl test strips, mobile
8 methadone vans and retain telehealth flexibilities that allow for audio-only induction of
9 buprenorphine.

10
11 The AMA also supports S. 445/H.R. 1384, the Mainstreaming Addiction Treatment (MAT) Act in
12 the Senate Health, Education, Labor and Pensions Committee (HELP). The MAT Act would
13 increase access to evidence-based treatment for opioid use disorder and end longstanding
14 administrative barriers to prescribing buprenorphine in-office for the treatment of opioid use
15 disorder.

16 17 *Access*

18
19 The AMA works tirelessly to preserve health care access and coverage for Americans across the
20 nation—especially the country’s most vulnerable patient populations. The 2022 updates include:

- 21
22 • Successfully urged the Biden Administration to take action to fix the “family glitch” and
23 provide affordable health care coverage;
- 24 • Working with health care stakeholder groups, urged the Administration to maintain the public
25 health emergency that expands coverage for care and extends key regulatory flexibilities until
26 there is an extended period of greater stability (the nationwide uninsured rate has dropped to
27 8%);
- 28 • Advocating to Congress to make the Affordable Care Act (ACA) subsidy expansions
29 permanent (extended for three years in Senate Reconciliation bill); and
- 30 • Successfully urged adoption of stronger network adequacy rules for Qualified Health Plans and
31 Medicare Advantage plans.

32
33 The AMA is also sounding the alarm that a federal court case could cause millions of Americans to
34 lose access to preventive services. *Kelley v. Becerra*, a lawsuit before a federal district court judge
35 in the Northern District of Texas, threatens the section of the Affordable Care Act (ACA) requiring
36 insurers and group health plans to cover more than 100 preventive health services—with no
37 additional cost to consumers. One of the ACA’s most popular and widely recognized benefits, the
38 provision resulted in an estimated 151.6 million people receiving preventive care without cost
39 sharing in 2020 alone.

40 41 *Drug Pricing*

42
43 As Congress prepared to leave Washington for its August recess, Senate negotiators reached
44 agreement on a reconciliation package passed by the Senate that addressed a number of important
45 issues, including provisions that promise to rein in the escalating costs of prescription drugs.
46 Specifically, the legislation would allow Medicare to negotiate its purchasing prices for drugs, with
47 the first 10 negotiated prices set to take effect in 2026. The legislation would also cap drug price
48 increases at the annual rate of inflation and end a Trump-era drug rebate rule. All of these
49 provisions promise to save money for both Medicare and for patients, although there are concerns
50 about the impact of lower prices on the amount practices receive for the acquisition of physician-

1 administered drugs under the average sales price (ASP) +6 percent payment methodology,
2 particularly for small physician practices. The AMA will work with affected specialties during the
3 implementation period to assess the impact and identify and advocate for solutions that preserve
4 access to these drugs in physician offices.

5
6 *Tobacco*

7
8 The AMA supported the U.S. Food and Drug Administration's (FDA) proposal to ban menthol-
9 flavored cigarettes, a move that will save hundreds of thousands of lives in the coming decades
10 while reducing health inequities. If the sale of menthol-flavored cigarettes is indeed banned, the
11 FDA projects a 15.1% drop in smoking within 40 years, which would help save between 324,000
12 to 654,000 lives. The agency also projects the ban would stop between 92,000 and 238,000
13 smoking-related deaths among African Americans—that is up to 6,000 Black lives saved each year.

14
15 The AMA has also warned of the dangers of electronic nicotine delivery systems and long called
16 for these products to have the same marketing and sales restrictions that are applied to tobacco
17 cigarettes, including bans on TV advertising. This year the AMA successfully pressured social
18 media companies to reject advertisements of e-cigarettes to youth. The AMA also recently
19 applauded the FDA's decision ordering the removal of all JUUL Labs Inc. e-cigarette products
20 from the U.S. market, recognizing that for too long, companies like JUUL have been allowed to
21 sell e-cigarettes that appeal to our nation's youth—ultimately creating another generation of young
22 people hooked on tobacco products.

23
24 *Gender-Affirming Care*

25
26 Despite the evidence base and consensus in the medical community that supports gender-affirming
27 care for transgender youth, some state legislators have pursued legislation to prohibit physicians
28 and other health care professionals from providing such care to minors. The AMA has worked with
29 the Federation to mitigate the harm these bills could have on patients.

30
31 To date, two states, Alabama and Arkansas, have enacted laws that prohibit gender-affirming
32 medical care for all minors, including puberty suppressing medication, hormone therapy, and
33 surgery. Both laws are currently tied up with legal challenges. Two additional states, Arizona and
34 Tennessee, have enacted legislation prohibiting surgery on minors and hormone therapy prior to
35 puberty, respectively. Because these interventions are not recommended for the age groups
36 specified, Arizona's and Tennessee's laws essentially—and unnecessarily—codify existing
37 standards of care.

38
39 In addition to legislation, two states have sought to prohibit access to gender-affirming care
40 through executive action. In February 2022, the Texas Attorney General issued an opinion deeming
41 puberty suppressing drugs, hormone therapy, and surgeries child abuse. Shortly thereafter, Texas
42 Governor Greg Abbott directed the Texas Department of Family and Protective Services to
43 investigate any reported instances of minors receiving gender-affirming treatments. The directive
44 was blocked by a Texas District Court. Lastly, in April 2022 the Florida Department of Health
45 issued guidance stating that social gender transition, puberty blockers, hormone therapy, and
46 gender reassignment surgery should not be treatment options for children or adolescents. The
47 Florida guidance is not law or regulation and therefore is not legally enforceable. However,
48 following a report by the Florida Agency for Health Care Administration finding insufficient
49 evidence that medical intervention for the treatment for gender dysphoria is safe and effective, the
50 Florida Board of Medicine began the rulemaking process in August 2022 to establish a new
51 standard of care for the treatment of minors with gender dysphoria.

1 *Public Service Loan Forgiveness Program*

2
3 The AMA is calling on the U.S. Department of Education (DOE) to make improvements to the
4 Public Service Loan Forgiveness (PSLF) program. In 2021, the DOE announced a change to the
5 PSLF program rules for a limited time as a result of COVID-19 that made millions of non-profit
6 and government employees eligible for loan forgiveness or additional credit through the [Limited](#)
7 [PSLF Waiver](#). This waiver ends on October 31, 2022, but the AMA has called for an extension.
8 Further, the AMA is urging the DOE to amend the program to assist California and Texas
9 physicians because those states' bans on the corporate practice of medicine interfere with
10 participation in the program. The AMA is also advocating for 501(c)(6) employers to potentially
11 qualify for the program as well. These changes would directly assist physicians with their loan
12 burdens and would encourage more physicians to practice in underserved areas.

13
14 *Immigration*

15
16 The AMA continues to fight for equitable treatment of physicians, residents, and students
17 immigrating to the U.S. The AMA wrote to the U.S. House of Representatives Committee on the
18 Judiciary Subcommittee on Immigration and Citizenship urging lawmakers to seek bipartisan
19 policy solutions that will ensure that patients are provided the best care and that immigration
20 barriers are addressed to resolve the physician workforce shortage and preserve patient access to
21 care. The AMA also submitted comments on the Temporary Increase of the Automatic Extension
22 Period of Employment Authorization and Documentation for Certain Renewal Applicants
23 temporary final rule. With the growing backlog of cases within the Department of Homeland
24 Security (DHS) negatively impacting both immigrants and U.S. businesses, the AMA applauded
25 the temporary final rule (TFR) and asked that this same extension be provided to physicians so that
26 they can maintain their lawful immigration status while DHS is working on streamlining their
27 extensions for employment authorization.

28
29 The AMA sent a letter strongly opposing any rules, regulations, or policies that would deter
30 immigrants, nonimmigrants, and their dependents from seeking visas or from utilizing noncash
31 public benefits including, but not limited to, Medicaid, Supplemental Nutrition Assistance Program
32 (SNAP), and housing assistance. Impeding access to non-cash public benefits for these individuals
33 and families could undermine population health.

34
35 AMA ADVOCACY ONGOING UPDATES

36
37 The AMA offers several ways to stay up to date on our advocacy efforts:

- 38
39 • Sign up for AMA Advocacy Update—a biweekly newsletter that provides updates on AMA
40 legislative, regulatory, and private sector efforts. Subscribers can read [stories from previous](#)
41 [editions here](#) and those looking to subscribe can use this [link](#).
42 • Join the [Physicians Grassroots Network](#) for updates on AMA calls to action on federal
43 legislative issues. And if you have connections with members of Congress, or are interested in
44 developing one, the [Very Influential Physician \(VIP\) program](#) can help grow these
45 relationships.
46 • Connect with the Physicians Grassroots Network on [Facebook](#), [Twitter](#), [LinkedIn](#) and
47 [Instagram](#).

1 CONCLUSION

2

3 There was no shortage of advocacy challenges for America's physicians in 2022. The AMA in
4 conjunction with the Federation represented physicians and patients very well once again; however,
5 significant work needs to be done to advance AMA policy on key issues as well as avoiding further
6 erosion of prior gains. The Recovery Plan for America's Physicians offers a blueprint moving
7 forward, and the AMA will continue to provide updates as efforts proceed.

OPINION OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS*

CEJA Opinion 1-I-22

Subject: Amendment to E-9.3.2, “Physician Responsibilities to Colleagues with Illness, Disability or Impairment”

Presented by: Peter A. Schwartz, MD, Chair

1 INTRODUCTION

2
3 At the 2022 Annual Meeting, the American Medical Association House of Delegates adopted the
4 recommendations of Council on Ethical and Judicial Affairs Report 3-A-22, “Amendment to E-
5 9.3.2, “Physician Responsibilities to Colleagues with Illness, Disability or Impairment.” The
6 Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the
7 next print edition of the *Code of Medical Ethics*.

8
9 E-9.3.2 - Physician Responsibilities to Colleagues with Illness, Disability or Impairment

10
11 Providing safe, high-quality care is fundamental to physicians’ fiduciary obligation to promote
12 patient welfare. Yet a variety of physical and mental health conditions—including physical
13 disability, medical illness, and substance use—can undermine physicians’ ability to fulfill that
14 obligation. These conditions in turn can put patients at risk, compromise physicians’
15 relationships with patients, as well as colleagues, and undermine public trust in the profession.
16 While some conditions may render it impossible for a physician to provide care safely, with
17 appropriate accommodations or treatment many can responsibly continue to practice, or resume
18 practice once those needs have been met. In carrying out their responsibilities to colleagues,
19 patients, and the public, physicians should strive to employ a process that distinguishes
20 conditions that are permanently incompatible with the safe practice of medicine from those that
21 are not and respond accordingly.

22
23 As individuals, physicians should:

- 24
25 (a) Maintain their own physical and mental health, strive for self-awareness, and promote
26 recognition of and resources to address conditions that may cause impairment.
27
28 (b) Seek assistance as needed when continuing to practice is unsafe for patients, in keeping
29 with ethics guidance on physician health and competence.
30
31 (c) Intervene with respect and compassion when a colleague is not able to practice safely.
32 Such intervention should strive to ensure that the colleague is no longer endangering

* Opinions of the Council on Ethical and Judicial Affairs will be placed on the Consent Calendar for informational reports, but may be withdrawn from the Consent Calendar on motion of any member of the House of Delegates and referred to a Reference Committee. The members of the House may discuss an Opinion fully in Reference Committee and on the floor of the House. After concluding its discussion, the House shall file the Opinion. The House may adopt a resolution requesting the Council on Ethical and Judicial Affairs to reconsider or withdraw the Opinion.

1 patients and that the individual receive appropriate evaluation and care to treat any
2 impairing conditions.

3
4 (d) Protect the interests of patients by promoting appropriate interventions when a
5 colleague continues to provide unsafe care despite efforts to dissuade them from
6 practice.

7
8 (e) Seek assistance when intervening, in keeping with institutional policies, regulatory
9 requirements, or applicable law.

10
11 Collectively, physicians should nurture a respectful, supportive professional culture by:

12
13 (f) Encouraging the development of practice environments that promote collegial mutual
14 support in the interest of patient safety.

15
16 (g) Encouraging development of inclusive training standards that enable individuals with
17 disabilities to enter the profession and have safe, successful careers.

18
19 (h) Eliminating stigma within the profession regarding illness and disability.

20
21 (i) Advocating for supportive services, including physician health programs, and
22 accommodations to enable physicians and physicians-in-training who require
23 assistance to provide safe, effective care.

24
25 (j) Advocating for respectful and supportive, evidence-based peer review policies and
26 practices to ensure fair, objective, and independent assessment of potential impairment
27 whenever and by whomever assessment is deemed appropriate to ensure patient safety
28 and practice competency. (II)

REPORT OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS

CEJA Report 4-I-22

Subject: Research Handling of De-Identified Patient Information

Presented by: Peter A. Schwartz, MD, Chair

1 Policy [D-315.969](#) adopted in November 2021 directs the Council on Ethical and Judicial Affairs to
2 “consider re-examining existing guidance relevant to the confidentiality of patient information,
3 striving to preserve the benefits of widespread use of de-identified patient data for purposes of
4 promoting quality improvement, research, and public health while mitigating the risks of re-
5 identification of such data.”
6
7 Independently, at its August 2021 meeting the Council concluded that in light of the complex
8 issues arising with the rapid development of data science and increasing research use of large
9 health-related data sets, along with recent changes in the Common Rule governing research with
10 human participants, it would reconsider guidance in Opinion [7.3.7](#), “Safeguards in the Use of DNA
11 Databanks” and would in addition review other existing guidance on confidentiality last updated in
12 2016 as part of the overall project to modernize the *AMA Code of Medical Ethics*.
13
14 This review is ongoing. The Council anticipates submitting its preliminary report to the House of
15 Delegates at the June 2023 Annual Meeting.

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (I-22)
Health System Consolidation
Informational Report

EXECUTIVE SUMMARY

There are two types of integration for firms to pursue when merging with or acquiring other firms. Horizontal consolidation occurs when one entity acquires or merges with another entity at the same level in an industry. An example of horizontal integration in health care would be two hospitals merging with one another. Vertical consolidation occurs when one entity acquires or merges with another entity at a different level of industry. In health care, an example of vertical consolidation would be a hospital or health system acquiring a physician practice.

Firms' market shares are a critical metric in the assessment of the competitive effects of mergers and acquisitions. In general, firms with larger market shares may be more able to engage in anticompetitive conduct. Market concentration can be measured by calculating the Herfindahl-Hirschman Index (HHI), which is a useful indicator of market power and serves as a signal of the likely impact of a merger on competition. The Department of Justice (DOJ) and the Federal Trade Commission (FTC) use the HHI as an aid in assessing the potential for anticompetitive effects of proposed horizontal mergers. They may also consider market shares and market concentration in the evaluation of vertical mergers. Over half (55 percent) of US health care markets experienced an increase in concentration between 2013 and 2017.

Consolidation in health care is under increased scrutiny by antitrust authorities and state regulators. At the federal level, the FTC is tasked with reviewing mergers involving hospitals and physicians. While a handful of mergers have been blocked in recent years, health care markets continue to become more consolidated. A challenge arises because such transactions mostly fall under the threshold required for FTC/DOJ notification and review. Thus, they can proceed without antitrust scrutiny that could otherwise assess and weigh their benefits and harms.

Hospital and hospital-physician mergers are shown to increase health care prices and spending. The impact of hospital and hospital-physician mergers on the quality of health care and patient outcomes is limited and inconclusive at this time. The American Medical Association (AMA) has robust policy and guidelines on hospital and hospital-physician mergers and acquisitions. In accordance with Policy D-215.984, the Council will continue to review and report back to the House of Delegates any new data that become available, especially with regards to the impact of these mergers on health care prices and quality of care.

This report is the first in a series on this and related topics. Potential future topics may include physician satisfaction and burnout associated with mergers, acquisitions, and consolidation; anti-trust issues; hurdles physicians face when starting a private practice; quality of care; and impacts on patient outcomes and mortality.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-I-22

Subject: Health System Consolidation

Presented by: Lynn Jeffers, MD, MBA, Chair

1 At the 2022 Annual Meeting, the House of Delegates adopted Policy D-215.984, “Health System
2 Consolidation,” which was sponsored by the Private Practice Physicians Section. Policy D-215.984
3 asks the American Medical Association (AMA) to (1) “study nationwide health system and
4 hospital consolidation for the benefit of patients and physicians who face an existential threat from
5 health care consolidation,” and (2) “regularly review and report back on these issues to keep the
6 House of Delegates apprised on relevant changes that may impact the practice of medicine, with
7 the first report no later than A-23.” This report, which is presented for the information of the
8 House of Delegates, summarizes hospital and hospital-physician group merger and acquisition
9 activity, including background and trends on hospital and hospital-physician group consolidation.
10 This is the first report of a series the Council will be working on addressing this and related topics.

11
12 The Council notes that this report specifically addresses hospital and hospital-physician group
13 consolidation, regardless of ownership model. Further information on the corporate practice of
14 medicine and private equity investment in health care can be found in CMS Report 2-I-22, which is
15 before the House at this meeting. A primary purpose of this report is to provide background and
16 baseline knowledge for upcoming reports on this topic. A glossary of common terms and
17 abbreviations can be found in Appendix A.

18 19 BACKGROUND

20 21 *Horizontal and Vertical Integration*

22
23 There are two types of integration for firms to pursue when merging with or acquiring other firms.
24 Horizontal consolidation occurs when one entity acquires or merges with another entity at the same
25 level in an industry. An example of horizontal integration in health care would be two hospitals
26 merging with one another. Vertical consolidation occurs when one entity acquires or merges with
27 another entity at a different level of industry. In health care, an example of vertical consolidation
28 would be a hospital or health system acquiring a physician practice.

29
30 A critical question is whether mergers and acquisitions are beneficial or harmful to society.
31 Theoretically, both types of integration can result in both benefits and harms. Horizontal
32 integration can lead to economies of scale, which could reduce the cost of production and lower
33 prices, but it can also lead to the exercise of market power and increase prices or lower quality.
34 Horizontal integration could also lead to potential loss of physician autonomy. Vertical integration
35 between physicians and hospitals has several potential benefits, including improved care
36 coordination, improved alignment of provider incentives through the “internalization” of
37 externalities, less duplication of services, and economies of scale for administrative functions such
38 as deployment of health records, which reduce prices or improve quality. However, vertical
39 integration could also hurt merging parties’ competitors by inhibiting them from accessing needed
40 supplies for production or raising their costs. Moreover, Medicare billing practices could make

1 hospital-based outpatient care more expensive than that based in a physician office. In these cases,
2 vertical integration could lead to higher prices or spending. In short, each type of integration could
3 lead to different outcomes and could have different impacts on price, quality, and/or spending.

4 5 *Market Definition, Market Shares, and the Herfindahl-Hirschman Index (HHI)*

6
7 Firms' market shares are a critical metric in the assessment of the competitive effects of mergers
8 and acquisitions. In general, firms with larger market shares may be more able to engage in
9 anticompetitive conduct. One way to assess the level of market competition is by determining the
10 level of market concentration. Market concentration can be measured by calculating the HHI,
11 which is a useful indicator of market power and serves as a signal of the likely impact of a merger
12 on competition. The Department of Justice (DOJ) and the Federal Trade Commission (FTC) use
13 the HHI as an aid in assessing the potential for anticompetitive effects of proposed horizontal
14 mergers. They may also consider market shares and market concentration in the evaluation of
15 vertical mergers. The HHI is the sum of the squared market shares for all firms in a market. As an
16 example, a market with 4 firms that each held 25 percent of the market share would have an HHI of
17 2,500. The largest value HHI can reach is 10,000, indicating a monopoly, where one entity holds
18 the entire market share. A higher HHI indicates greater concentration and suggests lower market
19 competition.¹

20
21 Health care markets are generally considered to be local, as health care consumers need to travel to
22 obtain care. Studies typically define hospital geographic markets as metropolitan statistical areas
23 (MSAs). Markets that are very large (e.g., New York, Chicago), can be defined as smaller parts of
24 those MSAs called metropolitan divisions. The HHI is calculated for each MSA. Using data from
25 2013, 2016, and 2017, one study found that in 95 percent of MSA-level markets in the United
26 States, at least one hospital (or hospital system) had a market share of 30 percent or greater in those
27 years. Seventy-two percent of markets had one hospital (or hospital system) with a share of 50
28 percent or more in 2016 and 2017. Additionally, in 40 percent of markets, a single hospital (or
29 hospital system) had a market share of 70 percent or more in 2016 and 2017.² Over half (55
30 percent) of markets experienced an increase in concentration between 2013 and 2017. In 17 percent
31 of markets, the HHI equaled 10,000 in both of those years, indicating a monopoly. In 2017, the
32 average HHI across markets was 3,853 and 92 percent of markets were considered highly
33 concentrated.³ It is crucial to note that the study cited here considers the potential weakness with
34 HHI calculation and looked only at comparable hospitals within a market when calculating market
35 concentration. The study specifically outlines this when explaining the data and methods used in
36 calculating HHI for these markets.

37 38 *Changes in Practice Ownership and Physician Employment*

39
40 The COVID-19 pandemic put tremendous strain on the health care industry, particularly on smaller
41 practices. With smaller practices finding it difficult to continue to operate independently, larger
42 health systems had an opportunity to acquire them. The Coronavirus Aid, Relief, and Economic
43 Security Act and the Paycheck Protection Program and Health Care Enhancement Act allocated
44 \$175 billion for grants to providers that were partly intended to make up for revenue lost due to
45 coronavirus, but analysis shows that the first \$50 billion in grants were not targeted to providers
46 most vulnerable to revenue losses.⁴ The resulting economic pressure on physicians could
47 potentially lead to more mergers or closing of private practices, resulting in physicians then seeking
48 employment within a hospital or health system.

49
50 However, changes in physician practice arrangements were already underway prior to the COVID-
51 19 pandemic. According to the AMA's 2020 Physician Practice Benchmark Survey, almost 40

1 percent of physicians worked directly for a hospital or for a practice that was at least partially
2 owned by a hospital or health system—up from 29 percent in 2012. In 2020, 50.2 percent of
3 physicians were employed, compared to 41.8 percent in 2012, and 44 percent had an ownership
4 stake in their practice—lower than the 53.2 percent who were owners in 2012. In fact, 2020 was
5 the first year in which less than half (49.1 percent) of physicians worked in practices that were
6 wholly owned by physicians (i.e., private practice).⁵ This percentage includes the physicians who
7 are private practice owners (38.4 percent of all physicians), the employed physicians who work for
8 them (8.2 percent), and the physicians who are on contract with the practice (2.5 percent).⁶ As the
9 number of physicians in private practice has fallen, the share of physicians who work directly for a
10 hospital or for a practice at least partially owned by a hospital or health system has increased.

11 *Antitrust Enforcement and Regulation*

12
13
14 Consolidation in health care is under increased scrutiny by antitrust authorities and state
15 regulators.⁷ At the federal level, the FTC is tasked with reviewing mergers involving hospitals and
16 physicians. While a handful of mergers have been blocked in recent years, health care markets
17 continue to become more consolidated. The FTC cites several constraints on their ability to enforce
18 antitrust laws in the health care sector. Most notably, the FTC and DOJ antitrust division budgets
19 have remained flat, even as the pace of mergers has increased.⁸ It is important to note that vertical
20 integration is a particular challenge to regulate. For example, this would include a hospital or health
21 system acquiring a physician practice. A challenge arises because such transactions mostly fall
22 under the threshold required for FTC/DOJ notification and review. Thus, they can proceed without
23 antitrust scrutiny that could otherwise assess and weigh their benefits and harms. Another noted
24 challenge is the inability of the FTC to enforce antitrust rules on non-profit hospitals (although it
25 can review mergers that involve a non-profit hospital). In 2019, 66 percent of hospital and health
26 system mergers and acquisitions involved a non-profit entity purchasing another non-profit entity,
27 putting these transactions out of the scope of FTC review.⁹

28
29 In 2013, the FTC and state of Idaho sued St Luke’s Health System and Saltzer Medical Group for
30 violating the Clayton Act and state antitrust laws. The complaint alleged anticompetitive effects in
31 the primary care market. According to the complaint, the combination of St. Luke’s and Saltzer
32 would give it the market power to demand higher rates for health care services provided by primary
33 care physicians in Nampa, Idaho and surrounding areas, leading to higher costs for health care
34 consumers.¹⁰ The district court did note that they believed that St. Luke’s and Saltzer genuinely
35 intended to move towards a better health care system, but ultimately found that the “huge market
36 share” of the post-merger entity “creates a substantial risk of anticompetitive price increases” in the
37 primary care market in Nampa, Idaho, where the facilities are located. The ruling was appealed and
38 upheld in 2015, resulting in the unwinding of the merger of these two entities.¹¹

39
40 States play a significant role in regulating hospital markets. States have their own antitrust laws,
41 and state attorneys general and other regulators have access to the local market level data needed to
42 oversee and challenge proposed mergers in their states. In addition to challenging hospital mergers
43 outright, state strategies to address consolidation include all-payer rate setting for hospitals
44 (Maryland, Pennsylvania, and Vermont) and the Massachusetts Health Policy Commission.

45 *Summary of Recent Transactions*

46
47
48 The 2021 Health Care Services Acquisition Report highlights hospital merger and acquisition
49 activities for the past five years. Hospital merger and acquisition activity dropped off in 2020 as the
50 coronavirus pandemic swept the United States and hospitals’ finances were ravaged as a result.¹²
51 Sixty-five of the 79 hospital merger and acquisition deals announced in 2020 were United States-

1 only targets that were not involved in bankruptcy proceedings.¹³ These deals covered 119 hospitals
 2 and 15,996 beds. The total acquired revenue figure for 2020 was nearly \$16.4 billion.¹⁴ Full details
 3 on all hospital and health system mergers and acquisitions can be found in the 2021 Health Care
 4 Services Acquisition Report (Twenty-Seventh Edition). The table below shows notable hospital
 5 transactions in the United States in 2020:¹⁵

Notable US Hospital Transactions, 2020

Acquirer	Target	Price	Hospitals	Beds
Novant Health	New Hanover Regional Medical Center	\$1,500,000,000	1	677
Prime Healthcare Services	St. Francis Medical Center	\$275,000,000	1	344
Banner Health	Wyoming Medical Center	\$207,000,000	1	212
Carle	2 Advocate Aurora hospitals	\$190,000,000	2	231
Orlando Health	Bayfront Health St. Petersburg	\$147,135,471	1	343
Chan Soon-Shiong Family Foundation	St. Vincent Medical Center	\$135,000,000	1	320
LCMC Health	East Jefferson General Hospital	\$90,000,000	1	309
Iron Stone Real Estate Partners	St. Christopher’s Hospital for Children	\$65,000,000	1	188

Source: HealthCareMandA.com, January 2021. Health Care Services Acquisition Report (Twenty-Seventh Edition. Does not include transactions that took place outside of the United States.)

6 The table below shows the largest physician medical group transactions from 2016-2020:¹⁵

Notable US Physician Medical Group Transactions, 2020

Acquirer	Target	Price	Year
KKR & Co. L.P.	Envision Healthcare Corporation	\$9,900,000,000	2018
Envision Healthcare Holdings, Inc.	AmSurg Corp.	\$6,726,000,000	2016
The Blackstone Group	TeamHealth Holdings, Inc.	\$6,100,000,000	2016
Optum	DaVita Medical Group	\$4,340,000,000	2017
Optum	Surgical Care Affiliates, Inc.	\$3,277,410,000	2017
West Street Capital Partners VII	Capital Vision Services LP	\$2,700,000,000	2019
Partners Group	EyeCare Partners	\$2,200,000,000	2019
Summit Partners	Sound Inpatient Physicians Holdings, LLC	\$2,150,000,000	2018
Ares Management L.P.	DuPage Medical Group	\$1,450,000,000	2017
Aspen Dental Management, Inc.	Clear Choice Management Services	\$1,100,000,000	2020

Source: HealthCareMandA.com, January 2021. Health Care Services Acquisition Report (Twenty-Seventh Edition. Does not include transactions that took place outside of the United States.)

1 *Impacts on Health Care Price and Quality*

2

3 Previous studies show that both horizontal and vertical integration impact the price of health care.
4 However, research on the impact of hospital and hospital-physician consolidation on quality of care
5 is limited and inconclusive. Research suggests that horizontal and vertical integration among
6 providers is associated with higher health care prices paid by private insurers. In Medicare,
7 payment policies protect Medicare from increased prices due to horizontal consolidation but have
8 led to higher Medicare costs in the case of vertical integration.

9

10 In the case of horizontal integration, the 2020 Medicare Payment Advisory Commission reviewed
11 published research on hospital consolidation and concluded that the “preponderance of evidence
12 suggests that hospital consolidation leads to higher prices.” An analysis of data from employer-
13 sponsored coverage found that hospitals that do not have any competitors within a 15-mile radius
14 have prices that are 12 percent higher than hospitals in markets with four or more competitors.
15 Furthermore, a separate analysis of hospital mergers over a 5-year period found that mergers of two
16 hospitals within five miles of one another resulted in an average price increase of 6.2 percent and
17 that price increases continued in the two years following the merger.¹⁶

18

19 There is evidence that prices increase even when hospitals merge with other hospitals in different
20 geographic markets. One analysis found that prices at hospitals acquired by out-of-market systems
21 increased by about 17 percent more than unacquired, stand-alone hospitals. One reason for rising
22 prices following mergers is that larger hospital systems can influence the dynamics of negotiations
23 with insurers and shift volume to higher cost facilities. For example, hospital systems with
24 significant bargaining power may require that insurers include all hospitals in their system in a
25 provider network. This can lead to higher cost hospitals being in a provider network when there are
26 lower cost hospitals nearby. In one recent antitrust case in California, the Sutter Health system was
27 accused of violating antitrust laws by using its market power to illegally drive up prices. In the
28 settlement, Sutter Health agreed to stop requiring that all of its hospitals be included in an insurer’s
29 network and also agreed to pay additional damages.¹⁷

30

31 Vertical integration between hospitals and physicians can also raise prices or spending. A study
32 analyzing highly concentrated markets in California found that an increase in the share of
33 physicians in practices owned by a hospital was associated with a 12 percent increase in premiums
34 for private plans sold in the state’s Affordable Care Act Marketplace. Additionally, a study
35 conducted to examine Medicare beneficiaries’ pattern of health care utilization found that “patients
36 are more likely to choose a high-cost, low-quality hospital when their physician is owned by that
37 hospital.” In May 2022, *Health Affairs* published a study on the price effects of vertical integration
38 and joint contracting in Massachusetts. This study found that vertical integration and joint
39 contracting led to price increases from 2013 to 2017, from 2.1 percent to 12.0 percent for primary
40 care physicians and from 0.7 percent to 6.0 percent for specialists, with the greatest increases seen
41 in large health systems.¹⁸

42

43 Studies examining the impact of consolidation on quality of care have produced mixed results.
44 Some studies have shown that quality does not improve, or even gets worse, after vertical
45 integration and others have shown modest improvements. One study of 15 integrated delivery
46 networks found no evidence that hospitals in these systems provide better clinical quality or safety
47 scores than competitors. Another study found that larger hospital-based provider groups had higher
48 per beneficiary Medicare spending and higher readmission rates than smaller groups. However, one
49 other study found that vertical integration had a limited positive effect on a small subset of quality
50 measures.¹⁹ Regarding horizontal consolidation, studies have shown that quality may decrease in
51 highly concentrated markets. One study found that risk-adjusted one-year mortality for heart

1 attacks in Medicare patients was 4.4 percent higher in more highly concentrated hospital markets
2 compared to less concentrated markets. A study published in 2020 followed hospitals for three
3 years after a merger and compared outcome measures with a control group of hospitals that had no
4 change in ownership. The analysis found that scores for 30-day readmissions and mortality rates
5 among patients discharged from a hospital did not improve in the hospitals that merged, when
6 compared to the control group. Given the differences in these results, it is imperative for these
7 systems to continue to collect data and monitor potential impacts of consolidation on the quality of
8 care. In sum, although previous research generally finds that horizontal and vertical integration
9 among providers is associated with higher health care prices, the net effect of such integration on
10 quality is yet unknown.

11

12 AMA POLICY AND ADVOCACY

13

14 The Council reviewed relevant AMA policy and highlights Policy H-215.960, established by
15 Council on Medical Service Report 7-A-19: (a) health care entity mergers should be examined
16 individually, taking into account case-specific variables of market power and patient needs; (b) the
17 AMA strongly supports and encourages competition in all health care markets; (c) the AMA
18 supports rigorous review and scrutiny of proposed mergers to determine their effects on patients
19 and providers; (d) antitrust relief for physicians remains a top AMA priority; and (e) close
20 monitoring of health care markets is a key aspect of AMA antitrust activity.

21

22 The AMA has long been a strong advocate for competitive health care markets and antitrust relief
23 for physicians and maintains that health care markets should be sufficiently competitive to allow
24 physicians to have adequate choices and practice options. AMA efforts to obtain antitrust relief for
25 physicians, maximize their practice options, and protect patient-physician relationships include
26 legislative advocacy, advocacy at the FTC and DOJ, and the creation of practical physician
27 resources. Furthermore, the AMA has pursued alternative solutions that promote competition and
28 choice, including: eliminating state certificate of need laws; repealing the ban on physician-owned
29 hospitals; reducing the administrative burden to enable physicians to compete with hospitals; and
30 achieving meaningful price transparency (Policy H-215.960).

31

32 In addition, the AMA strongly advocates that Congress repeal limits to the whole hospital
33 exception of the Stark physician self-referral law, which essentially bans physician ownership of
34 hospitals and places restrictions on expansions of already existing physician-led hospitals.
35 Repealing this ban would allow new entrants into hospital markets, thereby increasing competition.
36 The AMA firmly believes that physician-owned hospitals should be allowed to compete equally
37 with other hospitals, and that the federal ban restricts competition and choice (Policy D-215.995).

38

39 In the event of a hospital or health system merger, acquisition, consolidation or affiliation, the
40 AMA believes a joint committee with merging medical staffs should be established to resolve at
41 least the following issues: (a) medical staff representation on the board of directors; (b) clinical
42 services to be offered by the institutions; (c) process for approving and amending medical staff
43 bylaws; (d) physicians are encouraged and expected to work with others to deliver effective,
44 efficient, and appropriate care; (e) a mechanism is provided for the open and transparent sharing of
45 clinical and business information by all parties to improve care; and (f) a clinical information
46 system infrastructure exists that allows capture and reporting of key clinical quality and efficient
47 performance data for all participants and accountability across the system to those measures
48 (Policy H-215.969).

1 DISCUSSION

2
3 While it is recognized that most hospital markets are highly concentrated and do not function as
4 well as they could, or should, it is also recognized that hospital markets are local, and states play a
5 significant role in regulating them. States have their own antitrust laws, and state attorneys general
6 and other regulators have better access to the local market-level data needed to oversee and
7 challenge proposed mergers in their states. States can take on mergers themselves or join federal
8 antitrust efforts.

9
10 Consistent with Policy D-215.984, the Council will continue to monitor trends in health system
11 consolidation and the impact on physicians and their patients, using additional data when available.
12 As previously noted in CMS Report 7-A-19, the Council remains concerned regarding the potential
13 negative consequences for physicians and patients in highly concentrated hospital markets (such as
14 increased prices, reduced choice, and fewer physician practice options). In addition to reviewing
15 the current literature, the Council received input from AMA antitrust experts during the
16 development of this report, and notes that AMA staff are readily available to assist and advise
17 AMA members and state medical associations with questions or concerns about physician-hospital
18 relations or hospital consolidation. Nonetheless, the Council believes it is not possible to actively
19 oppose all future hospital mergers. Attempting to address hospital mergers in the same manner the
20 AMA has addressed major health insurance mergers would require enormous resources and may
21 alienate AMA members who work for hospitals and health systems.

22
23 While previous studies suggest that hospital and hospital-physician consolidation is associated with
24 higher health care prices, the impact on quality of care is still unknown. The economic pressures
25 facing physicians were exacerbated by the COVID-19 pandemic and could result in continued
26 mergers—both horizontal and vertical. Struggling private practices may find it beneficial to join
27 with other private practices to form a larger practice (horizontal integration) or be acquired by a
28 hospital or health system (vertical integration).

29
30 CONCLUSION

31
32 Hospital and hospital-physician mergers are shown to increase health care prices and spending.
33 Nonetheless, the impact of hospital and hospital-physician mergers on the quality of health care
34 and patient outcomes is limited and inconclusive at this time. The AMA has robust policy and
35 guidelines on hospital and hospital-physician mergers and acquisitions. In accordance with Policy
36 D-215.984, the Council will continue to review and report back to the House of Delegates as any
37 new data become available, especially with respect to the impact of these mergers on health care
38 prices and quality of care. The Council’s review could include monitoring relevant FTC-DOJ
39 mergers to determine trends and better understand the impact of these mergers on hospitals, health
40 systems, and physician groups.

41
42 This report represents the first in a series on health system consolidation and related topics.
43 Potential future report topics may include physician satisfaction and burnout associated with
44 mergers, acquisitions, and consolidation; anti-trust issues; hurdles physicians face when starting a
45 private practice either within a hospital employment or non-employed setting before and after a
46 hospital merger; quality of care; and impacts on patient outcomes and mortality.

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⁸ Schwartz, *Supra* note 4.

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¹¹ Saint Alphonsus Med. Center-Nampa Inc. v. St. Luke's Health Sys., Ltd. Case No. 14-35173. United States Court of Appeals, Ninth Circuit. February 10, 2015.

¹² The Health Care Services Acquisition Report. Twenty-Seventh Edition. Irving Levin Associates. 2021.

¹³ *Ibid.*

¹⁴ *Ibid.*

¹⁵ *Ibid.*

¹⁶ Schwartz, *Supra* note 4.

¹⁷ Schwartz, *Supra* note 4.

¹⁸ Curto, *Supra* note 7.

¹⁹ Schwartz, *Supra* note 4.

APPENDIX A

Glossary of Terms

Antitrust – The regulation of the concentration of economic power, particularly in regard to monopolies and other anticompetitive practices. Antitrust laws exist as both federal and state statutes.

Department of Justice (DOJ) – A federal executive department of the United States government. Specific Antitrust Division housed within the Department whose mission is to promote economic competition through enforcing and providing guidance on antitrust laws and principles. The DOJ Antitrust Division works closely with the Federal Trade Commission (FTC) to review potential mergers and acquisitions.

Federal Trade Commission (FTC) – An independent agency of the United States government whose principal mission is the enforcement of civil U.S. antitrust law and the promotion of consumer protection. These laws promote vigorous competition and protect consumers from anticompetitive mergers and business practices. The FTC shares jurisdiction over federal civil antitrust enforcement with the DOJ Antitrust Division.

Herfindahl-Hirschman Index (HHI) – A commonly accepted measure of market concentration calculated by squaring the market share of each firm competing in the market and then summing the resulting numbers. HHI calculations of 10,000 indicate a monopoly.

Horizontal Integration – A business strategy in which one company acquires or merges with another that operates at the same level in an industry. An example in health care would be two hospitals merging or two physician practices merging.

Integration vs. Consolidation – Closely related, but not synonymous. Consolidation typically refers to mergers and acquisitions. Consolidation does not necessarily imply integration. Integration means firms are truly integrating their operations, for the purpose of aligning and creating efficiency.

Metropolitan Statistical Area (MSA) – A core area containing a substantial population nucleus, together with adjacent communities having a high degree of economic and social integration with that core. MSAs are determined with the U.S. Census and are one way to define geographic markets when calculating the HHI. Particularly large MSAs (i.e., New York City, Chicago, Los Angeles, etc.) are further broken down into submarkets.

Vertical Integration – The combination in one company of two or more stages of production normally operated by separate companies. An example in health care: hospitals can buy physician groups or health systems can form drug companies.