



2022 AMA Medical Student Section (MSS) Interim Meeting Honolulu, HI November 10-11

Policy Materials

Section resolutions

Resolution 001 – Tribal Public Health Authority
Resolution 002 – Amendment to AMA Policy Firearms and High-Risk Individuals H-145.972 to Include Medical Professionals as a Party Who Can Petition the Court
Resolution 003 – Purchased and Referred Care Expansion
Resolution 004 – Increased Education and Access to Fertility Resources for U.S. Medical Students
Resolution 005 – Advocating for Utilization of State-level Waivers in Post-COVID-19 Coverage Protection
Resolution 006 – Medicaid Managed Care for Indian Health Care Providers
Resolution 007 – Increased Health Privacy on Mobile Apps in Light of Roe v. Wade
Resolution 008 – Supporting Legislative and Regulatory Efforts Against Fertility Fraud
Resolution 009 – New Policies to Respond to the Gun Violence Public Health Crisis
Resolution 010 – Against Direct Contracting Entities
Resolution 011 – Tribal Health Program Electronic Health Record Modernization
Resolution 012 – Amend Preventing Resident Physician Suicide 310.054MSS to Include Annual Opt-out Mental Health Screening for Residents

For the best user experience, please download a copy of this handbook to your personal device

Resolution 013 – Reconsideration of the Birthday Rule
Resolution 014 – Indian Health Service Graduate Medical Education
Resolution 015 – Preventing Human Papillomavirus (HPV) infection and HPV-associated cancers in people who are incarcerated
Resolution 016 – Medicaid Hearing Coverage
Resolution 017 – AMA opposition of "heartbeat" laws which indicate first evidence of embryonic cardiac activity as presence of fetal heartbeat
Resolution 018 – Estrogen as a risk factor for stroke in patients with migraine with aura
Resolution 019 – Regulation of Skin Bleaching Agents and Colorism as a Public Health Concern
Resolution 020 – Lack of Access to Abortion is a Threat to Public Health
Resolution 021 – Support Further Intervention in Caregiver Support for End-of-Life Patients
Resolution 022 – Amending Policy H-80.999, Sexual Assault Survivors to Improve Knowledge and Access to No-cost Rape Test Kits
Resolution 023 – Specialized Psychiatric Facilities for Pregnant and Postpartum Individuals
Resolution 024 – Billing for Traditional Healing Services
Resolution 025 – Studying Effects of Online Education on Medical Education Outcomes during COVID-19 Pandemic
Resolution 026 – Special Diabetes Program for Indians
Resolution 027 – Recognition of the Disproportionate Impact of Infertility on Physicians
Resolution 028 – Including Gender Inclusive Language in Menstrual Healthcare
Resolution 029 – Naloxone Alternatives or Adjuncts to Combat Synthetic Opioid-Induced Respiratory Depression
Resolution 030 – Research of Plastic Use in Medicine
Resolution 031 – Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training
Resolution 032 – Addressing the Impact of Medicare Transition on Spousal Healthcare
Resolution 033 – The Health Care Related Effects of Recent Changes to the US Mexico Border
Resolution 034 – Conservatorship and Guardianship Reform

Resolution 035 – Advocating for the Regulation of Waste Products in Industrialized Farming

Resolution 036 – Emergency Anti-Epileptic Interventions

Resolution 037 – Gender Pronoun Use in Medical Education

Resolution 038 – Studying Population-Based Payment Policy Disparities

Resolution 039 – School-to-prison pipeline

Resolution 040 – Changing Medical School Drug Testing Policies

Resolution 041 – Supporting Research into Heat Response Plans

Resolution 042 – Advocating for Health Coverage Expansion for Post-COVID (Long-COVID) Conditions

Resolution 043 – Researching New CCHD Screening Practices in Pigmented Neonates

Resolution 044 – Environmental Health Equity in Federally Subsidized Housing

Resolution 045 – Increase Resident Physician Pay

Resolution 046 – Encouraging increased accessibility and utilization of occupational pulmonary lung disease screenings

Resolution 047 – Increasing Diversity of Stem Cell Biobanks and Disease Models

Resolution 048 – Discussions on Elective Sterilization in Undergraduate Medical Education

Resolution 049 – Amend Civil and Human Rights H-65.959 to Increase Protections

Resolution 050 – Waste Receptacles in Men's Restroom Stalls for Menstrual Product Disposal

Resolution 051 – Providing Modest Attire Options at Hospitals for Patients and Employees

Resolution 052 – Improving Cardiovascular Screenings by Including Lipoprotein(a) (Lp(a))

Resolution 053 – Ensuring Basic Ophthalmology Education in Medical Education

Resolution 054 – Expanded Housing Voucher Anti-Discrimination Protections

Resolution 055 – Advocating for access to safer smoking kits as part of harm reduction services

Resolution 056 – Ensuring Fair Opportunities for International Medical Students

Resolution 057 – Use of ICD and CPT Codes to Improve Response to Human Trafficking

Resolution 058 – Artificial Intelligence-Integrated Software for Image Manipulation Detection

Resolution 059 – Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment

Resolution 060 – Elective Personal Finance Curriculum in Medical Education

Resolution 061 – Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement

Resolution 062 – Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants

Resolution 063 – Ground Ambulance Services and Surprise Billing

Resolution 064 – Encouraging Universal Return-to-Play Protocols for Common Sport Injuries in Collegiate and Professional Athletes

Resolution 065 – Expanding Medical Nutrition Therapy Coverage in Medicare and Medicaid Plans

Resolution 066 – Increased regulation of commercial electric scooter use

Resolution 067 – Introduction of Pre-discharge Individualized Fall Risk Assessments for Older Adults

Resolution 068 – Increasing regulation and labeling of fragrances in personal care products, cosmetics, and drugs

Resolution 069 – Enabling Transmission of Third Party Data and Metadata to Electronic Health Records

Resolution 070 – School Based Mental Health Programs for Children Exposed to Gun Violence

Resolution 071 – Addressing Medical Misinformation Online

Resolution 072 – Sleep Deprivation as a Public Health Crisis

Resolution 073 – Decreasing the Burden of Out-of-Pocket Costs for Biologic Therapies

Resolution 074 – Encouraging the Transition from Artificial Turf to Natural Grass Surfaces for Athletic Use

Resolution 075 – Mitigating Barriers Faced by Muslim Healthcare Workers

Resolution 076 – Emphasizing and Expanding Sun Protection Lessons in K-12 Children

Resolution 077 – Amending Existing Preventative Policy to Decrease Comorbidities in Patients with Developmental Disabilities
Resolution 078 – Mental Health Protocols for Surgery
Resolution 079 – Support and Advocacy for Permanent Standard Time
Resolution 080 – Amend AMA-MSS 65.017 to Expand LGBTQ+ Health Training
Resolution 081 – Establishment of a Climate Change Standing Committee
Resolution 082 – Amendment to AMA Policy Sharing of Medical Disciplinary Data Among Nations D-275.975
Resolution 083 – Establishing and Maintaining Patient Libraries in Hospitals
Resolution 084 – Combating Antimicrobial Resistance through Ethnopharmacology
Resolution 085 – Against Legacy Preferences as a Factor in Medical School Admissions
Late Resolution 001 - Sunset Report Update

Section reports

Delegate Report A – Status of Pending MSS-Authored Resolutions to the House of Delegates
IOPTF Report – Internal Operating Procedures Task Force Report
CEQM MIC Report A – Laying the First Steps Towards a Transition to a Financial and Citizenship Need Blind Model for Organ Procurement and Transplantation
CEQM WIM Report A – Expansion of Medicaid Coverage of HPV Screening
CME Report A – Residency Application Support for Students of Low-Income Backgrounds

Informational reports

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 001
(I-22)

Introduced by: Alec Calac, University of California San Diego School of Medicine; Brooke Warren, University of California San Francisco School of Medicine; Julia Seiberling, University of California Riverside School of Medicine; Hailey Baker, Tamee Livermont, Katie Wilson, University of Minnesota Medical School; Adrienne Nguyen, Des Moines University College of Osteopathic Medicine; Brianna Baldwin, University of Virginia School of Medicine; Krishna Channa, University of Connecticut School of Medicine; Lala Forrest, Frank H. Netter School of Medicine

Subject: Tribal Public Health Authority

Sponsored by: Region 1, Region 2, Region 4, Region 6, Region 7, Association of Native American Medical Students, American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, American Indian and Alaska Native Tribes and Villages ("Tribal Nations") and Tribal Epidemiology Centers (TECs) are "public health authorities" under federal law at 25 U.S.C. §1621m and federal regulation at 45 C.F.R. § 164.501¹; and

Whereas, Tribal Nations and TECs have the legal authority to collect, receive, and disseminate public health data as necessary to respond to public health threats¹; and

Whereas, As such, Tribal Nations and TECs have the same public health authority designation as, for example, the United States (US) Centers for Disease Control and Prevention (CDC), and state and local health departments¹; and

Whereas, Despite their recognition as public health authorities, Tribal Nations and TECs have varying access to data from the CDC and the Indian Health Service (IHS)²; and

Whereas, The U.S. Government Accountability Office, in a 2022 report, found a lack of policies affirming Tribal Nations and TECs' authority to access CDC and IHS data, guidance for TECs on how to request data, and agency procedures on how to respond to such requests²; and

Whereas, During the COVID-19 pandemic, reports emerged that county and state public health agencies refused to share case and mortality data with Tribal Nations and TECs in California and the Great Plains Area, citing a lack of authority to access such data and restrictions outlined by the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA)³⁻⁴; and

Whereas, As public health authorities, Tribal Nations and TECs are authorized to access and manage HIPAA-inclusive data, given that they are Covered Entities⁵⁻⁶; and

Whereas, By preventing Tribal Nations and TECs from accessing their public health data, local and state governments and federal agencies like the IHS, infringe upon Tribal sovereignty and do not give special attention to the health and health-related needs of American Indians and Alaska Natives, potentially harming their quality of life and healthcare outcomes (H-350.976); therefore be it

RESOLVED, Our AMA advocate to achieve enactment of reforms to reaffirm American Indian and Alaska Native Tribes and Tribal Epidemiology Centers' status as public health authorities; and be it further

RESOLVED, Our AMA make a suggestion to the Department of Health and Human Services to develop sub-agency (e.g, CDC, IHS) guidance on Public Health and Tribal-affiliated data-sharing with American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers; and be it finally

RESOLVED, Our AMA encourages the use of data-sharing agreements between local and state public health departments and American Indian and Alaska Native Tribes and Villages and Tribal Epidemiology Centers.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Milam S. Improving Data Sharing for Tribal Health: What Public Health Departments Need to Understand About HIPAA Data Privacy Requirements. The Network for Public Health Law. Published December 2, 2021. Accessed August 26, 2022.
<https://www.networkforphl.org/news-insights/improving-data-sharing-for-tribal-health-what-public-health-departments-need-to-understand-about-hipaa-data-privacy-requirements/>
2. United States Government Accountability Office. Tribal Epidemiology Centers: HHS Actions Needed to Enhance Data Access. (GAO-22-104698).; 2022.
3. Cimini K. 'We're born Indian and we die white': California Indigenous fear COVID deaths undercounted. Published March 2, 2021. Accessed August 26, 2022.
<https://calmatters.org/california-divide/2021/03/california-indigenous-fear-covid-deaths-undercounted/>
4. Center for Disease Control and Prevention/National Committee on Vital and Health Statistics. Full Committee Meeting July 20-21, 2022 Tribal Epidemiology Centers: Data Access and Privacy. CDC. Accessed August 26, 2022.
<https://www.youtube.com/watch?v=WlqUsHpPEu8&t=7069s>
5. Milam S. Tribal HIPAA Hybrid Entity FAQs. The Network for Public Health Law. Published March 13, 2020. Accessed August 26, 2022.
<https://www.networkforphl.org/resources/tribal-hipaa-hybrid-entity-faqs/>
6. Indian Health Service. Health Insurance Portability and Accountability Act (HIPAA). Indian Health Service. Published 2022. Accessed August 26, 2022.
<https://www.ihs.gov/HIPAA/>

RELEVANT AMA AND AMA-MSS POLICY

Full Commitment by our AMA to the Betterment and Strengthening of Public Health Systems D-440.922

Our AMA will: (1) champion the betterment of public health by enhancing advocacy and support for programs and initiatives that strengthen public health systems, to address pandemic threats, health inequities and social determinants of health outcomes;

(2) develop an organization-wide strategy on public health including ways in which the AMA can strengthen the health and public health system infrastructure and report back regularly on progress;

(3) work with the Federation and other stakeholders to strongly support the legal authority of health officials to enact reasonable, evidence-based public health measures, including mandates, when necessary to protect the public from serious illness, injury, and death and actively oppose efforts to strip such authority from health officials; and

(4) advocate for (a) consistent, sustainable funding to support our public health infrastructure, (b) incentives, including loan forgiveness and debt reduction, to help strengthen the governmental public health workforce in recruiting and retaining staff, (c) public health data modernization and data governance efforts as well as efforts to promote interoperability between health care and public health; and (d) efforts to ensure equitable access to public health funding and programs.

Res. 407, I-20; Modified: CSAPH Rep. 2, I-21; Reaffirmed: CMS Rep. 5, A-22

Role of Physicians and Physician Organizations in Efforts to Collect Physician-Specific Health Care Data H-406.998

Our AMA: (1) believes that physicians, as patient advocates and possessing unique qualifications in the review and analysis of health care data, must take the initiative in developing data collection systems at the local level which maintain high standards of confidentiality, accuracy and fairness;

(2) urges state medical societies, national medical specialty societies, hospital medical staffs and individual physicians to: (a) participate in health care data collection programs designed to improve the quality of care; (b) be aware of the limitations of health care data; (c) encourage active involvement of physician organizations and practicing physicians in all aspects of health care data collection and interpretation; and (d) develop strategies to assist state agencies and others in improving the collection and interpretation of health data;

(3) urges health data commissions and other entities that collect, evaluate, and disseminate health care data to: (a) facilitate active involvement of physician organizations and practicing physicians in all aspects of the efforts to collect health care data; (b) provide adequate opportunity for physician organizations and practicing physicians to review and respond to proposed data interpretations and disclosures; (c) ensure accuracy of information in the data base; and (d) assure valid interpretation and use of health care data;

(4) encourages relevant physician organizations to develop effective mechanisms to assist physicians in evaluating, using, and responding to physician-specific health care data;

(5) encourages medical societies to use this information for educational purposes and for addressing such areas as utilization variation, quality assessment and appropriate cost containment activities;

(6) encourages medical societies to play an active role in appropriate data collection and dissemination activities at the local level; and

(7) urges state medical societies, hospital medical staffs and physicians to propose, monitor, and seek to influence quality of care and cost containment legislation to comply with AMA principles.

BOT Rep. Y, I-85; Reaffirmed: CLRPD Rep. 2, I-95; BOT Rep. P, A-91; BOT Rep. Q, I-92; CMS Rep. 10, A-96; Reaffirmation A-01; Reaffirmation A-05; Reaffirmed: CMS Rep. 1, A-15

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 non-federal 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 DRAFT (APRIL 8, 2022 BATCH) Resolution: 308 (A-22) Page 6 of 7 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

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. 2, I-98; Reaffirmed: Res. 22, A-07; Reaffirmation: A-12; Reaffirmed: Res. 233, A-13

Plan for Continued Progress Toward Health Equity H-180.944

Health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research, and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

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

Universal Access for Essential Public Health Services D-440.924

Our AMA: (1) supports equitable access to the 10 Essential Public Health Services and the Foundational Public Health Services to protect and promote the health of all people in all communities;

- (2) encourages state, local, tribal, and territorial public health departments to pursue accreditation through the Public Health Accreditation Board (PHAB);
- (3) will work with appropriate stakeholders to develop a comprehensive list of minimum necessary programs and services to protect the public health of citizens in all state and local jurisdictions and ensure adequate provisions of public health, including, but not limited to clean water, functional sewage systems, access to vaccines, and other public health standards; and
- (4) will work with the National Association of City and County Health Officials (NACCHO), the Association of State and Territorial Health Officials (ASTHO), the Big Cities Health Coalition, the Centers for Disease Control and Prevention (CDC), and other related entities that are working to assess and assure appropriate funding levels, service capacity, and adequate infrastructure of the nation's public health system, including for rural jurisdictions.

Res. 419, A-19; Modified: CSAPH Rep. 2, A-22

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 002
(I-22)

Introduced by: Amanda Kahn, Elizabeth Suschana, Catriona Hong, Rodolfo Valentini, University of Connecticut School of Medicine; Julia Houshmand, University of Miami Miller School of Medicine; Amber Lockner University of Oklahoma College of Medicine; Annie Cherner, Caitlin Aguirre University of Texas Medical Branch; Emily Smith Carle Illinois College of Medicine; Rachel Donaldson, Christine Fasana University of South Carolina School of Medicine Greenville; Katie McLaughlin University of Minnesota Medical School Duluth Campus; Jennifer Geller Rutgers Robert Wood Johnson Medical School; Dilpreet Kaeley, University of Toledo College of Medicine and Life Sciences

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

Sponsored by: Region 2, Region 3, Region 4, Region 5, Region 6, Region 7, PsychSIGN

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

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

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

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

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

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

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

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

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

Whereas, Since 2014, the ever-growing firearm epidemic has worsened, with the number of mass shootings increasing from 273 per year in 2014 to 691 per year in 2021, the number of deaths due to gun violence has increased from 12,418 people per year in 2014 to 19,411 people per year in 2020¹³; and

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

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

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

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

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

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

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

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

RESOLVED, That our AMA work with relevant stakeholders to develop state-specific training programs for medical professionals on how to use Extreme Risk Protection Order/Red Flag Laws; and be it further

1 RESOLVED, That our AMA will work with relevant stakeholders to update medical curricula with
2 training surrounding how to approach conversations about Extreme Risk Protection Order/Red
3 Flag laws with patients and families; and be it further
4

5 RESOLVED, That our AMA supports amending policy “Firearms and High-Risk Individuals H-
6 145.972” by addition to read:
7

8 **Firearms and High-Risk Individuals H-145.972**

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

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Extreme risk protection orders. Giffords Law Center Web site.
https://giffords.org/lawcenter/gun-laws/policy-areas/who-can-have-a-gun/extreme-risk-protection-orders/#footnote_2_5623. Updated 2022. Accessed 8/17/22, .
2. Rhoads K, Baker, Chang S, et al. Relating to gun violence protective orders. . 2019(The Senate Thirtieth Legislature, 2019).
3. Bipartisan safer communities act of 2022. Ballotpedia Web site.
https://ballotpedia.org/Bipartisan_Safer_Communities_Act_of_2022. Accessed Aug 17, 2022.
4. Readout of white house meeting with state legislative leaders on extreme risk protection order (ERPO) legislation. The White House Web site.
<https://www.whitehouse.gov/briefing-room/statements-releases/2022/08/19/readout-of-white-house-meeting-with-state-legislative-leaders-on-extreme-risk-protection-order-erpo-legislation/>. Updated 2022. Accessed August 30, 2022.
5. Kivisto AJ, Phalen PL. Effects of risk-based firearm seizure laws in connecticut and indiana on suicide rates, 1981–2015. *PS*. 2018;69(8):855-862.
<https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201700250>. Accessed Aug 25, 2022. doi: 10.1176/appi.ps.201700250.
6. Wintemute GJ, Pear VA, Schleimer JP, et al. Extreme risk protection orders intended to prevent mass shootings. *Ann Intern Med*. 2019;171(9):655-658.
<https://www.acpjournals.org/doi/10.7326/M19-2162>. Accessed Aug 17, 2022. doi: 10.7326/M19-2162.
7. Red flag gun protection law. New York State Web site.
<https://www.ny.gov/programs/red-flag-gun-protection-law>. Updated 2022. Accessed Aug 30, 2022.

8. Extreme risk protection orders in washington DC. Giffords Law Center Web site. <https://giffords.org/lawcenter/state-laws/extreme-risk-protection-orders-in-washington-dc/>. Updated 2021. Accessed August 27, 2022.
9. Stafstrom S, Horn M, Palm C, et al. An act concerning risk protection orders or warrants and disqualifiers for firearm permits and eligibility certificates. . (Session Year 2021).
10. Extreme risk protection orders in connecticut. Giffords Law Center Web site. https://giffords.org/lawcenter/state-laws/extreme-risk-protection-orders-in-connecticut/#footnote_3_16230. Updated 2021. Accessed 8/26/22, .
11. *Definition and list of health professionals*. World Health Organization; 2013. <https://www.ncbi.nlm.nih.gov/books/NBK298950/>. Accessed Aug 29, 2022.
12. Frattaroli S, Hoops K, Irvin NA, et al. Assessment of physician self-reported knowledge and use of maryland's extreme risk protection order law. *JAMA Netw Open*. 2019;2(12):e1918037. <https://pubmed.ncbi.nlm.nih.gov/31860108/>. Accessed Aug 31, 2022. doi: 10.1001/jamanetworkopen.2019.18037.
13. Gun violence archive 2022. Gun Violence Archive Web site. <https://www.gunviolencearchive.org/>. Updated 2022. Accessed Sep 18, 2022.
14. Mascia J. The buffalo shooting suspect once threatened a mass shooting. why wasn't he disarmed? *The Trace*. May 16, 2022. Available from: <https://www.thetrace.org/2022/05/buffalo-shooting-red-flag-law-new-york/>. Accessed Aug 20, 2022.
15. Southall A, Marcius CR, Newman A. Before the massacre, erratic behavior and a chilling threat. *The New York Times*. May 15 2022. Available from: <https://www.nytimes.com/2022/05/15/nyregion/gunman-buffalo-shooting-suspect.html?smid=url-share>. Accessed Aug 20, 2022.
16. Gutowski S. A look at the state of red flag laws after buffalo. <https://thedispatch.com/p/a-look-at-the-state-of-red-flag-laws>. Updated 2022. Accessed Aug 31, 2022.
17. Geiderman JM, Marco CA. Mandatory and permissive reporting laws: Obligations, challenges, moral dilemmas, and opportunities. *Journal of the American College of Emergency Physicians Open*. 2020;1(1):38-45. <https://onlinelibrary.wiley.com/doi/abs/10.1002/emp2.12011>. Accessed Aug 30, 2022. doi: 10.1002/emp2.12011.
18. Mental health professionals' duty to warn. National Conference of State Legislatures Web site. <https://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx>. Updated 2022. Accessed August 30, 2022.
19. Blackwood KL, Christopher PP. U.S. extreme risk protection orders to prevent firearm injury: The clinician's role. *Ann Intern Med*. 2021;174(12):1738-1739. <https://www.acpjournals.org/doi/full/10.7326/M21-2792>. Accessed Aug 31, 2022. doi: 10.7326/M21-2792.
20. Boudreaux ED, Camargo CA, Arias SA, et al. Information for CME credit — improving suicide risk screening and detection in the emergency department. *American journal of preventive medicine*. 2016;50(4):A4. <https://www.clinicalkey.es/playcontent/1-s2.0-S0749379716000404>. doi: 10.1016/j.amepre.2016.01.014.
21. Roatan K. Universal screening can help identify people at risk for suicide. *PEW*. Jan 25, 2022. Available from: <https://www.pewtrusts.org/en/research-and-analysis/articles/2022/01/25/universal-screening-can-help-identify-people-at-risk-for-suicide>. Accessed August 27, 2022.
22. Swanson JW, Nestadt PS, Barnhorst AV, Frattaroli S. Risk-based temporary firearm removal orders: A new legal tool for clinicians. *Harvard Review of Psychiatry*. 2021;29(1):6–9. https://journals.lww.com/hrpjjournal/Fulltext/2021/01000/Risk_Based_Temporary_Firear

m_Removal_Orders__A_New.2.aspx. Accessed Aug 10, 2022. doi: 10.1097/HRP.0000000000000278.

23. HIPAA vs FERPA infographic 2018. CDC Web site. <https://www.cdc.gov/phlp/docs/hipaa-ferpa-infographic-508.pdf>. Updated 2018. Accessed August 30, 2022.
24. HIPAA privacy rule and disclosures of protected health information for extreme risk protection orders. HHS.gov Web site. <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/extreme-risk-protection-orders/index.html>. Updated 2021. Accessed August 27, 2022.

RELEVANT AMA AND AMA-MSS 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.

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

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

1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

3. Our AMA will support the development of reimbursement structures that incentivize physicians to counsel patients on firearm-related injury risk and prevention.

4. Our AMA supports the inclusion of firearm-related violence and suicide epidemiology, as well as evidence-based firearm-related injury prevention education in undergraduate and graduate medical education training programs, where appropriate.

Res. 219, I-11; Reaffirmation A-13; Modified: Res. 903, I-13; Appended: Res. 419, A-17;

Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmed: CSAPH Rep. 3, I-21; Modified: Res. 436, A-22

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

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to

inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

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

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.

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

Gun Violence as a Public Health Crisis D-145.995

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

Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18

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.

Res. 410, A-13

Waiting Period Before Gun Purchase H-145.992

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

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

Gun Regulation H-145.999

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

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

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

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

Res. 214, I-16

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

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

Therefore, the AMA:

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

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

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

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

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

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

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

2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these

firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.

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

Mental Health Crisis D-345.972

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

- a) Improve suicide prevention efforts, through support, payment and insurance coverage for mental and behavioral health and suicide prevention services, including, but not limited to, the National Suicide Prevention Lifeline;
- b) Increase access to affordable and effective mental health care through expanding and diversifying the mental and behavioral health workforce;
- c) Expand research into the disparities in youth suicide prevention;
- d) Address inequities in suicide risk and rate through education, policies and development of suicide prevention programs that are culturally and linguistically appropriate;
- e) Develop and support resources and programs that foster and strengthen healthy mental health development; and
- f) Develop best practices for minimizing emergency department delays in obtaining appropriate mental health care for patients who are in mental health crisis.

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

Res. 425, A-22

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

Our AMA:

- (1) Recognizes youth and young adult suicide as a serious health concern in the US;
- (2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
- (3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;
- (4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
- (5) Encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and among youth and young adults with disabilities;

- (6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults;
 - (7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;
 - (8) Will publicly call attention to the escalating crisis in children and adolescent mental health in this country in the wake of the COVID-19 pandemic;
 - (9) Will advocate at the state and national level for policies to prioritize children's mental, emotional and behavioral health;
 - (10) Will advocate for a comprehensive system of care including prevention, management and crisis care to address mental and behavioral health needs for infants, children and adolescents; and
 - (11) Will advocate for a comprehensive approach to the child and adolescent mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy.
- Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed in lieu of: Res. 001, I-16; Appended: CSAPH Rep. 3, A-21; Appended - BOT Action in response to referred for decision: CSAPH Rep. 3, A-21

Senior Suicide H-25.992

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

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

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

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

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

HIPAA Law And Regulations D-190.989

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

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

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

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

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

Our AMA supports: (1) the alignment of federal privacy law and regulations (42 CFR Part 2) with the Health Insurance Portability and Accountability Act (HIPAA) and applicable state law for the purposes of treatment, payment and health care operations, while ensuring protections are in place against the use of "Part 2" substance use disorder records in criminal proceedings; and (2) the sharing of substance use disorder patient records as required by the HIPAA Privacy Rule and as applies to state law for uses and disclosures of protected health information for treatment, payment and health care operations to improve patient safety and enhance the quality and coordination of care.

Res. 220, A-19

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

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

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

Data on Firearm Deaths and Injuries H-145.984

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

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

Handgun Violence 145.001MSS

The AMA-MSS recognizes that handgun violence and accidents represent a significant public health hazard, and supports the following methods of addressing this hazard: (1) strict federal regulation of the manufacture, sale, importation, distribution, and licensing of handguns and their component parts, including a mandatory 7-day waiting period and police background check for all handgun purchases; (2) supports the taxation of handgun and handgun ammunition sales to be used to help cover medical bills for the victims of handgun violence and to fund public education on the prevention of violence; and (3) educational programs that can demonstrate a reduction in the deaths and injuries caused by handguns. (Reaffirmed: MSS GC Rep F, I-10) (Consolidated and Reaffirmed Multiple Policies: GC Rep C, I-12) (Reaffirmed: MSS GC Report A, I-17)

Prevention of Unintentional Firearm Accidents in Children 145.004MSS

AMA-MSS will ask the AMA to increase efforts to reduce pediatric firearm morbidity and mortality by encouraging its members: (1) to inquire as to the presence of household firearms as a part of childproofing the home; (2) to educate patients to the dangers of firearms to children; (3) to encourage patients to educate their children and neighbors as to the dangers of firearms; and (4) to routinely remind patients to obtain firearm safety locks and store firearms under lock and key; and that the AMA encourage state medical societies to work with other organizations to increase public education about firearm safety. (AMA Amended Res 165, I-89 Adopted [H-

145.990]) (Reaffirmed: MSS Rep D, I-99) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I21)

Gun Safety Counseling in Undergraduate Medical Education 145.011MSS

AMA-MSS will ask the AMA to (1) advocate for the inclusion of strategies for counseling patients on safe gun storage and use in undergraduate medical education; (2) add additional language to AMA Policy H-145.976 prohibiting limitations on the ability of medical students to discuss firearms with patients; and (3) advocate that the Association of American Medical Colleges, Agency for Health, Research and Quality, and other relevant professional medical societies develop gun safety counseling modules to be used in undergraduate medical education. (MSS Res 2, A-13) (AMA Res 903, I-13 Adopted with Change in Title [H-145.976]) (Reaffirmed: MSS GC Rep A, I-19)

Strengthening our Gun Policies on Background Checks and the Mentally Ill 145.013MSS

AMAMSS (1) supports strengthening of the National Instant Criminal Background Check System (NICS) and encourages states to mandate reporting patients with mental illnesses who pose a risk to themselves or others so that their gun licenses can be suspended and their firearms removed until they are deemed fit; (2) encourages the use of smart gun technology on all firearms so that only the lawful owner can discharge a weapon; and (3) supports universal background checks for people buying guns through any medium. (MSS Res 18, A-13) (Reaffirmed: MSS GC Rep A, I-19)

Preventing Fire-Arm Related Injury and Morbidity in Youth 145.014MS

AMA-MSS will ask the AMA to collaborate with firearms owners and training organizations to develop and distribute firearm safety materials that are appropriate for the clinical setting. (MSS Res 30, I-14) (Reaffirmed: MSS GC Rep A, I-19)

Expansion of Federal Gun Restriction Laws to Include Dating Partners and Convicted Stalkers 145.015MSS

AMA-MSS supports legislation that would expand the current federal prohibitions on firearm purchases to include individuals subject to domestic violence restraining orders, convicted stalkers, and persons charged with domestic violence and intimate partner violence even if no legal relationship exists. (MSS Res 03, A-18)

Increasing the Legal Age of Purchasing Ammunition and Firearms from 18 to 21 145.017MSS

AMA-MSS support bans on the possession, unsupervised use, and purchase of firearms and ammunition by youths under the age of 21. (MSS Res 18, A-18)

Opposing Unregulated, Non-Commercial Firearm Manufacturing 145.020MSS

AMA-MSS will ask the AMA to (1) support legislation that opposes: a) unregulated, non-commercial firearm manufacturing, such as via 3-D printing, regardless of the material composition or detectability of such weapons; b) production and distribution of 3-D firearm blueprints; and (2) issue a statement of concern to Congress and the Bureau of Alcohol, Tobacco, Firearms and Explosives regarding the manufacturing of firearms using 3-D printers and the online dissemination of 3-D firearm blueprints as a public health issue. (MSS Res 07, I-18, HOD I-18 Adopted)

AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations 145.022MSS

AMA-MSS will ask the AMA to amend policy G-640.020 as follows: G-640.020 – Political Action Committees and Contributions Our AMA: (1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care; (2) Encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process; (3) Opposes legislative initiatives that improperly limit individual and collective participation in the democratic process; (4) Supports AMPAC’s policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates; (5) Encourages AMPAC to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions; (6) Urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs; (7) will continue to work through its constituent societies to achieve and 100 percent rate of contribution to AMPAC by members; and (8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their subsidiaries; and (9) Calls upon all candidates for public office to refuse contributions from any organization that opposes public health measures to reduce firearm violence. (MSS Res. 61, I-19)

Amend H-145.976, to Reimburse Physicians for Firearm Counseling 145.023MSS

AMA-MSS will ask the AMA to amend Policy H-145.976, “Firearm Safety Counseling in Physician Led Health Care Teams,” by addition as follows: H-145.976 – FIREARM SAFETY COUNSELING IN PHYSICIAN-LED HEALTH CARE TEAMS 1. Our AMA: (a) will oppose any restrictions on physicians’ and other members of the physician-led health care team’s ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians’ and other AMA-MSS Digest of Policy Actions/ 64 members of the physician-led health care team’s discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education. 2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties. 3. Our AMA will support the development of reimbursement structures that incentivize physicians to counsel patients on firearm-related injury risk and prevention. (MSS Res. 30, I-21)

Use of Individualized Violence Risk Assessments in Reporting of Mental Health Professionals for Firearm Background Checks 145.012MSS

AMA-MSS encourages mental health professionals to use individualized violence risk assessments, rather than categorical exclusion criteria, in reports to state or federal authorities for firearm background checks. (MSS Res 15, A-13) (Reaffirmed: MSS GC Rep A, I-19)

Strengthening our Gun Policies on Background Checks and the Mentally Ill 145.013MSS

AMA-MSS (1) supports strengthening of the National Instant Criminal Background Check System (NICS) and encourages states to mandate reporting patients with mental illnesses who pose a risk to themselves or others so that their gun licenses can be suspended and their firearms removed until they are deemed fit; (2) encourages the use of smart gun technology on all firearms so that only the lawful owner can discharge a weapon; and (3) supports universal background checks for people buying guns through any medium. (MSS Res 18, A-13) (Reaffirmed: MSS GC Rep A, I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 003
(I-22)

Introduced by: Alec Calac, University of California San Diego School of Medicine; Julia Seiberling, University of California Riverside School of Medicine; Lyndsay Kandi, University of Arizona College of Medicine; Hailey Baker, University of Minnesota Medical School; Canaan Hancock, Dell Medical School at University of Texas-Austin; Brianna Baldwin, University of Virginia School of Medicine

Subject: Purchased and Referred Care Expansion

Sponsored by: Region 1, Region 2, Region 4, Region 6, Region 7, Association of Native American Medical Students, PsychSIGN

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, The Indian Health Service (IHS), an agency within the United States (U.S.) Department of Health and Human Services, is responsible for providing health services to American Indians and Alaska Natives (AI/AN)¹; and

Whereas, The IHS is funded each year through appropriations by the U.S. Congress¹; and

Whereas, The IHS is underfunded relative to other federal health programs, IHS per capita health care expenditures are \$4,078, while the Veterans Healthcare Administration is \$10,692 and Medicaid and Medicare are \$8,109 and \$13,185, respectively²; and

Whereas, The IHS is considered the payor of last resort, ensuring that no payments shall be made from the Indian Health Service to any provider of treatment at an IHS, Tribal, and Urban Indian Health Program to the extent that such provider is eligible to receive payment for the treatment from any other federal, state, local, or private source of reimbursement for which the patient is eligible³; and

Whereas, These sources of reimbursement include, but are not limited to, Medicare Part A and B, State Medicaid, State or other federal health programs (e.g., Veterans Health Administration), private insurance, and funds from Tribal health programs³; and

Whereas, AI/AN individuals have the highest rates of uninsurance compared to other racial and ethnic groups, even after passage of the Affordable Care Act, with 48.7% of people served by the Indian Health Service having no insurance coverage⁴; and

Whereas, IHS, Tribal, and Urban Indian Health Programs are often limited to primary care services due to funding limitations and facility constraints, among other factors⁵; and

Whereas, The IHS operates the Purchased/Referred Care Program (PRCP), a non-entitlement referral program that may cover medical and dental care provided away from an IHS or Tribal Health Program^{5,7}; and

Whereas, If the IHS is requested to pay through PRCP, then an AI/AN patient must meet the PRCP residency requirements, notification requirements, medical priority, and use of alternate resources such as private insurance, Medicaid, other sources of health funding⁵; and Whereas, PRCP funding is limited, restricting access to non-emergent medical specialty care part-way through the fiscal year unless an AI/AN patient is facing a “life-or-limb” situation⁶⁻⁸; and

Whereas, Reporting of PRCP claims is limited, but in a recent 2018 report on federal funding shortfalls, the U.S. Commission on Civil Rights reported that in Fiscal Year 2013, the IHS PRCP denied an estimated 147,000 medical claims as needed by AI/AN patients—amounting to \$761 million in unmet need⁹; and

Whereas, Tribal Health Programs often augment PRCP funding with their own funds to increase access to medical specialty care¹⁰; and

Whereas, More than 70 percent of the AI/AN population lives in Urban Areas, yet Urban Indian Health Programs are not eligible to participate in PRCP, limiting access to care^{5,11}; and

Whereas, Community benefit is a legal term for expenditures made by non-profit hospitals to fulfill their charitable obligations as tax-exempt health care institutions¹²; and

Whereas, In 2019, 180 California nonprofit hospitals reported a total of over \$6 billion in community benefit expenditures, \$2.9 billion of which were attributed to coverage of Medicaid shortfalls, and another \$861 million attributed to financial assistance for uninsured patients (63% of all expenditures)¹²; and

Whereas, Community benefit dollars have the potential to increase access to comprehensive, high-quality specialty care for AI/AN patients in states with large AI/AN populations, like California¹²; and

Whereas, Our AMA supports special allocations of community benefit dollars to meet unmet health needs (H-215.961); therefore be it

RESOLVED, our AMA will advocate fully funding the Indian Health Service Purchased/Referred Care Program and expanding eligibility to patients served by Urban Indian Health Programs; be it further

RESOLVED, our AMA encourages nonprofit hospitals to allocate community benefit dollars to increase access to specialty care for patients referred from Indian Health Service, Tribal, and Urban Indian Health Programs.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. About the Indian Health Service. U.S. Department of Health and Human Services. Accessed August 25, 2022. <https://www.ihs.gov/aboutihs/>
2. Khetpal V, Roosevelt J Jr, Adashi EY. A Federal Indian Health Insurance Plan: Fulfilling a solemn obligation to American Indians and Alaska Natives in the United States. *Prev Med Rep.* 2021;25:101669. Published 2021 Dec 16. doi:10.1016/j.pmedr.2021.101669

3. 42CFR136.61: Indian Health. Accessed August 31, 2022.
<https://www.govinfo.gov/app/details/CFR-2007-title42-vol1/CFR-2007-title42-vol1-part136>
4. Bhaskar R, O'Hara BJ. Indian Health Service Coverage among American Indians and Alaska Natives in Federal Tribal Areas. *J Health Care Poor Underserved*. 2017;28(4):1361-1375. doi:10.1353/hpu.2017.0120
5. Purchased and Referred Care. Indian Health Service. Accessed August 31, 2022.
<https://www.ihs.gov/prc/>
6. Khetpal V, Roosevelt J Jr, Adashi EY. A Federal Indian Health Insurance Plan: Fulfilling a solemn obligation to American Indians and Alaska Natives in the United States. *Prev Med Rep*. 2021;25:101669. Published 2021 Dec 16. doi:10.1016/j.pmedr.2021.101669
7. Indian Health Manual: Purchased and Referred Care. *IHS*. Accessed August 31, 2022.
<https://www.ihs.gov/ihm/pc/part-2/chapter-3-purchased-referred-care/#2-3.1D>
8. Medical Priority Levels. *IHS*. Accessed August 31, 2022.
https://www.ihs.gov/sites/ihm/themes/responsive2017/display_objects/documents/pc/58619-1_Manual_Exhibit_2-3-B_IHS_MedicalPrioritiesRolesAndResponsibilities.pdf
9. Broken Promises: Continuing Federal Funding Shortfall for Native Americans. *U.S. Commission on Civil Rights*. Published December 2018.
10. Bark, L. Purchase Referred Care is affected by federal funding, third-party payer options. *Cherokee Phoenix*. Published July 18, 2022. Accessed August 31, 2022.
https://www.cherokeephoenix.org/health/purchase-referred-care-is-affected-by-federal-funding-third-party-payer-options/article_447c0622-06e0-11ed-8071-a70240d11ad9.html
11. Urban Indian Health. *Urban Indian Health Institute*. Accessed August 31, 2022.
<https://www.uihi.org/urban-indian-health/>
12. Barnett, K. Community Benefit in California: A New Chapter. *Public Health Institute*. Published February 2022. Accessed August 31, 2022.
https://2mjt5a2emh374130j5vkxw9g-wpengine.netdna-ssl.com/wp-content/uploads/2022/02/Community-Benefit-in-California_-A-New-Chapter-final.pdf

RELEVANT AMA AND AMA-MSS POLICY

Community Benefit Dollars for Diabetes Prevention H-215.961

1. Our AMA supports allocating community benefit dollars to cover the cost of enrolling patients in an in-person or virtual diabetes prevention program that is part of the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program.
2. Our AMA will work with the American Hospital Association and other stakeholders to develop and disseminate a position paper with guidance for covering the costs of the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program with community benefit dollars.
3. Our AMA encourages each state medical society to work with their respective hospitals and local Diabetes Prevention Program providers to offer the Center for Disease Control and Prevention's Diabetes Prevention Recognition Program to patients.
4. Our AMA encourages that private and public payors offer the Centers for Disease Control and Prevention's Diabetes Prevention Recognition Program to patients as part of their suite of benefits.

Res. 427, A-16

Access to Specialty Care H-160.952

The AMA: (1) continues to encourage primary care and other medical specialty organizations to collaborate in developing guidelines to delineate the clinical circumstances under which treatment by primary care physicians, referral for initial or ongoing specialist care, and direct

patient self-referral to other specialists are appropriate, timely, and cost-effective; (2) encourages the medical specialty organizations that develop referral guidelines to document the impact of the guidelines on the quality, accessibility, timeliness, and cost-effectiveness of care; and (3) urges all health plans that control access to services through a primary care case manager to cover direct access to and services by a specialist other than the case manager without financial penalty when that access is in conformance with such collaboratively developed guidelines.

CMS Rep. 1, A-94; Reaffirmed and Modified: CMS Rep. 7, A-05; Reaffirmation A-09; Reaffirmed in lieu of Res. 815, I-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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 004
(I-22)

Introduced by: Shreya Mandava, University of Virginia School of Medicine; Winona Gbedey, University of Texas Health San Antonio Long School of Medicine; Anudeeta Gautam, Lewis Katz School of Medicine at Temple University; Sophie Kim, Lewis Katz School of Medicine at Temple University; Alicia Podwojniak, Rowan School of Osteopathic Medicine; Dhruv Puri, University of California San Diego; Elisabeth Fassas, University of Maryland School of Medicine; Priya Desai, Boston University School of Medicine; Allie Conry, University of South Carolina School of Medicine; Cecily Negri, Southern Illinois University School of Medicine; Sara Kazyak, Abhijay Kumar, Aarti Patel, Pragathi Pathanjeli, Wayne State University School of Medicine; Itisha S. Jefferson, Loyola University Stritch School of Medicine; Dieu Thao Nguyen University of South Carolina School of Medicine Greenville; Cloe Nazeer, Oakland University William Beaumont School of Medicine; Erin Myers, Michigan State University College of Human Medicine

Subject: Increased Education and Access to Fertility Resources for U.S. Medical Students

Sponsored by: Region 2, Region 3, Region 5, Region 6, Region 7, American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, The Centers for Disease Control (CDC) and Prevention define infertility as the inability to conceive after one year (or longer) of unprotected sex, which has an increased prevalence in women aged 35 years or older¹; and

Whereas, The American College of Obstetricians and Gynecology (ACOG) reports peak fertility occurs in the late teens and early twenties and issued a committee opinion acknowledging that fertility decreases drastically in a woman's early thirties^{2,3}; and

Whereas, ACOG has acknowledged advanced maternal age to be a pregnant woman who is 35 years of age or older and mothers considered to be of advanced maternal age have been found to be at greater risk of adverse pregnancy outcomes, including chromosomal abnormalities, adverse maternal outcomes, and miscarriage or stillbirth^{4,5}; and

Whereas, An increasing number of females have been enrolling in medical school over the years, with 55.5% of 2021-2022 matriculants identifying as female⁶; and

Whereas, 68.5% of medical students report taking one or more gap years in between their undergraduate institution and medical school in 2021 compared with 66.3% and 65.2% in 2020 and 2019 respectively, effectively increasing the average age of medical school matriculants^{7,8,9}; and

Whereas, The percentage of students pursuing non-degree research years has increased in the last 15 years, and only 81% of matriculating MD-only students graduated in 4 years, the lowest percentage to date¹⁰; and

Whereas, The average age of females completing their medical training is 31 and on average, the age for female physicians give birth for the first time at 32 compared to 27 for non-physicians¹¹; and

Whereas, An estimated 25% of female physicians experience infertility, and the rate of female physicians seeking fertility evaluation and requiring the use of reproductive technology is six times higher than that of the general population^{12,13,14}; and

Whereas, The rate of miscarriage among medical and surgical residents in North America is almost three times higher than that of their non-physician counterparts¹⁵; and

Whereas, Female physicians have reported that their careers significantly influenced their family planning and childbearing decisions, with many delaying childbearing to achieve certain career milestones or balance a less “family-friendly” specialty¹⁶; and

Whereas, The most comprehensive study on physician fertility to date found that nearly 55% of female participants would have attempted to conceive earlier in their careers if they had known the prevalence of infertility among female physicians was as prevalent an issue as it is¹⁶; and

Whereas, While medical students are more knowledgeable about fertility than their non-medical student counterparts, several studies have found medical trainees are underprepared to address topics such as age-related fertility decline, gamete preservation, and the effectiveness of assisted reproductive technologies^{17,18,19,20}; and

Whereas, Although 8.8% of matriculating medical students identified as gay, lesbian, or bisexual and 0.7% identified as transgender or non-binary in 2019, there is little research on fertility experiences among physicians of sexual and gender minority backgrounds²¹; and

Whereas, Transgender and non-binary individuals have complex fertility needs and face challenges such as lack of timely information regarding gamete preservation, which may further impact medical trainees in this population²²; and

Whereas, Studies show that the average cost of an in vitro fertilization (IVF) cycle is \$13,000 and a successful IVF pregnancy costs upwards of \$112,77^{23,24,25}; and

Whereas, Oocyte cryopreservation is currently the gold standard for fertility preservation for female patients with the estimated costs of one cycle being \$7,000-\$9,253 with a long-term estimated storage cost of \$343-\$1,000 per year as of 2017^{26,27,28}; and

Whereas, Sperm cryopreservation is the process of retrieving and freezing the semen sample with an estimated cost for one cycle of \$745²⁶; and

Whereas, 73% of medical school graduates finished with education debt in 2021 with an average of \$203,062 for those indebted, not including any accumulated undergraduate debt²⁹; and

Whereas, Only seventeen states have laws that require insurers to either cover or offer coverage for infertility diagnosis and treatment³⁰; and

Whereas, Coverage of fertility benefits for faculty at the top 14 U.S. Medical Schools for research as defined by the U.S. News and World Reports vary widely in their application, particularly for cycle and coverage limitations for IVF coverage and limited fertility preservation, even in states with legislation requiring infertility diagnosis and treatment coverage or options³¹; and

Whereas, AMA Policy H-420.952 supports the WHO designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and preservation; and

Whereas, AMA Policy H-185.922 supports the coverage of gamete preservation for individuals for whom a medical diagnosis or treatment modality is expected to result in loss of fertility; and

Whereas, AMA Policy H-310.902 encourages insurance providers to cover fertility preservation and infertility treatment for residents and fellows, as well as supports the accommodation of those persons seeking those services and treatments; and

Whereas, Although AMA Policy H-185.990 and H-185.926 support insurance coverage for the diagnosis and treatment of infertility regardless of marital status or sexual orientation, there is a current lack of policy specifically addressing fertility issues among medical students; therefore be it

RESOLVED, Our AMA will work with the Association of American Medical Colleges and other appropriate organizations to develop gender- and sexual minority-inclusive educational initiatives that raise awareness about (1) how peak child-bearing years correspond to the peak career-building years for many medical students and trainees; (2) the significant decline in oocyte quality and quantity and increase in miscarriage and infertility rates, with increasing age; (3) the high rate of infertility among physicians; and (4) various fertility preservation options and including cryopreservation of oocytes and sperm and associated costs; and be it further

RESOLVED, Our AMA will work with relevant organizations to investigate mechanisms by which medical students can preserve fertility (such as cryopreservation of oocytes, sperm, and embryos), with associated mechanisms for insurance coverage.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Infertility FAQs. cdc.gov. <https://www.cdc.gov/reproductivehealth/infertility/index.htm>. Published 2022. Accessed September 22, 2022.
2. American College of Obstetricians and Gynecologists. Having a Baby After Age 35: How Aging Affects Fertility and Pregnancy Frequently Asked Questions. ACOG.org. Published October 2020. Accessed August, 21 2022. <https://www.acog.org/womens-health/faqs/having-a-baby-after-age-35-how-aging-affects-fertility-and-pregnancy>
3. American College of Obstetricians and Gynecologists Committee on Gynecologic Practice and Practice Committee. Female age-related fertility decline. Committee

- Opinion No. 589. *Fertil Steril*. 2014 Mar;101(3):633-4. doi: 10.1016/j.fertnstert.2013.12.032.
4. Committee on Clinical Consensus—Obstetrics; Society for Maternal-Fetal Medicine. Pregnancy at Age 35 Years or Older. *Am J Obstet Gynecol*. 2022 Jul 15:S0002-9378(22)00576-2. doi: 10.1016/j.ajog.2022.07.022.
 5. Frick AP. Advanced maternal age and adverse pregnancy outcomes. *Best Pract Res Clin Obstet Gynaecol*. 2021 Jan;70:92-100. doi: 10.1016/j.bpobgyn.2020.07.005.
 6. Applicants, First-Time Applicants, Acceptees, And Matriculants To U.S. MD-Granting Medical Schools By Sex, 2012-2013 Through 2021-2022. Association of American Medical Colleges; 2021:1.
 7. Association of American Medical Colleges. (2022). *Matriculating student questionnaire (MSQ)*. AAMC. <https://www.aamc.org/data-reports/students-residents/report/matriculating-student-questionnaire-msq>
 8. Association of American Medical Colleges. (2020, December). *Matriculating Student Questionnaire: 2020 All Schools Summary Report*. AAMC. <https://www.aamc.org/media/50081/download>
 9. Association of American Medical Colleges. (2019, December). *Matriculating Student Questionnaire: 2019 All Schools Summary Report*. AAMC. <https://www.aamc.org/media/38916/download>
 10. Pathipati AS, Taleghani N. Research in Medical School: A Survey Evaluating Why Medical Students Take Research Years. *Cureus*. 2016;8(8):e741. Published 2016 Aug 18. doi:10.7759/cureus.741
 11. Cusimano MC, Baxter NN, Sutradhar R, et al. Delay of pregnancy among physicians vs Nonphysicians. *JAMA Internal Medicine*. 2021. doi:10.1001/jamainternmed.2021.1635.
 12. Marshall AL, Arora VM, Salles A. Physician fertility: A call to action. *Academic Medicine*. 2020;95(5):679-681. doi:10.1097/acm.0000000000003079 2
 13. Rangel EL, Castillo-Angeles M, Easter SR, et al. Incidence of Infertility and Pregnancy Complications in US Female Surgeons. *JAMA Surg*. 2021;156(10):905. doi:10.1001/jamasurg.2021.3301
 14. Farren J, Jalnibrant M, Ameye L, et al. Post-traumatic stress, anxiety and depression following miscarriage or ectopic pregnancy: A prospective cohort study. *BMJ Open*. 2016;6(11). doi:10.1136/bmjopen-2016-011864
 15. Rangel EL, Castillo-Angeles M, Easter SR, et al. Incidence of Infertility and Pregnancy Complications in US Female Surgeons. *JAMA Surg*. 2021;156(10):905. doi:10.1001/jamasurg.2021.3301
 16. Stentz NC, Griffith KA, Perkins E, Jones RD, Jagsi R. Fertility and Childbearing Among American Female Physicians. *J Womens Health (Larchmt)*. 2016;25(10):1059-1065. doi:10.1089/jwh.2015.5638
 17. Nouri K, Huber D, Walch K, et al. Fertility awareness among medical and non-medical students: a case-control study. *Reprod Biol Endocrinol*. 2014;12(1):94. doi:10.1186/1477-7827-12-94
 18. Yu L, Peterson B, Inhorn MC, Boehm JK, Patrizio P. Knowledge, attitudes, and intentions toward fertility awareness and oocyte cryopreservation among obstetrics and gynecology resident physicians. *Hum Reprod*. Published online December 17, 2015:dev308. doi:10.1093/humrep/dev308
 19. Kudesia R, Chernyak E, McAvey B. Low fertility awareness in United States reproductive-aged women and medical trainees: creation and validation of the Fertility & Infertility Treatment Knowledge Score (FIT-KS). *Fertility and Sterility*. 2017;108(4):711-717. doi:10.1016/j.fertnstert.2017.07.1158

20. Roberts LM, Kudesia R, Zhao H, Dolan S, Rose M. A cross-sectional survey of fertility knowledge in obstetrics and gynecology residents. *Fertil Res and Pract*. 2020;6(1):22. doi:10.1186/s40738-020-00091-2
21. Matriculating Student Questionnaire 2019 All Students Report. Association of American Medical Colleges; 2019:28.
22. Access to fertility services by transgender and nonbinary persons: an Ethics Committee opinion. *Fertility and Sterility*. 2021;115(4):874-878. doi:10.1016/j.fertnstert.2021.01.049
23. American Society for Reproductive Medicine. White paper: access to care summit—September 10-11, 2015; Washington, DC. <https://www.asrm.org/globalassets/asrm/asrm-content/news-and-publications/news-and-research/press-releases-and-bulletins/pdf/atcwhitepaper.pdf>. Published June 13, 2018.
24. Katz P, Showstack J, Smith JF, et al. Costs of infertility treatment: results from an 18-month prospective cohort study. *Fertil Steril*. 2011;95(3):915-921. doi:10.1016/j.fertnstert.2010.11.026
25. Klitzman R. How much is a child worth? Providers' and patients' views and responses concerning ethical and policy challenges in paying for ART. Linkov I, ed. PLoS ONE. 2017;12(2):e0171939. doi:[10.1371/journal.pone.0171939](https://doi.org/10.1371/journal.pone.0171939)
26. Kyweluk MA, Reinecke J, Chen D. Fertility Preservation Legislation in the United States: Potential Implications for Transgender Individuals. *LGBT Health*. 2019;6(7):331-334. doi:10.1089/lgbt.2019.0017
27. Ubaldi FM, Cimadomo D, Vaiarelli A, et al. Advanced Maternal Age in IVF: Still a Challenge? The Present and the Future of Its Treatment. *Front Endocrinol (Lausanne)*. 2019;10:94. Published 2019 Feb 20. doi:10.3389/fendo.2019.00094
28. Cost of Egg & Embryo Freezing in the U.S. PFCLA. <https://www.pfcla.com/blog/egg-freezing-costs>. Published June 29, 2022. Accessed September 20, 2022.
29. Association of American Medical Colleges. (2021). Medical Student Education: Debt, Costs, and Loan Repayment Fact Card for the Class of 2021; AAMC.
30. State Laws Related to Insurance Coverage for Infertility Treatment. Published March 12, 2021. <https://www.ncsl.org/research/health/insurance-coverage-for-infertility-laws.aspx>
31. State Laws Related to Insurance Coverage for Infertility Treatment. Published March 12, 2021. <https://www.ncsl.org/research/health/insurance-coverage-for-infertility-laws.aspx>

RELEVANT AMA AND AMA-MSS POLICY

Recognition of Infertility as a Disease H-420.952

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

Res. 518, A-17

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. 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

Reproductive Health 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.

Res. 804, I-16

Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions 65.042MSS

(1) Our AMA-MSS will ask our AMA to amend policy H-185.990, by addition as follows: INFERTILITY AND FERTILITY PRESERVATION INSURANCE COVERAGE, H-185.990 It is the policy of the AMA that (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, 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; and (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. (2) Our AMA-MSS will ask our AMA to amend policy H185.950 by addition as follows: REMOVING FINANCIAL BARRIERS TO CARE FOR TRANSGENDER PATIENTS, H-185.950 Our AMA supports public and private health insurance coverage for medically necessary treatment of gender dysphoria as recommended by the patient's physician, including gender-affirming hormone therapy and gender-affirming surgery. (MSS Res. 042, Nov. 2020) (AMA Res. 012, Adopt as Amended and Reaffirm Policy H-185.950 in Lieu of the Second Resolve, Appended: Res. 012, A-22 [H-185.990], A22)

Infertility and Infertility Insurance Coverage 420.010MSS

AMA-MSS (1) supports research into the underlying cause of rising sub- and infertility trends; and (2) supports efforts to improve access and insurance coverage for fertility service among racial minorities and LGBTQ persons. (MSS Res 24-I-17)

Family Planning for Medical Students 295.207MSS

AMA-MSS (1) encourages medical schools to create informative resources that promote a culture that is supportive of their students who are parents and to provide openly accessible information to prospective and current students regarding family planning in the specific medical school including parental leave and relevant make up work, options to preserve fertility, breastfeeding policies, accommodations during pregnancy, and resources for childcare that span the institution and surrounding area; and (2) supports the development of comprehensive requirements for medical schools regarding guidelines and resources for family leave and parenthood; and

(3) supports medical schools providing six weeks of parental leave for medical students of all genders, medical school or broader licensure-related policies that allow for students to take a full six week leave without delaying graduation, and

(4) encourages medical schools to make these formal policies easily accessible for both current and prospective students (MSS Res. 51, I-19) (Amended MSS WIM Report A, A-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 005
(I-22)

Introduced by: Rommel Morales, Michaela Stamper, Northeast Ohio Medical University;
Kaylee Scarnati, Julianna Sim, Vincent Smith, Aditya Acharya, University of
Toledo; Maggie Stull, University of Kentucky; Constance Fontanet,
Dartmouth College; Christine Fasana, University of South Carolina

Subject: Advocating for Utilization of State-level Waivers in Post-COVID-19 Coverage
Protection

Sponsored by: Region 4 and Region 5

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, The Families First Coronavirus Response Act (FFRCA) increased the Federal
Medical Assistance Percentage by 6.2% on January 1, 2020, providing increased funding for
states to be able to better respond to the pandemic and is set to end on the last day of the
calendar quarter in which the COVID-19 public health emergency ends¹; and

Whereas, Preliminary data in April 2022 showed that total Medicaid and CHIP enrollment grew
to 88.3 million, with an increase of 17 million since the prior year especially due to utilization of
FFRCA - with OK, MO, NE, and UT experiencing >45% enrollment since January 2020²; and

Whereas, The FFCRA expanded paid sick leave for COVID-19 to 2 weeks at full pay, 2 weeks
at $\frac{2}{3}$ pay, and 10 weeks of paid expanded family and medical leave at $\frac{2}{3}$ pay - allowing for
individual and caretaking needs³; and

Whereas, The FFCRA also expanded insurance coverage of coronavirus testing among
insurance modalities (private, Medicare, Medicaid, CHIP, Tricare, Indian Health Service),
respiratory protection devices, unemployment compensation, and nutritional assistance (SNAP,
WIC, etc.), but expired in December 2020⁴; and

Whereas, Millions of beneficiaries will lose coverage through the FFCRA continuous enrollment
requirement, leaving large variability across states in considerations for maintaining,
transitioning, or dropping healthcare coverage⁵; and

Whereas, 33% of those expected to lose coverage are Latino and 15% are Black, totalling 4.6
and 2.2 million, respectively⁶; and

Whereas Administrative burden will increase due to the large volume of applications required to
be redetermined for eligibility leading to further coverage losses⁷; and

Whereas, To primarily address the administrative burden that will pass onto CMS with the expiration of FFCRA in applications and income verification, and the potential for gaps in coverage, the Centers for Medicare & Medicaid Services have allowed states to apply for waivers under Section 1902(e)(14)(A) to promote continuous coverage⁸; and

Whereas, The strategies implemented in Section 1902(e)(14)(A) waivers include (1) renewal based on SNAP eligibility, (2) renewal for individuals with no income, (3) simplifying asset verification, (4) streamlining beneficiary contact information, and (5) extending time intervals for fair hearings⁸; and

Whereas, Utilization of Social Security Act Section 1902(e)(14) mitigated coverage loss that would have disproportionately affected communities of Black, Latinx, and other POC groups, as well as minimized gaps in lower income populations and those who lost employment⁹; and

Whereas, Only 27 states have approved waivers, with a number of 1902(e)(14) waivers being severely underutilized, and 3 at-risk states of significant pediatric coverage loss having no approved waivers to date^{8,10}; and

Whereas, AMA policy H-165.826 and AMA-MSS policy 270.030MSS on state-level waivers pertain specifically to Section 1332 of the Affordable Care Act to allow for pilot programs to increase quality and affordability, but is distinct from CMS Section 1902(e)(14) waiver authorities¹¹; and

Whereas, Section 1902(e)(14) waivers will last in the unwinding period 12 months after the public health emergency is officially declared to be ended, and must be urgently utilized to derive maximum benefit⁷; therefore be it

RESOLVED, That our AMA advocate for relevant legislative bodies, state medical societies, and stakeholders in utilizing CMS Section 1902(e)(14) waivers at the state-level; and be it further

RESOLVED, That our AMA-MSS immediately forward this resolution to the I-22 AMA House of Delegates.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Medicaid's Federal Medical Assistance Percentage (FMAP). <https://crsreports.congress.gov/product/pdf/R/R43847>. Accessed September 1, 2022.
2. Corallo B, Moreno S. Analysis of Recent National Trends in Medicaid and CHIP Enrollment. KFF. <https://www.kff.org/coronavirus-covid-19/issue-brief/analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/>. Published September 12, 2022. Accessed September 1, 2022.
3. Families First Coronavirus Response Act: Employee Paid Leave Rights. U.S. Department of Labor. <https://www.dol.gov/agencies/whd/pandemic/ffcra-employee-paid-leave>. Accessed September 1, 2022.

4. The Families First Coronavirus Response Act: Summary of Key Provisions. The Families First Coronavirus Response Act: Summary of Key Provisions. KFF. <https://www.kff.org/coronavirus-covid-19/issue-brief/the-families-first-coronavirus-response-act-summary-of-key-provisions/>. Published March 23, 2020. Accessed September 1, 2022.
5. William E, Drake P. Headed Back to School: A Look at the Ongoing Effects of COVID-19 on Children's Health and Well-Being. KFF. <https://www.kff.org/coronavirus-covid-19/issue-brief/headed-back-to-school-a-look-at-the-ongoing-effects-of-covid-19-on-childrens-health-and-well-being/>. Published August 5, 2022. Accessed September 1, 2022.
6. Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches. ASPE Office of Health Policy. https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf. Published August 19, 2022. Accessed September 22, 2022.
7. Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency. Centers for Medicare & Medicaid Services. <https://www.medicare.gov/federal-policy-guidance/downloads/sho22001.pdf>. Published March 3, 2022. Accessed September 20, 2022.
8. CMS Spotlights State Strategies for Protecting Continuity of Health Coverage when PHE Lifts – Center For Children and Families. <https://ccf.georgetown.edu/2022/08/11/cms-spotlights-state-strategies-for-protecting-continuity-of-health-coverage-when-phe-lifts/>. Accessed September 1, 2022.
9. Serafi K, O'Connor K, Boozang PM. Leveraging Section 1902(e)(14) Waiver Authority Amid Unwinding. Manatt, Phelps & Phillips, LLP. <https://www.manatt.com/insights/white-papers/2022/leveraging-section-1902e14-waiver-authority-am>. Published June 21, 2022. Accessed September 1, 2022.
10. COVID-19 PHE Unwinding Section 1902(e)(14)(A) Waiver Approvals. Medicaid.gov. <https://www.medicare.gov/covid-19-phe-unwinding-section-1902e14a-waiver-approvals/index.html> Accessed September 22, 2022.
11. Section 1332: State Innovation Waivers. CMS. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-. Accessed September 1, 2022.

RELEVANT AMA AND AMA-MSS POLICY

Affordable Care Act Section 1332 Waivers H-165.826

1. Our AMA supports the criteria outlined in Section 1332 of the Affordable Care Act for the approval of State Innovation Waivers:
 - a. The waiver proposal will provide coverage to at least a comparable number of the state's residents as would be provided absent the waiver;
 - b. The waiver proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver;
 - c. The waiver proposal will provide coverage that is at least as comprehensive for the state's residents as would be provided absent the waiver; and
 - d. The waiver proposal will not increase the federal deficit.

2. Our AMA supports the deficit neutrality requirement of Section 1332 waivers being enforced over the period of the waiver and in total over the ten-year budget plan submitted by a state, not in each individual year of the waiver.
3. Our AMA supports legislation to allow other federal savings projected to be achieved as a result of a Section 1332 waiver, including any reductions in the cost of the tax exclusion for employer-sponsored coverage, to be included in the amount of federal pass-through funding provided to a state to subsidize state innovations. CMS Rep. 01, I-17

Advocacy and Studies on ACA Section 1332 (State Innovation Waivers) to Improve States' Abilities to Innovate and Improve Healthcare Benefits, Access and Affordability
270.030MSS

Our AMA-MSS will ask (1) that our AMA advocate that the "deficit-neutrality" component of the current HHS rule for Section 1332 waiver qualification be considered only on long-term, aggregate cost savings of states' innovations as opposed to having costs during any particular year, including in initial "investment" years of a program, reduce the ultimate likelihood of waiver approval; and (2) that our AMA study reforms that can be introduced under Section 1332 of the ACA in isolation and/or in combination with other federal waivers to improve healthcare benefits, access and affordability for the benefit of patients, healthcare providers and states, and encourages state societies to do the same. (MSS Res 07, A-16) (Reaffirmed: MSS GC Report A, I-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 006
(I-22)

Introduced by: Alec Calac, University of California San Diego School of Medicine; Sarah Mae Smith, University of California Irvine School of Medicine; Julia Seiberling, University of California Riverside School of Medicine; Rajvarun Grewal, Matinder Dhillon, California Health Sciences University - College of Osteopathic Medicine; Hailey Baker, University of Minnesota Medical School; Cole Howie, University of Arkansas; Brianna Baldwin, University of Virginia School of Medicine; Anna Klunk, Philadelphia College of Osteopathic Medicine; Nishanth Ganeshbabu, Tufts University School of Medicine; Nehal Lakdawala, University of Connecticut School of Medicine; Krishna Channa, University of Connecticut School of Medicine

Subject: Medicaid Managed Care for Indian Health Care Providers

Sponsored by: Region 1, Region 2, Region 6, Association of Native American Medical Students, PsychSIGN

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, The Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, is responsible for providing health services to American Indians and Alaska Natives (AI/AN)¹; and

Whereas, The IHS is underfunded relative to other federal health programs, IHS per capita health care expenditures are \$4,078, while figures for Veterans Healthcare Administration is \$10,692 and Medicaid and Medicare are \$8,109 and \$13,185, respectively²; and

Whereas, The IHS is considered the payor of last resort, ensuring that no payments shall be made from the Indian Health Service to any provider of treatment at an IHS, Tribal, and Urban Indian Health Program to the extent that such provider is eligible to receive payment for the treatment from any other federal, state, local, or private source of reimbursement for which the patient is eligible³; and

Whereas, IHS' sources of reimbursement include, but are not limited to, Medicare Part A and B, State Medicaid, State or other federal health programs (e.g., Veterans Health Administration), private insurance, and funds from Tribal health programs³; and

Whereas, Payments for IHS patients' medical care received from public programs such as Medicaid and Medicare or from private insurers—increased from about \$943 million in fiscal year 2015 to about \$1.15 billion in fiscal year 2019 at its federal facilities⁴; and

Whereas, IHS third-party collections are increasingly important, as they represent a significant portion of IHS, Tribal, and Urban Indian Health Programs' health care delivery budget and are also used to procure services, supplies, and pharmaceuticals⁴⁻⁵; and

Whereas, An estimated 725,000 AI/AN patients served by the IHS (28.3% of population served) have Medicaid coverage⁵; and
Whereas, As of July 2021, 41 states, including the District of Columbia, contract with Managed Care Organizations (MCO) to provide for the delivery of Medicaid health benefits and additional services⁶⁻⁷; and

Whereas, Managed Care Organizations (MCO) play a significant role in the delivery of healthcare to Medicaid enrollees because states choose which populations and services to include in managed care contracts (e.g. persons with disabilities, dual-eligible Medicaid and Medicare beneficiaries)⁷; and

Whereas, There are Indian Health Care Medicaid Managed Care Provisions (42 C.F.R. § 438.14) protecting the rights of Indian Health Care Providers (IHCP) that must be followed by state Medicaid programs or their contracted MCO⁸; and

Whereas, An IHCP is a health care program operated by the IHS or by an Indian Tribe, Tribal Organization, or Urban Indian Organization, as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603)⁹; and

Whereas, These provisions include: (1) allowing AI/AN Medicaid enrollees to obtain MCO-covered services from out-of-network IHCPs; (2) requiring MCOs to pay out-of-network IHCPs that are federally qualified health centers (FQHC) at the same rate that they would pay an in-network FQHC; and (3) requiring MCOs to pay out-of-network IHCPs that are not an FQHC at the IHS rate⁸; and

Whereas, In 2019, the Center for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG) formed a Managed Care Subcommittee to address Medicaid managed care issues identified by IHCPs, AI/AN Medicaid enrollees, and Tribal leaders⁸; and

Whereas, Key issues identified by the CMS TTAG Subcommittee included denying AI/AN enrollees the right to receive services from an IHCP of their choice, denial of claims made by IHCPs to MCOs, inadequate State oversight of MCOs, and incorrect reimbursement from MCOs to IHCPs for their services⁸; and

Whereas, Greater compliance with Indian Health Care Medicaid Managed Care Provisions (42 C.F.R. § 438.14) will improve the availability of health care services offered by IHCPs⁹; therefore be it

RESOLVED, Our AMA suggests that CMS to direct state Medicaid agencies with Medicaid Managed Care Organizations (MCO) to:

- (a) Recognize the importance of onboarding and annual refresher training regarding Indian Health Care Medicaid Managed Care Provisions (42 C.F.R. § 438.14)
- (b) Consider the enrollment of in-state and neighboring-state Indian Health Care Providers (IHCPs) as in-network.
- (c) Suggest that Indian Health Care Providers (IHCPs) be paid at the in-network rate and not less than the amount the MCO would pay to a non-IHCP, regardless of IHCP network status.
- (d) Share best practices for working with Indian Health Care Providers (Indian Health Service, Tribal, and Urban Indian Health Programs) between Medicaid Managed Care Organizations.

- (e) Consider convening a Tribal Advisory Committee or hire a Tribal liaison to facilitate care coordination agreements and payment for managed care services.
- (f) Consider utilizing the CMS Indian Managed Care Addendum to facilitate agreements between MCOs and IHCPs.

RESOLVED, Our AMA suggests CMS to direct state Medicaid agencies planning to implement or with Medicaid Managed Care Organizations to engage in robust and meaningful Tribal consultation; and be it finally

RESOLVED, Our AMA suggests CMS to conduct regular audits of Medicaid Managed Care Organizations to ensure compliance with Indian Health Care Medicaid Managed Care Provisions, including, but not limited to, correction of claims, development of new policies and processes, and evaluation and measurement tools.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

Click here to enter references. References should follow the AMA Reference Citation Format. Sample citations are shown below.

1. About the Indian Health Service. U.S. Department of Health and Human Services. Accessed August 25, 2022. <https://www.ihs.gov/aboutihs/>
2. Khetpal V, Roosevelt J Jr, Adashi EY. A Federal Indian Health Insurance Plan: Fulfilling a solemn obligation to American Indians and Alaska Natives in the United States. *Prev Med Rep.* 2021;25:101669. Published 2021 Dec 16. doi:10.1016/j.pmedr.2021.101669
3. 42CFR136.61
4. Rosenberg M. Information on ThirdParty Collections and Processes to Procure Supplies and Services. *United States Government Accountability Office.* Published online March 2022. <https://www.gao.gov/assets/720/719433.pdf>
5. IHS Profile. *Indian Health Service.* Published online August 2020. <https://www.ihs.gov/newsroom/factsheets/ihsprofile/>
6. Managed Care. *Centers for Medicare and Medicaid Services.* Published online 2022. <https://www.medicare.gov/medicaid/managed-care/index.html>
7. Hinton E, Stolyar L. 10 Things to Know About Medicaid Managed Care. *KFF.* <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicare-managed-care/>. Published February 23, 2022.
8. Medicaid Managed Care Listening Session. *National Indian Health Board.* Published online March 4, 2021. https://www.nihb.org/tribalhealthreform/wp-content/uploads/2021/03/Medicaid-Managed-Care-Listening-Session_March-4.pdf
9. Farb J. Facilities Reported Expanding Services Following Increases in Health Insurance Coverage and Collections. *United States Government Accountability Office.* Published online September 2019. <https://www.gao.gov/assets/gao-19-612.pdf>

RELEVANT AMA AND AMA-MSS POLICY

Indian Health Service H-350.977

The policy of the AMA is to support efforts in Congress to enable the Indian Health Service to meet its obligation to bring American Indian health up to the general population level. The AMA specifically recommends: (1) Indian Population: (a) In current education programs, and in the

expansion of educational activities suggested below, special consideration be given to involving the American Indian and Alaska native population in training for the various health professions, in the expectation that such professionals, if provided with adequate professional resources, facilities, and income, will be more likely to serve the tribal areas permanently; (b) Exploration with American Indian leaders of the possibility of increased numbers of nonfederal American Indian health centers, under tribal sponsorship, to expand the American Indian role in its own health care; (c) Increased involvement of private practitioners and facilities in American Indian care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

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

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

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

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

CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, 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 non reservation American Indians in an effort to improve their quality of life.

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

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

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

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

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

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

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

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

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

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.

Transforming Medicaid and Long-Term Care and Improving Access for the Uninsured H-290.982

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients; (2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible. (3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches; (4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs; (5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care; (6) urges states to administer their Medicaid and SCHIP programs through a single state agency; (7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs; (8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children; (9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;

- (10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;
 - (11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;
 - (12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;
 - (13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;
 - (14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;
 - (15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;
 - (16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;
 - (17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
 - (18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and
 - (19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.
- BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmation: A-22; Reaffirmed: CMS Rep. 3, A-22

Monitoring Medicaid Managed Care H-290.985

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

Medicaid Waivers for Managed Care Demonstration Projects H-290.987

- (1) Our AMA adopts the position that the Secretary of Health and Human Services should determine as a condition for granting waivers for demonstration projects under Section 1115(a) of the Medicaid Act that the proposed project: (i) assist in promoting the Medicaid Act's objective of improving access to quality medical care, (ii) has been preceded by a fair and open process for receiving public comment on the program, (iii) is properly funded, (iv) has sufficient provider reimbursement levels to secure adequate access to providers, (v) does not include provisions designed to coerce physicians and other providers into participation, such as those that link participation in private health plans with participation in Medicaid, and (vi) maintains adequate funding for graduate medical education.
- (2) Our AMA advocates that CMS establish a procedure which state Medicaid agencies can implement to monitor managed care plans to ensure that (a) they are aware of their responsibilities under EPSDT, (b) they inform patients of entitlement to these services, and (c) they institute internal review mechanisms to ensure that

children have access to medically necessary services not specified in the plan's benefit package.

BOT Rep. 24, A-95; Reaffirmation A-99; Reaffirmation A-00; Reaffirmation I-04; Modified: CMS Rep. 1, A-14

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 007
(I-22)

Introduced by: Andrew Alexander, Texas A&M College of Medicine; Matthew Swanson, Frank H Netter MD School of Medicine at Quinnipiac University; Nina Singh, NYU Grossman School of Medicine; Paul Suhwan Lee, University of Rochester MD; Sarah Holzmman, California Health Sciences University

Subject: Increased Health Privacy on Mobile Apps in Light of Roe v. Wade

Sponsored by: American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, In June 2022, the U.S. Supreme Court ruling in Dobbs v. Jackson Women's Health Organization overturned previous precedent regarding abortion access established by both Roe v. Wade and Planned Parenthood v. Casey, meaning that patients receiving abortions and physicians providing abortions may now be prosecuted by some states for this treatment even in the case of medical necessity¹; and

Whereas, mHealth apps are defined as mobile wireless technologies for public health, which have been shown to increase access to health information, services and skills, as well as promote positive changes in health behaviors to prevent the onset of acute and chronic diseases²; and

Whereas, Many mobile apps and devices, including period-tracking apps, are not covered entities under the Health Insurance Portability and Accountability Act (HIPAA), allowing the entities owning them to sell health information and personally identifiable information to third-parties^{3,4}; and

Whereas, Information, such as location data, IP addresses, and fingerprint or face identification can be acquired by apps and used to identify an individual or their activities, which could be used for prosecution of abortion or discrimination of protected groups⁵⁻⁸; and

Whereas, Companies such as Kochava and Weight Watchers have attempted to collect and/or sell the personally identifiable information of at least 125 million people, including children as young as age 8^{5,9}; and

Whereas, Companies such as Flo Health have sold information from period tracking apps to third parties, like marketing companies, Facebook, and Google, without permission from their users¹⁰; and

Whereas, A 2021 review of 20,911 apps in the medical, health, and fitness categories in the Google play store found that 28% offered no privacy policies and 88% included code that could potentially collect user data¹¹; and

Whereas, A woman in Nebraska was prosecuted for having an abortion by using information obtained from Facebook via warrant as evidence that she had an abortion, indicating that information collected by mobile apps can be and already has been used to prosecute those receiving abortions¹²; and

Whereas, Companies selling user data have offered heatmaps and other information identifying specific individuals who go to abortion clinics, and sometimes offer this data for free, providing a way to obtain data usable to prosecute those receiving abortions without a need for a warrant^{5,13}; and

Whereas, The Federal Trade Commission (FTC) has recently filed a complaint against a company selling location information that would allow for the identification of individuals receiving an abortion, indicating that the federal government believes that the prosecution of abortions via sold data is indeed a real possibility and danger^{5,14}; and

Whereas, States such as Texas allow for an individual to sue another for receiving an abortion, leading to both a monetary incentive and a tool via data selling to target those receiving abortions¹⁵; and

Whereas, The FTC is currently hindered in its enforcement capabilities by an inability to force penalties for first-time offenses of the FTC Act, therefore incentivizing companies to sell sensitive health information or personally-identifying information without repercussion^{14,16}; and

Whereas, This sale of information could also be used to identify and possibly prosecute healthcare providers who provide abortions even in medically necessary scenarios¹³; and

Whereas, There is a risk that software used for workplace monitoring could lead to sensitive health information like pregnancy being disclosed through a company mandating its employees use monitoring software on their personal computers, allowing for them to view sensitive health information on employee computers or watch employees as they work¹⁶; and

Whereas, AMA policy H-480.943 calls for increased privacy, security, and patient education surrounding the use of mobile health applications, but does not consider these actions regarding mobile applications that are not health-related; and

Whereas, Although D-315.968 seeks to enact the AMA Privacy Principles when it comes to legislation regarding health apps and tools, it does not cover these principles with regards to non-health software explicitly mentioned by these principles, such as non-health apps that can track location, nor does it or any other policy seek to act on the AMA Privacy Principles in any form besides legislative action; and

Whereas, The passage of D-315.968 in A-22 indicates that similar policy must be created to fulfill enactment of the AMA Privacy Principles; therefore be it

RESOLVED, That AMA policy H-480.943 be amended by addition and deletion as follows:

Integration Addressing of Mobile Health Applications and Devices Into Practice H-480.943

1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers

that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.

2. Our AMA supports that mobile mHealth-apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical and/or personally identifying information.

3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mobile mHealth-apps, and how their information and data can potentially be collected and used, including period-tracking apps that could be used to identify pregnancies.

4. Our AMA encourages the mobile mHealth-app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information and/or personally identifying information.

5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mobile mHealth-app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.

6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mobile mHealth-apps that ~~he or she~~ they prescribes, or recommends, or discuss with patients and ~~document the patient's understanding of such risks~~.

7. Our AMA supports further development of research and evidence regarding the impact that mobile mHealth-apps have on quality, costs, patient safety and patient privacy.

8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mobile mHealth apps and associated devices into care delivery.

RESOLVED, That AMA policy D-315.968 be amended by addition as follows:

Supporting Improvement to Patient Data Privacy D-315.968

Our AMA will strengthen patient and physician data privacy protections by advocating for legislation that reflects the AMA's Privacy Principles with particular focus on mobile health apps and other digital health tools, in addition to non-health apps and software capable of generating patient data.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. *Dobbs v. Jackson Women's Health Organization*
2. MHealth: Use of Mobile Wireless Technologies for Public Health. https://apps.who.int/gb/ebwha/pdf_files/EB139/B139_8-en.pdf.
3. Banerjee S, Hemphill T, Longstreet P. Wearable devices and healthcare: Data Sharing and Privacy. *The Information Society*. 2017;34(1):49-57. doi:10.1080/01972243.2017.1391912
4. Belfort R, Bernstein WS, Dworkowitz A, Pawlak B, Yi P. June 2020 a shared responsibility - ehealth initiative. EHIDC. <https://www.ehdc.org/sites/default/files/resources/files/RWJFConsumerHealth.pdf>. Published June 2020. Accessed March 16, 2022.
5. FTC Sues Kochava for Selling Data that Tracks People at Reproductive Health Clinics, Places of Worship, and Other Sensitive Locations. Federal Trade Commission. Published August 29, 2022. Accessed September 1, 2022. <https://www.ftc.gov/news-events/news/press-releases/2022/08/ftc-sues-kochava-selling-data-tracks-people-reproductive-health-clinics-places-worship-other>
6. Staff the PNO, Staff DPI and CTO. Cohen K, et al. Location, health, and other sensitive information: FTC committed to fully enforcing the law against illegal use and sharing of highly sensitive data. Federal Trade Commission. <https://www.ftc.gov/business-guidance/blog/2022/07/location-health-and-other-sensitive-information-ftc-committed-fully-enforcing-law-against-illegal>. Published September 6, 2022.
7. FTC Explores Rules Cracking Down on Commercial Surveillance and Lax Data Security Practices. Federal Trade Commission. Published August 10, 2022. Accessed September 1, 2022. <https://www.ftc.gov/news-events/news/press-releases/2022/08/ftc-explores-rules-cracking-down-commercial-surveillance-lax-data-security-practices>
8. Washington D, Slaughter R. *UNITED STATES of AMERICA Federal Trade Commission Regarding the Commercial Surveillance and Data Security Advance Notice of Proposed Rulemaking.*; 2022. Accessed September 1, 2022. https://www.ftc.gov/system/files/ftc_gov/pdf/RKS%20ANPR%20Statement%2008112022.pdf
9. Staff the PNO, Staff DPI and CTO. FTC takes action against company formerly known as Weight Watchers for illegally collecting kids' sensitive health data. Federal Trade Commission. <https://www.ftc.gov/news-events/news/press-releases/2022/03/ftc-takes-action-against-company-formerly-known-weight-watchers-illegally-collecting-kids-sensitive>. Published March 17, 2022.
10. Staff the PNO, Staff DPI and CTO. FTC finalizes order with Flo Health, a fertility-tracking app that shared sensitive health data with Facebook, Google, and others. Federal Trade Commission. <https://www.ftc.gov/news-events/news/press-releases/2021/06/ftc-finalizes-order-flo-health-fertility-tracking-app-shared-sensitive-health-data-facebook-google>. Published June 22, 2021.
11. Tangari G, Ikram M, Ijaz K, Kaafar MA, Berkovsky S. Mobile Health and Privacy: Cross Sectional Study. *The BMJ*. <https://www.bmj.com/content/373/bmj.n1248>. Published June 17, 2021.
12. Kaste M. Nebraska cops used facebook messages to investigate an alleged illegal abortion. NPR. <https://www.npr.org/2022/08/12/1117092169/nebraska-cops-used-facebook-messages-to-investigate-an-alleged-illegal-abortion>. Published August 12, 2022.

13. Location Data Firm Provides Heat Maps of Where Abortion Clinic Visitors Live. <https://www.vice.com/en/article/g5qaq3/location-data-firm-heat-maps-planned-parenthood-abortion-clinics-placer-ai>.
14. FTC v Kochava, Inc. Federal Trade Commission. Published August 29, 2022. Accessed September 1, 2022. <https://www.ftc.gov/legal-library/browse/cases-proceedings/ftc-v-kochava-inc>
15. Texas Legislature Online. Texas Senate Bill 8. Accessed October 28, 2021. <https://capitol.texas.gov/tlodocs/87R/billtext/pdf/SB00008H.pdf>
16. Washington D. *UNITED STATES of AMERICA Federal Trade Commission Statement of Chair Lina M. Khan Regarding the Commercial Surveillance and Data Security Advance Notice of Proposed Rulemaking Commission File No. R111004.*; 2022. Accessed September 1, 2022. https://www.ftc.gov/system/files/ftc_gov/pdf/Statement%20of%20Chair%20Lina%20M.%20Khan%20on%20Commercial%20Surveillance%20ANPR%2008112022.pdf

RELEVANT AMA AND AMA-MSS POLICY

Supporting Improvements to Patient Data Privacy D-315.968

Our AMA will strengthen patient data privacy protections by advocating for legislation that reflects the AMA's Privacy Principles with particular focus on mobile health apps and other digital health tools.

Res. 227, A-22

Integration of Mobile Health Applications and Devices into Practice H-480.943

1. Our AMA supports the establishment of coverage, payment and financial incentive mechanisms to support the use of mobile health applications (mHealth apps) and associated devices, trackers and sensors by patients, physicians and other providers that: (a) support the establishment or continuation of a valid patient-physician relationship; (b) have a high-quality clinical evidence base to support their use in order to ensure mHealth app safety and effectiveness; (c) follow evidence-based practice guidelines, especially those developed and produced by national medical specialty societies and based on systematic reviews, to ensure patient safety, quality of care and positive health outcomes; (d) support care delivery that is patient-centered, promotes care coordination and facilitates team-based communication; (e) support data portability and interoperability in order to promote care coordination through medical home and accountable care models; (f) abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services facilitated by the app; (g) require that physicians and other health practitioners delivering services through the app be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board; and (h) ensure that the delivery of any services via the app be consistent with state scope of practice laws.
2. Our AMA supports that mHealth apps and associated devices, trackers and sensors must abide by applicable laws addressing the privacy and security of patients' medical information.
3. Our AMA encourages the mobile app industry and other relevant stakeholders to conduct industry-wide outreach and provide necessary educational materials to patients to promote increased awareness of the varying levels of privacy and security of their information and data afforded by mHealth apps, and how their information and data can potentially be collected and used.
4. Our AMA encourages the mHealth app community to work with the AMA, national medical specialty societies, and other interested physician groups to develop app transparency

principles, including the provision of a standard privacy notice to patients if apps collect, store and/or transmit protected health information.

5. Our AMA encourages physicians to consult with qualified legal counsel if unsure of whether an mHealth app meets Health Insurance Portability and Accountability Act standards and also inquire about any applicable state privacy and security laws.

6. Our AMA encourages physicians to alert patients to the potential privacy and security risks of any mHealth apps that he or she prescribes or recommends, and document the patient's understanding of such risks

7. Our AMA supports further development of research and evidence regarding the impact that mHealth apps have on quality, costs, patient safety and patient privacy.

8. Our AMA encourages national medical specialty societies to develop guidelines for the integration of mHealth apps and associated devices into care delivery.

CMS Rep. 06, I-16; Reaffirmation: A-17

Police, Payer, and Government Access to Patient Health Information H-315.975

(1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define "health care operations" narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.

(2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.

(3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.

(4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.

(5) Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.

Res. 246, A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, I-06;

Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07; Reaffirmed: BOT Rep. 22, A-17;

Reaffirmed: BOT Rep. 16, I-21

Patient Privacy and Confidentiality H-315.983

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:

(a) That there exists a basic right of patients to privacy of their medical information and records,

and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received.

2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.

3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.

4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.

5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.

6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.

7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.

8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.

10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.

11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures

12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.

13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.

14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.

15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.

16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.

17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.

18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.

20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

BOT Rep. 9, A-98; Reaffirmation I-98; Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99; Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99; Reaffirmation A-00; Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01; Reaffirmed: BOT Rep. 19, I-01; Appended: Res. 524, A-02; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: BOT Rep. 24, I-04;

Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07;
 Reaffirmed: CEJA Rep. 6, A-11; Reaffirmed in lieu of Res. 705, A-1; 2Reaffirmed: BOT Rep. 17,
 A-13; Modified: Res. 2, I-14; Reaffirmation: A-17; Modified: BOT Rep. 16, A-18; Appended: Res.
 232, A-18; Reaffirmation: I-18; Reaffirmed: Res. 219, A-21; Reaffirmed: Res. 229, A-21;
 Reaffirmed: BOT Rep. 12, I-21; Reaffirmed: BOT Rep. 22, A-22

Supporting HIPAA Coverage of Patients Mobile Health Data 480.026MSS

Our AMA-MSS supports HIPAA or HIPAA-like requirements for all mobile health applications and wearable health technology such that data collected by these applications and devices is afforded the same privacy protections as standard medical records.

MSS Res. 039, Nov. 2020

Promoting Internet-Based Electronic Health Records and Personal Health Records 160.016MSS

AMA-MSS will ask the AMA to (1) advocate for the integration of provider and hospital electronic health records (EHRs) with Internet-based personal health records (PHRs) as an option for patients; and (2) advocate as a priority for all Internet-based PHRs to be fully HIPAA-compliant. MSS Res 15, A-10; AMA Res 809, I-10 Referred; Reaffirmed: MSS GC Rep A, I-14; Reaffirmed: MSS GC Rep A, I-19

Ethical Parameters for Recommending Mobile Medical Applications 140.029MSS

AMA-MSS ask the AMA to examine the issues related to physicians recommending medical software and apps to patients, especially those in which the physician has a vested interest, and to make recommendations as to how to conduct these interactions ethically. MSS Res 13, A-15; AMA Res 002, I-15 Reaffirmation; Reaffirmed: MSS GC Rep B, A-21

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 008
(I-22)

Introduced by: Aarti Patel, Chayton Fivecoat, Sara Kazyak, Pragathi Pathanjeli, Jovan Jande, Cole Sabinash, Leane Kuo, Wayne State University School of Medicine

Subject: Supporting Legislative and Regulatory Efforts against Fertility Fraud

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Illicit insemination, or fertility fraud, is defined as the failure on the part of a fertility doctor to obtain consent from a patient before inseminating her with his own sperm normally in the context of patients using assisted reproductive technology¹; and

Whereas, The results of a 1987 survey conducted showed that as many of 2% of fertility doctors polled had used their own sperm to inseminate their patients²; and

Whereas, Over the past several years, more than 50 fertility doctors in the United States have been accused of fertility fraud and nearly all of the physicians who have been accused were discovered as a result of DNA tests taken by their offspring³; and

Whereas, Physicians' inseminations of nonconsenting and unaware patients represent a gross trespass against all standards of modern practice⁴; and

Whereas, Engaging in illicit insemination exploits patients' ignorance of circumstance, trust, intense desire to conceive, and vulnerability and breaches other ethical obligations, including the duty to disclose all relevant medical information to patients and to deal honestly with them, robbing them of their decision-making autonomy⁴; and

Whereas, Former patients of these physicians speak of feeling violated and assaulted, their personal dignity and bodily integrity trampled, their family plans routed, and their trust broken⁵; and

Whereas, Illicit insemination is a violation of the ethical principle of respecting individual autonomy to make an informed decision regarding the nature of one's health⁵; and

Whereas, Illicit insemination is a violation of the ethical principle and physicians' responsibility to truth-telling^{5,6}; and

Whereas, These ethical, medical, and psychological issues patients and their children face as a result of physician actions directly contradicts the medical ethics principle of nonmaleficence⁷; and

Whereas, Only four states specifically penalize physicians for inseminating their own sperm into patients without express consent and there are no federal penalties^{2,8}; and

Whereas, In Texas, Senate Bill 1259 classified illicit insemination as a form of sexual assault⁹; and

Whereas, Indiana lawmakers introduced Senate Bill 174, making it legal for victims of fertility fraud to pursue legal action against physicians who commit acts of fertility fraud¹⁰; and

Whereas, Arizona lawmakers approved Senate Bill 1237 in 2021, giving victims and children conceived from illicit insemination the opportunity to pursue civil damages against the physician committing fertility fraud¹¹; and

Whereas, Utah House Bill 192 states that healthcare providers may not knowingly use their own gametes during assisted reproductive treatment without the patient's written consent, otherwise punishable as a third degree felony¹²; and

Whereas, A lack of laws regarding illicit insemination in the majority of states requires people and families affected to seek legal action through application of existing criminal laws, such as those written for criminal deception, sexual battery, or rape, which do not fully apply to or encompass the actions conducted^{5,13}; and

Whereas, The use of applicable criminal laws that were written without consideration for illicit insemination may result in relevant cases being a poor fit for existing law, expiring past the statutes of limitation, or lacking evidence due to temporal constraints^{5,13}; and

Whereas, The rise of consumer genetic testing is growing in popularity with estimates of 26 million testing kits bought in 2019 and an annual growth rate of 12.25%^{14,15}; and

Whereas, Hundreds of people who have been fathered by non-consensual insemination have discovered this information through consumer genetic testing^{16,17}; and

Whereas, A number of countries already have legislation that restrict the number of conceptions by an individual sperm donor in order to prevent unintentional consanguinity⁷; and

Whereas, The American Society of Reproductive Medicine recommends restricting conceptions by individual donors to 25 births per population of 800,000 to avoid unintentional consanguinity⁷; and

Whereas, Without measures to prevent illicit insemination by physicians, increased risk of consanguinity in communities can pose a significant threat to public health and lead to medical, psychological and ethical issues patients and their children must face¹⁸; therefore be it

RESOLVED, Our AMA acknowledges and opposes physicians using their own sperm to artificially inseminate patients without proper explicit and informed patient consent, otherwise known as illicit insemination or fertility fraud; and be it further

RESOLVED, Our AMA supports legislative and regulatory efforts to protect patients from physicians and healthcare practitioners who inseminate their own sperm into patients without their consent.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Fox D, Cohen IG, Adashi EY. Fertility Fraud, Legal Firsts, and Medical Ethics. *Obstetrics & Gynecology*. 2019;134(5):918-920. doi:10.1097/aog.0000000000003516
2. Eibschultz SR. "Dr., I Don't Want Your Baby!": Why America Needs a Fertility Patient Protection Act. *Iowa Law Review*. Published 2021. Accessed August 26, 2022. <https://ilr.law.uiowa.edu/print/volume-106-issue-2/dr-i-dont-want-your-baby-why-america-needs-a-fertility-patient-protection-act/#:~:text=Currently%20only%20four%20states%E2%80%9494Colorado,medical%20board%20in%20each%20state>
3. Mroz J. When an Ancestry Search Reveals Fertility Fraud. *The New York Times*. <https://www.nytimes.com/2022/02/28/health/fertility-doctors-fraud-rochester.html>. Published February 28, 2022. Accessed August 26, 2022.
4. Madeira J, Lindheim SR, Sauer MV. Against seminal principles: ethics, hubris, and lessons to learn from illicit inseminations. *Fertility and Sterility*. 2018;110(6):1003-1005. doi:10.1016/j.fertnstert.2018.08.028
5. Madeira J. *Understanding Illicit Insemination and Fertility Fraud from Patient Understanding Illicit Insemination and Fertility Fraud from Patient Experience to Legal Reform Experience to Legal Reform*. <https://www.repository.law.indiana.edu/cgi/viewcontent.cgi?article=3903&context=facpub>
6. American Medical Association. AMA Principles of Medical Ethics; 2016. <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/principles-of-medical-ethics.pdf>
7. Varkey B. Principles of Clinical Ethics and Their Application to Practice. *Med Princ Pract*. 2021;30(1):17-28. doi:10.1159/000509119
8. Zhang S. The Atlantic. The Atlantic. Published May 7, 2019. Accessed August 26, 2022. <https://www.theatlantic.com/science/archive/2019/05/cline-fertility-fraud-law/588877/>
9. Texas SB1259 | 2019-2020 | 86th Legislature. LegiScan. Published 2019. Accessed August 26, 2022. <https://legiscan.com/TX/bill/SB1259/2019>
10. SB174 | Indiana 2019 | Fertility fraud and deception. | TrackBill. Trackbill.com. Published 2019. Accessed August 26, 2022. <https://trackbill.com/bill/indiana-senate-bill-174-fertility-fraud-and-deception/1613859/>
11. *SENATE BILL 1237 an ACT AMENDING TITLE 12, CHAPTER 5.1, ARTICLE 1, ARIZONA REVISED STATUTES, by ADDING SECTION 12-567; RELATING to HEALTH CARE ACTIONS*. Accessed August 26, 2022. <https://www.azleg.gov/legtext/55Leg/1R/laws/0126.pdf>
12. HB0192. Utah.gov. Published 2022. Accessed August 26, 2022. <https://le.utah.gov/~2021/bills/static/HB0192.html>
13. Madeira J. *Uncommon Misconceptions: Holding Physicians Accountable for Insemination Fraud*. <https://scholarship.law.umn.edu/lawineq/vol37/iss1/6>
14. Regalado A. More than 26 million people have taken an at-home ancestry test. MIT Technology Review. Published February 11, 2019. Accessed August 26, 2022. <https://www.technologyreview.com/2019/02/11/103446/more-than-26-million-people-have-taken-an-at-home-ancestry-test/>
15. Research and Markets. World Consumer DNA (Genetic) Testing Market Report 2021. GlobeNewswire News Room. Published June 28, 2021. Accessed August 26, 2022. <https://www.globenewswire.com/en/news-release/2021/06/28/2253793/28124/en/World-Consumer-DNA-Genetic-Testing-Market-Report-2021.html>

16. Madeira JL. Baby Not on Board: How Can Children Born Through Illicit Insemination Get Justice? Bill of Health. Published January 22, 2019. Accessed August 26, 2022. <https://blog.petrieflom.law.harvard.edu/2019/01/22/baby-not-on-board-must-children-born-through-illicit-insemination-be-barred-from-recovery/#:~:text=In%20recent%20%E2%80%9Cillicit%20insemination%E2%80%9D%20lawsuits,patients%27%20profound%20and%20intimate%20trust>
17. DeVore B. Our Father Trailer: Netflix Doc Promises to Make Your Blood Boil. Collider. Published April 14, 2022. Accessed August 26, 2022. <https://collider.com/our-father-trailer-netflix-documentary-doctor-cline-scandal/>
18. Nelson MK, Hertz R, Kramer W. Gamete donor anonymity and limits on numbers of offspring: the views of three stakeholders. *Journal of Law and the Biosciences*. 2015;3(1):39-67. doi:10.1093/jlb/lsv045

RELEVANT AMA AND AMA-MSS POLICY

E-4.2.1 Assisted Reproductive Technology

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

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

Physicians should increase their awareness of infertility treatments and options for their patients. Physicians who offer assisted reproductive services should:

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

AMA Principles of Medical Ethics: I,V,VII

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

E-4.2.3 Therapeutic Donor Insemination

Therapeutic donor insemination using sperm from a woman's partner or a third-party donor can enable a woman or couple who might not otherwise be able to do so to fulfill the important life choice of becoming a parent (or parents).

However, the procedure also raises ethical considerations about safety for the woman and potential offspring, donor privacy, and the disposition of frozen semen, as well as the use of screening to select the sex of a resulting embryo.

Physicians who choose to provide artificial insemination should:

- (a) Provide therapeutic donor insemination in a nondiscriminatory manner. Physicians should not withhold or refuse services on the basis of nonclinical considerations, such as a patient's marital status.
- (b) Obtain informed consent for therapeutic donor insemination, after informing the patient (and partner, if appropriate):
 - (i) about the risks, benefits, likelihood of success, and costs of the intervention;
 - (ii) about the need to screen donated semen for infectious disease agents and genetic disorders when an individual proposes to donate sperm specifically for the patient's use in therapeutic donor insemination;
 - (iii) about the need to address in advance what will be done with frozen sperm (if any) from a known donor in the event the donor dies;
 - (iv) that state law will govern the status, obligations, and rights of the sperm donor, known or anonymous, in relation to a resulting child.
- (c) When sperm is collected specifically for use by an identified patient, obtain informed consent from the prospective donor, after informing the individual:
 - (i) about the need to test donated semen for infectious disease agents and genetic disorders;
 - (ii) whether and how the donor will be informed in the event the semen tests positive for infectious disease or genetic disorder;
 - (iii) that state law will govern the status, obligations, and rights of the donor in relation to a resulting child.
- (d) Counsel patients who choose to be inseminated with sperm from an anonymous donor to involve their partner (if any) in the decision.
- (e) Provide sex selection of sperm only for purposes of avoiding a sex-linked inheritable disorder. Physicians should not participate in sex selection of sperm for reasons of gender preference.

AMA Principles of Medical Ethics: I,V

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law. Issued: 2016

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 009
(I-22)

Introduced by: Anand Singh, Amanda Block, Anne Burnett Marion School of Medicine at Texas Christian University; Jenna Gage, University of Texas Medical Branch; Ida Vaziri, University of Texas Health San Antonio - Long School of Medicine; Courtney McCorkle, University of Oklahoma School of Community Medicine; Natasha Topolski, Sairandri Sathyanarayanan, McGovern Medical School at UTHealth; Olivia Marquardt, University of Cincinnati College of Medicine; Samantha Pavlock, Florida State University College of Medicine

Subject: New Policies to Respond to the Gun Violence Public Health Crisis

Sponsored by: Region 1, Region 3, Region 5

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Gun violence is a major public health crisis in the United States with the Centers for Disease Control and Prevention (CDC) most recently reporting 45,222 gun-related deaths in 2020—a 14% increase from 2019, and the most on record at the time and¹⁻³; and

Whereas, The CDC reported that gun-related injuries were one of the five leading causes of death for people aged 1 to 44 in the U.S. in 2020³⁻⁴; and

Whereas, A May 2022 letter in *The New England Journal of Medicine* based on 2020 CDC data suggests that gun-related injuries have surpassed motor vehicle crashes to now become the leading cause of death for children and young adults aged 1 to 19³⁻⁴; and

Whereas, According to 2020 CDC data, over 40% of gun-related deaths were homicides (19,384 deaths, or 79% of all homicides) and over 50% of gun deaths were suicides (24,292 deaths, or 53% of all suicides), accounting for 124 deaths a day³; and

Whereas, The Gun Violence Archive, an independent data research group that tracks gun-related incidents and defines a mass shooting using a statistical threshold as an event where four or more people are shot, reported 692 mass shootings in 2021 and 610 in 2020⁵⁻⁶; and

Whereas, The Gun Violence Archive reported that 246 mass shootings took place in the first five months of 2022⁶; and

Whereas, On May 24, 2022, 21 children and teachers were killed and 18 injured at Robb Elementary School in Uvalde, Texas, the second deadliest school shooting on record, ten years after 26 students and educators were killed in the Sandy Hook Elementary shooting⁷; and

Whereas, On June 1, 2022, two physicians, a patient, and another healthcare worker were killed and several injured in a mass shooting at the St. Francis Hospital in Tulsa, Oklahoma⁸; and

Whereas, Advocacy to address the gun violence public health crisis is crucial to support the AMA's goals of promoting racial justice and health equity, as CDC data shows that Black, American Indian and Alaska Native, and Hispanic people are disproportionately affected by gun homicides compared to white individuals⁹; and

Whereas, Multiple countries, including the United Kingdom, New Zealand, Norway, and Australia, quickly introduced and have adopted successful national legislation to ban semi-automatic and automatic weapons after just a single mass shooting¹⁰; and

Whereas, Approximately 20-25% of all handguns recovered at crime scenes were originally purchased as part of a multiple sale, which is the purchase of more than one gun within 5 business days¹¹; and

Whereas, Handguns sold in multiple sales are up to 64% more likely to be used in crime scenes than handguns sold individually¹²; and

Whereas, Many jurisdictions do not require background checks for the purchase of ammunition; however, research predicts that background checks for ammunition purchases would cut gun-related death rates by 81%¹³; and

Whereas, States have different firearm inheritance laws where it may be easier in some states for individuals to obtain a firearm, such as some states require the firearm to be registered while other states don't require a permit to own a firearm¹⁴⁻¹⁵; and

Whereas, Community firearm violence interventions work with community stakeholders to provide support and intervention to those at highest risk for being a victim and/or perpetrator of violence and have demonstrated success as cost-effective investments to prevent gun injuries, trauma, and deaths¹⁶⁻²⁹; and

Whereas, Hospital-based violence intervention programs are multidisciplinary programs that identify patients at risk of repeat violent injury and connect them with resources aimed at addressing underlying risk factors for violence³⁰; and

Whereas, Hospital-based Violence Intervention Programs have been shown to be a cost-effective way to reduce violence³¹⁻³⁶; and

Whereas, In 2020, our AMA announced a partnership with West Side United to invest \$6 million in community infrastructure programs in Chicago's west side neighborhoods to address issues relating to health inequities and economic vitality based on community needs, including affordable housing, access to healthy foods, financing local business projects, and supporting job creation efforts and educational programs³⁷; and

Whereas, In the wake of the Pulse Orlando mass shooting in 2016, our AMA declared gun violence as a public health crisis "requiring a comprehensive public health response and solution" yet the number of gun deaths have only continued to rise (D-145.995)³⁸; and

Whereas, Our AMA has adopted numerous policies to reduce gun trauma, injury and death, including H-145.996, H-145.975, H-145.997, D-145.996, H-145.983, H-145.978, H-145.984, H-145.979, H-145.985, H-145.990, H-145.992, H-145.993, H-145.999, H-515.971, and 145.001MSS, but as this crisis continues to escalate, further advocacy is needed; therefore be it

1 RESOLVED, That our AMA support evidence-based community firearm violence interruption
2 programs and hospital-based violence interruption programs; and be it further

3
4 RESOLVED, That our AMA support the institution of evidence-based policies on gun
5 inheritance, the limitation on purchases through multiple sales, and the implementation of
6 background checks for ammunition purchase.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Gramlich J. What the data says about gun deaths in the U.S. Pew Research Center. <https://www.pewresearch.org/fact-tank/2022/02/03/what-the-data-says-about-gun-deaths-in-the-u-s>. Published May 16, 2022. Accessed June 5, 2022.
2. Kegler SR, Simon TR, Zwald ML, et al. *Vital Signs*: Changes in firearm homicide and suicide rates — United States, 2019–2020. *MMWR Morb Mortal Wkly Rep*. 2022;71:656–663. <http://dx.doi.org/10.15585/mmwr.mm7119e1>. Accessed June 6, 2022.
3. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Fast Facts: Firearm Violence Prevention. [cdc.gov](https://www.cdc.gov/violenceprevention/firearms/fastfact.htm). Updated May 4, 2022. Accessed June 6, 2022. <https://www.cdc.gov/violenceprevention/firearms/fastfact.htm>.
4. Goldstick JE, Cunningham RM, Carter PM. Current Causes of Death in Children and Adolescents in the United States. *N Engl J Med*. 2022;386(20):1955-1956. doi:10.1056/NEJMc2201761
5. General Methodology. Gun Violence Archive. Updated June 23, 2021. Accessed June 6, 2022. <https://www.gunviolencearchive.org/methodology>.
6. Gun violence archive. Gun Violence Archive. <https://www.gunviolencearchive.org/>. Published September 21, 2022. Accessed September 21, 2022.
7. Sanchez R. 'We're in trouble.' 80 minutes of horror at Robb Elementary School. *CNN*. Updated May 29, 2022. Accessed June 6, 2022. <https://www.cnn.com/2022/05/29/us/uvalde-texas-elementary-school-shooting-week/index.html>.
8. Hanna J, Watts A. Gunman who killed 4 at Oklahoma medical building had been a patient of a victim, police chief says. *CNN*. Updated June 2, 2022. Accessed June 6, 2022. <https://www.cnn.com/2022/06/02/us/tulsa-hospital-shooting-thursday/index.html>.
9. *QuickStats*: Age-Adjusted Rates of Firearm-Related Homicide, by Race, Hispanic Origin, and Sex — National Vital Statistics System, United States, 2019. *MMWR Morb Mortal Wkly Rep*. 2021;70:1491. <http://dx.doi.org/10.15585/mmwr.mm7042a6>. Accessed June 6, 2022.
10. Barry E. These countries restricted guns after 1 mass shooting. *TIME*. May 27, 2022. Accessed May 27, 2022. <https://time.com/6182186/countries-banned-guns-mass-shooting>.
11. Christopher S. Koper, "Crime Gun Risk Factors: Buyer, Seller, Firearm, and Transaction Characteristics Associated with Gun Trafficking and Criminal Gun Use," National Institute of Justice, 2007, <https://www.ncjrs.gov/pdffiles1/nij/grants/221074.pdf>
12. Bulk gun purchases. Giffords. <https://giffords.org/lawcenter/gun-laws/policy-areas/crime-guns/bulk-gun-purchases/>. Published September 23, 2020. Accessed August 20, 2022.
13. Kalesan B, Mobily M, Keiser O, Fagan J, Galea S. Firearm legislation and firearm mortality in the USA: a cross-sectional, state-level study. *The Lancet*. [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(15\)01026-0/fulltext#articleInformation](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)01026-0/fulltext#articleInformation). Published March 10, 2016. Accessed August 20, 2022.

14. Library TSL. Guides: Gun laws: Gifts & inheritance. Gifts & Inheritance - Gun Laws - Guides at Texas State Law Library. <https://guides.sll.texas.gov/gun-laws/gifts-inheritance>. Accessed September 21, 2022.
15. Can Your Beneficiary Receive the Gun? Romano & Sumner. <https://romanosumner.com/blog/beneficiary-receive-gun/>. Accessed September 21, 2022.
16. EFSGV. The Educational Fund to Stop Gun Violence. <https://efsgv.org/>. Published February 17, 2022. Accessed September 21, 2022.
17. Sierra-Arevalo M, Charette Y, Papachristos AV. Evaluating the effect of project longevity on group-involved shootings and homicides in New Haven, Connecticut. *Crime & Delinquency*. 2016;63(4):446-467. doi:10.1177/0011128716635197
18. Branas CC, Kondo MC, Murphy SM, South EC, Polsky D, MacDonald JM. Urban Blight Remediation as a Cost-Beneficial Solution to Firearm Violence. *Am J Public Health*. 2016;106(12):2158-2164. doi:10.2105/AJPH.2016.303434
19. Skogan WG, Hartnett SM, Bump N, Dubois J. Evaluation of CeaseFire-Chicago. Northwestern University report to the National Institute of Justice. March 2008. <https://www.ojp.gov/pdffiles1/nij/grants/227181.pdf>
20. Henry DB, Knoblauch S, Sigurvinsdottir R. The Effect of Intensive CeaseFire Intervention on Crime in Four Chicago Police Beats: Quantitative Assessment. University of Chicago report to the McCormick Foundation, September 2014. https://cvg.org/wp-content/uploads/2019/09/McCormick_CreaseFire_Quantitative_Report_091114.pdf
21. Delgado SA, Alsabahi L, Wolff K, Alexander N, Cobar P, Butts JA. Evaluation of Cure Violence in the South Bronx and East New York, Brooklyn. Research and Evaluation Center, John Jay School of Criminal Justice, City University of New York. October 2017. <https://johnjayrec.nyc/2017/10/02/cvinsobronxeastny/>
22. Butts JA, Wolff KT, Misshula E, Delgado SA. Effectiveness of the Cure Violence Model in New York City. John Jay School of Criminal Justice, City University of New York. CUNY Academic Works. 2015. https://academicworks.cuny.edu/cgi/viewcontent.cgi?article=1472&context=jj_pubs
23. Picard-Fritsche S, Cerniglia L. Testing a Public Health Approach to Gun Violence: An Evaluation of Crown Heights Save Our Streets, a Replication of the Cure Violence Model. NCJ Number 241019. Center for Court Innovation report to the Bureau of Justice Assistance, USDOJ. 2013. <https://www.ojp.gov/ncjrs/virtual-library/abstracts/testing-public-health-approach-gun-violence-evaluation-crown>
24. Roman CG, Klein H, Wolff KT, Bellamy MD, Reeves K. Philadelphia CeaseFire: Findings from the Impact Evaluation. Temple University, January 2017. https://cvg.org/wp-content/uploads/2020/03/SummaryofPhilaCeaseFireFindingsFormatted_Jan2017.pdf
25. Investing in Intervention. <https://giffords.org/wp-content/uploads/2018/02/Investing-in-Intervention-02.14.18.pdf>. Published December 18, 2017. Accessed June 7, 2022.
26. Bonne SL, Violano P, Duncan TK, et al. Prevention of firearm violence through specific types of community-based programming: An Eastern Association for the Surgery of Trauma evidence-based review. *Ann Surg*. 2021;274(2):298-305. doi: 10.1097/SLA.0000000000004837. Accessed June 6, 2022.
27. Sichel CE, Javdani S, Shaw S, Liggett R. A role for social media? A community-based response to guns, gangs, and violence online. *J Community Psychol*. 2021;49(3):822-837. doi: 10.1002/jcop.22369. Accessed June 6, 2022.
28. Rosenblatt MS, Joseph KT, Dechert T, et al. American Association for the Surgery of Trauma Prevention Committee topical update: Impact of community violence exposure, intimate partner violence, hospital-based violence intervention, building community

- coalitions and injury prevention program evaluation. *J Trauma Acute Care Surg.* 2019;87(2):456-462. doi: 10.1097/TA.0000000000002313. Accessed June 6, 2022.
29. Zavala C, Buggs SA, Fischer KR. States should use Medicaid to support violence intervention efforts. *J Trauma Acute Care Surg.* 2022;92(2):e25-e27. doi: 10.1097/TA.0000000000003471. Accessed June 6, 2022.
 30. What is an HVIP? The HAVI. <https://www.thehavi.org/what-is-an-hvip>. Accessed September 21, 2022.
 31. President JCV, Cusick J, President V, et al. Hospital-based intervention programs reduce violence and save money. Center for American Progress. <https://www.americanprogress.org/article/hospital-based-intervention-programs-reduce-violence-and-save-money/>. Published June 15, 2022. Accessed September 21, 2022.
 32. Aboutanos MB, Altonen M, Vincent A, Broering B, Maher K, Thomson ND. Critical call for hospital-based domestic violence intervention: The Davis Challenge. *J Trauma Acute Care Surg.* 2019;87(5):1197-1204. doi:10.1097/TA.0000000000002450
 33. Juillard C, Cooperman L, Allen I, et al. A decade of hospital-based violence intervention: Benefits and shortcomings. *J Trauma Acute Care Surg.* 2016;81(6):1156-1161. doi:10.1097/TA.0000000000001261
 34. Bell TM, Gilyan D, Moore BA, et al. Long-term evaluation of a hospital-based violence intervention program using a regional health information exchange. *J Trauma Acute Care Surg.* 2018;84(1):175-182. doi:10.1097/TA.0000000000001671
 35. Smith R, Dobbins S, Evans A, Balhotra K, Dicker RA. Hospital-based violence intervention: risk reduction resources that are essential for success. *J Trauma Acute Care Surg.* 2013;74(4):976-982. doi:10.1097/TA.0b013e31828586c9
 36. Juillard C, Smith R, Anaya N, Garcia A, Kahn JG, Dicker RA. Saving lives and saving money: hospital-based violence intervention is cost-effective. *J Trauma Acute Care Surg.* 2015;78(2):252-258. doi:10.1097/TA.0000000000000527
 37. American Medical Association. AMA, West Side United invest \$6M to close health gaps in Chicago. Published Feb 26, 2020. Accessed June 6, 2022. <https://www.ama-assn.org/press-center/press-releases/ama-west-side-united-invest-6m-close-health-gaps-chicago>.
 38. AMA calls gun violence "a public health crisis." American Medical Association. Published June 14, 2016. Accessed May 27, 2022. <https://www.ama-assn.org/press-center/press-releases/ama-calls-gun-violence-public-health-crisis>.

RELEVANT AMA AND AMA-MSS POLICY

Gun Violence as a Public Health Crisis D-145.995

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

Res. 1011, A-16; Reaffirmation: A-18; Reaffirmation: I-18

Preventing Firearm-Related Injury and Morbidity in Youth D-145.996

Our American Medical Association will identify and support the distribution of firearm safety materials that are appropriate for the clinical setting.

Res. 216, A-15

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

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

Res. 410, A-13

Epidemiology of Firearm Injuries D-145.999

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; 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.

Res. 424, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13; Reaffirmation: A-18

Physician Involvement in State Regulations of Motor Vehicle Operation and/or Firearm Use by Individuals with Cognitive Deficits Due to Traumatic Brain Surgery H-10.960

Our AMA encourages the National Institutes of Health and other funders to expand research on cognitive impairment, including traumatic brain injury (TBI), as a risk factor for harm to self or others that may impact driving and/or firearm ownership, and the role of the physicians in policy advocacy and counseling patients so as to decrease the risk of morbidity and mortality.

CSAPH Rep. 3, I-21

Less-Lethal Weapons and Crowd Control H-145.969

Our AMA: (1) supports prohibiting the use of rubber bullets, including rubber or plastic-coated metal bullets and those with composites of metal and plastic, by law enforcement for the purposes of crowd control and management in the United States; (2) supports prohibiting the use of chemical irritants and kinetic impact projectiles to control crowds that do not pose an immediate threat; (3) recommends that law enforcement agencies have in place specific guidelines, rigorous training, and an accountability system, including the collection and reporting of data on injuries, for the use of kinetic impact projectiles and chemical irritants; (4) encourages guidelines on the use of kinetic impact projectiles and chemical irritants to include considerations such as the proximity of non-violent individuals and bystanders; for kinetic impact projectiles, a safe shooting distance and avoidance of vital organs (head, neck, chest, and abdomen), and for all less-lethal weapons, the issuance of a warning followed by sufficient time for compliance with the order prior to discharge; (5) recommends that law enforcement personnel use appropriate de-escalation techniques to minimize the risk of violence in crowd control and provide transparency about less-lethal weapons in use and the criteria for their use; and (6) encourages relevant stakeholders including, but not limited to manufacturers and government agencies to develop and test crowd-control techniques which pose a more limited risk of physical harm.

BOT Rep. 10, A-21; Reaffirmed: BOT Rep. 2, I-21

Violence Prevention H-145.970

Our AMA: (1) encourages the enactment of state laws requiring the reporting of all classes of prohibited individuals, as defined by state and federal law, to the National Instant Criminal Background Check System (NICS); (2) supports federal funding to provide grants to states to improve NICS reporting; and (3) encourages states to automate the reporting of relevant information to NICS to improve the quality and timeliness of the data.

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

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

Our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations and/or best practices for

media coverage of mass shootings, including informed discussion of the limited data on the relationship between mental illness and gun violence, recognizing the potential for exacerbating stigma against individuals with mental illness.

Res. 212, I-18; Modified: Res. 934, I-19

Firearms and High-Risk Individuals H-145.972

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. CSAPH Rep. 04, A-18; Reaffirmed: BOT Rep. 11, I-18; Reaffirmed: CSAPH Rep. 3, I-21

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

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

Res. 214, I-16

Increasing Toy Gun Safety H-145.974

Our American Medical Association (1) encourages toy gun manufacturers to take further steps beyond the addition of an orange tip on the gun to reduce the similarity of toy guns with real guns, and (2) encourages parents to increase their awareness of toy gun ownership risks.

Res. 406, A-15

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

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance

use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

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

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

1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

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

Use of Conducted Electrical Devices by Law Enforcement Agencies H-145.977

Our AMA: (1) recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) that is modeled after available national guidelines; (2) encourages additional independent research involving actual field deployment of CEDs to better understand the risks and benefits under conditions of actual use. Federal, state, and local agencies should accurately report and analyze the parameters of CED use in field applications; and (3) policy is that law enforcement departments and agencies have a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to CEDs.

CSAPH Rep. 6, A-09 Modified: Res. 501, A-14

Gun Safety H-145.978

Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed. 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.

Res. 425, I-98; Reaffirmed: Res. 409, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13

Prevention of Unintentional Shooting Deaths Among Children H-145.979

Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.

Res. 204, I-98 Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: CSAPH Rep. 01, A-19

Prevention of Ocular Injuries from BB and Air Guns H-145.982

The AMA encourages businesses that sell BB and air guns to make appropriate and safe protective eye wear available and encourages its use to their customers and to distribute educational materials on the safe use of non-powder guns.

Res. 416, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16

School Violence H-145.983

Our AMA: (1) encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property; (2) advocates for schools to remain gun-free zones except for school-sanctioned activities and professional law enforcement officers; and (3) opposes requirements or incentives of teachers to carry weapons.

Sub. Res. 402, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15;

Appended: Res. 402, A-18

Data on Firearm Deaths and Injuries H-145.984

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

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

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.
- 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

AMA Campaign to Reduce Firearm Deaths H-145.988

The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.

Res. 410, A-93; Reaffirmed: CLRPD Rep. 5, A-03; Reaffirmation A-13; Modified: CSAPH Rep. 1, A-13

Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns H-145.989

It is the policy of the AMA to encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the safe use of as well as the dangers inherent in the unsafe use of nonpowder (gas-loaded/spring-loaded) guns.

Res. 423, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21

Prevention of Firearm Accidents in Children H-145.990

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; (2) encourages state medical societies to work with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.

Res. 165, I-89; Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

Waiting Periods for Firearm Purchases H-145.991

The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country.

Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 401, A-17; Reaffirmation: A-18; Reaffirmation: I-18

Waiting Period Before Gun Purchase H-145.992

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

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

Restriction of Assault Weapons H-145.993

Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon and ban the sale and ownership to the public of all assault-type weapons, bump stocks and related devices, high capacity magazines and armor piercing bullets.

Sub. Res. 264, A-89; Reaffirmed: BOT Rep. 50, I-93; Amended: Res. 215, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17; Modified: Res. 433, A-18; Reaffirmation: A-18

Control of Non-Detectable Firearms H-145.994

Our AMA supports a ban on the (1) manufacture, importation, and sale of any firearm which cannot be detected by ordinary airport screening devices, including 3D printed firearms and (2) production and distribution of 3D firearm digital blueprints.

Sub. Res. 79, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CSAPH Rep. 01, A-18; Modified: BOT Rep. 11, I-18

Ban Realistic Toy Guns H-145.995

The AMA supports (1) working with civic groups and other interested parties to ban the production, sale, and distribution of realistic toy guns; and (2) taking a public stand on banning realistic toy guns by various public appeal methods.

Sub. Res. 140, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Firearm Availability H-145.996

1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as "red-flag" laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and "red-flag" laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

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

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

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

Therefore, the AMA:

- (A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
- (B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
- (C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
- (D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
- (E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
- (F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
- (G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

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

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

Gun Regulation H-145.999

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

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

Guns in Hospitals H-215.977

1. The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention:

- A. Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted.
- B. The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs.
- C. Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve

security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.

D. Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included.

E. Policies should undergo periodic reassessment and evaluation.

F. Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.

2. Our AMA will advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present BOT Rep. 23, I-94; Reaffirmation I-03; Reaffirmed: CSA Rep. 6, A-04; Reaffirmed: CSAPH Rep. 2, I-10; Appended: Res. 426, A-16

Addressing Adverse Effects of Active Shooter Drills on Children's Health 60.036MSS

Our AMA-MSS will ask our AMA to support that all school systems conduct evidence-based active shooter drills in a trauma-informed manner that (a) is cognizant of children's physical and mental wellness; (b) considers prior experiences that might affect children's response to a simulation; (c) avoids creating additional traumatic experiences for children; and (d) provides support for students who may be adversely affected.

Our AMA-MSS will ask our AMA to work with relevant stakeholders to raise awareness of ways to conduct active shooter drills that are safe for children and age appropriate.

(MSS Res. 053, Nov. 2020)

Handgun Violence 145.001MSS

The AMA-MSS recognizes that handgun violence and accidents represent a significant public health hazard, and supports the following methods of addressing this hazard:

(1) strict federal regulation of the manufacture, sale, importation, distribution, and licensing of handguns and their component parts, including a mandatory 7-day waiting period and police background check for all handgun purchases; (2) supports the taxation of handgun and handgun ammunition sales to be used to help cover medical bills for the victims of handgun violence and to fund public education on the prevention of violence; and (3) educational programs that can demonstrate a reduction in the deaths and injuries caused by handguns. (Reaffirmed: MSS GC Rep F, I-10) (Consolidated and Reaffirmed Multiple Policies: GC Rep C, I-12) (Reaffirmed: MSS GC Report A, I-17)

Prevention of Unintentional Firearm Accidents in Children 145.004MSS

AMA-MSS will ask the AMA to increase efforts to reduce pediatric firearm morbidity and mortality by encouraging its members: (1) to inquire as to the presence of household firearms as a part of childproofing the home; (2) to educate patients to the dangers of firearms to children; (3) to encourage patients to educate their children and neighbors as to the dangers of firearms; and (4) to routinely remind patients to obtain firearm safety locks and store firearms under lock and key; and that the AMA encourage state medical societies to work with other organizations to increase public education about firearm safety.

(AMA Amended Res 165, I-89 Adopted [H-145.990]) (Reaffirmed: MSS Rep D, I-99)

(Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I- 21)

Regulation of Handgun Safety and Quality 145.009MSS

AMA-MSS will ask the AMA to support legislation that seeks to apply the same quality and safety standards to domestically manufactured handguns that are currently applied to imported handguns. (MSS Amended Sub Res 22, I-97) (AMA Res 235, I-97 Adopted [H-145.985]) (Reaffirmed: MSS Rep B, I-02) (Reaffirmed: MSS Rep C, I-07) (Reaffirmed: MSS GC Report C, I- 12) (Reaffirmed: MSS GC Report A, I-17)

Gun Safety Counseling in Undergraduate Medical Education 145.011MSS

AMA-MSS will ask the AMA to (1) advocate for the inclusion of strategies for counseling patients on safe gun storage and use in undergraduate medical education; (2) add additional language to AMA Policy H-145.976 prohibiting limitations on the ability of medical students to discuss firearms with patients; and (3) advocate that the Association of American Medical Colleges, Agency for Health, Research and Quality, and other relevant professional medical societies develop gun safety counseling modules to be used in undergraduate medical education. (MSS Res 2, A-13) (AMA Res 903, I-13 Adopted with Change in Title [H-145.976]) (Reaffirmed: MSS GC Rep A, I-19)

Use of Individualized Violence Risk Assessments in Reporting of Mental Health Professionals for Firearm Background Checks 145.012MSS

AMA-MSS encourages mental health professionals to use individualized violence risk assessments, rather than categorical exclusion criteria, in reports to state or federal authorities for firearm background checks. (MSS Res 15, A-13) (Reaffirmed: MSS GC Rep A, I-19)

Strengthening our Gun Policies on Background Checks and the Mentally Ill 145.013MSS

AMA- MSS (1) supports strengthening of the National Instant Criminal Background Check System (NICS) and encourages states to mandate reporting patients with mental illnesses who pose a risk to themselves or others so that their gun licenses can be suspended and their firearms removed until they are deemed fit; (2) encourages the use of smart gun technology on all firearms so that only the lawful owner can discharge a weapon; and (3) supports universal background checks for people buying guns through any medium. (MSS Res 18, A-13) (Reaffirmed: MSS GC Rep A, I-19)

Preventing Fire-Arm Related Injury and Morbidity in Youth 145.014MSS

AMA-MSS will ask the AMA to collaborate with firearms owners and training organizations to develop and distribute firearm safety materials that are appropriate for the clinical setting. (MSS Res 30, I-14) (Reaffirmed: MSS GC Rep A, I-19)

Expansion of Federal Gun Restriction Laws to Include Dating Partners and Convicted Stalkers 145.015MSS

AMA-MSS supports legislation that would expand the current federal prohibitions on firearm purchases to include individuals subject to domestic violence restraining orders, convicted stalkers, and persons charged with domestic violence and intimate partner violence even if no legal relationship exists. (MSS Res 03, A-18)

Opposition to Armed Campuses 145.016MSS

AMA-MSS opposes an increase of firearms on school campuses. (MSS Res 16, A-18)

Increasing the Legal Age of Purchasing Ammunition and Firearms from 18 to 21

145.017MSS

AMA-MSS support bans on the possession, unsupervised use, and purchase of firearms and ammunition by youths under the age of 21.
(MSS Res 18, A-18)

Development and Implementation of guidelines for Responsible Media Coverage of Mass Shootings 145.018MSS

AMA-MSS will ask the AMA to encourage the Center for Disease Control, the National Institute of Mental Health, the Associated Press Managing Editors, the National Press Photographers Association, and other relevant organizations to develop guidelines for media coverage of mass shootings in a manner that is unlikely to provoke additional incidents.
(MSS Res 40, A-18)

Increasing Firearm Safety to Prevent Accidental Child Deaths 145.019MSS

AMA-MSS will ask the AMA to advocate for enactment of Child Access Prevention (CAP) Laws in all 50 states. (MSS Res 42, A-18)

Opposing Unregulated, Non-Commercial Firearm Manufacturing 145.020MSS

AMA-MSS will ask the AMA to (1) support legislation that opposes: a) unregulated, non-commercial firearm manufacturing, such as via 3-D printing, regardless of the material composition or detectability of such weapons; b) production and distribution of 3-D firearm blueprints; and (2) issue a statement of concern to Congress and the Bureau of Alcohol, Tobacco, Firearms and Explosives regarding the manufacturing of firearms using 3-D printers and the online dissemination of 3-D firearm blueprints as a public health issue.
(MSS Res 07, I-18, HOD I-18 Adopted)

Support for Warning Labels on Firearm Ammunition Packaging 145.021MSS

AMA-MSS will ask the AMA to support legislation requiring that packaging for any firearm ammunition produced in, sold in, or exported from the United States carry a legible, boxed warning that includes, at a minimum (a) text-based statistics and/or graphic picture-based warning labels related to the risks, harms, and mortality associated with firearm ownership and use, and (b) explicit recommendations that ammunition be stored securely and separately from firearms. (MSS Res. 49, I-19)

AMA Funding of Political Candidates who Oppose Research-Backed Firearm Regulations 145.022MSS

AMA-MSS will ask the AMA to amend policy G-640.020 as follows:

G-640.020 – Political Action Committees and Contributions

Our AMA: (1) Believes that better-informed and more active citizens will result in better legislators, better government, and better health care; (2) Encourages AMA members to participate personally in the campaign of their choice and strongly supports physician/family leadership in the campaign process; (3) Opposes legislative initiatives that improperly limit individual and collective participation in the democratic process; (4) Supports AMPAC's policy to adhere to a no Rigid Litmus Test policy in its assessment and support of political candidates; (5) Encourages AMPAC to consider the legislative agenda of our AMA and the recommendations of state medical PACs in its decisions; (6) Urges members of the House to reaffirm their commitment to the growth of AMPAC and the state medical PACs; (7) will continue to work through its constituent societies to achieve and 100 percent rate of contribution to AMPAC by members; and (8) Calls upon all candidates for public office to refuse contributions from tobacco companies and their

subsidiaries; and (9) Calls upon all candidates for public office to refuse contributions from any organization that opposes public health measures to reduce firearm violence.
(MSS Res. 61, I-19)

Amend H-145.976, to Reimburse Physicians for Firearm Counseling 145.023MSS

AMA-MSS will ask the AMA to amend Policy H-145.976, “Firearm Safety Counseling in Physician- Led Health Care Teams,” by addition as follows:

H-145.976 – FIREARM SAFETY COUNSELING IN PHYSICIAN-LED HEALTH CARE TEAMS

1. Our AMA: (a) will oppose any restrictions on physicians’ and other members of the physician-led health care team’s ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians’ and other members of the physician-led health care team’s discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm- related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

3. Our AMA will support the development of reimbursement structures that incentivize physicians to counsel patients on firearm-related injury risk and prevention.

(MSS Res. 30, I-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 010
(I-22)

Introduced by: Joely Hannan, University of Washington; Swathi Bhuma, Shruthi Bhuma, Chicago Medical School; Eshani Kishore, Paul L. Foster School of Medicine; Preston Wilson, Louisiana State University Health Shreveport; Braxton Howell, Christine Fasana, University of South Carolina School of Medicine Greenville; Olivia Marquardt, University of Cincinnati College of Medicine; Donald Bourne; University of Pittsburgh School of Medicine

Subject: Against Direct Contracting Entities

Sponsored by: Region 2, Region 3, Region 4, Region 5, Region 6, Association of Native American Medical Students, Asian Pacific American Medical Student Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Under the Trump administration, the Center for Medicare and Medicaid Innovation created a pilot project called Global and Professional Direct Contracting (GPDC) Model, which allowed designated for-profit healthcare entities, better known as Direct Contracting Entities (DCEs), to enter into a relationship with Medicare^{1,2}; and

Whereas, The Biden administration continued the project, changing the name to Accountable Care Organization Realizing Equity, Access, and Community Health (ACO-REACH) in response to concerns raised about for-profit entities in traditional Medicare²; and

Whereas, DCEs/ACO-REACH, scheduled to begin in January of 2023, would move seniors enrolled in Traditional Medicare into a for-profit insurance model without their consent by allowing CMS to automatically search two years of seniors' claims history — without their consent or knowledge — to find any visits with a participating DCE provider as the basis for aligning them with that DCE¹⁻³; and

Whereas, Searching patients' claim history is a violation of AMA policy (D-315.992) regarding patient privacy and moving seniors into a health plan they did not select is a violation of AMA policy (H-373.998) regarding patient choice; and

Whereas, DCEs/ACO-REACH are allowed to keep up to 40% of the dollars dedicated to patients in their care as profit, which exceeds the maximum medical loss ratio of 20% set by the Affordable Care Act (also known as the 80/20 rule), and therefore giving them a dangerous financial incentive to restrict seniors' care^{3,4}; and

Whereas, Medicare will reimburse DCEs/ACO-REACH at a higher rate for patients with more complex diagnoses, and as a result, create a strong incentive to engage in fraudulent “upcoding,” as demonstrated by Medicare Advantage plans^{1-3,5}; and

Whereas, Enrollees in Medicare Advantage plans (prior to the launch of DCEs/ACO-REACH, Medicare Advantage plans are the most similar insurance product in the market) generate 6%–16% higher diagnosis-based risk scores than they would under traditional fee-for-service Medicare and could increase Medicare spending by \$200 billion over ten years^{6,7}; and

Whereas, The federal government spent \$321 more per person for beneficiaries enrolled in Medicare Advantage plans (prior to the launch of DCEs/ACO-REACH, Medicare Advantage plans are the most similar insurance product in the market) than for those in traditional Medicare in 2019, a gap that amounted to \$7 billion in additional spending⁸; and

Whereas, Unlike Medicare Advantage, patients do not choose to enroll in DCEs/ACO-REACH, but are automatically enrolled if their primary care physician is in one, forcing patients to change their physician if they desire to withdraw from the model^{1,2}; and

Whereas, Physicians may not necessarily choose to be part of DCEs/ACO-REACH, but can find themselves in one if their group practice is acquired by another non-medical entity such as a private equity firm, and then find their patients having to choose between staying with them or leaving the DCEs/REACH^{1,2,4}; and

Whereas, Traditional Medicare limits the risk to the patient and burden on the physician by generally not requiring pre-approval for treatment and offering free choice of doctors and hospitals^{1,2}; and

Whereas, Traditional Medicare is beholden to taxpayers, for-profit health insurance companies have a fiduciary responsibility to maximize profit for its shareholders, which can be aided through narrow networks and denial of care, and Medicare Advantage (Prior to the launch of DCEs/ACO-REACH, Medicare Advantage can provide a comparison to Traditional Medicare) plans can deny coverage under more conditions and at a higher rate compared to Traditional Medicare^{6,9}; and

Whereas, Traditional Medicare outperforms Medicare Advantage (Prior to the launch of DCEs/ACO-REACH, Medicare Advantage can provide a comparison to Traditional Medicare) on measures such as post-acute care, quality of providers, and affordability for enrollees who are Black, under age 65 with disabilities, or in fair or poor health¹⁰; and

Whereas, Patient and physician choice is one of the highest priorities of the AMA (H-415.988, H-330.988); therefore be it

1 RESOLVED, That our AMA oppose any attempts to implement Direct Contracting Entities, such
 2 as Accountable Care Organization Realizing Equity, Access, and Community Health (ACO-
 3 REACH) program, and their relationship with Medicare; and be it further

4
 5 RESOLVED, That our AMA develop educational materials for physicians regarding Direct
 6 Contracting Entities, such as Accountable Care Organization Realizing Equity, Access, and
 7 Community Health (ACO-REACH) program so that they are aware of the implications of their
 8 individual or their employer's participation in this program; and be it further

9 RESOLVED, That this resolution be immediately forwarded to the AMA House of Delegates.

Fiscal Note: TBD

Date Received: 08/31/2022

References:

1. Global and Professional Direct Contracting (GPDC) Model (Center for Medicare and Medicaid Innovation, 2021). <https://innovation.cms.gov/innovation-models/gpdc-model>
2. Rogers, Susan. Medicare Direct Contracting: A Threat to Seniors and to Medicare's Future. Testimony before the: Senate Finance Committee Subcommittee on Fiscal Responsibility and Economic Growth. 2 Feb. 2022, https://pnhp.org/system/assets/uploads/2022/02/SusanRogersWrittenTestimony_SenateFinanceCommitteeFeb2022.pdf?eType=EmailBlastContent&eld=eabbed9f-2f13-406b-88f6-5dfd50209aab
3. RTI International. Global and Professional Direct Contracting Model Financial Operating Guide: Overview. 2021. <https://innovation.cms.gov/media/document/dc-financial-op-guide-overview>
3. Gilfillan, Richard, and Donald M. Berwick. "Medicare Advantage, Direct Contracting, And The Medicare 'Money Machine,' Part 1: The Risk-Score Game." *Health Affairs*, 29 Sept. 2021, <https://www.healthaffairs-org.pitt.idm.oclc.org/doi/10.1377/forefront.20210927.6239>
4. Gilfillan, Richard, and Donald M. Berwick. "Medicare Advantage, Direct Contracting, And The Medicare 'Money Machine,' Part 2: Building On The ACO Model." *Health Affairs*, 30 Sept. 2021, <https://www.healthaffairs-org.pitt.idm.oclc.org/doi/10.1377/forefront.20210928.795755>
5. Meyers, D. J., & Trivedi, A. N. (2021). Medicare Advantage chart reviews are associated with billions in additional payments for some plans. *Medical care*, 59(2), 96-100.
6. Geruso, M., & Layton, T. (2020). Upcoding: evidence from Medicare on squishy risk adjustment. *Journal of Political Economy*, 128(3), 984-1026.
7. Kronick, R. (2017). Projected coding intensity in Medicare Advantage could increase Medicare spending by \$200 billion over ten years. *Health Affairs*, 36(2), 320-327.
8. KFF. Published: Payments to Medicare Advantage plans boosted Medicare spending by \$7 billion in 2019. Published: Aug 17, 2021. Retrieved August 31, 2022, from <https://www.kff.org/medicare/press-release/payments-to-medicare-advantage-plans-boosted-medicare-spending-by-7-billion-in-2019/>
9. Schwartz, A. L., Chen, Y., Jagmin, C. L., Verbrugge, D. J., Brennan, T. A., Groeneveld, P. W., & Newhouse, J. P. (2022). Coverage Denials: Government And Private Insurer Policies For Medical Necessity In Medicare: Study examines medical necessity coverage denials in Medicare and private insurers. *Health Affairs*, 41(1), 120-128.

10. KFF. 2022. Beneficiary Experience, Affordability, Utilization, and Quality in Medicare Advantage and Traditional Medicare: A Review of the Literature. [online] Available at: <<https://www.kff.org/medicare/report/beneficiary-experience-affordability-utilization-and-quality-in-medicare-advantage-and-traditional-medicare-a-review-of-the-literature/>> [Accessed 22 September 2022].

RELEVANT AMA AND AMA-MSS POLICY

Health Insurance Market Regulation H-165.856

Our AMA supports the following principles for health insurance market regulation:

- (1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan;
- (2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection;
- (3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges;
- (4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium;
- (5) Insured individuals should be protected by guaranteed renewability;
- (6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices;
- (7) Guaranteed issue regulations should be rescinded;
- (8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.
- (9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage; and
- (10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically:
 - (a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed;
 - (b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and
 - (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.

CMS Rep. 7, A-03; Reaffirmed: CMS Rep. 6, A-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 2, I-07; Reaffirmed: BOT Rep. 7, A-09; Appended: Res. 129, A-09; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed in lieu of Res. 811, I-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed in lieu of Res. 125, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation: A-17; Reaffirmed: Res. 518, A-17; Reaffirmed: Res. 105, A-18; Reaffirmed: Joint CMS CSAPH Rep. 01, I-18

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.

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

Educating the American People About Health System Reform H-165.844

Our AMA reaffirms support of pluralism, freedom of enterprise, and strong opposition to a single payer system.

Res. 717, I-07; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19; Reaffirmed: CMS Rep. 2, A-22

Increasing Detection of Mental Illness and Encouraging Education D-345.994

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

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

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

Improving Physician Mental Health and Reducing Stigma through Revision of Medical Licensure Applications 345.007MSS

AMA-MSS aims to reduce stigmatization mental health issues in the medical community by (a) opposing state medical boards' practice of issuing licensing applications that equate seeking help for mental health issues with the existence of problems sufficient to create professional impairment and (b) opposing the breach in a physician's private health record confidentiality by requiring access to these records when an applicant reports treatment. MSS Res 17, I-13

Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools 345.009MSS

AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out

basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. MSS Res 15, I-15

Adequacy of Health Insurance Coverage Options H-165.846

1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:

A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.

B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.

C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.

D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.

2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.

3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.

CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09;

Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended:

CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12;

Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res.

101, A-19

Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.

B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.

C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding

(including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.

D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.

E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.

F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.

G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.

H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients
Res. 130, I-93; Res. 316, I-93Sub. 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

Opposition to Nationalized Health Care H-165.985

Our AMA reaffirms the following statement of principles as a positive articulation of the Association's opposition to socialized or nationalized health care:

(1) Free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations or promotion.

- (2) Freedom of patients to select and to change their physician or medical care plan, including those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services. (Reaffirmed: BOT Rep. I-93-25; Reaffirmed: CMS Rep. I-93-5)
 - (3) Full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.
 - (4) Freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, to participate or not participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service.
 - (5) Inclusion in all methods of medical care payment of mechanisms to foster increased cost awareness by both providers and recipients of service, which could include patient cost sharing in an amount which does not preclude access to needed care, deferral by physicians of a specified portion of fee income, and voluntary professionally directed peer review.
 - (6) The use of tax incentives to encourage provision of specified adequate benefits, including catastrophic expense protection, in health benefit plans.
 - (7) The expansion of adequate health insurance coverage to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing providers of uncompensated care, and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level.
 - (8) Development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately prefunded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family caregiving.
- BOT Rep. U, I-88; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: Sub. Res. 110, A-94;
Reaffirmed: CMS Rep. 7, I-97; Reaffirmed by CMS Rep. 9, A-98; Reaffirmed: CMS Rep. 4, A-99; Reaffirmation I-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08;
Reaffirmation A-09; Reaffirmed in lieu of Res. 112, A-09; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Modified: Speakers Rep., A-14; Reaffirmed: CMS Rep. 09, A-19

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 and substance use. 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

Nondiscrimination in Health Care Benefits H-185.986

Our AMA reaffirms its opposition to discriminatory benefit limitations, copayments or deductibles for the treatment of psychiatric illness under existing health care plans, and opposes discrimination in any proposed plans for national health care coverage or universal access for the people who are uninsured.

Res. 58, A-91; Reaffirmation A-97; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10;

Reaffirmed: CMS Rep. 01, A-20

Ending Medicare Advantage Auto-Enrollment H-285.905

Our AMA will work with the Centers for Medicare and Medicaid Services and/or Congress to end the procedure of "auto-enrollment" of individuals into Medicare Advantage Plans.

Res. 216, I-16; Reaffirmation: A-22

Medicare Advantage Policies H-285.913

Our AMA will: 1. pursue legislation requiring that any Medicare Advantage policy sold to a Medicare patient must include a seven-day waiting period that allows for cancellation without penalty;

2. pursue legislation to require that Medicare Advantage policies carry a separate distinct page, which the patient must sign, including the statement, "THIS COVERAGE IS NOT TRADITIONAL MEDICARE. YOU HAVE CHOSEN TO CANCEL YOUR TRADITIONAL MEDICARE COVERAGE; NOT ALL PHYSICIANS, HOSPITALS AND LABORATORIES ACCEPT THIS NEW MEDICARE ADVANTAGE POLICY AND YOU MAY PERMANENTLY LOSE THE ABILITY TO PURCHASE MEDIGAP SECONDARY INSURANCE" (or equivalent statement) and specifying the time period before they can resume their traditional Medicare coverage; and

3. petition the Centers for Medicare and Medicaid Services to implement the patient's signature page in a Medicare Advantage policy.

Res. 907, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmation: I-18

Patient Information and Choice H-373.998

Our AMA supports the following principles:

1. Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system.

2. Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.

3. In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees information on the amount of payment provided toward each type of service identified as a covered benefit.

4. Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements, and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs.

5. Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice.

6. Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront.

BOT Rep. QQ, I-91Reaffirmed: BOT Rep. TT, I-92Reaffirmed: Ref. Cmte. A, A-93Reaffirmed:

BOT Rep. UU, A-93Reaffirmed: CMS Rep. E, A-93Reaffirmed: CMS Rep. G, A-93Reaffirmed:

Sub. Res. 701, A-93Sub. Res. 125, A-93Reaffirmation A-93Reaffirmed: BOT Rep. 25, I-

93Reaffirmed: BOT Rep. 40, I-93Reaffirmed: CMS Rep. 5, I-93Reaffirmed: CMS Rep. 10, I-

93Reaffirmed: Sub. Res. 107, I-93Reaffirmed: BOT Rep. 46, A-94Reaffirmed: Sub. Res. 127, A-

94Reaffirmed: Sub. Res. 132, A-94Reaffirmed: BOT Rep. 16, I-94BOT Rep. 36 - I-

94Reaffirmed: CMS Rep. 8, A-95Reaffirmed: Sub. Res. 109, A-95Reaffirmed: Sub. Res. 125, A-

95Reaffirmed by Sub. Res. 107, I-95Reaffirmed: Sub. Res. 109, I-95Reaffirmed by Rules &

Credentials Cmt., A-96Reaffirmation A-96Reaffirmation I-96Reaffirmation A-97Reaffirmed:

Rules and Cred. Cmt., I-97Reaffirmed: CMS Rep. 3, I-97Reaffirmation I-98Reaffirmed: CMS

Rep. 9, A-98Reaffirmation A-99Reaffirmation A-00Reaffirmation I-00Reaffirmation A-

04Consolidated and Renumbered: CMS Rep. 7, I-05Reaffirmation A-07Reaffirmation A-

08Reaffirmed: CMS Rep. 4, A-09Reaffirmed: CMS Rep. 3, I-09Reaffirmation I-14Reaffirmed:

CMS Rep. 4, A-15Reaffirmation: A-17Reaffirmed: Res. 108, A-17Reaffirmation: A-19Reaffirmed

in lieu of: Res. 112, A-19

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.

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.

Res. 817, I-19; Modified: Res. 125, A-22

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.

Res. 707, I-98; Reaffirmed: BOT Rep. 23, A-09; Modified: CMS Rep. 01, A-19

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

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

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

Standardization of Advance Beneficiary Notification of Non-Coverage Forms for Medicare Advantage Plans and Original Fee-For-Service Medicare D-70.950

1. Our AMA will request the Centers for Medicare & Medicaid Services provide a standardized Advance Beneficiary Notice of Non-coverage (ABN) that will be sufficient notification to inform all Medicare Advantage Plan and Original (Fee-For-Service) Medicare beneficiaries when Medicare may deny payment for an item or service.

2. Our AMA will advocate that Medicare Advantage Plan requirements for carrier specific advance beneficiary notice of non-coverage and similar forms be eliminated.

Res. 109, A-14; Reaffirmation: I-18

Elimination of Subsidies to Medicare Advantage Plans D-390.967

1. Our AMA will seek to have all subsidies to private plans offering alternative coverage to Medicare beneficiaries eliminated, that these private Medicare plans compete with traditional Medicare fee-for-service plans on a financially neutral basis and have accountability to the Centers for Medicare and Medicaid Services.
 2. Our AMA will seek to prohibit all private plans offering coverage to Medicare beneficiaries from deeming any physician to be a participating physician without a signed contract specific to that product, and that our AMA work with CMS to prohibit all-products clauses from applying to Medicare Advantage plans and private fee-for-service plans.
- Res. 229, A-07; Modified: CMS Rep. 01, A-17

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930

Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.

BOT Action in response to referred for decision Res. 711, I-06Reaffirmation A-08Modified: CMS Rep. 01, A-19

Medicare Advantage Plans D-330.923

Our AMA encourages the Centers for Medicare & Medicaid Services to award Medicare Advantage Programs only to those health plans that meet all of the following criteria: (1) an 85% or higher medical loss ratio; (2) physician payment rates are no less than Medicare Fee for Service rates; and (3) use enforceable contracts that prohibit unilateral changes in physician payment rates.

Res. 837, I-08Reaffirmed: Res. 116, A-17Reaffirmation: I-18

Medicare Advantage Policies H-330.878

Our AMA supports that Medicare Advantage plans must provide enrollees with coverage for, at a minimum, all Part A and Part B original Medicare services, if the enrollee is entitled to benefits under both parts.

Res. 116, A-17Reaffirmation: I-18

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.

Res. 707, A-99Reaffirmed: CMS Rep. 5, A-09Modified: CMS Rep. 01, A-19

Medicare Advantage Step Therapy D-320.984

Our AMA will continue strong advocacy for the rejection of step therapy in Medicare Advantage plans and impede the implementation of the practice before it takes effect on January 1, 2019.

Res. 810, I-18Reaffirmation: A-22

Prior Authorization Relief in Medicare Advantage Plans H-320.938

Our AMA supports legislation and/or regulations that would apply the following processes and parameters to prior authorization (PA) for Medicaid and Medicaid managed care plans and Medicare Advantage plans:

- a. List services and prescription medications that require a PA on a website and ensure that patient informational materials include full disclosure of any PA requirements.
- b. Notify providers of any changes to PA requirements at least 45 days prior to change.
- c. Improve transparency by requiring plans to report on the scope of PA practices, including the list of services and prescription medications subject to PA and corresponding denial, delay, and approval rates.
- d. Standardize a PA request form.
- e. Minimize PA requirements as much as possible within each plan and eliminate the application of PA to services and prescription medications that are routinely approved.
- f. Pay for services and prescription medications for which PA has been approved unless fraudulently obtained.
- g. Allow continuation of medications already being administered or prescribed when a patient changes health plans, and only change such medications with the approval of the ordering physician.
- h. Make an easily accessible and responsive direct communication tool available to resolve disagreements between health plan and ordering provider.
- i. Define a consistent process for appeals and grievances, including to Medicaid and Medicaid managed care plans.

Res. 814, I-18Reaffirmation: A-22

Strengthening Medicare Through Competitive Bidding H-330.886

1. Our AMA supports the following principles to guide the use of competitive bidding among health insurers in the Medicare program:

- a. Eligible bidders should be subject to specific quality and financial requirements to ensure sufficient skill and capacity to provide services to beneficiaries.
- b. Bidding entities must be able to demonstrate the adequacy of their physician and provider networks.
- c. Bids must be based on a clearly defined set of standardized benefits that should include, at a minimum, all services provided under the traditional Medicare program and a cap on out-of-pocket expenses.
- d. Bids should be developed based on the cost of providing the minimum set of benefits to a standardized Medicare beneficiary within a given geographic region.

- e. Geographic regions should be defined to ensure adequate coverage and maximize competition for beneficiaries in a service area.
 - f. All contracting entities should be required to offer beneficiaries a plan that includes only the standardized benefit package. Expanded benefit options could also be offered for beneficiaries willing to pay higher premiums.
 - g. Processes and resources must be in place to provide beneficiary education and support for choosing among alternative plans.
2. Our AMA supports using a competitive bidding process to determine federal payments to Medicare Advantage plans.
- CMS Rep. 7, I-13

Managed Medicare Reimbursement H-330.928

The AMA advocates that Medicare managed care plans (e.g., Medicare Advantage, etc.) that use the RBRVS do so in a manner that maintains the relativity of the RBRVS utilized in the traditional Medicare program.

Sub. Res. 819, I-97Reaffirmation I-05Modified: CMS Rep. 1, A-15

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.

CMS Rep. 2, I-04Reaffirmation A-08Reaffirmed: CMS Rep. 01, A-18Reaffirmation: I-18

Evaluation of the Principles of the Health Care Access Resolution 165.009MSS

(1) AMA-MSS will amend the following MSS policies that pertain to universal health care access and coverage to read "affordable universal" care or coverage: MSS 165.004, MSS 165.007 and MSS 180.011; (2) AMA-MSS supports efforts to make health care more cost-effective by reducing administrative burdens, but only to such a degree that quality of care is not compromised; (3) AMA-MSS supports means of including both long-term care and prescription drug benefits into the guidelines for seeking affordable universal health care access and coverage; (4) AMA-MSS reaffirms its support for including preventative care and early intervention services into any plan calling for affordable universal health care access and coverage by reaffirming MSS 295.022 and MSS 170.001; (5) AMA-MSS reaffirms its support for parity in mental health care coverage by reaffirming MSS policy "Disparity of Mental Health Coverage"; (6) AMA-MSS encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality of health care; and that our AMA-MSS supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; (7) AMA-MSS will adopt policy to promote outcomes research as an effective mechanism to improve the quality of medical care for all persons and urge that the results of such research be used only for educational purposes and for improving practice parameters; (8) AMA-MSS will adopt policy to address the need to increase numbers of qualified health care professionals, practitioners, and providers in

underserved areas to increase timely access to quality care; (9) AMA-MSS supports the inclusion of adequate and timely payments to physicians and other providers into any plan calling for affordable universal health care access; (10) AMA-MSS reaffirms policies MSS 160.002 and MSS 160.004 that are related to the support of medical facilities for patients who are unable to afford medical care; (11) AMA-MSS reaffirms policies MSS 165.004, MSS 165.005 and MSS 165.006 and support the inclusion of the principles of continuity of health insurance coverage and continuity of medical care into any plan calling for affordable universal health care access; (12) AMA-MSS supports the inclusion of the principle of consumer choice of healthcare providers and practitioners into any plan calling for affordable universal health care access; (13) AMA-MSS supports the inclusion of reducing health care administrative cost and burden into any plan calling for affordable universal health care access. (MSS Rep C, A-04)

Maintaining Insurance Coverage and Empowering State Choice 165.015MSS

AMA-MSS (1) supports an individual mandate for health insurance coverage; and (2) supports proposals for state-choice in federal health insurance reform only if they maintain the standards of insurance quality and reach set forward under the 2010 Patients Protection and Affordable Care Act. (MSS Res 43, A-11)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 011
(I-22)

Introduced by: Alec Calac, Dhruv Puri, Meghana Pagadala, University of California San Diego School of Medicine; Kyle Lakatos, Julia Seiberling, University of California Riverside School of Medicine; Tamee Livermont, University of Minnesota Medical School-Duluth; Adrienne Nguyen, Des Moines University College of Osteopathic Medicine; Cole Howie, University of Arkansas Medical School; William Maher, University of Oklahoma College of Medicine; Rachel Donaldson, University of South Carolina School of Medicine Greenville; Brianna Baldwin, University of Virginia School of Medicine; Anna Klunk, Philadelphia College of Osteopathic Medicine; Krishna Channa, Nehal Lakdawala, University of Connecticut School of Medicine; Lala Forrest, Frank H. Netter MD School of Medicine

Subject: Tribal Health Program Electronic Health Record Modernization

Sponsored by: Region 1, Region 2, Region 4, Association of Native American Medical Students

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, The Indian Health Service (IHS), an agency within the United States Department of Health and Human Services, provides federal health care services to American Indians and Alaska Natives¹; and

Whereas, As of 2019, all 122 IHS facilities and more than 300 Tribes and Urban Indian (I/T/U) health facilities use the Resource and Patient Management System (RPMS), which handles everything from patient registration to insurance billing, including the electronic health record (EHR)^{2,3}; and

Whereas, Although the IHS regularly updates RPMS, it is built on outdated technology from 1985 that will become obsolete within the next decade, making new development more difficult each year⁴; and

Whereas, RPMS exists in a decentralized database system at IHS facilities across the country, making it difficult for patients to share their health information with new providers when they seek care at an outside facility⁴; and

Whereas, RPMS uses software code and features from the U.S. Department of Veterans Affairs (VA) "VistA" EHR system⁴; and

Whereas, In 2017, the VA made the decision to fully transition away from VistA to a commercial EHR by 2028 due to limited interoperability with other EHR products, known cybersecurity vulnerabilities, and costly maintenance⁴; and

Whereas, The IHS will stop receiving VA VistA updates making it more challenging and costly to update RPMS⁴; and

Whereas, In 2019, the U.S. Government Accountability Office listed RPMS as a critical federal legacy system in need of modernization, because its underlying code will be unsupportable in the next 5 to 10 years⁵; and

Whereas, In 2019, the IHS did not have a Congressional appropriation or proposed budget for health information technology (HIT) and electronic health record modernization⁵; and

Whereas, the VA serves 9 million patients per year and the IHS serves 2.2 million patients per year^{6,7}; and

Whereas, In fiscal year (FY) 2020, the VA received \$1.5 billion to modernize their EHR, while the IHS only received an appropriation of \$8 million to modernize their EHR⁸⁻⁹; and

Whereas, In FY21, the VA and IHS received an appropriation of \$2.6 billion and \$34.5 million to continue EHR modernization efforts, respectively, demonstrating a significant gap in federal health care expenditures per capita¹⁰⁻¹¹; and

Whereas, In 2021, after a period of Tribal consultations, the IHS announced the IHS Health Information Technology Modernization Program, through which they would fully replace RPMS at IHS facilities with commercially available solutions, with no estimated completion date due to funding challenges¹²; and

Whereas, Many Tribes and Urban Indian health facilities compact and contract with the IHS to assume full funding and control over all programs, services, and functions, and activities provided by the IHS¹³; and

Whereas, Non-IHS Tribal health facilities (79.4% of all I/T/U facilities) do not all use RPMS, minimizing their involvement in and potential benefit from any programs managed by and funds provided to the IHS for EHR modernization¹⁴; and

Whereas, A 2019 study of 21 Tribes in the Pacific Northwest found that over half used non-RPMS EHR and medical claims systems, and EHR modernization costs up to \$500,000 per Tribe with monthly maintenance costs up to \$3,000 per Tribe³; and

Whereas, The IHS National Tribal Budget Formulation Workgroup, representing all 12 IHS Service Areas, made FY23 funding recommendations for EHR modernization efforts ranging from \$282 million to \$1.76 billion¹⁶; therefore be it

RESOLVED, That our AMA supports adequate funding for electronic health record modernization and maintenance costs for Tribal and Urban Indian Health Programs with active self-governance compacts and contracts with the Indian Health Service; and be it finally

RESOLVED, That our AMA encourages per capita funding parity for electronic health record operations between the Indian Health Service and Veterans' Health Administration.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. About the Indian Health Service. U.S. Department of Health and Human Services. Accessed August 25, 2022. <https://www.ihs.gov/aboutihs/>
2. Habel, S. History of RPMS. Accessed September 21, 2022. http://smh101.com/articles/Hx_RPMS_final.html

3. Washington Tribes Electronic Health Record System Survey Results. *NPAIHB*. May 8, 2019. https://aihc-wa.com/wp-content/uploads/2019/05/NPAIHB-WA-EHR-Survey-Analysis_FINALDRAFT.pdf
4. The IHS Health Information Technology Modernization Program. U.S. Department of Health and Human Services. Accessed August 25, 2022. <https://www.ihs.gov/hit/>
5. Harris C. Agencies Need to Develop Modernization Plans for Critical Legacy Systems. *United States Government Accountability Office*. Published online June 2019. <https://www.gao.gov/assets/gao-19-471.pdf>
6. About VA. <https://www.va.gov/health/aboutVHA.asp>
7. About IHS. For Patients. <https://www.ihs.gov/forpatients/>
8. Cullen T, Demaree M, Elffer S. Closing The Health Disparity Gap For American Indians And Alaska Natives Through Health IT Modernization. *Health Affairs*. Published online January 27, 2020. <https://www.healthaffairs.org/doi/10.1377/forefront.20200122.299286/full/>
9. Smith W. COVID-19 in Indian Country: The Impact of Federal Broken Promises on Native Americans. *National Indian Health Board*. Published online July 17, 2020. <https://www.usccr.gov/files/2020/2020-07-17-William-Smith-Testimony.pdf>
10. NIHB Legislative and Policy Agenda. Published April 2022. <https://www.nihb.org/covid-19/wp-content/uploads/2022/04/2022-NIHB-Legislative-and-Policy-Agenda-.pdf>
11. VA Requests 2.6b in FY 2021. Health Data Management. <https://www.healthdatamanagement.com/articles/va-requests-2-6b-in-fy-2021-for-cerner-ehr-system>
12. Fowler E. Indian Health Service (IHS) Health Information Technology (HIT) Modernization initiative. U.S. Department of Health and Human Services. Published online April 2021. https://www.ihs.gov/sites/newsroom/themes/responsive2017/display_objects/documents/2021_Letters/DTLL_DUIOLL_04012021.pdf
13. Differences Between Title I Contracting and Title V Compacting Under the Indian Self-Determination Education Assistance Act (ISDEAA). U.S. Department of Health and Human Services. Accessed August 25, 2022. https://www.ihs.gov/sites/selfgovernance/themes/responsive2017/display_objects/documents/TitleIandV.pdf
14. Calac AJ, Hoss A. Vaccine Passports and Indian Country: Nothing Fast About It. *Public Health Rep*. 2022;137(4):637-642. doi:10.1177/00333549221094557
15. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2023NationalTribalBudgetFormulationWorkSessionMaterials.pdf

RELEVANT AMA AND AMA-MSS POLICY

Improving Health Care of American Indians H-350.976

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

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

(3) State and local governments give special attention to the health and health-related needs of 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.

LRPD 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 non federal 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

Principles for Hospital Sponsored Electronic Health Records D-478.973

1. Our AMA will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).

2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.

3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.

4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.

BOT Rep. 1, I-15; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 012
(I-22)

Introduced by: Nishanth Ganeshbabu, Kira Szulborski, Alessandra Zaccardelli, Tufts University School of Medicine

Subject: Amend Preventing Resident Physician Suicide 310.054MSS to Include Annual Opt-out Mental Health Screening for Suicide Prevention

Sponsored by: PsychSIGN

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Between 2000 and 2014, 66 resident physicians died by suicide - the second most prevalent cause of resident death in that time frame after neoplastic diseases¹; and

Whereas, Psychological autopsy studies of physicians show that psychiatric illnesses such as depression and substance abuse contribute to suicide among physicians^{2,3}; and

Whereas, Resident physicians presenting with depression or depressive symptoms may be as high as 43.2% with depressive symptoms increasing by 15.8% within a year of the onset of residency training, with 28% of resident physicians experiencing a major depressive episode during training⁴; and

Whereas, Medical interns have increased mean Patient Health Questionnaire (PHQ-9) depression scores from baseline through first year⁵, and residents demonstrate increased suicidal ideation of nearly 370% in the first three months of training⁵, as well as high rates of burnout signs⁶, which has independently been associated with increased risk for depression and suicide⁷; and

Whereas, Residency program directors tend to underestimate the rates of burnout among resident physicians as 43% of residents reported that the inability to take time off of work as a significant barrier to seeking help⁸; and

Whereas, Screening for burnout in gynecology residents found 89.8% demonstrated moderate burnout⁹, and depression screening in Otolaryngology-Head and Neck Surgery residents was demonstrated to be cost effective in identifying and treating mental health⁹; and

Whereas, Tools have been developed to evaluate physician burnout including the AMA sponsored Physician Well-Being Index (PWBI), which has been used to screen physicians, stratify by distress level, and identify individuals likely to benefit from individualized support¹⁰, and the American Foundation for Suicide Prevention (AFSP) Interactive Screening Program (ISP), a confidential, anonymous, web-based stress and depression questionnaire, and subsequent counselor meeting¹¹; and

Whereas, The University of California, San Diego, School of Medicine (UCSD) implemented AFSP's ISP, and in the first year found that of the 374 respondents, 101 respondents and 251 respondents had a high risk and moderate risk for suicide, respectively, of which less than 20% received treatment¹²; and

Whereas, UCSD implemented AFSP's ISP, and found that over the course of 7 years, 180 physicians and trainees at UCSD have accepted referrals for mental health care, with the majority saying they would not have done so on their own¹³; and

Whereas, Institutions that rely on self-referral to establish mental health care are likely to miss individuals in need as seen at Northwestern University, where 110 residents and fellows felt they would benefit from mental health care, but less than half sought medical treatment¹⁴; and

Whereas, Resident physicians face barriers to accessing mental health assessments including cost, time, stigma, and pervasive cultures of stoicism, even when mental health services are available and free, resulting in low utilization¹⁵; and

Whereas, Opt-out/auto-enrollment strategy refers to when "a preferred behavior occurs automatically but can be disregarded," contrary to opt-in/self-referral strategy where "active steps must be taken to perform a preferred behavior"¹⁶; and

Whereas, Opt-out strategy makes target behavior more likely by conveying a sense of normalcy¹⁸ and leveraging status-quo bias, "a preference for familiarity where people tend to resist change and prefer the current state of affairs"¹⁷; and

Whereas, Previous studies comparing opt-out versus opt-in methods showed opt-out strategies significantly increased participation across various domains, including COVID-19 surveillance testing (opt-out screening had 5.1% increased testing compared to opt-in)¹⁸, HIV testing (opt-out screening had 12% increased uptake compared to opt-in)¹⁹, and colorectal screening (opt-out screening had 19.5% increase screening than opt-in)²⁰; and

Whereas, Annual opt-out mental health screenings can mitigate cost, time, and stigma barriers by offering "access to a no-cost evaluation in the same location and contiguous with workday time slots where trainees will not have to sacrifice personal time and funds to obtain evaluation"²¹; and

Whereas, Opt-out mental health program implemented in West Virginia University (WVU) found that postgraduate year 1 (PGY-1) and PGY-2 resident physicians showed a 93% attendance in auto-enrolled wellness appointments, of which a majority mentioned they were "likely to return for future visits if they had concerns about depression, anxiety, and burnout"²²; and

Whereas, Opt-out mental health screening implemented in WVU used "wellness days" biannually where residents who participated were not required to come to work, were not required to use sick/personal/vacation days, and did not bear any personal cost²²; and

Whereas, Opt-out mental health screening implemented in WVU were scheduled 1 hour visits with a licensed therapist with experience with residents where all information obtained confidential (not shared with administration) and stored in a separate electronic health record system²²; and

Whereas, 85% of internal medicine and internal medicine-pediatrics residents participating in an opt-out mental health program at the University of Colorado (UC) agreed the program should continue in the future, with the majority of interns feeling that the program positively affected their wellness regardless of whether they attended the appointment²³; and

Whereas, Opt-out mental health screening implemented at UC provided “half-days” for interns where students could take off half of a clinic day to meet with an in-house mental health provider, or opt-out and still take off half of a clinic day²³; and

Whereas, Opt-out mental health screening implemented at UC was provided at no personal cost to the interns and all information obtained was kept confidential²³; and

Whereas, Policy 345.009MSS supports medical school creation of suicide prevention screening programs that would be available to all medical students on an opt-out basis and ensure anonymity, but a similar program does not exist for resident physicians; and

Whereas, The AMA endorses Policy 310.054MSS, but does not have existing provision to incorporate opt-out mental health screenings for resident physicians; therefore be it

RESOLVED, that AMA policy 310.054MSS, “Preventing Resident Physician Suicide,” be amended to include annual opt-out mental health awareness screening as a means to address resident physician suicide as follows:

Preventing Resident Physician Suicide, 310.054MSS:

Preventing Resident Physician Suicide: AMA-MSS (1) urges residency programs to include consideration of resident mental health and average daily workload in deciding work hours for residents; (2) encourages residency programs to create mental health resources available for all physicians in order to create a supportive environment aimed at reducing burnout; and (3) encourages residency programs to identify factors in their own programs that might negatively impact resident mental health and to address those identified factors to the best of their abilities; and (4) encourages residency programs to includes an annual opt-out mental health awareness screening for suicide prevention.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Yaghmour NA, Brigham TP, Richter T, et al. Causes of Death of Residents in ACGME-Accredited Programs 2000 Through 2014: Implications for the Learning Environment. *Acad Med*. 2017;92(7):976-983.
2. Dutheil F, Aubert C, Pereira B, et al. Suicide among physicians and health-care workers: A systematic review and meta-analysis. *PLoS One*. 2019;14(12):e0226361.
3. Menon NK, Shanafelt TD, Sinsky CA, et al. Association of Physician Burnout With Suicidal Ideation and Medical Errors. *JAMA Netw Open*. 2020;3(12):e2028780.
4. Mata DA, Ramos MA, Bansal N, et al. Prevalence of Depression and Depressive Symptoms Among Resident Physicians: A Systematic Review and Meta-analysis. *JAMA*. 2015;314(22):2373-2383.

5. Sen S, Kranzler HR, Krystal JH, et al. A prospective cohort study investigating factors associated with depression during medical internship. *Arch Gen Psychiatry*. 2010;67(6):557-565.
6. Dyrbye LN, West CP, Satele D, et al. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Acad Med*. 2014;89(3):443-451.
7. Shanafelt TD, Balch CM, Dyrbye L, et al. Special report: suicidal ideation among American surgeons. *Arch Surg*. 2011;146(1):54-62.
8. Holmes EG, Connolly A, Putnam KT, et al. Taking Care of Our Own: A Multispecialty Study of Resident and Program Director Perspectives on Contributors to Burnout and Potential Interventions. *Acad Psychiatry*. 2017;41(2):159-166.
9. Kligerman MP, Devine EE, Bentzley JP, Megwalu UC. Cost-Effectiveness of Depression Screening for Otolaryngology-Head and Neck Surgery Residents. *Laryngoscope*. 2021;131(3):502-508.
10. Dyrbye LN, Satele D, Sloan J, Shanafelt TD. Utility of a brief screening tool to identify physicians in distress. *J Gen Intern Med*. 2013;28(3):421-427.
11. Interactive Screening Program. American Foundation for Suicide Prevention <https://afsp.org/interactive-screening-program>. Published 2019. Accessed.
12. Moutier C, Norcross W, Jong P, et al. The suicide prevention and depression awareness program at the University of California, San Diego School of Medicine. *Acad Med*. 2012;87(3):320-326.
13. Moutier C. Creating a Safety Net: Preventing Physician Suicide AAMC. <https://www.aamc.org/news-insights/creating-safety-net-preventing-physician-suicide>. Published 2016. Accessed August 29, 2022, 2022.
14. Aaronson AL, Backes K, Agarwal G, Goldstein JL, Anzia J. Mental Health During Residency Training: Assessing the Barriers to Seeking Care. *Acad Psychiatry*. 2018;42(4):469-472.
15. Clough BA, March S, Chan RJ, Casey LM, Phillips R, Ireland MJ. Psychosocial interventions for managing occupational stress and burnout among medical doctors: a systematic review. *Syst Rev*. 2017;6(1):144.
16. Cho I, Bates DW. Behavioral Economics Interventions in Clinical Decision Support Systems. *Yearb Med Inform*. 2018;27(1):114-121.
17. Batra M, McPhillips H, Shugerman R. Improving Resident Use of Mental Health Resources: It's Time for an Opt-Out Strategy to Address Physician Burnout and Depression (Commentary). *J Grad Med Educ*. 2018;10(1):67-69.
18. Oakes AH, Epstein JA, Ganguly A, Park SH, Evans CN, Patel MS. Effect of Opt-In vs Opt-Out Framing on Enrollment in a COVID-19 Surveillance Testing Program: The COVID SAFE Randomized Clinical Trial. *JAMA Netw Open*. 2021;4(6):e2112434.
19. Soh QR, Oh LYJ, Chow EPF, Johnson CC, Jamil MS, Ong JJ. HIV Testing Uptake According to Opt-In, Opt-Out or Risk-Based Testing Approaches: a Systematic Review and Meta-Analysis. *Curr HIV/AIDS Rep*. 2022.
20. Mehta SJ, Khan T, Guerra C, et al. A Randomized Controlled Trial of Opt-in Versus Opt-Out Colorectal Cancer Screening Outreach. *Am J Gastroenterol*. 2018;113(12):1848-1854.
21. Shapiro P, Barishansky S. Safeguarding Trainee Health: A Call for an Annual Opt-Out Mental Health Screening. In. Vol 14: Am Psychiatric Assoc; 2019:6-6.
22. Sofka S, Grey C, Lerfald N, Davisson L, Howsare J. Implementing a Universal Well-Being Assessment to Mitigate Barriers to Resident Utilization of Mental Health Resources. *J Grad Med Educ*. 2018;10(1):63-66.

23. Major A, Williams JG, McGuire WC, Floyd E, Chacko K. Removing Barriers: A Confidential Opt-Out Mental Health Pilot Program for Internal Medicine Interns. *Acad Med.* 2021;96(5):686-689.

RELEVANT AMA AND AMA-MSS POLICY

Access to Confidential Health Services for Medical Students and Physicians H-295.858

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

research into identifying and addressing modifiable risk factors for burnout, depression and suicide across the continuum of medical education.

6. Our AMA encourages the development of alternative methods for dealing with the problems of student-physician mental health among medical schools, such as: (a) introduction to the concepts of physician impairment at orientation; (b) ongoing support groups, consisting of students and house staff in various stages of their education; (c) journal clubs; (d) fraternities; (e) support of the concepts of physical and mental well-being by heads of departments, as well as other faculty members; and/or (f) the opportunity for interested students and house staff to work with students who are having difficulty. Our AMA supports making these alternatives available to students at the earliest possible point in their medical education.

7. Our AMA will engage with the appropriate organizations to facilitate the development of educational resources and training related to suicide risk of patients, medical students, residents/fellows, practicing physicians, and other health care professionals, using an evidence-based multidisciplinary approach.

CME Rep. 01, I-16; Appended: Res. 301, A-17; Appended: Res. 303, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 312, A-18; Reaffirmed: BOT Rep. 15, A-19

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

Our AMA:

- (1) Recognizes youth and young adult suicide as a serious health concern in the US;
- (2) Encourages the development and dissemination of educational resources and tools for physicians, especially those more likely to encounter youth or young adult patients, addressing effective suicide prevention, including screening tools, methods to identify risk factors and acuity, safety planning, and appropriate follow-up care including treatment and linkages to appropriate counseling resources;
- (3) Supports collaboration with federal agencies, relevant state and specialty medical societies, schools, public health agencies, community organizations, and other stakeholders to enhance awareness of the increase in youth and young adult suicide and to promote protective factors, raise awareness of risk factors, support evidence-based prevention strategies and interventions, encourage awareness of community mental health resources, and improve care for youth and young adults at risk of suicide;
- (4) Encourages efforts to provide youth and young adults better and more equitable access to treatment and care for depression, substance use disorder, and other disorders that contribute to suicide risk;
- (5) Encourages continued research to better understand suicide risk and effective prevention efforts in youth and young adults, especially in higher risk sub-populations such as Black, LGBTQ+, Hispanic/Latinx, Indigenous/Native Alaskan youth and young adult populations, and among youth and young adults with disabilities;
- (6) Supports the development of novel technologies and therapeutics, along with improved utilization of existing medications to address acute suicidality and underlying risk factors in youth and young adults;
- (7) Supports research to identify evidence-based universal and targeted suicide prevention programs for implementation in middle schools and high schools;
- (8) Will publicly call attention to the escalating crisis in children and adolescent mental health in this country in the wake of the COVID-19 pandemic;
- (9) Will advocate at the state and national level for policies to prioritize children's mental, emotional and behavioral health;
- (10) Will advocate for a comprehensive system of care including prevention, management and crisis care to address mental and behavioral health needs for infants, children and adolescents; and

(11) Will advocate for a comprehensive approach to the child and adolescent mental and behavioral health crisis when such initiatives and opportunities are consistent with AMA policy. Res. 424, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Reaffirmed in lieu of: Res. 001, I-16; Appended: CSAPH Rep. 3, A-21; Appended - BOT Action in response to referred for decision: CSAPH Rep. 3, A-21

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

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

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

Suicide Prevention Program for Medical Students 295.058MSS

AMA-MSS will ask the AMA to encourage medical schools to adopt those suicide prevention programs demonstrated to be most effective. (AMA Amended Res 315, A-95 Adopted [H-345.984]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Preventing Resident Physician Suicide 310.054MSS

AMA-MSS (1) urges residency programs to include consideration of resident mental health and average daily workload in deciding work hours for residents; (2) encourages residency programs to create mental health resources available for all physicians in order to create an supportive environment aimed at reducing burnout; and (3) encourages residency programs to identify factors in their own programs that might negatively impact resident mental health and to address those identified factors to the best of their abilities. (MSS Res 38, A-17)

Implementation of an Annual Mental Health Awareness and Suicide Prevention Program at Medical Schools 345.009MSS

AMA-MSS supports medical schools to create a mental health awareness and suicide prevention screening program that would: 1) be available to all medical students on an opt-out basis, 2) ensure anonymity, confidentiality, and protection from administration, 3) provide proactive intervention for identified at-risk students by mental health professionals, and 4) educate students and faculty about personal mental health and factors that may contribute to suicidal ideation. (MSS Res 15, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Addressing Medical Student Mental Health Through Data Collection and Screening 345.012MSS

AMA-MSS will ask that our AMA (1) encourage study of medical student mental health, including but not limited to rates and risk factors of depression and suicide; and (2) encourage medical schools to confidentially gather and release information regarding reporting rates of depression/suicide on an opt-out basis from its students. (MSS Res 14, I-16) (AMA Res 303, A17 Adopted as Amended [appended to H-295.858]) (Reaffirmed: MSS GC Report A, I-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 013
(I-22)

Introduced by: Kimberly Ibarra, Sam Houston State College of Osteopathic Medicine; Anand Singh, Anne Burnett Marion School of Medicine at Texas Christian University

Subject: Reconsideration of the Birthday Rule

Sponsored by: Region 1, Region 2, Region 3, Region 4, Region 6

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Self-insured coverage is either a self-administered process or a third party administrator where the employer collects premiums from enrollees and assumes responsibility of paying employees' and dependents' medical claims¹; and

Whereas, The Health Insurance Portability And Accountability Act of 1996 (HIPAA), established protections for "self-insured" and "insured" coverage, whereby newborns, adopted children, and new parents not enrolled under a health plan could enroll under a period of "special enrollment" upon the birth, adoption, or placement for adoption of a new child²; and

Whereas, Under HIPAA, as long as enrollment occurs within 30 days of birth, health insurance coverage is effective as of the date of birth and cannot be subject to pre-existing condition exclusion²; and

Whereas, If a health plan's benefits are provided through an insurance company or Health Maintenance Organization (HMO), state laws may amend HIPAA requirements to allow for additional considerations; such as extending the enrollment period²; and

Whereas, The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting organization governed by the chief insurance regulators from all 50 states, the District of Columbia, and five U.S. territories to coordinate regulation of multistate insurers³; and

Whereas, Coordination of Benefits (COB) as defined by the NAIC is the provision to eliminate over-insurance and establish a prompt and orderly claims payment system when a person is covered by more than one group insurance and/or group service plan¹; and

Whereas, State law permits insurers to follow a COB to determine insurers' responsibilities under an insurance claim in the event the "insured" is covered by more than one health plan, in the identification of a "primary" and "secondary" benefit payer⁴; and

Whereas, Newborns of parents with separate insurance policies are subjected to a COB at birth^{2,4}; and

Whereas, The birthday rule is a COB model regulation set by the NAIC in which a newborn takes as primary coverage the plan of the parent whose birthday comes first in the calendar year^{2,4}; and

Whereas, The recently publicized case of the Kjelshus family resulted in a \$200,000 bill for a NICU stay because the parents were unaware of their coordination of benefits, specifically the birthday rule, that resulted in the father's inferior policy determining their child's insurance coverage solely due to the fact of having a birthday only 2 weeks earlier than his spouse in the calendar year⁵; and

Whereas, The birthday rule has led to confusion and frustration of parents when a child is automatically enrolled under the parent with the earlier birthday in the calendar year without considering the quality of insurance coverage between both parents, showing that simple awareness is not enough to address the problem⁵; and

Whereas, H.R.4636I, known as the Empowering Parents' Healthcare Choices Act of 2021, currently in the House Subcommittee on Health, would give parents with dual policies 60 days before the birthday rule would take effect from the date of an infant's birth to choose which plan is primary and to notify the insurer of their choice effectively reclaiming parental choice⁶; therefore be it

RESOLVED, Our AMA will support evidence-based legislation that support a parent's, or primary parent when relevant, choice of their dependent's health insurance plan under the event of multiple insurers; and be it further

RESOLVED, That our AMA amend Policy H-190.969: "Delay in Payments Due to Disputes in Coordination of Benefits" by addition as follows:

Delay in Payments Due to Disputes in Coordination of Benefits, H-190.969

Our AMA:

(1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;

(2) includes the "birthday rule" as a last resort only after parents have been allowed a choice of insurer and have failed to choose, and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims;

(3) urges state medical associations to advocate for the inclusion of the "employer first rule", and "birthday rule" as a last resort only after parents have been allowed a choice of insurer and have failed to choose, in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits;

(4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays;

(5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation;

(6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and

- 1 (7) urges private sector health care accreditation organizations to (a) develop and utilize
- 2 standards that incorporate summary statistics on claims processing performance,
- 3 including claim payment timeliness, and (b) require accredited health plans to provide
- 4 this information to patients, physicians, and other purchasers of health care services.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. National Association of Insurance Commissioners'. Consumer Glossary. Accessed August 31, 2022. https://content.naic.org/consumer_glossary#C
2. U.S. Department of Labor, U.S. Department of Labor Employee Benefits Security Administration. Fact Sheet: Health Insurance Portability and Accountability Act (HIPAA). www.dol.gov. Accessed August 31, 2022. <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/fact-sheets/hipaa.pdf>
3. National Association of Insurance Commissioners'. About. Accessed August 31, 2022. <https://content.naic.org/about>
4. National Association of Insurance Commissioners'. NAIC Model Laws, Regulations, Guidelines and Other Resource. content.naic.org. Published 2013. Accessed August 31, 2022. <https://content.naic.org/sites/default/files/inline-files/MDL-120.pdf>
5. Anthony C. Proposed Law Would End Health Insurance "Birthday Rule" That Snags New Parents. NPR. <https://www.npr.org/sections/health-shots/2021/07/27/1016485053/proposed-law-would-end-health-insurance-birthday-rule-that-snags-new-parents>. Published July 27, 2021. Accessed August 31, 2022.
6. Davids S. Text - H.R.4636 - 117th Congress (2021-2022): Empowering Parents' Healthcare Choices Act of 2021. Published July 23, 2021. Accessed August 31, 2022. <http://www.congress.gov/>

RELEVANT AMA AND AMA-MSS POLICY

Delay in Payments Due to Disputes in Coordination of Benefits, H-190.969

Our AMA:

- (1) urges state and federal agencies to exercise their authority over health plans to ensure that beneficiaries' claims are promptly paid and that state and federal legislation that guarantees the timely resolution of disputes in coordination of benefits between health plans is actively enforced;
- (2) includes the "birthday rule" and the "employer first rule" in any and all future AMA model legislation and model medical service agreements that contain coordination of benefits information and/or guidance on timely payment of health insurance claims;
- (3) urges state medical associations to advocate for the inclusion of the "employer first rule", and "birthday rule" in state insurance statutes as mechanisms for alleviating disputes in coordination of benefits;
- (4) includes questions on payment timeliness in its Socioeconomic Monitoring System survey to collect information on the extent of the problem at the national level and to track the success of state legislation on payment delays;
- (5) continues to encourage state medical associations to utilize the prompt payment provisions contained in the AMA Model Managed Care Medical Services Agreement and in AMA model state legislation;

(6) through its Advocacy Resource Center, continue to coordinate and implement the timely payment campaign, including the promotion of the payment delay survey instrument, to assess and communicate the scope of payment delays as well as ensure prompt payment of health insurance claims and interest accrual on late payments by all health plans, including those regulated by ERISA; and

(7) urges private sector health care accreditation organizations to (a) develop and utilize standards that incorporate summary statistics on claims processing performance, including claim payment timeliness, and (b) require accredited health plans to provide this information to patients, physicians, and other purchasers of health care services.

CMS Rep. 8, I-98; Reaffirmation I-04; Reaffirmed in lieu of Res. 729, A-13

Health Insurance for Children H-185.948

Our AMA supports requiring all children to have adequate health insurance as a strategic priority. Res. 610, I-08; Reaffirmed: CMS Rep. 01, A-18

Multiple Coverage in Voluntary Health Insurance H-185.999

(1) Over-insurance can arise when an individual is insured under two or more policies of health insurance. When the reimbursement from this multiple coverage exceeds the expenses against which the individual has insured himself, a profit may result. Over-insurance thus encourages wasteful use of the public's health care dollar. (2) A solution to this problem can be accomplished by the use of contract language and the application of coordination of benefits provisions which operate to enable persons covered under two or more group programs to be fully reimbursed for their expenses of insured services without receiving more in total benefits than the amount of such expenses. (3) Therefore, the AMA encourages the health insurance companies and prepayment plans to adopt policy provisions and mechanisms based upon the preceding principles which would control the adverse effects of over-insurance.

CMS Rep. F, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18

Adequacy of Health Insurance Coverage Options H-165.846

1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:

A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.

B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.

C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.

D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.

2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.

3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.

CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09;

Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended:

CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19

Increasing Coverage for Children H-165.877

Our AMA: (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant women; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children and recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs; (4) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18; (5) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23; (6) seeks to have introduced or support federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families; (7) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package; (8) advocates that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits; (9) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage; (10) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage; (11) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group; (12) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; and (13) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in identifying and encouraging enrollment in Medicaid of the estimated three million children currently eligible for but not covered under this program.

Sub. Res. 208, A-97; CMS Rep. 7, A-97; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, I-99; Reaffirmed: Res. 238 and Reaffirmation A-00; Reaffirmation A-02; Reaffirmation A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-08; Modified: Speakers Rep. 2, I-14; Reaffirmed: CMS Rep. 01, A-18

Mitigating the Negative Effects of High-Deductible Health Plans, H-185.918

Our AMA: (1) encourages ongoing research and advocacy to develop and promote innovative health plan designs, including designs that can recognize that medical services may differ in the amount of health produced and that the clinical benefit derived from a specific service can vary among patients; (2) encourages employers to: (a) provide robust education to help patients make good use of their benefits to obtain the care they need, (b) take steps to collaborate with their employees to understand employees' health insurance preferences and needs, (c) tailor

their benefit designs to the health insurance preferences and needs of their employees and their dependents, and (d) pursue strategies to help enrollees spread the costs associated with high out-of-pocket costs across the plan year; and (3) encourages state medical associations and state and national medical specialty societies to actively collaborate with payers as they develop innovative plan designs to ensure that the health plans are likely to achieve their goals of enhanced access to affordable care. CMS Rep. 2, I-20

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 014
(I-22)

Introduced by: Alec Calac, University of California San Diego School of Medicine; Kyle Lakatos, University of California San Francisco School of Medicine; Julia Seiberling, University of California Riverside School of Medicine; Rajvarun Grewal, Matinder Dhillon, California Health Sciences University College of Medicine; Hailey Baker, Katie Wilson, University of Minnesota Medical School; Lyndsay Kandi, University of Arizona College of Medicine; Adrienne Nguyen, Des Moines University College of Osteopathic Medicine; Canaan Hancock, Dell Medical School at University of Texas-Austin; Donald Bourne, University of Pittsburgh School of Medicine; Brianna Baldwin, University of Virginia School of Medicine; Krishna Channa, University of Connecticut School of Medicine; Lala Forrest, Frank H. Netter MD School of Medicine

Subject: Indian Health Service Graduate Medical Education

Sponsored by: Region 1, Region 2, Region 4, Region 6, Region 7, Association of Native American Medical Students, PsychSIGN, American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

1 Whereas, Patients require a sufficient, well-trained supply of primary care physicians to meet
2 the nation's current and projected demand for health care services (H-200.949); and
3

4 Whereas, The Indian Health Service (IHS), an agency within the U.S. Department of the Health
5 Human Services, is responsible for providing federal health services to American Indians and
6 Alaska Natives¹; and
7

8 Whereas, In areas where the IHS has substantial direct care obligations, the IHS physician
9 vacancy rate ranges from 21 to 46 percent²; and
10

11 Whereas, IHS officials note that the vacancies mentioned above are longstanding and thus
12 have negative effects longitudinally, including inequitable access to healthcare, decreased
13 quality of patient care, and adverse impact on employee morale²; and
14

15 Whereas, The U.S. Government Accountability Office has found that 57% of medical residents
16 stay to practice in the geographical location where they completed their complete their graduate
17 residency training^{3,4}; and
18

19 Whereas, The IHS is the only large federal health system to lack formalized graduate medical
20 education (GME) partnerships with academic medical centers and teaching hospitals⁵; and
21

22 Whereas, Federal systems like the Veterans Health Administration have 75 years of
23 partnerships with teaching hospitals through its Office of Academic Affiliations, supporting
24 11,000 GME positions⁶; and

Whereas, The nation's \$15 billion in GME funding flows heavily to non-rural, non-American Indian and Alaska Native communities⁵; therefore be it

RESOLVED, our AMA advocates for the establishment of an Indian Health Service (IHS) equivalent to the Veterans Health Administration Office of Academic Affiliations; and be it further

RESOLVED, our AMA supports the development of dedicated graduate medical education (GME) funding streams at Indian Health Service, Tribal, and Urban Indian Health Programs.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. About the Indian Health Service. U.S. Department of Health and Human Services. Accessed August 25, 2022. <https://www.ihs.gov/aboutihs/>
2. Agency Faces Ongoing Challenges Filling Provider Vacancies. U.S. Government Accountability Office. Published August 2018. Accessed August 25, 2022. <https://www.gao.gov/assets/gao-18-580.pdf>
3. Locations and Types of Graduate Training Were Largely Unchanged, and Federal Efforts May Not Be Sufficient to Meet Needs. U.S. Government Accountability Office. Published June 2017. Accessed August 25, 2022. <https://www.gao.gov/products/gao-17-411>
4. Report on Residents. Association of American Medical Colleges. Published 2021. Accessed August 31, 2022. <https://www.aamc.org/data-reports/students-residents/report/report-residents>
5. Tobey M, Ott A, Owen M. The Indian Health Service and the Need for Resources to Implement Graduate Medical Education Programs. JAMA. 2022;328(4):327–328. doi:10.1001/jama.2022.10359
6. Petrakis IL, Kozal M. Academic medical centers and the US Department of Veterans Affairs: a 75-year partnership influences medical education, scientific discovery, and clinical care. Acad Med. Published online May 4, 2022. doi:10.1097/ACM.0000000000004734

RELEVANT AMA AND AMA-MSS POLICY

Funding to Support Training of the Health Care Workforce H-310.916

1. Our American Medical Association will insist that any new GME funding to support graduate medical education positions be available only to Accreditation Council for Graduate Medical Education (ACGME) and/or American Osteopathic Association (AOA) accredited residency programs, and believes that funding made available to support the training of health care providers not be made at the expense of ACGME and/or AOA accredited residency programs.
2. Our AMA strongly advocates that: (A) there be no decreases in the current funding of MD and DO graduate medical education while there is a concurrent increase in funding of graduate medical education (GME) in other professions; and (B) there be at least proportional increases in the current funding of MD and DO graduate medical education similar to increases in funding of GME in other professions.
3. Our AMA will advocate to appropriate federal agencies, and other relevant stakeholders to oppose the diversion of direct and indirect funding away from ACGME-accredited graduate medical education programs.

Sub. Res. 913, I-09; Appended: Res. 917, I-15 Appended: Res. 309, I-20; Reaffirmed: Res. 305, A-21

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.

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

Improving Health Care of American Indians H-350.976

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

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

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

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

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

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

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

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

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

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

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

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

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 non federal 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

AMA Support of American Indian Health Career Opportunities H-350.981

AMA policy on American Indian health career opportunities is as follows:

(1) Our AMA, and other national, state, specialty, and county medical societies recommend

special programs for the recruitment and training of American Indians in health careers at all levels and urge that these be expanded.

(2)) Our AMA supports the inclusion of American Indians in established medical training programs in numbers adequate to meet their needs. Such training programs for American Indians should be operated for a sufficient period of time to ensure a continuous supply of physicians and other health professionals, prioritize consideration of applicants who self-identify as American Indian or Alaska Native and can provide some form of affiliation with an American Indian or Alaska Native tribe in the United States, and support the successful advancement of these trainees.

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

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

(5) Our AMA acknowledges long-standing federal precedent that membership or lineal descent from an enrolled member in a federally recognized tribe is distinct from racial identification as American Indian or Alaska Native and should be considered in medical school admissions even when restrictions on race-conscious admissions policies are in effect.

CLRPD Rep. 3, I-98; Reaffirmed: Res. 221, A-07; Reaffirmation A-12; Reaffirmed: CME Rep. 1, A-22; BOT Action in response to referred for decision: Res. 308, A-22

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 015
(I-22)

Introduced by: Hayley Dunlop, TJ Atchison, Ohio State University College of Medicine; Pragi Patel, Meghana Kudrimoti, Ohio State University College of Medicine; Jara Crawford, Indiana University School of Medicine; Cecily Negri, Southern Illinois University School of Medicine; Emily Smith, Carle Illinois College of Medicine; Cloe Nazeer, Oakland University William Beaumont School of Medicine; Sereena Jivraj, Anne Burnett Marion School of Medicine at Texas Christian University; Parker Davis, University of Texas Southwestern College of Medicine; Joeun Jeong, University of Texas McGovern Medical School; Brooke Taylor, University of South Carolina School of Medicine Greenville; Kira Szulborski, Tufts University College of Medicine

Subject: Preventing Human Papillomavirus (HPV) infection and HPV-associated cancers in people who are incarcerated

Sponsored by: Region 3

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

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

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

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

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

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

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

Whereas, HPV vaccination programs in the United States have been expanded beyond female-only programs to prevent HPV infection in all people;⁶ and

Whereas, HPV vaccination is now FDA approved up to 46 years of age for all people, and is recommended routinely for individuals aged 11-26 and may be recommended in 27-45 year-olds after discussion with their clinician;⁹ and

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

Whereas, Most incarcerated women between 18-26 years of age have not received HPV immunization but would be willing to if offered;¹¹ and

Whereas, People with criminal-legal histories are five times more likely to develop cervical cancer in their lifetimes than the general population;¹⁰ and

Whereas, The Federal Bureau of Prisons' Clinical Guidelines support routine cervical cancer screening in carceral facilities as a means of cervical cancer prevention;⁶ and

Whereas, Many carceral facilities under state and federal jurisdiction are not equipped to provide basic gynecological medical care including gynecologic testing and procedures that require specialized diagnostic equipment;⁷ and

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

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

Whereas, Between 32% and 42% of formerly incarcerated individuals were medically insured eight to ten months after release from their carceral facility;¹⁴ and

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

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

Whereas, AMA policy H-440.872 supports HPV vaccination and cervical cancer prevention worldwide and AMA Policy D-440.995 advocates for "the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations"; therefore be it

RESOLVED, That our AMA amend Policy H-440.872, "HPV Vaccine and Cervical Cancer Prevention Worldwide," as follows:

HPV Vaccine and ~~Cervical~~ HPV-Associated 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

1 young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer
2 screening to appropriate patient groups that benefit most from preventive measures,
3 including but not limited to ~~low-income and pre-sexually active populations~~ patients with
4 low socioeconomic status, patients who are pre-sexually active, and patients who are
5 incarcerated, and (c) recommends HPV vaccination for all groups for whom the federal
6 Advisory Committee on Immunization Practices recommends HPV vaccination.
7

8 RESOLVED, That our AMA amend Policy H-430.986, "Health Care While Incarcerated," as
9 follows:
10

11 **Health Care While Incarcerated H-430.986**

- 12 1. Our AMA advocates for adequate payment to health care providers, including primary
13 care and mental health, and addiction treatment professionals, to encourage improved
14 access to comprehensive physical and behavioral health care services to juveniles and
15 adults throughout the incarceration process from intake to re-entry into the community.
16 2. Our AMA advocates and requires a smooth transition including partnerships and
17 information sharing between correctional systems, community health systems and state
18 insurance programs to provide access to a continuum of health care services for
19 juveniles and adults in the correctional system.
20 3. Our AMA encourages state Medicaid agencies to accept and process Medicaid
21 applications from juveniles and adults who are incarcerated.
22 4. Our AMA encourages state Medicaid agencies to work with their local departments of
23 corrections, prisons, and jails to assist incarcerated juveniles and adults who may not
24 have been enrolled in Medicaid at the time of their incarceration to apply and receive an
25 eligibility determination for Medicaid.
26 5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of
27 juveniles and adults upon intake into the criminal legal system and throughout the
28 incarceration process, and to reinstate coverage when the individual transitions back into
29 the community.
30 6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social
31 Security Act that bars the use of federal Medicaid matching funds from covering
32 healthcare services in jails and prisons.
33 7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services
34 (CMS) to revise the Medicare statute and rescind related regulations that prevent
35 payment for medical care furnished to a Medicare beneficiary who is incarcerated or in
36 custody at the time the services are delivered.
37 8. Our AMA advocates for necessary programs and staff training to address the
38 distinctive health care needs of women and adolescent females who are incarcerated,
39 including gynecological care and obstetrics care for individuals who are pregnant or
40 postpartum.
41 9. Our AMA will collaborate with state medical societies, relevant medical specialty
42 societies, and federal regulators to emphasize the importance of hygiene and health
43 literacy information sessions, as well as information sessions on the science of
44 addiction, evidence-based addiction treatment including medications, and related stigma
45 reduction, for both individuals who are incarcerated and staff in correctional facilities.
46 10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon
47 release in order to accelerate access to comprehensive health care, including mental
48 health and substance use disorder services, and improve health outcomes among this
49 vulnerable patient population, as well as adequate funding; (b) the collaboration of
50 correctional health workers and community health care providers for those transitioning
51 from a correctional institution to the community; (c) the provision of longitudinal care

from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.

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

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

13. Our AMA encourages collaboration with stakeholders to provide Human papillomavirus (HPV) vaccination to people who are incarcerated for the prevention of HPV-associated cancers.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

- Centers for Disease Control and Prevention. HPV cancers are preventable. Centers for Disease Control and Prevention. <https://www.cdc.gov/hpv/hcp/protecting-patients.html#:~:text=Cancers%20Caused%20by%20HPV%20Are%20Preventable&text=HPV%20vaccination%20could%20prevent%20more,the%20United%20States%20every%20year.&text=Cervical%20cancer%20is%20the%20only,detection%20at%20an%20early%20stage>. Published November 1, 2021. Accessed August 28, 2022.
- Emerson, A., Allison, M., Kelly, P.J. and Ramaswamy, M., 2020. Barriers and facilitators of implementing a collaborative HPV vaccine program in an incarcerated population: a case study. *Vaccine*, 38(11), pp.2566-2571.
- Curry, S.J., Krist, A.H., Owens, D.K., Barry, M.J., Caughey, A.B., Davidson, K.W., et al, 2018. Screening for cervical cancer: US Preventive Services Task Force recommendation statement. *Journal of the American Medical Association*, 320(7), pp.674-686.
- Centers for Disease Control and Prevention. Human papillomavirus. 2018. Web site <https://www.cdc.gov/std/hpv/stdfact-hpv.htm>. Accessed September 22, 2022;17
- D'Souza G, Westra WH, Wang SJ, Van Zante A, Wentz A, Kluz N, Rettig E, Ryan WR, Ha PK, Kang H, Bishop J. Differences in the prevalence of human papillomavirus (HPV) in head and neck squamous cell cancers by sex, race, anatomic tumor site, and HPV detection method. *JAMA oncology*. 2017 Feb 1;3(2):169-77.
- Federal Bureau of Prisons. Preventive Health Care Screening - Federal Bureau of Prisons. <https://www.bop.gov/resources/pdfs/phc.pdf>. Published June 2018. Accessed August 28, 2022.
- Sufrin, C., Kolbi-Molinas, A. and Roth, R., 2015. Reproductive justice, health disparities and incarcerated women in the United States. *Perspectives on Sexual and Reproductive Health*, 47(4), pp.213-219.
- Athanasίου, A., Bowden, S., Paraskevaidi, M., Fotopoulou, C., Martin-Hirsch, P., Paraskevaidis, E. and Kyrgiou, M., 2020. HPV vaccination and cancer prevention. *Best Practice & Research Clinical Obstetrics & Gynaecology*, 65, pp.109-124.
- Saslow, D., Andrews, K.S., Manassaram-Baptiste, D., Smith, R.A., Fontham, E.T. and American Cancer Society Guideline Development Group, 2020. Human papillomavirus vaccination 2020 guideline update: American Cancer Society guideline adaptation. *CA: A Cancer Journal for Clinicians*, 70(4), pp.274-280.

10. Nelson B. Cervical and anal cancer prevention in jails and prisons: “A missed opportunity.” *Cancer Cytopathology*. 2020;128(4):227-228. doi:10.1002/cncy.22268
11. Moore, A., Cox-Martin, M., Dempsey, A.F., Berenbaum Szanton, K. and Binswanger, I.A., 2019. HPV vaccination in correctional care: knowledge, attitudes, and barriers among incarcerated women. *Journal of Correctional Health Care*, 25(3), pp.219-230.
12. Emerson, A., Allison, M., Saldana, L., Kelly, P.J. and Ramaswamy, M., 2021. Collaborating to offer HPV vaccinations in jails: results from a pre-implementation study in four states. *BioMed Central Health Services Research*, 21(1), pp.1-7.
13. Ramaswamy, M., Allison, M., Musser, B., Satterwhite, C., Armstrong, R. and Kelly, P.J., 2020. Local Health Department Interest in Implementation of a Jail-Based Human Papillomavirus Vaccine Program in Kansas, Iowa, Missouri, and Nebraska. *Journal of Public Health Management and Practice: JPHMP*, 26(2), p.168.
14. Albertson, E.M., Scannell, C., Ashtari, N. and Barnert, E., 2020. Eliminating gaps in Medicaid coverage during reentry after incarceration. *American Journal of Public Health*, 110(3), pp.317-321.
15. Musselwhite, L.W., Oliveira, C.M., Kwaramba, T., de Paula Pantano, N., Smith, J.S., Fregnani, J.H., et al., 2016. Racial/ethnic disparities in cervical cancer screening and outcomes. *Acta Cytologica*, 60(6), pp.518-526.

RELEVANT AMA AND AMA-MSS POLICY

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

Screening for HPV-Related Anal Cancer H-460.913

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

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

Insurance Coverage for HPV Vaccine D-440.955

Our AMA:

- (1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices;

(2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and
 (3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.

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

Health Care While Incarcerated H-430.986

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

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

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

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

Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:

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

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

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

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

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

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

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

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

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

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

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

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

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

CCB/CLRPD Rep. 3, A-14

Screening for HPV-Related Anal Cancer H-460.913

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

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

Cancer and Health Care Disparities Among Minority Women D-55.997

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

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

Quality of Pap Smear Analysis H-525.994

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

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

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

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

CDC; and (e) that correctional facilities or detention centers be able to request and receive all necessary funding for COVID-19 vaccination and testing, according to CDC or local public health guidelines.

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 016
(I-22)

Introduced by: Christian Wooten, University of California Los Angeles; Cecily Negri, Southern Illinois University School of Medicine; Richard Easterling, University of Mississippi; Rajadhar Reddy, Baylor College; Anand Singh, Texas Christian University Anne Burnett School of Medicine; Jenna Gage, Sean O' Leary, University of Texas Medical Branch at Galveston; Angela Liu, Texas College of Osteopathic Medicine; Alex Soltany, Wake Forest University School of Medicine; Christine Fasana, University of South Carolina School of Medicine Greenville; Victoria Kozar, Nehal Lakdawala University of Connecticut School of Medicine; Archita Goyal, Tufts University School of Medicine

Subject: Medicaid Hearing Coverage

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

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Approximately 37.5 million Americans, aged 18 over, self-report having a little, moderate, or a lot of trouble hearing or are deaf¹; and

Whereas, In the United States, 28.8 million people would benefit from hearing aid use, with only 16% of those who would benefit from hearing aid use between the ages of 20-69 actually utilizing hearing aids²; and

Whereas, The World Health Organization estimates that unaddressed hearing loss poses an annual global loss of \$980 billion³; and

Whereas, Individuals covered by Medicaid have substantially greater tendency to report hearing problems than those covered by private insurance⁴; and

Whereas, Under Medicaid, audiological examinations, hearing aids, and medically necessary hearing-related services are mandated for anyone under the age of 21, while there are significant variations between state Medicaid coverage for hearing services for patients aged 21 and over⁵; and

Whereas, As of 2018, only 28 states' Medicaid programs provide variable hearing aid coverage for adults with certain severities of hearing loss, 18 states have no coverage, and 4 states do not specify coverage⁶; and

Whereas, Of the 28 states that provide variable hearing aid coverage, only 21% were ranked to provide "fair" coverage (on a scale of poor, fair, good, excellent) and most states provide only some coverage for the devices but not the services⁶; and

Whereas, Prior to recent FDA guidance on over-the-counter hearing aids, the average price for a pair of hearing aids in the US was \$4,700, but a study found a mere \$2,500 would constitute a catastrophic expense for 77% of Americans with functional hearing loss, putting them into poverty for the year⁷⁻⁸; and

Whereas, Over-the-counter hearing aids are expected to cost up to \$1,000 or more for a pair, and it is estimated that more than half of Americans cannot afford an \$1,000 emergency expense⁹⁻¹⁰; and

Whereas, Lower-income people are twice as likely to experience more trouble hearing while using their hearing aids, compared to their higher-income counterparts due to reduced access and affordability of required supportive services¹¹; and

Whereas, The onus of hearing aid access and costs pose such an obstacle to needed care that individuals often go without needed medical care¹²; and

Whereas, Untreated hearing loss is associated with increased risks of social isolation, falls, and cognitive decline, all of which can contribute to increased hospitalizations and associated healthcare costs^{4,11,14}; and

Whereas, Current AMA-MSS policy (25.003MSS) asks the AMA to increase access to hearing aids, it does not include a proposal for Medicaid to make hearing exams, hearing aids, cochlear implants, and aural rehabilitative services mandatory benefits; and

Whereas, Current AMA policy (H185.929) supports coverage that provides all hearing-impaired infants and children access to hearing services and devices, including digital hearing aids, but does not extend to adults 18-65 on public insurance such as Medicaid; therefore be it

RESOLVED, That our AMA amend H-185.929 by addition to read as follows:

Hearing Aid Coverage H-185.929

1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.
8. Our AMA advocate that hearing exams, hearing aids, cochlear implants, and aural rehabilitative services be covered in all Medicaid programs and any new public insurance programs

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Blackwell DL, Lucas JW, Clarke TC. Summary health statistics for U.S. adults: National Health Interview Survey, 2012. National Center for Health Statistics. Vital Health Stat 10(260). 2014. Accessed April 24, 2021.
2. NIDCD Epidemiology and Statistics Program, based on December 2015 Census Bureau estimates of the noninstitutionalized U.S. population, personal communication; May 2016. Accessed August 24, 2021.
3. World Health Organization. Deafness and Hearing Loss. Who.int. Published April 1, 2021. <https://www.who.int/news-room/fact-sheets/detail/deafness-and-hearing-loss>. Accessed April 15, 2022.
4. Katch H, Van de Water P. Medicaid and Medicare Enrollees Need Dental, Vision, and Hearing Benefits. Center on Budget and Policy Priorities. <https://www.cbpp.org/research/health/medicaid-and-medicare-enrollees-need-dental-vision-and-hearing-benefits>. Published December 8, 2020. Accessed August 24, 2021.
5. Medicaid. Hearing Loss Association of America. <https://www.hearingloss.org/hearing-help/financial-assistance/medicaid/>. Accessed August 24, 2021.
6. Arnold ML, Hyer K, Chisolm T. Medicaid Hearing Aid Coverage For Older Adult Beneficiaries: A State-By-State Comparison. Health Affairs. 2017;36(8):1476-1484. doi:10.1377/hlthaff.2016.1610. Accessed April 7th, 2022.
7. Jilla AM, Johnson CE, Huntington-Klein N. Hearing aid affordability in the United States. Disability and Rehabilitation: Assistive Technology. Published online October 28, 2020:1-7. doi:10.1080/17483107.2020.1822449. Accessed April 7th, 2022.
8. Sinha S, Irani UD, Manchaiah V, Bhamla MS. LoCHAid: An ultra-low-cost hearing aid for age-related hearing loss. Menezes P de L, ed. PLOS ONE. 2020;15(9):e0238922. doi:10.1371/journal.pone.0238922. Accessed April 7th, 2022.
9. Bennett K. Survey: Less than half of Americans have savings to cover a \$1,000 surprise expense. Bankrate. <https://www.bankrate.com/banking/savings/financial-security-january-2022/>. Published January 19, 2022. Accessed September 21, 2022.
10. Crouch, M. (2022, August 16). The FDA approves cheaper, over-the-counter hearing aids. AARP. Retrieved September 21, 2022, from <https://www.aarp.org/health/healthy-living/info-2022/fda-over-the-counter-hearing-aids.html>
11. Willink A, Hernando MA, Steege S. Why State Medicaid Programs Should Cover Hearing Aids for Adults. JAMA Otolaryngology Head Neck Surg. 2019;145(11):999–1000. doi:10.1001/jamaoto.2019.2616. Accessed August 24, 2021.
12. Blazer, Dan G., et al. Hearing Health Care for Adults: Priorities for Improving Access and Affordability. The National Academies Press, 2016. Accessed April 7th, 2022.
13. Sinha S, Irani UD, Manchaiah V, Bhamla MS. LoCHAid: An ultra-low-cost hearing aid for age-related hearing loss. Menezes P de L, ed. PLOS ONE. 2020;15(9):e0238922. doi:10.1371/journal.pone.0238922. Accessed April 7th, 2022.
14. Zonderman AB, Resnick SM. Hearing loss and cognition in the Baltimore Longitudinal Study of Aging. Neuropsychology. 2011;25(6):763–70. Accessed August 24, 2021.

RELEVANT AMA AND AMA-MSS POLICY

Hearing Aid Coverage H-185.929

1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.
6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.
7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.

CMS Rep. 6, I-15; Appended: Res. 124, A-19

Increasing Patient Access to Hearing, Dental and Vision Services D-185.972

Our AMA will: (1) promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment or dementia in later life, to physicians as well as to the public; (2) promote, and encourage other stakeholders, including public, private, and professional organizations and relevant governmental agencies, to promote the conduct and acceleration of research into specific patterns and degrees of hearing loss to determine those most linked to cognitive impairment or dementia and amenable to correction; (3) work with interested national medical specialty societies and state medical associations to encourage and promote research into hearing loss as a contributor to cognitive impairment, and to increase patient access to hearing loss identification and remediation services; and (4) work with interested national medical specialty societies and state medical associations to encourage and promote research into vision and dental health and to increase patient access to vision and dental services.

Res. 113, A-22

Increased Affordability and Access to Hearing Aids and Related Care 25.003MSS

AMA-MSS will ask the AMA to 1) support policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences to the elderly; 2) encourage increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids; and 3) support the availability of over-the-counter hearing aids for the treatment of age-related mild-to-moderate hearing loss.

MSS CEQM Rep I-18, Adopted; AMA Res 124, A-19, Adopted [H-185.929]

Evaluation of the Principles of the Health Care Access Resolution 165.009MSS

(1) AMA-MSS supports efforts to make health care more cost-effective by reducing administrative burdens, but only to such a degree that quality of care is not compromised; (2) AMA-MSS supports means of including both long-term care and prescription drug benefits into the guidelines for seeking affordable universal health care access and coverage; (3) AMA-MSS encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality of health care; and that our AMA-MSS supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; (4) AMA-MSS will adopt policy to promote outcomes research as an effective

mechanism to improve the quality of medical care for all persons and urge that the results of such research be used only for educational purposes and for improving practice parameters; (5) AMA- MSS will adopt policy to address the need to increase numbers of qualified health care professionals, practitioners, and providers in underserved areas to increase timely access to quality care; (6) AMA-MSS supports the inclusion of adequate and timely payments to physicians and other providers into any plan calling for affordable universal health care access; (7) AMA-MSS supports the inclusion of the principles of continuity of health insurance coverage and continuity of medical care into any plan calling for affordable universal health care access; (8)AMA-MSS supports the inclusion of the principle of consumer choice of healthcare providers and practitioners into any plan calling for affordable universal health care access; (9) AMA-MSS supports the inclusion of reducing health care administrative cost and burden into any plan calling for affordable universal health care access. (MSS Rep C, A-04) (Modified: MSS GC Rep B, I-09) (Modified: GC Rep A, I-16) (Reaffirmed: MSS GC Report A, I-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 017
(I-22)

Introduced by: Brooke Buckingham, University of Toledo College of Medicine; Kayla Edwards, University of Cincinnati College of Medicine

Subject: AMA opposition of heartbeat laws which indicate first evidence of embryonic cardiac activity as presence of fetal heartbeat

Sponsored by: American Women's Medical Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

1 Whereas, Complications in pregnancy prior to fetal viability may require termination to protect
2 the life of the pregnant person and restricting access to abortion care may increase the risk for
3 maternal mortality¹⁻⁶; and
4

5 Whereas, Roe v. Wade (1973), which established that abortion is included in the right to privacy
6 and prevented states from restricting abortion before fetal viability, was overturned by the United
7 States Supreme Court on June 24, 2022^{6,7}; and
8

9 Whereas, Prior to the overturn of Roe v. Wade, some states made State Supreme Court
10 decisions protecting the right to abortion under the state constitution, while other states had
11 abortion bans pre-dating the Roe v. Wade decision⁸; and
12

13 Whereas, Thirteen states including Arkansas, Idaho, Kentucky, Louisiana, Mississippi, Missouri,
14 North Dakota, Oklahoma, South Dakota, Tennessee, Texas, Utah, and Wyoming have trigger
15 laws which have gone into effect following the overturn of Roe v. Wade, and include legal
16 repercussions for those who receive or perform abortions^{7,9-10}; and
17

18 Whereas, Approximately 64% of reported abortions in these listed states are performed after a
19 gestational age of 6 weeks¹¹; and
20

21 Whereas, Adolescents, people of color, those living in rural areas, those with low incomes, and
22 incarcerated people can face disproportionate effects of restrictions on abortion access^{3,12}; and
23

24 Whereas, Nearly half of people who seek abortions nationally live below the federal poverty
25 level and lack access to family and work supports like maternity leave, paid sick days,
26 consistent work scheduling, or affordable child care¹³; and
27

28 Whereas, The laws restricting abortion in many states, including Texas, define "fetal heartbeat"
29 as "cardiac activity or the steady and repetitive rhythmic contraction of the fetal heart within the
30 gestational sac"¹⁴; and
31

Whereas, The ACOG reports that while electronic impulses indicating cardiac activity may be audible in early pregnancy (around 6 weeks of gestation), this cannot be considered a “heartbeat” until the chambers of the heart have been developed (around 17-20 weeks of gestation)¹⁵; and

Whereas, Laws restricting abortion access oppose existing AMA policy by violating patient privacy in receiving healthcare services (H-5.993), and interfering with a physician’s ethical obligation to civil society by ignoring the social determinants of health in regards to a pregnant person’s decision to terminate a pregnancy (H-65.960); and

Whereas, Laws restricting abortion access oppose existing AMA policy by compromising a physician’s ability to use his or her medical judgement in regards to which treatment is in the best interest of the patient (H-5.989), discouraging shared decision making, and criminalizing physicians for performing medical abortions in accordance with best medical practice (H-160.946); and therefore it be

RESOLVED, the AMA oppose “heartbeat” laws and adopt the stance that the term “heartbeat” is not clinically or physiologically accurate until about 17 to 20 weeks when the four chambers of the heart are fully developed and can be detected via ultrasound; and it be further

RESOLVED, the AMA lobby for amendments to state laws already in place which indicate that a “fetal heartbeat” is synonymous with the first evidence of embryonic cardiac activity.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Kole MB, Villavicencio J, Werner EF. Reproductive services for the patient at increased risk for morbidity and mortality during the second trimester. *Seminars in Perinatology*. 2020;44(5):151270. doi:10.1016/j.semperi.2020.151270 (1)
2. Vilda D, Wallace ME, Daniel C, Evans MG, Stoecker C, Theall KP. State Abortion Policies and Maternal Death in the United States, 2015–2018. *Am J Public Health*. 2021 Sep;111(9):1696-1704. doi: 10.2105/AJPH.2021.306396. Epub 2021 Aug 19. PMID: 34410825; PMCID: PMC8589072. (2)
3. Increasing Access to Abortion: ACOG Committee Opinion Summary, Number 815. *Obstet Gynecol*. 2020 Dec;136(6):1240-1241. doi: 10.1097/AOG.0000000000004177. PMID: 33214528. (3)
4. Addante AN, Eisenberg DL, Valentine MC, Leonard J, Maddox KEJ, Hoofnagle MH. The association between state-level abortion restrictions and maternal mortality in the United States, 1995-2017. *Contraception*. 2021;104(5):496-501. doi:10.1016/j.contraception.2021.03.018
5. Latt SM, Milner A, Kavanagh A. Abortion laws reform may reduce maternal mortality: an ecological study in 162 countries. *BMC Womens Health*. 2019;19(1):1. Published 2019 Jan 5. doi:10.1186/s12905-018-0705-y
6. Loach 9892 55458423 411223885 1 - independence institute. <https://i2i.org/wp-content/uploads/Roe-v.-Wade.pdf>. Accessed August 30, 2022. (4)
7. Goldberg J. U.S. Supreme Court case summaries: Privacy law 1891-present. Center for Reproductive Rights. <https://reproductiverights.org/u-s-supreme-court-case-summaries-privacy-law-1891-present/>. Published January 26, 2021. Accessed August 30, 2022. (5)

8. Sobel L, Ramaswamy A, Salganicoff A. Abortion at SCOTUS: Dobbs v. Jackson Women's Health. <https://www.kff.org/womens-health-policy/issue-brief/abortion-at-scotus-dobbs-v-jackson-womens-health/>. Published May 4, 2022. Accessed August 30, 2022. (6)
9. Abortion laws by State. Center for Reproductive Rights. <https://reproductiverights.org/maps/abortion-laws-by-state/>. Published August 25, 2022. Accessed September 22, 2022.
10. Nash E, Guarnieri I. Abortion policy in the absence of Roe. Guttmacher Institute. <https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe>. Published August 24, 2022. Accessed September 22, 2022.
11. Kortsmit K, Mandel MG, Reeves JA, et al. Abortion Surveillance — United States, 2019. *MMWR Surveill Summ* 2021;70(No. SS-9):1–29. DOI: <http://dx.doi.org/10.15585/mmwr.ss7009a1>.
12. Jerman J, Jones RK, Onda T. Characteristics of U.S. abortion patients in 2014 and changes since 2008. Guttmacher Institute. <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014#fn1>. Published June 10, 2016. Accessed August 30, 2022. (7)
13. Jones RK, Jerman J. Population Group abortion rates and lifetime incidence of abortion: United States, 2008–2014. *American Journal of Public Health*. 2022;112(9):1284-1296. doi:10.2105/ajph.2017.304042 (8)
14. 86(R) HB 1501 - enrolled version - capitol.texas.gov. <https://capitol.texas.gov/tlodocs/86R/billtext/pdf/HB01501F.pdf>. Accessed August 30, 2022. (10)
15. ACOG Guide to language and Abortion. ACOG. <https://www.acog.org/contact/media-center/abortion-language-guide>. Accessed August 30, 2022. (9)

RELEVANT AMA AND AMA-MSS POLICY

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.

Res. 028, A-22

Right to Privacy in Termination of Pregnancy H-5.993

The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities.

Freedom of Communication Between Physicians and Patients H-5.989

It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient; (2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship; (3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and (4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.

Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13

Protecting the Patient-Physician Relationship H-165.837

Our AMA: (1) supports protecting the patient-physician relationship by continuing to advocate for: the obligation of physicians to be patient advocates; the ability of patients and physicians to privately contract; the viability of the patient-centered medical home; the use of value-based decision-making and shared decision-making tools; the use of consumer-directed health care alternatives; the obligation of physicians to prioritize patient care above financial interests; and the importance of financial transparency for all involved parties in cost-sharing arrangements; and (2) will continue to advocate protecting the patient-physician relationship in the context of bundled payment methodologies, comparative effectiveness research and physician profiling. CMS Rep. 4, A-10; Reaffirmed: CMS Rep. 01, A-20

Government Interference in Patient Counseling H-373.995

1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.

4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.

5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:

A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?

B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?

C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?

D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?

E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?

F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?

G. Is there a process for appeal to accommodate individual patients' circumstances?

6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

Res. 201, A-11; Reaffirmation: I-12; Appended: Res. 717, A-13; Reaffirmed in lieu of Res. 5, I-13; Appended: Res. 234, A-15; Reaffirmation: A-19

AMA Stance on the Interference of the Government in the Practice of Medicine H-270.959

1. Our AMA opposes the interference of government in the practice of medicine, including the use of government-mandated physician recitations.

2. Our AMA endorses the following statement of principles concerning the roles of federal and state governments in health care and the patient-physician relationship:

A. Physicians should not be prohibited by law or regulation from discussing with or asking their patients about risk factors, or disclosing information to the patient (including proprietary information on exposure to potentially dangerous chemicals or biological agents), which may affect their health, the health of their families, sexual partners, and others who may be in contact with the patient.

B. All parties involved in the provision of health care, including governments, are responsible for acknowledging and supporting the intimacy and importance of the patient-physician relationship and the ethical obligations of the physician to put the patient first.

C. The fundamental ethical principles of beneficence, honesty, confidentiality, privacy, and advocacy are central to the delivery of evidence-based, individualized care and must be respected by all parties.

D. Laws and regulations should not mandate the provision of care that, in the physician's clinical judgment and based on clinical evidence and the norms of the profession, are either not necessary or are not appropriate for a particular patient at the time of a patient encounter. Res. 523, A-06; Appended: Res. 706, A-13; Reaffirmed: Res. 250, A-22

Health, In All Its Dimensions, Is a Basic Right H-65.960

Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

Res. 021, A-19; Reaffirmed: Res. 234, A-22

The Criminalization of Health Care Decision Making H-160.946

The AMA opposes the attempted criminalization of health care decision-making especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public; and will develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decision-making, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decision-making.

Sub. Res. 202, A-95; Reaffirmed: Res. 227, I-98; Reaffirmed: BOT Rep. 2, A-07; Reaffirmation A-09; Reaffirmation: I-12; Reaffirmed: BOT Rep. 9, A-22; Reaffirmed: Res. 250, A-22; Reaffirmed: Res. 252, A-22

Public Funding of Abortion Services 5.001MSS

AMA-MSS will ask the AMA to: (1) continue its support of education and choice with respect to reproductive rights; (2) continue to actively support legislation recognizing abortion as a compensable service; and (3) continue opposition to legislative measures which interfere with medical decision making or deny full reproductive choice, including abortion, based on a patient's dependence on government funding. (AMA Sub Res 89, I-83, Adopted [H-5.998]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS Res 27, A-16) (Reaffirmed: MSS Res 059, A-21)

Patient Confidentiality and Reproductive Health 5.003MSS

AMA-MSS condemns the attempts of the Department of Justice to subpoena medical records in cases involving abortion. (MSS Amended Res 11, A-04) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

MSS Stance on Challenges to Women's Rights to Reproductive Health Care Access 5.005MSS

AMA-MSS opposes legislation that would restrict a woman's right to obtain medical services associated with her reproductive health, as defined in policy 5.001 MSS, on the grounds that they interfere with a physician's ability to provide medical care. (MSS Res 6, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS Res 27, A16) (Reaffirmed: MSS Res 059, A-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 018
(I-22)

Introduced by: Catriona Hong, Julia Silverman, Elizabeth Suschana, Amanda Kahn, Rodolfo Valentini, University of Connecticut School of Medicine; Samantha Pavlock, Florida State University College of Medicine; Dilpreet Kaeley, University of Toledo College of Medicine; Jhillika Patel, Robert Wood Johnson Medical School; John Slunecka, University of South Dakota Sanford School of Medicine; Natasha Topolski, Sairandri Sathyanarayanan McGovern Medical School at University of Texas Health; Katie McLaughlin, University of Minnesota Medical School - Duluth Campus

Subject: Estrogen as a risk factor for stroke in patients with migraine with aura

Sponsored by: Region 3 and American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Migraine is a leading cause of disability, lost productivity, and incurred medical expenses for patients, with frequent late diagnosis and subsequent financial burden¹; and

Whereas, Migraine affects roughly 1 in 6 individuals, with women affected 2-3 times more than men, and migraine with aura affecting 25% of patients with migraine^{2,3,4}; and

Whereas, Aura is defined as a specific focal neurologic symptom³; and

Whereas, Multiple studies, and the World Health Organization (WHO), have identified that lack of knowledge surrounding migraine diagnosis has remained a principal barrier in the correct diagnosis and treatment of migraine, with only 40% of patients with migraine professionally diagnosed, and non-neurologists accurately diagnosing only 8.3% of patients with migraine^{5,6}; and

Whereas, 25% of reproductive-age women use a short-acting contraceptive pill, the most common being the estrogen and progestin-containing combined oral contraceptive (COC) pill⁷⁻⁸; and

Whereas, While the COC pill is most commonly known to be used to prevent pregnancy, 14% of individuals use them for non-contraceptive reasons such as: to increase bone density, promote menstrual cycle regularity, lower risk of endometrial, ovarian, and colorectal cancer, treat acne, prevent premenstrual syndrome, decrease dysmenorrhea or menorrhagia, reduce hirsutism, and in the prevention of menstrual migraines⁸⁻¹⁰; and

Whereas, COC are inconsistently cited in the literature as increasing the risk of myocardial infarction and stroke, with the American Academy of Family Physicians acknowledging that this statement stems from "limited-quality evidence from observational studies"¹¹⁻¹⁷; and

Whereas, The original COCs formulation which contained 2-4x the current dose of estrogen demonstrated increased risk of cardiovascular events, however, it has since been determined that the risk of ethinyl estradiol is dose-dependent and has not been proven to increase the risk of stroke with current low dose COCs¹¹⁻¹⁵; and

Whereas, A recent study has found that route of administration of estrogen, i.e. transdermal patches or rings, effects risk of adverse events, and oral administration has the highest risk¹⁸⁻²¹; and

Whereas, Migraine with aura is associated with a 2 fold increase in risk of stroke as compared to migraine without aura, and patients with “unspecified migraine type” on COCs are cited to have a 2 to 4 fold increase in stroke risk, which does not take into account migraine type and thus may not accurately determine risk^{11,18,21-23}; and

Whereas, the American Headache Society (AHS) and the American College of Cardiology endorsed a literature review echoing the lack of conclusive evidence surrounding the risks of estrogen in migraine with aura, while also endorsing the individual assessment of risk of using COCs in these patients^{5,16,24-25}; and

Whereas, hormone replacement therapy (HRT) used in postmenopausal women utilizes estrogen as a major component, however a review of limited data did not find an association between cardiovascular disease and the use of postmenopausal HRT in patients with or without migraine with aura²⁶⁻²⁸; and

Whereas, While current guidelines by the American College of Obstetricians and Gynecologists (ACOG), Centers for Disease Control (CDC), and WHO discourage estrogen use in individuals with migraine with aura, these guidelines are largely inconsistent with each other^{22,29-32}; and

Whereas, AMA policies H-425.976, H-75.990, H-75.991, and H-75.992 involving contraceptives focus only on preconception, fertility, family planning, preventing pregnancy, the use of long-acting contraceptives, and the development of new contraceptives; and

Whereas, AMA-MSS policy 75.011MSS calls for the release of accurate information regarding the risks of contraception, which cannot be fulfilled given the lack of sound evidence; and

Whereas, Preconception care refers to the healthcare an individual receives during their reproductive years in order to ensure a healthy baby, focusing on overall health and wellness, and while contraceptives may be used to prevent unwanted pregnancy, preconception care does not refer to the safety, efficacy or regulation of contraceptives³³; and

Whereas, No current AMA or AMA-MSS policy exists regarding migraine in any context, despite its prevalence, and no policy exists regarding the risk of stroke in the administration of estrogen, however, as seen in H-425.978, the AMA strongly backs stroke prevention; and

Whereas, Due to the lack of new research on the safety of administering estrogen in doses as seen in today’s COCs and hormonal replacement therapy, current medical teaching reflects outdated information, leading to potential disinformation, contradicting AMA policy D-440.914 and H-75.995; therefore be it

RESOLVED that our AMA support further research regarding the role of estrogen as a risk factor for stroke and cardiovascular events at the dosages and routes found in combined oral

1 contraceptive pills, vaginal rings, transdermal patches, and hormone replacement therapy in
2 individuals with migraine and migraine with aura; and be it further
3

4 RESOLVED that our AMA work with relevant stakeholders to advocate for increased education
5 and assessment, when indicated, of migraine with aura consistent with current diagnostic
6 guidelines in medical practice sites inclusive of but not limited to primary care, obstetrics and
7 gynecology, neurology, and cardiology clinics.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. "The Facts about Migraine." *American Migraine Foundation*, 19 July 2022, <https://americanmigrainefoundation.org/resource-library/migraine-facts/>.
2. Burch, R., P. Rizzoli, and E. Loder, The Prevalence and Impact of Migraine and Severe Headache in the United States: Figures and Trends From Government Health Studies. *Headache*, 2018. 58(4): p. 496-505.
3. Shankar Kikkeri, N. and S. Nagalli, Migraine with Aura, in StatPearls. 2022, StatPearls Publishing: Treasure Island (FL).
4. Vetvik KG, MacGregor EA. Sex differences in the epidemiology, clinical features, and pathophysiology of migraine. *Lancet Neurol*. 2017 Jan;16(1):76-87.
5. "Headache Disorders." *World Health Organization*, World Health Organization, <https://www.who.int/news-room/fact-sheets/detail/headache-disorders>.
6. Rai, N.K., et al., Factors associated with delayed diagnosis of migraine: A hospital-based cross-sectional study. *Journal of family medicine and primary care*, 2019. 8(6): p. 1925-1930.
7. Daniels K, Abma JC. Current Contraceptive Status Among Women Aged 15-49: United States, 2017-2019. *NCHS Data Brief*. 2020 Oct;(388):1-8. PMID: 33151146.
8. Cooper, D.B., P. Patel, and H. Mahdy, Oral Contraceptive Pills, in StatPearls. 2022, StatPearls Publishing: Treasure Island (FL).
9. Armstrong, C., ACOG Guidelines on Noncontraceptive Uses of Hormonal Contraceptives. *American Family Physician*, 2010. 82(3): p. 288-295.
10. Kamani Mustafa, Akgor Utku, Gültekin Murat (2022) Review of the literature on combined oral contraceptives and cancer cancer 16 1416
11. Carlton, C., M. Banks, and S. Sundararajan, Oral Contraceptives and Ischemic Stroke Risk. *Stroke*, 2018. 49(4): p. e157-e159.
12. Gillum, L.A., S.K. Mamidipudi, and S.C. Johnston, Ischemic Stroke Risk With Oral Contraceptives A Meta-analysis. *JAMA*, 2000. 284(1): p. 72-78.
13. Sheikh, H.U., et al., Risk of Stroke Associated With Use of Estrogen Containing Contraceptives in Women With Migraine: A Systematic Review. *Headache*, 2018. 58(1): p. 5-21.
14. Xu, Z., et al., Current use of oral contraceptives and the risk of first-ever ischemic stroke: A meta-analysis of observational studies. *Thrombosis research*, 2015. 136(1): p. 52-60.
15. Kao, A., History of Oral Contraception. *AMA Journal of Ethics*, 2000. 2(6): p. 55-56.
16. Mukherjee, Debabrata, and Carlton C, Banks M, Sundararajan S. "Oral Contraceptives and Ischemic Stroke Risk." *American College of Cardiology*, 28 Mar. 2018, <https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2018/03/28/14/02/oral-contraceptives-and-ischemic-stroke-risk>.

17. Nettleton, William, and Valerie King. "The Risk of MI and Ischemic Stroke with Combined Oral Contraceptives." *American Family Physician*, 1 Nov. 2016, <https://www.aafp.org/pubs/afp/issues/2016/1101/p691.html>.
18. Tepper, N.K., et al., Safety of hormonal contraceptives among women with migraine: A systematic review. *Contraception*, 2016. 94(6): p. 630-640.
19. Mary, L. and P. Jacqueline, Migraine and the Contraceptive Pill or the Contraceptive Patch | Health. 2017.
20. Gupta, D. R., et al. (2022). "Non-oral routes, novel formulations and devices of contraceptives: An update." *Journal of Controlled Release* 345: 798-810.
21. "Combined Hormonal Birth Control: Pill, Patch, and Ring." ACOG, 2018, <https://www.acog.org/womens-health/faqs/combined-hormonal-birth-control-pill-patch-ring>.
22. Calhoun, A.H. and P. Batur, Combined hormonal contraceptives and migraine: An update on the evidence. *Cleveland Clinic journal of medicine*, 2017. 84(8): p. 631.
23. Tietjen, G.E. and Maly, E.F. (2020), Migraine and Ischemic Stroke in Women. A Narrative Review. *Headache: The Journal of Head and Face Pain*, 60: 843-863.
24. Allais, G., et al., Treating migraine with contraceptives. *Neurological Sciences*, 2017. 38(1): p. 85-89.
25. "Migraine with Aura, Contraceptives and Stroke Risk." American Headache Society, 24 Nov. 2020, <https://americanheadachesociety.org/news/migraine-aura-contraceptives-stroke-risk/>.
26. Carrasquilla, G.D., et al., Postmenopausal hormone therapy and risk of stroke: A pooled analysis of data from population-based cohort studies. *PLoS medicine*, 2017. 14(11): p. e1002445.
27. Løkkegaard, E., L.H. Nielsen, and N. Keiding, Risk of Stroke With Various Types of Menopausal Hormone Therapies. *Stroke*, 2017. 48(8): p. 2266-2269.
28. Boardman HM, Hartley L, Eisinga A, Main C, Roqué i Figuls M, Bonfill Cosp X, Gabriel Sanchez R, Knight B. Hormone therapy for preventing cardiovascular disease in postmenopausal women. *Cochrane Database Syst Rev*. 2015 Mar 10;(3):CD002229. doi: 10.1002/14651858.CD002229.pub4. PMID: 25754617.
29. Jelena Pavlovic, H.S., Migraine and Contraceptives. 2022.
30. Hutchinson, Susan, and Catherine Stika. "Contraceptive Options for Women with Migraine - American Headache Society." *American Headache Society*, Jan. 2022, <https://americanheadachesociety.org/wp-content/uploads/2021/01/AHS-First-Contact-Hormones-Contrceptive-Options.pdf>.
31. Lucas, S., Migraine and Other Headache Disorders: ACOG Clinical Updates In Women's Health Care Primary and Preventive Care Review Summary Volume XVIII, Number 4. *Obstetrics and gynecology*, 2019. 134(1): p. 211.
32. Reddy, N., et al., The complex relationship between estrogen and migraines: a scoping review. *Systematic reviews*, 2021. 10(1): p. 72-4.
33. "Preconception Health and Health Care Is Important for All." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 20 Sept. 2022, <https://www.cdc.gov/preconception/overview.html>.

RELEVANT AMA AND AMA-MSS POLICY

Reducing the Risk of Flight-Associated Venous Thrombosis D-45.998

Our AMA will continue to monitor research on developments concerning the relationship between air travel and venous thromboembolism and respond appropriately when more definitive results become available, and urges the Federal Aviation Administration and individual airlines to provide more comprehensive educational modalities detailing DVT prevention for all

long-duration domestic and international airline flights. CSA Rep. 4, A-04 Appended: Res. 516, A-10; Reaffirmed in lieu of Res. 503, A-15

Drug Interactions Between Oral Contraceptives and Antibiotics H-75.986

It is the policy of the AMA that: (1) women who are prescribed rifampin concomitantly with oral contraceptives are faced with a significant risk of oral contraceptive failure and should be counseled about the additional use of nonhormonal contraceptive methods during the course of rifampin therapy; and (2) women using combined oral contraceptives should be informed about the small risk of interactions with antibiotics and that it is not possible to identify in advance the women who may be at risk of oral contraceptive failure. Women who are not comfortable with the small risk of interaction should be counseled about the additional use of nonhormonal contraceptive methods. Women who have had previous oral contraceptive failures or who develop breakthrough bleeding during concomitant use of antibiotics and oral contraceptives should be counseled about the use of alternate methods of contraception if they engage in intercourse during the period of concomitant use, as they may be part of the subset of women at high risk of contraceptive failure.

CSA Rep. 8, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Reducing Unintended Pregnancy H-75.987

Our AMA: (1) urges health care professionals to provide care for women of reproductive age, to assist them in planning for pregnancy and support age-appropriate education in esteem building, decision-making and family life in an effort to introduce the concept of planning for childbearing in the educational process; (2) supports reducing unintended pregnancies as a national goal; and (3) supports the training of all primary care physicians and relevant allied health professionals in the area of preconception counseling, including the recognition of long-acting reversible contraceptives as efficacious and economical forms of contraception.

Res. 512, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-15; Appended: Res. 502, A-15; Reaffirmation I-16

Development and Approval of New Contraceptives H-75.990

Our AMA: (1) supports efforts to increase public funding of contraception and fertility research; (2) urges the FDA to consider the special health care needs of Americans who are not adequately served by existing contraceptive products when considering the safety, effectiveness, risk and benefits of new contraception drugs and devices; and (3) encourages contraceptive manufacturers to conduct post-marketing surveillance studies of contraceptive products to document the latter's long-term safety, effectiveness and acceptance, and to share that information with the FDA.

BOT Rep. O, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21

Requirements or Incentives by Government for the Use of Long-Acting Contraceptives H-75.991

(1) Involuntary use of long-acting contraceptives because of child abuse raises serious questions about a person's fundamental right to refuse medical treatment, to be free of cruel and unusual punishment, and to procreate. The state's compelling interest in protecting children from abuse may be served by less intrusive means than imposing contraception on parents who have committed child abuse. The needs of children may be better met by providing close supervision of the parents, appropriate treatment and social services, and foster placement care when necessary. There is not sufficient evidence to demonstrate that long-acting contraceptives are an effective social response to the problem of child abuse. Before long-acting contraceptives could be considered as a response to individual cases of child abuse, the issue

would need to be addressed by society broadly. Society must be careful about taking shortcuts to save resources when constitutional rights are involved.

(2) Serious questions are raised by plea bargains, or negotiations with child welfare authorities, that result in the use of long-acting contraceptives. Such agreements are made in inherently coercive environments that lack procedural safeguards. In addition, cultural and other biases may influence decisions by the state to seek the use of a long-acting contraceptive.

(3) If welfare or other government benefits were based on the use of long-acting contraceptive agents, individuals would be required to assume a potentially serious health risk before receiving their benefits. Government benefits should not be made contingent on the acceptance of a health risk.

(4) Individuals should not be denied access to effective contraception because of their indigence. Use of long-acting contraceptives should be covered by Medicaid and other health insurance programs, both public and private.

(5) Long-acting contraceptives may be medically contraindicated. Assessing the health risks of long-acting contraceptives is substantially outside the purview of courts and legislatures.

BOT Rep. EE, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmation A-04; Reaffirmed: CSAPH Rep. 1, A-14

Contraceptive Advertising H-75.995

Our AMA supports the concept of providing accurate and balanced information on the effectiveness, safety and risks/benefits of contraception in all public media and urges that such advertisements include appropriate information on the effectiveness, safety and risk/benefits of various methods.

Res. 4, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Over-the-Counter Access to Oral Contraceptives D-75.995

1. Our AMA will recommend to the US Food and Drug Administration that manufacturers of oral contraceptives be encouraged to submit the required application and supporting evidence for the Agency to consider approving a switch in status from prescription to over-the-counter for such products. 2. Our AMA encourages the continued study of issues relevant to over-the-counter access for oral contraceptives.

Sub. Res. 507, A-13

Sexuality Education, Abstinence, and Distribution of Condoms in Schools H-170.968

Our AMA: (1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction; (2) Urges schools to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (c) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (d) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (e) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and (f) are part of an overall health education program; (3) Continues to monitor future research findings related

to emerging initiatives that include abstinence-only, school-based sexuality education, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate; (4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program; (5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems; (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes; (7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and (8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy.

CSA Rep. 7 and Reaffirmation I-99; Reaffirmed: Res. 403, A-01; Modified Res. 441, A-03; Appended: Res. 834, I-04; Reaffirmed: CSAPH Rep. 7, A-09

Support for Medicare Coverage of Contraceptive Methods D-330.900

Our AMA will work with the Centers for Medicare and Medicaid Services and other stakeholders to include coverage for all US Food and Drug Administration-approved contraceptive methods for contraceptive and non-contraceptive use for all patients covered by Medicare, regardless of eligibility pathway (age or disability). Res. 117, A-19

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

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

Stroke Prevention and Care Legislation H-425.978

Our AMA supports comprehensive stroke legislation such as S.1274, the Stroke Treatment and Ongoing Prevention Act (STOP Stroke Act) as introduced, and work with Congress to enact legislation that will help improve our nation's system of stroke prevention and care. Res. 215, I-01 Reaffirmed: BOT Rep. 22, A-11 Reaffirmed: BOT Rep. 7, A-21

Preconception Care H-425.976

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

- (1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan;
- (2) Consumer awareness--increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts;
- (3) Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes;
- (4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact);

- (5) Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth);
 - (6) Pre-pregnancy checkup--offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy;
 - (7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception care;
 - (8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes;
 - (9) Research--increase the evidence base and promote the use of the evidence to improve preconception health; and
 - (10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor preconception health.
2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health.
3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-care and recommend it be appropriately documented in the medical record.
- Res. 414, A-06; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17; Appended: Res. 401, A-19

Addressing Public Health Disinformation Disseminated by Health Professionals D-440.914

- Our AMA will collaborate with relevant health professional societies and other stakeholders:
- (a) on efforts to combat public health disinformation disseminated by health professionals in all forms of media,
 - (b) address disinformation that undermines public health initiatives, and
 - (c) implement a comprehensive strategy to address health-related disinformation disseminated by health professionals that includes:
 - (1) Maintaining AMA as a trusted source of evidence-based information for physicians and patients.
 - (2) Ensuring that evidence-based medical and public health information is accessible by engaging with publishers, research institutions and media organizations to develop best practices around paywalls and preprints to improve access to evidence-based information and analysis.
 - (3) Addressing disinformation disseminated by health professionals via social media platforms and addressing the monetization of spreading disinformation on social media platforms.
 - (4) Educating health professionals and the public on how to recognize disinformation as well as how it spreads.
 - (5) Considering the role of health professional societies in serving as appropriate fact-checking entities for health-related information disseminated by various media platforms.
 - (6) Encouraging continuing education to be available for health professionals who serve as fact-checker to help prevent the dissemination of health-related disinformation.
 - (7) Ensuring licensing boards have the authority to take disciplinary action against health professionals for spreading health-related disinformation and affirms that all speech in which a health professional is utilizing their credentials is professional conduct and can be scrutinized by their licensing entity.
 - (8) Ensuring specialty boards have the authority to take action against board certification for health professionals spreading health-related disinformation.

(9) Encouraging state and local medical societies to engage in dispelling disinformation in their jurisdictions. Res. 411, I-21; Modified: BOT Rep. 15, A-22

AMA Endorsement of Screening Tests or Standards G-600.064

(1) Delegates, state, or specialty societies submitting a resolution seeking endorsement or AMA adoption of specific screening tests must also submit an evidence-based review that determines the strength or quality of the evidence supporting their request, and that evaluates the degree to which the test satisfies the minimal criteria for validating the appropriateness of the screening test, which are: (a) the test must be able to detect the target condition earlier than without screening and with sufficient accuracy to avoid producing large numbers of false-positive and false-negative results; and (b) screening for and treating persons with early disease should improve the likelihood of favorable health outcomes compared with treating patients when they present with signs or symptoms of disease. (2) This review will be made available to the reference committee, which will either recommend to the House of Delegates that the resolution be referred or not be adopted.

CSA Rep. 7, A-02; CC&B Rep. 3, I-08; Reaffirmed: CCB/CLRPD Rep. 3, A-12; Reaffirmed: CCB/CLRPD Rep. 1, A-22

5.006MSS Transparency on Restrictions of Care 5.006MSS: AMA-MSS (1) supports advocating that all

medical institutions provide medically accurate information on the full breadth of reproductive health options available for patients, including, but not limited to, all forms of contraception, emergency care during miscarriages, and infertility treatments, regardless of the institution's willingness to perform the aforementioned services; (2) endorses the timely referral of patients seeking reproductive services from healthcare providers with religious commitments to accessible health care systems offering the aforementioned services, all the while avoiding any undue burden to the patient; and (3) supports advocating that all facilities and hospitals disclose all restrictions in care at their facility, and all physicians seeking employment at their facility. (MSS Res 13, A-17) (Amended: MSS Res 125, Nov. 2020)

Ending Discrimination Against Contraception 75.009MSS: AMA-MSS will ask the AMA to support the concept of equity among all forms of prescription contraception in order to offer women the option of affordable contraceptives which would include support from state and federal agencies. (MSS Res 34, I-03) (Reaffirmed Existing Policy in Lieu of AMA Res 107, A-04) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

Informed Consent with Regards to Advertising and Prescribing Contraceptives 75.011MSS:

AMA-MSS: (1) supports continued research that explores alternative mechanisms of contraceptives; and (2) supports the concept of providing accurate and balanced information on the effectiveness, safety and risks/benefits of contraception in all public media and urges that such advertisements include appropriate information on the effectiveness, safety and risk/benefits of various methods with the addition of information regarding possible secondary mechanisms of contraceptive methods when conclusive and quantitative data is available. (MSS Rep B, A-04) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

Recognizing Long-Acting Reversible Contraceptives (LARCs) as Efficacious and Economical Forms of Contraception 75.012

MSS: That our AMA (1) study unintended pregnancies and their consequences with a focus on current efficacious and economic methods to overcome the problem; and (2) support the training of all primary care providers in the area of preconception counseling. (MSS 30, A-14) (Reaffirmation A15; Appended: Res. 502, A-15 Adopted with Change in Title [H-75.987]) (Reaffirmed: MSS GC Rep A, I-19)

Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraception Placement: 75.013

MSS AMA-MSS will ask (1) that our AMA recognize the practice of immediate postpartum and post-abortive long-acting reversible contraception placement to be a safe and cost effective way of reducing future unintended pregnancies, (2) that our AMA support the coverage of immediate postpartum long-acting reversible contraception device and placement by Medicaid, Medicare, and private insurers, and that this service be billed separately from the obstetrical global fee, and (3) that our AMA encourage relevant specialty organizations to provide training for physicians regarding (i) patients who are eligible for immediate postpartum long-acting

reversible contraception, and (ii) immediate postpartum long-active reversible contraception placement protocols and procedures. (MSS Res 10, I-15) (AMA Res 101, A-16 Adopted as Amended [H-75.984]) (Reaffirmed: MSS GC Rep B, A-21)

310.048 MSS Training in Reproductive Health Topics as a Requirement for Accreditation of Family Medicine Residencies: AMA-MSS supports our AMA working with the Accreditation Council for Graduate Medical Education to protect patient access by advocating for preservation of accreditation requirements for family medicine residencies in reproductive health topics, including contraceptive counseling, family planning, and counseling for unintended pregnancy. (Late Res 2, A-13) (Reaffirmed: MSS GC Rep A, I-19)(MSS Res 2, I-13)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 019
(I-22)

Introduced by: Chioma Owo, Bryan Ubanwa, Faith Portuphy, Benjamin Akande, Ndanzia Mpunga, Sam Oshoba, University of Texas Health San Antonio; Itisha S. Jefferson, Loyola University Stritch School of Medicine; Rodolfo Valentini and Daniel Nyancho, University of Connecticut

Subject: Regulation of Skin Bleaching Agents and Colorism as a Public Health Concern

Sponsored by: Region 7, Association of Native American Medical Students, Asian Pacific American Medical Student Association, PsychSIGN, American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Colorism is the prejudicial or preferential treatment of individuals from the same-race based on the hue of their skin tone, unlike racism, which is the prejudice, discrimination, or antagonism against individuals from marginalized racial or ethnic groups¹; and

Whereas, Colorism is a conscious or unconscious bias that leads to systemic inequality by privileging light skin and demonizing dark skin, creating advantages in career, education, beauty, and overall opportunities^{2,3}; and

Whereas, Racism is a socially constructed, quasi-scientific classification, unlike colorism, as an individual's skin tone is a visual fact that can not be disputed or hidden¹; and

Whereas, Colorism, comparable to racism, originated in colonialism and slavery, which were used to establish and maintain racial hierarchies and promote non-white inferiority³; and

Whereas, The psychosocial impact of colorism on darker-skinned ethnicities may manifest as poor self-esteem, mental health, self-reported physical health, and increased usage of dangerous skin-bleaching products compared to their lighter-skin peers^{2,3}; and

Whereas, Skin bleaching is the use of agents intended to inhibit melanin production in order to uniformly lighten the appearance of the skin, often used without medical supervision³; and

Whereas, Prevalence of skin bleaching globally in 2020 was 27.7% in all individuals, with a 28% lifetime prevalence in males^{2,4}; and

Whereas, Skin bleaching and skin lightening practices are common among non-White women, it has become increasingly common among men and young adults⁵; and

Whereas, Colorism is pervasive in Latin America, East and Southeast Asia, the Caribbean and Africa, this has resulted in the heavy practice of skin bleaching in these regions¹; and

Whereas, the United States is a country developed from immigration and interracial unions, the perceived need to actively seek out and utilize skin bleaching products is increasing as a result of the effects of colorism¹; and

Whereas, Skin bleaching is a multi-billion dollar industry globally, and has generated a significant advertising and social media presence³; and

Whereas, Marketing via misleading names such as skin brighteners, skin toners, or dark spot removal creams may contribute to the increased prevalence of skin bleaching agents, which are easily available over the counter (OTC)⁶; and

Whereas, Skin bleaching is associated with individuals who live in urban areas, have lower educational attainment, and have ethnic heritage from Asian, African, and Caribbean countries³;

Whereas, One meta-analysis found topical corticosteroids to be the most abused lightening agent, followed by 1-4-dihydroxybenzene (hydroquinone) due to easy availability OTC, mercury and other chemical agents, which are present in unregulated concentrations and cause adverse effects when applied long-term^{4,5}; and

Whereas, Topical corticosteroids are agents that can cause telangiectasia, dyspigmentation, photosensitivity, adrenal suppression, hypertension, and diabetes³; and

Whereas, Hydroquinone is an agent that can cause epidermis disruption, irritant dermatitis, burning sensation, ochronosis, and fetal growth retardation^{3,4,5}; and

Whereas, Mercury is an agent that can cause gingivitis, desquamation, dyspigmentation, neuropsychiatric complications, muscle weakness, and fetal abnormalities³; and

Whereas, Skin bleaching product ingredients and concentrations are often unregulated and mislabeled, leading to consumers being unaware of the hazardous ingredients and risks associated with the practice³; and

Whereas, No Food and Drug Administration (FDA) approved OTC skin lightening product currently exists on the market, and on April 19, 2022, the FDA took action and issued 12 warning letters to companies in violation of selling OTC products containing hydroquinone⁸; and

Whereas, Culturally and socially conscious medical practitioners and other skincare professionals can and should understand skin tone concerns, be aware of the common signs of skin bleaching, identify skin bleaching complications, provide patient education, and raise awareness on the serious dangers of this practice^{2,3}; therefore be it

1 RESOLVED, That our AMA recognizes skin bleaching as a public health concern among people
2 of color populations; and be it further

4 RESOLVED, That our AMA discourages the excessive use of skin bleaching agents for cosmetic
5 or other non-medical purposes; and be it further

7 RESOLVED, That our AMA collaborates with appropriate stakeholders to enhance education
8 about the dangers of skin bleaching to skin of color patients and health care providers; and be it
9 further

11 RESOLVED, That our AMA supports the continued efforts to regulate skin bleaching and/or
12 lightening agents; and be it further

14 RESOLVED, That our AMA amend Policy H-65.952, "Racism as a Public Health Threat" by
15 addition to read as follows:

17 Racism and Colorism as a Public Health Threat, H-65.952

18 1. Our AMA acknowledges that, although the primary drivers of racial health
19 inequity are systemic and structural racism, racism and colorism within medical
20 research and health care delivery have caused and continue to cause harm to
21 marginalized communities and society as a whole.

22 2. Our AMA recognizes racism and colorism, in its systemic, cultural,
23 interpersonal, and other forms, as a serious threat to public health, to the
24 advancement of health equity, and a barrier to appropriate medical care.

25 3. Our AMA encourages the development, implementation, and evaluation of
26 undergraduate, graduate, and continuing medical education programs and
27 curricula that engender greater understanding of: (a) the causes, influences, and
28 effects of systemic, cultural, institutional, and interpersonal racism and colorism;
29 and (b) how to prevent and ameliorate the health effects of racism and colorism.

30 4. Our AMA: (a) supports the development of policy to combat racism and
31 colorism and its effects; and (b) encourages governmental agencies and
32 nongovernmental organizations to increase funding for research into the
33 epidemiology of risks and damages related to racism and colorism, and how to
34 prevent or repair them.

35 5. Our AMA will work to prevent and combat the influences of racism, colorism,
36 and bias in innovative health technologies.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Tharps LL. The difference between racism and colorism. Time.
<https://time.com/4512430/colorism-in-america/>. Published October 6, 2016. Accessed
September 22, 2022.
2. Daftary K, Krishnam NS, Kundu RV. Uncovering the roots of skin bleaching: Colorism
and its detrimental effects. *Journal of Cosmetic Dermatology*. May 2022;1.
doi:10.1111/jocd.15049
3. Sommerlad M. Skin lightening: Causes and complications. *Clinical and Experimental*
Dermatology. 2021;47(2):264-270. doi:10.1111/ced.14972

4. Sagoe D. et al. The global prevalence and correlates of skin bleaching: a meta-analysis and meta-regression analysis. *Int J Dermatol*. 2019;58(1):24-44.
5. Benn EK. et al. Skin bleaching and dermatologic health of African and Afro-Caribbean populations in the US: New Directions for methodologically rigorous, multidisciplinary, and culturally sensitive research. *Dermatology and Therapy*. 2016;6(4):453-459. doi:10.1007/s13555-016-0154-1
6. Shivakumar S, Jafferany M. "The unfair drive to be fair": Psychosocial aspects and implications of the use of skin lightening agents. *Dermatologic Therapy*. 2020;33(6). doi:10.1111/dth.14091
7. Owolabi JO. et al. Effects of skin lightening cream agents – hydroquinone and kojic acid, on the skin of adult female experimental rats. *Clinical, Cosmetic and Investigational Dermatology*. 2020;Volume 13:283-289. doi:10.2147/ccid.s233185
8. Center for Drug Evaluation and Research. OTC skin lightening products. U.S. Food and Drug Administration. <https://www.fda.gov/drugs/drug-safety-and-availability/fda-works-protect-consumers-potentially-harmful-otc-skin-lightening-products#:~:text=All%20OTC%20skin%20lightening%20products,the%20products%20from%20the%20marketplace>. Accessed September 22, 2022.

RELEVANT AMA AND AMA-MSS POLICY

Representation of Dermatological Pathologies in Varying Skin Tones H-295.853

Our AMA encourages comprehensive, inclusive and equitable representation of a diverse range of skin tones in all dermatologic and other relevant medical educational resources for medical students, physicians, non-physician healthcare providers and patients.

Res. 505, I-21

Racism as a Public Health Threat H-65.952

Our AMA: 1) 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) 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) 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) (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) will work to prevent and combat the influences of racism and bias in innovative health technologies.

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 020
(I-22)

Introduced by: Samantha Crowley, Juliana Craig, Laurie Lapp, Tessa Meurer, Andrew Norton, Leela Shah, Sophie Vrba, Nick VanDerwerker, University of Wisconsin School of Medicine and Public Health; Megan Quamme, Medical College of Wisconsin; Priya Desai, Boston University School of Medicine; Sara Kazyak, Aarti Patel, Wayne State University School of Medicine; Sairandri Sathyanarayanan, Renato Guerrieri, McGovern Medical School at UTHealth; Grace Keegan, University of Chicago Pritzker School of Medicine; Julia Silverman, University of Connecticut School of Medicine; Anudeeta Gautam, Christopher Dasaro, Krysten Floyd, Lewis Katz School of Medicine at Temple University; Lavinia Wainwright, Eastern Virginia Medical School; Kayla Tran, Rosalind Franklin University Chicago Medical School; Elisabeth McCallum, University of California, Irvine School of Medicine; Kyle Cotner, University of Toledo College of Medicine; Shreya Mandava, University of Virginia School of Medicine

Subject: Lack of Access to Abortion is a Threat to Public Health

Sponsored by: Region 1, Region 2, Region 3, Region 5, Region 7, American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, The *Dobbs v Jackson Women's Health Organization* (2022) decision overturned the federal protection of abortion as established in *Roe v. Wade* (1973)¹; and

Whereas, After the overturning of *Roe v. Wade*, abortion is now banned or severely restricted in twenty-six states and three U.S. territories, including trigger bans in 13 states²⁻⁶; and

Whereas, The 14 states with the most restrictive abortion laws also have the worst maternal and child health outcomes⁷⁻¹⁰; and

Whereas, Research indicates the number of maternal deaths will increase 13% in the first year after a nationwide abortion ban, and 24% in subsequent years, and for Black women, these numbers increase to 18% and 39% respectively, proving the urgent need for action¹¹; and

Whereas, Pregnant people who are denied access to abortion care are more likely to remain in contact with and less likely to leave physically and emotionally abusive partners, which is of particular importance as intimate partner violence during pregnancy and the post-partum period is a leading cause of pregnancy-associated deaths^{12,13}; and

Whereas, The inability to access abortion care has negative socioeconomic consequences for both the pregnant person and their families, as people who gave birth after denial of abortion are four times more likely to live in poverty for at least four years after childbirth than those who received abortions^{14,15}; and

Whereas, Inequities in abortion access disproportionately impact low-income people and people of color, and worsen existing disparities in maternal and infant mortality and rates of pre-term and low birthweight births^{16,17}; and

Whereas, Half of patients seeking abortion care in the US have incomes below the federal poverty line¹⁸; and

Whereas, The Hyde Amendment, passed in 1977, bans state use of federal Medicaid dollars to pay for abortions with exceptions only for rape, incest, and life of the pregnant person^{19,20}; and

Whereas, Nearly 1 in 5 (19%) women of reproductive age in the United States receive healthcare coverage through Medicaid²¹; and

Whereas, People of color are more likely to be impacted by the Hyde Amendment restrictions, with 29% of Black women and 25% of Hispanic women receiving Medicaid compared to 15% of white women aged 18-49²²; and

Whereas, The Turnaway Study found that women who were unable to afford pregnancy termination due to The Hyde Amendment's restriction of Medicaid coverage of abortion and subsequently had a child were more likely than women who received an abortion to be unemployed, receiving public assistance and living below the poverty line one year post clinic visit despite no economic difference in the women the year prior²³⁻²⁵; and

Whereas, A study recently published in the American Journal of Public Health found states with restrictions on Medicaid coverage of abortion care had a 29% higher total maternal mortality than states without Medicaid coverage restrictions²⁶; and

Whereas, Restrictions on the funding of abortion care through federally funded insurance programs lead to higher rates of unintended birth and furthers economic hardship on low income pregnant people^{27,28}; and

Whereas, The American College of Obstetrics and Gynecology recommends that the Hyde Amendment and other federal and state restrictions on insurance coverage of abortion be eliminated²⁹; and

Whereas, At the June 2022 Annual Meeting of the House of Delegates, the American Medical Association recognized that "healthcare, including reproductive services like contraception and abortion, is a human right"; however, the overturning of Roe v. Wade necessitates urgent action by the AMA to address the heightened threat to public health posed by the recent onslaught of abortion bans introduced at the state and federal level³⁰⁻³²; and

Whereas, Our AMA issued a statement on June 24, 2022 in response to the Dobbs v. Jackson Supreme Court ruling, stating, "we will oppose any law or regulation that compromises or criminalizes patient access to safe, evidence-based medical care, including abortion"; however, there has been no explicit condemnation of the Hyde Amendment by the AMA³³; and therefore be it

RESOLVED, Our AMA recognize that policies and legislation that limit access to abortion care are serious threats to public health; and be it further

- 1 RESOLVED, Our AMA recognize the Hyde Amendment as a racist policy and support efforts to
2 repeal it; and be it further
3
4 RESOLVED, Our AMA will advocate for the explicit codification of protections for abortion care
5 in all circumstances into federal law; and be it further
6
7 RESOLVED, Our AMA-MSS immediately forward this resolution to the House of Delegates.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Supreme Court of the United States. 19-1392 Dobbs v. Jackson Women's Health Organization (06/24/2022). Published online 2022:213.
2. Abortion Laws by State. Center for Reproductive Rights. Accessed August 31, 2022. <https://reproductiverights.org/maps/abortion-laws-by-state/>
3. State Bans on Abortion Throughout Pregnancy. Guttmacher Institute. Published March 14, 2016. Accessed August 31, 2022. <https://www.guttmacher.org/state-policy/explore/state-policies-later-abortions>
4. Times TNY. Tracking the States Where Abortion Is Now Banned. *The New York Times*. <https://www.nytimes.com/interactive/2022/us/abortion-laws-roe-v-wade.html>. Published May 24, 2022. Accessed August 31, 2022.
5. Sidik SM. The effects of overturning Roe v. Wade in seven simple charts. *Nature*. 2022;608(7922):254-257. doi:10.1038/d41586-022-02139-3
6. 60 Days After Dobbs: State Legal Developments on Abortion | Brennan Center for Justice. Accessed September 22, 2022. <https://www.brennancenter.org/our-work/research-reports/60-days-after-dobbs-state-legal-developments-abortion>
7. Stone D. *Policy Paradox: The Art of Political Decision Making*.; 2001. <https://www.norton.com/books/Policy-Paradox>
8. Addante AN, Eisenberg DL, Valentine MC, Leonard J, Maddox KEJ, Hoofnagle MH. The association between state-level abortion restrictions and maternal mortality in the United States, 1995-2017. *Contraception*. 2021;104(5):496-501. doi:10.1016/j.contraception.2021.03.018
9. Pabayo R, Ehntholt A, Cook DM, Reynolds M, Muennig P, Liu SY. Laws Restricting Access to Abortion Services and Infant Mortality Risk in the United States. *Int J Environ Res Public Health*. 2020;17(11):E3773. doi:10.3390/ijerph17113773
10. Wilkinson TA, Maslowsky J, Berlan ED. The Pediatrician in the Post-Roe Landscape. *JAMA Pediatr*. Published online August 15, 2022. doi:10.1001/jamapediatrics.2022.2868
11. Stevenson AJ, Root L, Menken J. The maternal mortality consequences of losing abortion access. Published online June 29, 2022. doi:10.31235/osf.io/7g29k
12. Campbell J, Matoff-Stepp S, Velez ML, Cox HH, Laughon K. Pregnancy-Associated Deaths from Homicide, Suicide, and Drug Overdose: Review of Research and the Intersection with Intimate Partner Violence. *J Womens Health*. 2021;30(2):236-244. doi:10.1089/jwh.2020.8875
13. Roberts SC, Biggs MA, Chibber KS, Gould H, Rocca CH, Foster DG. Risk of violence from the man involved in the pregnancy after receiving or being denied an abortion. *BMC Med*. 2014;12(1):144. doi:10.1186/s12916-014-0144-z
14. Jones K, Bernstein A. The Economic Effects of Abortion Access: A Review of the Evidence (Fact Sheet). Institute for Women's Policy Research. Published July 22, 2019. Accessed February 22, 2020. <https://iwpr.org/publications/economic-effects-abortion-access-fact->

sheet/

15. Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States | AJPH | Vol. 108 Issue 3. Accessed June 9, 2022. <https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304247>
16. Population Group Abortion Rates and Lifetime Incidence of Abortion: United States, 2008–2014 | AJPH | Vol. 112 Issue 9. Accessed August 31, 2022. <https://ajph.aphapublications.org/doi/10.2105/AJPH.2017.304042>
17. Redd SK, Rice WS, Aswani MS, et al. Racial/ethnic and educational inequities in restrictive abortion policy variation and adverse birth outcomes in the United States. *BMC Health Serv Res.* 2021;21(1):1139. doi:10.1186/s12913-021-07165-x
18. Jerman J, Jones RK, Onda T. Characteristics of U.S. Abortion Patients in 2014 and Changes Since 2008. Published online May 10, 2016. Accessed August 31, 2022. <https://www.guttmacher.org/report/characteristics-us-abortion-patients-2014>
19. State Funding of Abortions Under Medicaid. KFF. Published May 13, 2022. Accessed August 31, 2022. <https://www.kff.org/medicaid/state-indicator/abortion-under-medicaid/>
20. S.142 - 113th Congress (2013-2014): Hyde Amendment Codification Act. Published January 24, 2013. Accessed August 31, 2022. <http://www.congress.gov/>
21. Health Insurance Coverage of Women Ages 15-49. KFF. Published October 23, 2020. Accessed September 21, 2022. <https://www.kff.org/other/state-indicator/health-insurance-coverage-of-women-ages-15-49/>
22. The Hyde Amendment: A Discriminatory Ban on Insurance Coverage of Abortion. Guttmacher Institute. Published April 23, 2021. Accessed September 21, 2022. <https://www.guttmacher.org/fact-sheet/hyde-amendment>
23. Advancing New Standards in Reproductive Health, University of California San Francisco. The Turnaway Study. ANSIRH. Accessed August 31, 2022. <https://www.ansirh.org/research/ongoing/turnaway-study>
24. Abortion in the Lives of Women Struggling Financially: Why Insurance Coverage Matters. Guttmacher Institute. Published July 12, 2016. Accessed August 31, 2022. <https://www.guttmacher.org/gpr/2016/07/abortion-lives-women-struggling-financially-why-insurance-coverage-matters>
25. Miller S, Wherry L, Foster DG. *The Economic Consequences of Being Denied an Abortion*. National Bureau of Economic Research; 2020:w26662. doi:10.3386/w26662
26. State Abortion Policies and Maternal Death in the United States, 2015–2018 | AJPH | Vol. 111 Issue 9. Accessed August 31, 2022. https://ajph.aphapublications.org/doi/10.2105/AJPH.2021.306396?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Aacrossref.org&rfr_dat=cr_pub++0pubmed
27. Research brief: The impact of Medicaid coverage restrictions on abortion. Ibis Reproductive Health. Published October 7, 2014. Accessed August 31, 2022. <https://www.ibisreproductivehealth.org/publications/research-brief-impact-medicaid-coverage-restrictions-abortion>
28. Upadhyay UD, McCook AA, Bennett AH, Cartwright AF, Roberts SCM. State abortion policies and Medicaid coverage of abortion are associated with pregnancy outcomes among individuals seeking abortion recruited using Google Ads: A national cohort study. *Soc Sci Med.* 2021;274:113747. doi:10.1016/j.socscimed.2021.113747
29. The American College of Obstetrics and Gynecology. Increasing Access to Abortion. 2020;136(6):9.
30. American Medical Association House of Delegates Resolution 028 Preserving Access to Reproductive Health Services Pg. 97-102. Published online June 10, 2022. <https://www.ama-assn.org/system/files/a22-saturday-tote.pdf>
31. Texas State Law Library. Texas Abortion “Trigger” Law Effective August 25th, 2022. Published July 7, 2022. Accessed September 21, 2022.

<https://www.sll.texas.gov/spotlight/2022/07/texas-abortion-trigger-law-effective-august-25th-2022/>

32. Graham L. Protecting Pain-Capable Unborn Children from Late-Term Abortions Act. Published online September 13, 2022:27.
33. Ruling an egregious allowance of government intrusion into medicine. American Medical Association. Accessed August 31, 2022. <https://www.ama-assn.org/press-center/press-releases/ruling-egregious-allowance-government-intrusion-medicine>

RELEVANT AMA AND AMA-MSS POLICY

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.

Res. 028, A-22

2.2.3 Mandatory Parental Consent to Abortion

In many jurisdictions, unemancipated minors are not permitted to request or receive abortion services without their parents' knowledge and consent. Physicians should ascertain the law in their state on parental involvement to ensure that their practices are consistent with their legal obligations. In many places, the issue of confidentiality for minors who seek an abortion implicates competing ethical concerns apart from the abortion issue itself.

When an unemancipated minor requests abortion services, physicians should:

- (a) Strongly encourage the patient to discuss the pregnancy with her parents (or guardian).
- (b) Explore the minor patient's reasons for not involving her parents (or guardian) and try to correct misconceptions that may be motivating the patient's reluctance to involve parents. If the patient is unwilling to involve her parents, encourage her to seek the advice and counsel of adults in whom she has confidence, including professional counselors, relatives, friends, teachers, or the clergy.
- (c) Explain to the minor patient under what circumstances the minor's confidentiality will be abrogated, including:
 - (i) life-threatening emergency; or
 - (ii) when parental notification is required by applicable law.
- (d) Try to ensure that the minor patient carefully considers the issues involved and makes an informed decision.

(e) Not feel or be compelled to require a minor patient to involve her parents before she decides whether to undergo an abortion.

AMA Principles of Medical Ethics: III,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

4.2.7 Abortion

The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion in accordance with good medical practice and under circumstances that do not violate the law.

AMA Principles of Medical Ethics: III,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

7.3.5 Research Using Human Fetal Tissue

Research with human fetal tissue research has led to the development of a number of important research and medical advances, such as the development of polio vaccine. Fetal tissue has also been used to study the mechanism of viral infections and to diagnose viral infections and inherited diseases, as well as to develop transplant therapies for a variety of conditions, for example, parkinsonism.

However, the use of fetal tissue for research purposes also raises a number of ethical considerations, including the degree to which a woman's decision to have an abortion might be influenced by the opportunity to donate fetal tissue. Concerns have also been raised about potential conflict of interest when there is possible financial benefit to those who are involved in the retrieval, storage, testing, preparation, and delivery of fetal tissues.

To protect the interests of pregnant women as well as the integrity of science, physicians who are involved in research that uses human fetal tissues should:

(a) Abstain from offering money in exchange for fetal tissue.

(b) In all instances, obtain the woman's voluntary, informed consent in keeping with ethics guidance, including when using fetal tissue from a spontaneous abortion for purposes of research or transplantation. Informed consent includes a disclosure of the nature of the research including the purpose of using fetal tissue, as well as informing the woman of a right to refuse to participate.

(c) Ensure that when fetal tissue from an induced abortion is used for research purposes:

(i) the woman's decision to terminate the pregnancy is made prior to and independent of any discussion of using the fetal tissue for research purposes;

(ii) decisions regarding the technique used to induce abortion and the timing of the abortion in relation to the gestational age of the fetus are based on concern for the safety of the pregnant woman.

(d) Ensure that when fetal tissue is to be used for transplantation in research or clinical care:

(i) the donor does not designate the recipient of the tissue;

(ii) both the donor and the recipient of the tissue give voluntary, informed consent.

(e) Ensure that health care personnel involved in the termination of a pregnancy do not benefit from their participation in the termination, or from use of the fetal tissue for transplantation.

AMA Principles of Medical Ethics: I,III,IV,V

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

Issued: 2016

Oppose the Criminalization of Self-Managed Abortion H-5.980

Our AMA: (1) opposes the criminalization of self-managed abortion and the criminalization of patients who access abortions as it increases patients' medical risks and deters patients from seeking medically necessary services; and (2) will advocate against any legislative efforts to criminalize self-managed abortion and the criminalization of patients who access abortions; and (3) will oppose efforts to enforce criminal and civil penalties or other retaliatory efforts against these patients and requirements that physicians function as agents of law enforcement – gathering evidence for prosecution rather than as a provider of treatment.

Res. 007, A-18; Modified: Res. 027, A-22

Late-Term Pregnancy Termination Techniques H-5.982

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

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

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

(4) In recognition of the constitutional principles regarding the right to an abortion articulated by the Supreme Court in Roe v. Wade, and in keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery.

BOT Rep. 26, A-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Policy on Abortion H-5.990

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

Res. 158, A-90; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 1, A-09; Reaffirmed: CEJA Rep. 03, A-19

Accurate Reporting on AMA Abortion Policy H-5.988

Our AMA HOD cautions members of the Board of Trustees, Councils, employees and members of the House of Delegates to precisely state current AMA policy on abortion and related issues in an effort to minimize public misperception of AMA policy and urges that our AMA continue efforts to refute misstatements and misquotes by the media with reference to AMA abortion policy.

Sub. Res. 21, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CEJA Rep. 8, A-11;
Reaffirmed: CEJA Rep. 1, A-21

Medical Training and Termination of Pregnancy H-295.923

1. Our AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy.

2. Our AMA supports the availability of abortion education and exposure to procedures for termination of pregnancy, including medication abortions, for medical students and resident/fellow physicians and opposes efforts to interfere with or restrict the availability of this education and training.

3. Our AMA encourages the Accreditation Council for Graduate Medical Education to consistently enforce compliance with the standardization of abortion training opportunities as per the requirements set forth by the Review Committee for Obstetrics and Gynecology and the American College of Obstetricians and Gynecologists' recommendations.

Res. 315, I-94; Reaffirmed: CME Rep. 2, A-04; Modified: CME Rep. 2, A-14; Modified: CME Rep. 1, A-15 Appended: Res. 957, I-17; Modified: Res. 309, I-21

Abortion H-5.995

Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice.

Sub. Res. 43, A-73; Reaffirmed: I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: CMS Rep. 1, I-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: CEJA Rep. 01, A-20

Public Funding of Abortion Services H-5.998

The AMA reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

Sub. Res. 89, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: BOT Rep. 12, A-05;
Reaffirmed: CMS Rep. 1, A-15

Right to Privacy in Termination of Pregnancy H-5.993

The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good

medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities.

Violence Against Medical Facilities and Health Care Practitioners and Their Families H-5.997

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

Res. 82, I-84; Reaffirmed by CLRPD Rep. 3 - I-94; ;Res. 422, A-9 5Reaffirmation I-99;
Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19

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

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

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

- a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities;
- b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines;
- c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities;
- d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements;
- e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance;
- f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and
- g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

Res. 621, A-22

Pregnancy Termination H-5.983

The AMA adopted the position that pregnancy termination be performed only by appropriately trained physicians (MD or DO).

Res. 520, A-95; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13

Freedom of Communication Between Physicians and Patients H-5.989

It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient;

(2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship;

(3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and

(4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.

Sub. Res. 213, A-91; Reaffirmed: Sub. Res. 232, I-91; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed by Sub. Res. 133 and BOT Rep. 26, A-97; Reaffirmed by Sub. Res. 203 and 707, A-98; Reaffirmed: Res. 703, A-00; Reaffirmed in lieu of Res. 823, I-07; Reaffirmation I-09; Reaffirmation: I-12; Reaffirmed in lieu of Res. 5, I-13

Public Funding of Abortion Services 5.001MSS

AMA-MSS will ask the AMA to: (1) continue its support of education and choice with respect to reproductive rights; (2) continue to actively support legislation recognizing abortion as a compensable service; and (3) continue opposition to legislative measures which interfere with medical decision making or deny full reproductive choice, including abortion, based on a patient's dependence on government funding. (AMA Sub Res 89, I-83, Adopted [H-5.998]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS Res 27, A-16) (Reaffirmed: MSS Res 059, A-21)

Condemnation of Violence Against Abortion Clinics 5.002MSS

AMA-MSS will ask the AMA to condemn the violence directed against abortion clinics and family planning centers as a violation of the right to access health care. (AMA Amended Res 82, I 84, Adopted [H-5.997]) (Reaffirmed: MSS COLRP Rep B, I-95) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Patient Confidentiality and Reproductive Health 5.003MSS

AMA-MSS condemns the attempts of the Department of Justice to subpoena medical records in cases involving abortion. (MSS Amended Res 11, A-04) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

MSS Stance on Challenges to Women's Right to Reproductive Health Care Access 5.005MSS

AMA-MSS opposes legislation that would restrict a woman's right to obtain medical services associated with her reproductive health, as defined in policy 5.001 MSS, on the grounds that they interfere with a physician's ability to provide medical care. (MSS Res 6, A-06) (Reaffirmed: MSS GC Rep D, I-11) (Reaffirmed: MSS Res 27, A16) (Reaffirmed: MSS Res 059, A-21)

Transparency on Restrictions of Care 5.006MSS

AMA-MSS (1) supports advocating that all medical institutions provide medically accurate information on the full breadth of reproductive health options available for patients, including, but not limited to, all forms of contraception, emergency care during miscarriages, and infertility treatments, regardless of the institution's willingness to perform the aforementioned services; (2) endorses the timely referral of patients seeking reproductive services from healthcare providers with religious commitments to accessible health care systems offering the aforementioned services, all the while avoiding any undue burden to the patient; and (3) supports advocating that all facilities and hospitals disclose all restrictions in care at their facility, and all physicians seeking employment at their facility. (MSS Res 13, A-17) (Amended: MSS Res 125, Nov. 2020)

Ending the Risk Evaluation and Mitigation Strategy (REMS) on Mifepristone 5.007MSS

AMAMSS will ask the AMA to support efforts urging the Food and Drug Administration (FDA) to lift the Risk Evaluation and Mitigation Strategy (REMS) on mifepristone. (MSS Res 14-I-17)

Expanding AMA Support for Advanced Practice Providers who Provide First Trimester Abortion Care 5.008MSS

AMA-MSS supports state and federal legislation that allows appropriately trained and credentialed advanced practice clinicians to perform first trimester medical and aspiration abortions in accordance with individual state licensing requirements. (MSS Res. 08, I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 021
(I-22)

Introduced by: Abbigayle Rawls (Willgruber), University of Kentucky College of Medicine;
Melissa Murphy, University of Kentucky College of Medicine; Catriona Hong,
University of Connecticut School of Medicine

Subject: Support Further Intervention in Caregiver Support for End-of-Life Patients

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Caregivers of end-of-life patients in the hospital often struggle with insufficient emotional, mental, and financial resources due to the immediate nature and lack preparation for this stage^{1,2}

Whereas, Research regarding the assessment of caregiver death preparedness has shown that several important caregiver attributes exist when assessing preparedness for death in end-of-life patients include: knowing symptoms of decline, understanding their own emotions and grief, accessing and appraising supports to manage and plan for death, completing end-of-life tasks in advance, accepting that the loss is imminent, reflecting on their caregiving and finding meaning, closing and renewing relationships, and completing the family members life; and¹

Whereas, When the caregiver attributes are assessed and addressed, more specialized support and attention can be given to caregivers during end-of-life care for loved ones; and²

Whereas, Caregiver self-reported stress has been shown to be decreased by 52% with programs such as the Hospice Caregiver Support Project which utilize a social work as a valuable part of the care team; and³

Whereas, Social workers help identify and refer caregivers to projects that may assist with both funding and patient care in order to reduce stress and burden on caregivers, leading to reduced use of respite care services and reported caregiver stress; and³

Whereas, Maintaining hope, managing expectation, and preparing caregivers for the patient's death are important goals that healthcare providers must address; and^{4,5,6}

Whereas, Multiple studies have highlighted a common theme of hopelessness and inability to prepare for a loved one's death, with one study reporting approximately 20% of caregivers could neither "maintain hope nor prepare for the patient's death," and^{4,5,6}

Whereas, The assessment of caregiver stress and understanding of death utilizing validated measures including the Burden Scale for Family Caregivers (BSFC) can provide useful insight into the understanding and thought-process of dying and grief surrounding a loved one's death, and can additionally help identify gaps in emotional wellbeing for caregivers; and^{7,8}

Whereas, BSFC provides healthcare providers with knowledge of the gaps in caregiver needs that can be address while going through the end-of-life process in the hospital; and^{7,8}

Whereas, Measures such as the BSFC will assess caregiver preparedness for the death of a loved one, and will assist in identifying areas of need for intervention; and^{7,8}

Whereas, Studies have shown the BSFC is a valid measure for identifying caregiver needs; and^{9,10}

Whereas, Health care providers can play a significant role in expectation management and preparation in the perimortem period; and^{4,9}

Whereas, Addressing social isolation and lack of preparation for a loved one's death, may reduce prolonged grief symptoms and lead to better long-term outcomes for caregivers, including reducing stressors, reducing social isolation, and providing a more open space to discuss death and the process of dying; and^{5,6,7}

Whereas, Continuity of care has been identified as a key factor in ensuring continued caregiver support and increased understanding and comfortableness with end-of-life care; and⁹

Whereas, Recent study of a three-step model, physician-driven, nurse-aided caregiver support strategy demonstrated reduction in grief symptoms; and¹⁰

Whereas, The model is as follows: Step 1: prepare for patient's death with caregiver (interdisciplinary team of professionals, including social work and nursing), Step 2: during the dying process and in death, in the patient's room, address all concerns and respects family and patient's wishes regarding spiritual practices or comfort needs (interdisciplinary team separately), Step 3: after the patient's death, express sympathies, help support emotions and express feelings of caregiver (interdisciplinary team together) to best reduce prolonged grief symptoms; and¹⁰

Whereas, Additional research is needed to address viability of interdisciplinary end-of-life care programs in hospital settings, and the three-step model should be led and addressed by the physicians and nurses who are caring for the patient on a daily basis; and¹⁰

Whereas, The three-step model while displaying significant reductions in prolonged grief symptoms, needs to have further study and implementation in the hospital and healthcare system therefore be it¹⁰

RESOLVED, That the AMA encourage a standard common practice such as the three-step support model for caregiver support in the hospital, and encourage that continuity of care is maintained in end-of-life care; and

RESOLVED, That the AMA encourage the use of the currently validated BSFC to subsequently understand and address gaps in caregiver needs, especially utilizing social services and other hospital support programs to address gaps.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Durepos P, Kaasalainen S, Ploeg J, Sussman T, Akhtar-Danesh N. How do family caregivers prepare for death and bereavement in dementia? A concept analysis. *Journal of Pain and Symptom Management*. 2018;56(6). doi:10.1016/j.jpainsymman.2018.10.007
2. Breen LJ, Aoun SM, O'Connor M, Howting D, Halkett GKB. Family caregivers' preparations for death: A qualitative analysis. *Journal of Pain and Symptom Management*. 2018;55(6):1473-1479. doi:10.1016/j.jpainsymman.2018.02.018
3. Empeño J, Raming NT, Irwin SA, Nelesen RA, Lloyd LS. The hospice caregiver support project: Providing support to reduce caregiver stress. *Journal of Palliative Medicine*. 2011;14(5):593-597. doi:10.1089/jpm.2010.0520
4. Shirado A, Morita T, Akazawa T, et al. Both maintaining hope and preparing for death: Effects of physicians' and nurses' behaviors from bereaved family members' perspectives. *Journal of Pain and Symptom Management*. 2013;45(5):848-858. doi:10.1016/j.jpainsymman.2012.05.014
5. Bijnsdorp FM, Onwuteaka-Philipsen BD, Boot CR, van der Beek AJ, Pasman HR. Caregiver's burden at the end of life of their loved one: Insights from a longitudinal qualitative study among working family caregivers. *BMC Palliative Care*. 2022;21(1). doi:10.1186/s12904-022-01031-1
6. Wu EX, Collins A, Briggs S, Stajduhar KI, Kalsi A, Hilliard N. Prolonged grief and bereavement supports within a caregiver population who transition through a palliative care program in British Columbia, Canada. *American Journal of Hospice and Palliative Medicine*. 2021;39(3):361-369. doi:10.1177/10499091211030442
7. Graessel E, Berth H, Lichte T, Grau H. Subjective caregiver burden: Validity of the 10-item short version of the burden scale for family caregivers BSFC-S. *BMC Geriatrics*. 2014;14(1). doi:10.1186/1471-2318-14-23
8. Pendergrass A, Malnis C, Graf U, Engel S, Graessel E. Screening for caregivers at risk: Extended validation of the short version of the burden scale for family caregivers (BSFC-S) with a valid classification system for caregivers caring for an older person at home. *BMC Health Services Research*. 2018;18(1). doi:10.1186/s12913-018-3047-4
9. Kupeli N, Sampson EL, Leavey G, et al. Context, mechanisms and outcomes in end-of-life care for people with advanced dementia: Family carers perspective. *BMC Palliative Care*. 2019;18(1). doi:10.1186/s12904-019-0467-9
10. Kentish-Barnes N, Chevret S, Valade S, et al. A three-step support strategy for relatives of patients dying in the intensive care unit: A cluster randomised trial. *The Lancet*. 2022;399(10325):656-664. doi:10.1016/s0140-6736(21)02176-0

RELEVANT AMA AND AMA-MSS POLICY

Good Palliative Care H-70.915

Our AMA: (1) encourages all physicians to become skilled in palliative medicine; (2) recognizes the importance of providing interdisciplinary palliative care for patients with disabling chronic or life-limiting illness to prevent and relieve suffering and to support the best possible quality of life for these patients and their families; (3) encourages education programs for all appropriate health care professionals, and the public as well, in care of the dying patient; and the care of patients with disabling chronic or life-limiting illness; (4) supports improved reimbursement for

health care practices that are important in good care of the dying patient, such as the coordination and continuity of care, "maintenance" level services, counseling for patient and family, use of multidisciplinary teams, and effective palliation of symptoms; (5) encourages physicians to become familiar with the use of current coding methods for reimbursement of hospice and palliative care services; (6) advocates for reimbursement of Evaluation and Management (E/M) codes reflecting prolonged time spent on patients' care outside of the face-to-face encounter in non-hospital settings; (7) continues to monitor the development and performance on the CMS 30-day mortality measures and enrollments in the Medicare hospice program and the VA hospice programs and continues to work to have CMS exclude palliative patients from mortality measures; (8) supports efforts to clarify coding guidance or development of codes to capture "comfort care," "end-of-life care," and "hospice care;" (9) encourages research in the field of palliative medicine to improve treatment of unpleasant symptoms that affect quality of life for patients; and (10) encourages research into the needs of dying patients and how the care system could better serve them.

Palliative Care and End-of-Life Care H-295.875

Our AMA: 1. Reaffirms the Council on Medical Education's support of palliative medicine as a medical subspecialty with certification recognized by the American Board of Medical Specialties, and also encourages the inclusion of palliative medicine in the core curriculum of undergraduate and graduate medical education. 2. Encourages the training of all allied health workers in the use of palliative care techniques and interdisciplinary team care. 3. Will continue its efforts in producing and distributing clinical CME programs on pain management and end-of-life care. 4. Our AMA will work with relevant national medical specialty organizations to petition the American Board of Medical Specialties and relevant specialty boards to support development of innovative fellowship models that would qualify physicians for board certification in the fields of hospice and palliative medicine as well as geriatrics.

BOT Rep. 5, A-06; Appended: Res. 322, A-14; Reaffirmed: BOT Rep. 05, I-16

End-of-Life Care H-85.949

Our AMA supports: (1) Medicare coverage of and appropriate payment for supportive care services, including assistance with activities of daily living, as needed, under Medicare's hospice benefit; (2) study and pilot testing by the Centers for Medicare & Medicaid Services of care models that allow concurrent use of Medicare's hospice and skilled nursing facility (SNF) benefits for the same condition; and (3) increased access to comprehensive interdisciplinary palliative care services by Medicare patients in skilled nursing facilities.

CMS Rep. 1, I-21

Advance Care Planning 5.1

The process of advance care planning is widely recognized as a way to support patient self-determination, facilitate decision making, and promote better care at the end of life. Although often thought of primarily for terminally ill patients or those with chronic medical conditions, advance care planning is valuable for everyone, regardless of age or current health status. Planning in advance for decisions about care in the event of a life-threatening illness or injury gives individuals the opportunity to reflect on and express the values they want to have govern their care, to articulate the factors that are important to them for quality of life, and to make clear any preferences they have with respect to specific interventions. Importantly, these discussions also give individuals the opportunity to identify who they would want to make decisions for them should they not have decision-making capacity.

Proactively discussing with patients what they would or would not want if recovery from illness or injury is improbable also gives physicians opportunity to address patients' concerns and expectations and clarify misunderstandings individuals may have about specific medical

conditions or interventions. Encouraging patients to share their views with their families or other intimates and record them in advance directives, and to name a surrogate decision maker, helps to ensure that patients' own values, goals, and preferences will inform care decisions even when they cannot speak for themselves.

Physicians must recognize, however that patients and families approach decision making in many different ways, informed by culture, faith traditions, and life experience, and should be sensitive to each patient's individual situations and preferences when broaching discussion of planning for care at the end of life.

Physicians should routinely engage their patients in advance care planning in keeping with the following guidelines:

(a) Regularly encourage all patients, regardless of age or health status, to:

(i) think about their values and perspectives on quality of life and articulate what goals they would have for care if they faced a life-threatening illness or injury, including any preferences they may have about specific medical interventions (such as pain management, medically administered nutrition and hydration, mechanical ventilation, use of antibiotics, dialysis, or cardiopulmonary resuscitation);

(ii) identify someone they would want to have make decisions on their behalf if they did not have decision-making capacity;

(iii) make their views known to their designated surrogate and to (other) family members or intimates.

(b) Be prepared to answer questions about advance care planning, to help patients formulate their views, and to help them articulate their preferences for care (including their wishes regarding time-limited trials of interventions and surrogate decision maker). Physicians should also be prepared to refer patients to additional resources for further information and guidance if appropriate.

(c) Explain how advance directives, as written articulations of patients' preferences, are used as tools to help guide treatment decisions in collaboration with patients themselves when they have decision-making capacity, or with surrogates when they do not, and explain the surrogate's responsibilities in decision making. Involve the patient's surrogate in this conversation whenever possible.

(d) Incorporate notes from the advance care planning discussion into the medical record. Patient values, preferences for treatment, and designation of surrogate decision maker should be included in the notes to be used as guidance when the patient is unable to express his or her own decisions. If the patient has an advance directive document or written designation of proxy, include a copy (or note the existence of the directive) in the medical record and encourage the patient to give a copy to his or her surrogate and others to help ensure it will be available when needed.

(e) Periodically review with the patient his or her goals, preferences, and chosen decision maker, which often change over time or with changes in health status. Update the patient's medical records accordingly when preferences have changed to ensure that these continue to reflect the individual's current wishes. If applicable, assist the patient with updating his or her advance directive or designation of proxy forms. Involve the patient's surrogate in these reviews whenever possible.

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

Educating Physicians About Advance Care Planning H-85.956

Our AMA: (1) will continue efforts to better educate physicians in the skills necessary to increase the prevalence and quality of meaningful advance care planning, including the use of advance directives, and to improve recognition of and adherence to a patient's advance care decisions; (2) supports development of materials to educate physicians about the requirements and implications of the Patient Self-Determination Act, and supports the development of materials (including, but not necessarily limited to, fact sheets and/or brochures) which physicians can use to educate their patients about advance directives and requirements of the Patient Self-Determination Act; (3) encourages residency training programs, regardless of or in addition to current specialty specific ACGME requirements, to promote and develop a high level of knowledge of and ethical standards for the use of such documents as living wills, durable powers of attorney for health care, and ordering DNR status, which should include medical, legal, and ethical principles guiding such physician decisions. This knowledge should include aspects of medical case management in which decisions are made to limit the duration and intensity of treatment; (4) will work with medical schools, graduate medical education programs and other interested groups to increase the awareness and the creation of personal advance directives for all medical students and physicians; (5) encourages development of a model educational module for the teaching of advance directives and advance care planning; and (6) in conjunction with interested stakeholders, will provide educational resources for medical students, physicians, allied health professionals, patients, and their families on end-of-life care. CCB/CLRPD Rep. 3, A-14; Appended: Res. 307, A-14; Reaffirmed: BOT Rep. 05, I-16; Reaffirmed in lieu of: Res. 121, A-17; Appended: Res. 601, A-22

Decisions Near the End of Life H-140.966

Our AMA believes that: (1) The principle of patient autonomy requires that physicians must respect the decision to forgo life-sustaining treatment of a patient who possesses decision-making capacity. Life-sustaining treatment is any medical treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment includes, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

(2) There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

(3) Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death. More research must be pursued, examining the degree to which palliative care reduces the requests for euthanasia or assisted suicide.

(4) Physicians must not perform euthanasia or participate in assisted suicide. A more careful examination of the issue is necessary. Support, comfort, respect for patient autonomy, good communication, and adequate pain control may decrease dramatically the public demand for euthanasia and assisted suicide. In certain carefully defined circumstances, it would be humane to recognize that death is certain and suffering is great. However, the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician-assisted suicide at this time.

(5) Our AMA supports continued research into and education concerning pain management. CEJA Rep. B, A-91; Reaffirmed by BOT Rep. 59, A-96; Reaffirmation A-97; Appended: Sub. Res. 514, I-00; Reaffirmed: CEJA Rep. 6, A-10

Physicians and Family Caregivers: Shared Responsibility H-210.980

Our AMA: (1) specifically encourages medical schools and residency programs to prepare physicians to assess and manage caregiver stress and burden;

(2) continues to support health policies that facilitate and encourage health care in the home;

- (3) reaffirm support for reimbursement for physician time spent in educating and counseling caregivers and/or home care personnel involved in patient care;
 - (4) supports research that identifies the types of education, support services, and professional caregiver roles needed to enhance the activities and reduce the burdens of family caregivers, including caregivers of patients with dementia, addiction and other chronic mental disorders; and
 - (5) (a) encourages partner organizations to develop resources to better prepare and support lay caregivers; and (b) will identify and disseminate resources to promote physician understanding of lay caregiver burnout and develop strategies to support lay caregivers and their patients.
- Res. 308, I-98; Reaffirmation A-02; Reaffirmed: CME Rep. 2, A-12; Appended: Res. 305, A-17

Workforce and Coverage for Pain Management H-185.931

1. Our AMA supports efforts to improve the quality of care for patients with pain, ensuring access to multiple analgesic strategies, including non-opioid options and interventional approaches when appropriate, with a focus on achieving improvement in function and activities of daily living.
2. Our AMA supports guidance on pain management for different clinical indications developed by the specialties who manage those conditions and disseminated the same way other clinical guidelines are promoted, such as through medical journals, medical societies, and other appropriate outlets.
3. Our AMA will advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician led, and recognize the interdependency of treatment methods in addressing chronic pain.
4. Our AMA supports health insurance coverage that gives patients access to the full range of evidence-based chronic pain management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits.
5. Our AMA supports efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, as well as an expanded behavioral health workforce to improve the availability of services to address the psychological, behavioral, and social aspects of pain and pain management within multidisciplinary pain clinics. Patients and their caregivers should be involved in the decision-making process.
6. Our AMA supports an expanded availability of comprehensive multidisciplinary pain medicine clinics for patients in both urban and rural areas, and an improvement in payment models for comprehensive multidisciplinary pain clinics services such that such services can become more financially viable. CMS/CSAPH Rep. 1, A-15; Reaffirmed: BOT Rep. 5, I-15; Reaffirmed: BOT Rep. 19, A-16; Reaffirmed in lieu of Res. 117, A-16; Modified: BOT Rep. 38, A-18; Reaffirmed in lieu of: Res. 228, I-18; Reaffirmation: A-19

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 022
(I-22)

Introduced by: Cloe Nazeer, Oakland University William Beaumont School of Medicine;
Joeun Grace Jeong, McGovern Medical School; Jessyca Judge, Michigan
State University College of Human Medicine; Julia Houshmand, University of
Miami Miller School of Medicine

Subject: Amending Policy H-80.999, "Sexual Assault Survivors" to Improve
Knowledge and Access to No-cost Rape Test Kits

Sponsored by: Region 3, American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Rape/sexual assault affected 319,950 individuals in the United States in the year
2020, which is a rate of 1.2 individuals per 1,000¹; and

Whereas, The estimated lifetime cost of rape is \$122,461 per victim including but not limited to
medical forensic examination, hospitalization/emergency department bills, sexually transmitted
infection testing/treatment, criminal justice costs, mental health costs such as depression and/or
PTSD treatment, abortion costs, and emergency contraceptive costs²; and

Whereas, With more restricted access to abortion, the financial burden to rape/sexual assault
victims is likely to increase, i.e. crossing state lines, hotel/housing costs, taking days off work,
etc.^{3,4,5}; and

Whereas, The mental effect of rape/sexual assault may impact how victims present to the
hospital, as victims may be in a vulnerable state with impaired rational thought, memory
consolidation, and reduced energy and/or tonic immobility due to trauma⁶; and

Whereas, Medical forensic exams, also known as rape test kits, involve a partnership between
the healthcare provider and the crime lab to collect any DNA evidence on the body of the victim
or at the scene of the crime, physical examination to look for signs of abuse, and medical history
taking to aid in criminal case investigation^{7,8}; and

Whereas, Rape test kits, are not financially covered by all states if the provider administering
the examination is not a registered Sexual Assault Nurse Examiner (SANE) or Sexual Assault
Forensic Examiner (SAFE)⁹; and

Whereas, Receiving care by SANE/SAFEs is associated with better psychological well-being of
survivors, increased use of STI prophylaxis and emergency contraception, and higher quality
evidence collection resulting in better legal outcomes¹⁰; and

Whereas, Healthcare staff not trained as SANE/SAFEs have reported discomfort providing
sexual assault services due to lack of knowledge about evidence collection and support needs,
leading to increased isolation and stigmatization of victims¹¹; and

Whereas, The speed at which medical forensic examinations must be done is between 72 and 96 hours after the assault has taken place¹², making this a time-sensitive examination; and

Whereas, While there are more than 6,000 hospitals nationally⁹; only 800-900 SANE programs have been identified in the United States⁹; and

Whereas, The Department of Justice explains that states are required to work with local medical providers to inform victims of the availability of no-cost forensic exams, i.e. a victim can call their local police department or hotline/crisis center to obtain information about local SANES/SAFEs⁹; and

Whereas, It is likely that victims who do not interact with law enforcement may not know how to access no-cost medical forensic examinations; and

Whereas, Groups of individuals that have historically under-reported rape and sexual assault, such as African-American and Hispanic women and the LGBTQ+ community^{13,14,15}, are less likely to interact with law enforcement and become informed about no-cost rape test kits; and

Whereas; Information about the availability of SANE/SAFEs is currently limited, and existing databases are only available in certain areas, are outdated, and are often missing information¹⁶; and

Whereas, Creating and ensuring accessibility to a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers would allow all victims to quickly access information on where and how to receive a time-sensitive, no-cost medical forensic examination; and

Whereas, Increasing accessibility to information on SANE/SAFE locations and providers would allow minority and other vulnerable populations to have more equal opportunities to receive no-cost medical forensic examination; therefore be it

RESOLVED, That our American Medical Association amend Policy H-80.999, "Sexual Assault Survivors," by addition to read as follows:

Sexual Assault Survivors, H-80.999

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.

2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.

3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including

through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.

4. Our AMA will (a) advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations; (b) support and advocate appropriate stakeholders, such as the Health Resources and Services Administration, the United States Government Accountability Office, and the Office on Violence Against Women, in the creation and implementation of a national database of Sexual Assault Nurse Examiner and Sexual Assault Forensic Examiner providers.

5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Morgan RE, Thompson A. Criminal victimization, 2020 - Bureau of Justice Statistics. Bureau of Justice Statistics. <https://bjs.ojp.gov/sites/g/files/xyckuh236/files/media/document/cv20.pdf>. Published 2021. Accessed August 31, 2022.
2. Peterson C, DeGue S, Florence C, Lokey CN. Lifetime economic burden of rape among U.S. adults. *American Journal of Preventive Medicine*. 2017;52(6):691-701. doi:10.1016/j.amepre.2016.11.014
3. Chakraborty P, Murawsky S, Smith MH, McGowan ML, Norris AH, Bessett D. How Ohio's proposed abortion bans would impact travel distance to access abortion care. *Perspectives on Sexual and Reproductive Health*. 2022;54(2):54-63. doi:10.1363/psrh.12191
4. Smith MH, Muzyczka Z, Chakraborty P, et al. Abortion travel within the United States: An observational study of cross-state movement to obtain abortion care in 2017. *The Lancet Regional Health - Americas*. 2022;10:100214. doi:10.1016/j.lana.2022.100214
5. Matsuura H. Abortion tourism in a post-Roe v. Wade era. *Biodemography and Social Biology*. 2022;67(2):99-101. doi:10.1080/19485565.2022.2100051
6. National Institute of Justice. Sexual Assault Kits. National Institute of Justice. <https://nij.ojp.gov/sites/g/files/xyckuh171/files/media/document/unsubmitted-kits.pdf>. Accessed September 22, 2022
7. What is a sexual assault forensic exam? RAINN. <https://www.rainn.org/articles/rape-kit>. Accessed September 22, 2022.
8. Subramanian S, Green JS. The General Approach and Management of the Patient Who Discloses a Sexual Assault. *Mo Med*. 2015;112(3):211-217
9. Ramaswamy A, Frederiksen B, Rae M, Ranji U, Salganicoff A, McDermott D. Out-of-pocket charges for rape kits and services for sexual assault survivors. Kaiser Family Foundation. <https://www.kff.org/womens-health-policy/issue-brief/out-of-pocket-charges-for-rape-kits-and-services-for-sexual-assault-survivors/>. Published March 18, 2022. Accessed August 30, 2022.
10. Thiede E, Miyamoto S. Rural Availability of Sexual Assault Nurse Examiners (SANEs). *J Rural Health*. 2021;37(1):81-91. doi:10.1111/jrh.12544

11. Carter-Snell C, Jakubec S, Hagen B. Collaboration with Rural and Remote Communities to Improve Sexual Assault Services. *J Community Health*. 2020;45(2):377-387. doi:10.1007/s10900-019-00744-4
12. Sadej I. Sexual assault evidence collection kits: The many barriers to access. *Public Health Post*. <https://www.publichealthpost.org/research/sexual-assault-evidence/>. Published March 4, 2022. Accessed September 22, 2022.
13. Barlow JN. Black women, the forgotten survivors of sexual assault. *American Psychological Association*. <https://www.apa.org/pi/about/newsletter/2020/02/black-women-sexual-assault>. Published February 2020. Accessed September 22, 2022.
14. Harrell E. Bureau of Justice Statistics Special Report. <https://bjs.ojp.gov/content/pub/pdf/bvvc.pdf>. Published August 2007. Accessed September 22, 2022.
15. Office for Victims of Crime (OVC). The numbers. Sexual Assault: The Numbers | Responding to Transgender Victims of Sexual Assault. https://ovc.ojp.gov/sites/g/files/xyckuh226/files/pubs/forged/sexual_numbers.html. Published June 2014. Accessed September 22, 2022.
16. Clowers, N. Information on the Availability of Forensic Examiners. United States Government Accountability Office. <https://www.gao.gov/assets/700/696048.pdf>. Published December 12, 2018. Accessed 31 August 2022.

RELEVANT AMA AND AMA-MSS POLICY

Sexual Assault Survivors H-80.999

1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.
 2. Our AMA advocates for the legal protection of sexual assault survivors' rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (a) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (b) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (c) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (d) be informed of these rights and the policies governing the sexual assault evidence kit; and (e) access to emergency contraception information and treatment for pregnancy prevention.
 3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
 4. Our AMA will advocate for increased post-pubertal patient access to Sexual Assault Nurse Examiners, and other trained and qualified clinicians, in the emergency department for medical forensic examinations.
 5. Our AMA will advocate at the state and federal level for (a) the timely processing of all sexual examination kits upon patient consent; (b) timely processing of "backlogged" sexual assault examination kits with patient consent; and (c) additional funding to facilitate the timely testing of sexual assault evidence kits.
- Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: Res. 202, I-17; Appended: Res. 902, I-18; Appended: Res. 210, A-22

Increasing Patient Access to Sexual Assault Nurse Examiners 360.001MSS

AMA-MSS will ask the AMA to advocate for increased patient access to Sexual Assault Nurse Examiners in the Emergency Department, including the transfer of victims to other facilities with Sexual Assault Nurse Examiners when they are not available. (MSS Res 12, A-18)

Sexual Assault Survivor's Rights 515.010MSS

AMA-MSS will ask that our AMA (1) advocate for the legal protection of sexual assault survivors' rights and will work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (i) receive a medical forensic examination free of charge, which includes but is not be limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (ii) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (iii) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (iv) be informed of these rights and the policies governing the sexual assault evidence kit; and (2) collaborate AMA-MSS Digest of Policy Actions/ 241 with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016. (MSS Res 21, A-17)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 023
(I-22)

Introduced by: Jordyn Lee, Elisabeth Hayes, Samantha Hicks, Florida Atlantic University
Charles E. Schmidt College of Medicine; Revati Gummaluri, Rowan
University School of Osteopathic Medicine; Julia Houshmand, University of
Miami Miller School of Medicine; Samyukthaa Saiprakash, Sam Houston
School of Osteopathic Medicine; Jennifer Oruebor, Texas A&M School of
Medicine

Subject: Specialized Psychiatric Facilities for Pregnant and Postpartum Individuals

Sponsored by: PsychSIGN, American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Postpartum psychosis, which affects 1 to 2 per 1000 women after giving birth and is characterized by delusions and hallucinations, is a psychiatric emergency that requires prompt inpatient hospitalization and treatment due to imminent risk of self-harm or infanticide¹; and

Whereas, Postpartum depression, which affects up to 15% of women in the postpartum period, has been shown to have significant detrimental effect on mother-infant bonding²; and

Whereas, Inadequate maternal bonding can have long-term negative impacts on both mother and child, including increased maternal mortality and children having increased incidence of psychological issues, lower social competence, and lower adaptive functioning^{3,4}; and

Whereas, 11% of pregnancy-related deaths are related to mental health conditions, the highest rate of preventable death in the category⁵; and

Whereas, Maternal depressive symptoms are correlated with increased hospitalization and death rates in children⁶; and

Whereas, Effective treatment of mood disorders and suicidality during pregnancy and postpartum is therefore critical to public health, and such individuals may benefit greatly from specialized intensive outpatient treatment, partial hospitalization, or inpatient psychiatric treatment⁷; and

Whereas, Many mothers and child-bearing persons prefer to receive treatment in specialized treatment facilities, such as Mother-Baby Units (MBUs), rather than general inpatient psychiatric facilities due to the former's more tailored care—including breastfeeding support, medication advice, bolstering mother-baby bonding, and family visitation⁸; and

Whereas, Pregnant women with schizophrenia in crisis that are admitted for inpatient psychiatric services resulted in poorer psychosocial outcomes including increased substance

use, involvement of child protective services, and the infant being displaced from the home⁹; and

Whereas, Minority individuals, individuals of lower socioeconomic status, and individuals with preexisting bipolar or psychotic disorders are at increased risk of experiencing suicidality and requiring admission to a psychiatric unit in the postpartum period, highlighting increased need for reproductive psychiatric care in these populations^{10,11}; and

Whereas, Specialized inpatient perinatal psychiatric centers provide superior treatment in that they allow for joint mother-baby admission to encourage bonding, assist in the development of parenting skills, and increase maternal confidence^{12,13}; and

Whereas, Intensive outpatient and partial hospitalization programs for pregnant and postpartum women are able to offer evidence-based treatment by interdisciplinary teams which is not readily available otherwise¹⁴; and

Whereas, In the U.S., there are currently three specialized inpatient perinatal psychiatric centers, and fewer than thirty intensive outpatient and partial hospitalization perinatal day treatment psychiatry programs, making physical distance to care a barrier to access¹⁵; and

Whereas, Brexanolone, the only FDA-approved drug specifically for postpartum depression, must be administered as an IV infusion over sixty hours in a certified healthcare facility, and there are only 71 such facilities in the U.S.¹⁶; and

Whereas, AMA policy H-420.953 supports improvements in current mental health services for postpartum women and advocates for continued funding of “support programs” that address perinatal and postpartum psychiatric disorders, but does not appropriately address the need for specialized and intensive treatment centers, especially for at-risk individuals; therefore be it

RESOLVED, That our AMA amend current policy H-420.953, “Improving Mental Health Services for Pregnant and Postpartum Mothers” by insertion and deletion as follows:

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

Our AMA: ~~(1) supports improvements in current mental health services~~ development of inpatient, partial hospitalization, and intensive outpatient psychiatry centers which are specialized in the treatment of pregnant individuals and postpartum psychiatric disorders including postpartum psychosis and postpartum depression, particularly in states that currently lack these facilities for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; ~~and~~ (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs; ~~and~~ (5) encourages development of protocols and infrastructure to provide prompt access to specialized resources and treatment for pregnant and postpartum patients in psychiatric crisis situations.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. VanderKruik R, Barreix M, Chou D, et al. The global prevalence of postpartum psychosis: a systematic review. *BMC Psychiatry*. 2017;17(1):272. Published 2017 Jul 28. doi:10.1186/s12888-017-1427-7
2. Tietz A, Zietlow AL, Reck C. Maternal bonding in mothers with postpartum anxiety disorder: the crucial role of subclinical depressive symptoms and maternal avoidance behaviour. *Arch Womens Ment Health*. 2014;17(5):433-442. doi:10.1007/s00737-014-0423-x
3. Faisal-Cury A, Levy RB, Matijasevich A. The Relationship Between Mother-Child Bonding Impairment and Suicidal Ideation in São Paulo, Brazil. *Matern Child Health J*. 2021;25(5):706-714. doi:10.1007/s10995-020-03024-z
4. Closa-Monasterolo R, Gispert-Llaurado M, Canals J, et al. The Effect of Postpartum Depression and Current Mental Health Problems of the Mother on Child Behaviour at Eight Years. *Matern Child Health J*. 2017;21(7):1563-1572. doi:10.1007/s10995-017-2288-x
5. Trost, S. L., Beauregard, J. L., Smoots, A. N., Ko, J. Y., Haight, S. C., Moore Simas, T. A., Byatt, N., Madni, S. A., & Goodman, D. (2021). Preventing pregnancy-related mental health deaths: Insights from 14 US maternal mortality review committees, 2008–17. *Health Affairs*, 40(10), 1551–1559. <https://doi.org/10.1377/hlthaff.2021.00615>
6. Jacques, N., de Mola, C. L., Joseph, G., Mesenburg, M. A., & da Silveira, M. F. (2019). Prenatal and postnatal maternal depression and infant hospitalization and mortality in the first year of life: A systematic review and meta-analysis. *Journal of Affective Disorders*, 243, 201–208. <https://doi.org/10.1016/j.jad.2018.09.055>
7. Posmontier B, Geller PA, Horowitz JA, Elgohail M, Chiarello L. Intensive Perinatal Mental Health Programs in the United States: A Call to Action. *Psychiatr Serv*. 2022;73(8):930-932. doi:10.1176/appi.ps.202100384
8. Griffiths, J., Lever Taylor, B., Morant, N. et al. A qualitative comparison of experiences of specialist mother and baby units versus general psychiatric wards. *BMC Psychiatry* 19, 401 (2019).
9. Harris EL, Frayne J, Allen S, Renganathan K, Nguyen TN. Psychiatric admission during pregnancy in women with schizophrenia who attended a specialist antenatal clinic. *J Psychosom Obstet Gynaecol*. 2019;40(3):211-216. doi:10.1080/0167482X.2018.1461832
10. Admon LK, Dalton VK, Kolenic GE, et al. Trends in Suicidality 1 Year Before and After Birth Among Commercially Insured Childbearing Individuals in the United States, 2006-2017. *JAMA Psychiatry*. 2021;78(2):171-176. doi:10.1001/jamapsychiatry.2020.3550
11. Barnett B, Morgan M. Postpartum psychiatric disorder: who should be admitted and to which hospital?. *Aust N Z J Psychiatry*. 1996;30(6):709-714. doi:10.3109/00048679609065035
12. Christl B, Reilly N, Yin C, Austin MP. Clinical profile and outcomes of women admitted to a psychiatric mother-baby unit. *Arch Womens Ment Health*. 2015;18(6):805-816. doi:10.1007/s00737-014-0492-x
13. Griffen, A., McIntyre, L., Belsito, J. Z., Burkhard, J., Davis, W., Kimmel, M., Stuebe, A., Clark, C., & Meltzer-Brody, S. (2021). Perinatal Mental Health Care in the United States: An overview of policies and programs. *Health Affairs*, 40(10), 1543–1550. <https://doi.org/10.1377/hlthaff.2021.00796>

RELEVANT AMA AND AMA-MSS POLICY

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

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

Res. 102, A-12; Modified: Res. 503, A-17

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

1. Our AMA acknowledges that structural racism and bias negatively impact the ability to provide optimal health care, including maternity care, for people of color.
2. Our AMA encourages physicians to raise awareness among colleagues, residents and fellows, staff, and hospital administrators about the prevalence of racial and ethnic inequities and the effect on health outcomes, work to eliminate these inequities, and promote an environment of trust.
3. Our AMA encourages physicians to pursue educational opportunities focused on embedding equitable, patient-centered care for patients who are pregnant and/or within 12 months postpartum into their clinical practices and encourages physician leaders of health care teams to support similar appropriate professional education for all members of their teams.
4. Our AMA will continue to monitor and promote ongoing research regarding the impacts of societal (e.g., racism or unaffordable health insurance), geographical, facility-level (e.g., hospital quality), clinician-level (e.g., implicit bias), and patient-level (e.g., comorbidities, chronic stress or lack of transportation) barriers to optimal care that contribute to adverse and disparate maternal health outcomes, as well as research testing the effectiveness of interventions to address each of these barriers.
5. Our AMA will promote the adoption of federal standards for clinician collection of patient-identified race and ethnicity information in clinical and administrative data to better identify inequities. The federal data collection standards should be: (a) informed by research (including real-world testing of technical standards and standardized definitions of race and ethnicity terms to ensure that the data collected accurately reflect diverse populations and highlight, rather than obscure, critical distinctions that may exist within broad racial or ethnic categories), (b) carefully crafted in conjunction with clinician and patient input to protect patient privacy and provide non-discrimination protections, and (c) lead to the dissemination of best practices to guide respectful and non-coercive collection of accurate, standardized data relevant to maternal health outcomes.
6. Our AMA supports the development of a standardized definition of maternal mortality and the allocation of resources to states and Tribes to collect and analyze maternal mortality data (i.e., Maternal Mortality Review Committees and vital statistics) to enable stakeholders to better understand the underlying causes of maternal deaths and to inform evidence-based policies to improve maternal health outcomes and promote health equity.
7. Our AMA encourages hospitals, health systems, and state medical associations and national medical specialty societies to collaborate with non-clinical community organizations with close ties to minoritized and other at-risk populations to identify opportunities to best support pregnant persons and new families.

8. Our AMA encourages the development and funding of resources and outreach initiatives to help pregnant individuals, their families, their communities, and their workplaces to recognize the value of comprehensive prepregnancy, prenatal, peripartum, and postpartum care. These resources and initiatives should encourage patients to pursue both physical and behavioral health care, strive to reduce barriers to pursuing care, and highlight care that is available at little or no cost to the patient.
 9. Our AMA supports adequate payment from all payers for the full spectrum of evidence-based prepregnancy, prenatal, peripartum, and postpartum physical and behavioral health care.
 10. Our AMA encourages hospitals, health systems, and states to participate in maternal safety and quality improvement initiatives such as the Alliance for Innovation on Maternal Health program and state perinatal quality collaboratives.
 11. Our AMA will advocate for increased access to risk-appropriate care by encouraging hospitals, health systems, and states to adopt verified, evidence-based levels of maternal care.
- Joint CMS/CSAPH Rep. 1, I-21

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 024
(I-22)

Introduced by: Alec Calac, Meghana Pagadala, Dhruv Puri, UC San Diego School of Medicine, Kyle Lakatos, University of California San Francisco School of Medicine; Julia Seiberling, University of California Riverside School of Medicine; Meagan Chriswell, University of Colorado School of Medicine; Hailey Baker, Tamee Livermont, Katie Wilson, University of Minnesota Medical School; Adrienne Nguyen, Des Moines University College of Osteopathic Medicine; Canaan Hancock, Dell Medical School at UT-Austin; Brianna Baldwin, University of Virginia School of Medicine; Anna Klunk, Philadelphia College of Osteopathic Medicine; Nishanth Ganeshbabu, Tufts University School of Medicine; Lala Forrest, Frank H. Netter School of Medicine

Subject: Billing for Traditional Healing Services

Sponsored by: Region 1, Region 4, Region 7, and Association of Native American Medical Students

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

1 Whereas, The Indian Health Service (IHS), an agency within the U.S. Department of Health and
2 Human Services, is responsible for providing health services to American Indians and Alaska
3 Natives (AI/AN), as a federal trust responsibility and treaty obligations to American Indian and
4 Alaska Native Tribes and Villages¹⁻²; and

5 Whereas, The IHS is underfunded relative to other federal health programs, IHS per capita
6 health care expenditures are \$4,078, while figures for Medicaid and Medicare are \$8,109 and
7 \$13,185, respectively³; and

8 Whereas, The IHS is considered the payor of last resort and is only utilized after other federal,
9 state, local, or private source of reimbursement for which the patient is eligible have been
10 exhausted⁴; and

11
12 Whereas, Reimbursement sources utilized before IHS payment include, but are not limited to,
13 Medicare Part A and B, State Medicaid, State or other federal health programs (e.g., Veterans
14 Health Administration), private insurance, and funds from Tribal health programs⁴; and

15
16 Whereas, Payments for IHS patients' medical care received from public programs such as
17 Medicaid and Medicare or from private insurers—increased from about \$943 million in fiscal
18 year 2015 to about \$1.15 billion in fiscal year 2019 at its federal facilities⁵; and

19
20 Whereas, Third-party collections are increasingly important, representing a significant portion of
21 IHS, Tribal, and Urban Indian Health Programs' health care delivery budget, and also used to
22 procure services, supplies, and pharmaceuticals⁵; and
23

1 Whereas, The IHS, through offerings of Western medicine and traditional healing services,
2 works to ensure that culturally-appropriate health care services are available and accessible to
3 AI/AN patients⁶; and
4

5 Whereas, Traditional medicine is the sum total of the knowledge, skills, and practices based on
6 the theories, beliefs, and experiences specific to different cultures, whether explicable or not,
7 used in the maintenance of health as well as in the prevention, diagnosis, improvement or
8 treatment of physical and mental illness⁷; and
9

10 Whereas, In a survey of 150 AI/AN patients at one Urban Indian Health Program, 38% reported
11 seeking medical care from both a physician and a traditional healer in their community⁸; and
12

13 Whereas, In another rural, reservation-based setting of 2,595 AI/AN adolescents and adults, 41
14 to 60% sought biomedical services for physical health concerns; 8 to 23% sought traditional
15 healing services for physical health concerns; and 10-23% used Western and traditional healing
16 services, while 3 to 40% used only traditional healing⁹; and
17

18 Whereas, Among AI/AN patients who see both a physician and a traditional healer, more than
19 half (61.4%) trust the advice of their traditional healer(s) over their physician, and may also limit
20 disclosure of their medical history due to medical distrust and poor coordination of care^{8,10}; and
21

22 Whereas, The AMA recognizes the "medicine man" and other traditional healing figures as an
23 integral and culturally necessary part in delivering health care to AI/AN patients (H-350.976);
24 and
25

26 Whereas, A study evaluating the efficacy of many traditional Cherokee medicines found that
27 their use was efficient for treating intended illness, and was adopted by European settlers
28 following their introduction to them¹¹; and
29

30 Whereas, Connections to traditional culture, including food, has a positive impact on spiritual
31 and physical health and decreases rates of chronic disease within AI/AN populations^{12,13}; and
32

33 Whereas, The Alaska Native Medical Center, the major referral unit for AI/AN patients within the
34 state of Alaska, offers a Traditional Healing Clinic in conjunction with other health services to
35 provide whole-person care to patients¹⁴; and
36

37 Whereas, The IHS cannot bill private insurance and state Medicaid programs and Medicaid
38 managed care organizations for traditional healing services, limiting reimbursement for and
39 implementation of traditional healing services at IHS, Tribal, and Urban Indian health facilities¹⁵;
40 and
41

42 Whereas, Traditional healing practices and knowledge are widely considered sacred and not
43 shared with outside healthcare practitioners¹⁶; and
44

45 Whereas, The diversity of traditional healing practices between AI/AN Tribes and Villages
46 creates challenges for creating medical billing codes and reimbursement processes; and
47

48 Whereas, The state of Arizona, in consultation with Tribes, is seeking Section 1115
49 demonstration authority to cover traditional healing services furnished by the IHS to AI/AN
50 Medicaid enrollees¹⁷⁻¹⁸; and
51

Whereas, The proposed Arizona Section 1115 Medicaid waiver for traditional healing services would (1) allow IHS, Tribal, and Urban Indian Health Programs and AI/AN Tribes and Villages designate and contract with traditional healing providers; (2) coordinate medical care and traditional healing delivery to prevent medical contraindications; and (3) require patient evaluation of traditional healing services¹⁸; and

Whereas, While the IHS and Congress have long noted their acceptance and respect for AI/AN traditional healing services, the Indian Health Care Improvement Act does not explicitly define or authorize traditional healing services to be paid for by the IHS¹⁷⁻¹⁹; therefore be it

RESOLVED, Our AMA advocate that federal laws be enacted that would authorize payment from the Indian Health Service for traditional healing services provided by Indian Health Service, Tribal, and Urban Indian Health Programs; and be it finally

RESOLVED, Our AMA place as an advocacy priority of its organization that county and state medical societies and American Indian and Alaska Native Tribes and Villages encourage state Medicaid programs and managed care organizations to cover traditional healing services provided at Indian Health Service, Tribal, and Urban Indian Health facilities.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. About the Indian Health Service. U.S. Department of Health and Human Services. Accessed August 25, 2022. <https://www.ihs.gov/aboutihs/>
2. Basis for Health Services. U.S. Department of Health and Human Services. Accessed August 26, 2022. <https://www.ihs.gov/newsroom/factsheets/basisforhealthservices/>
3. Khetpal V, Roosevelt J Jr, Adashi EY. A Federal Indian Health Insurance Plan: Fulfilling a solemn obligation to American Indians and Alaska Natives in the United States. *Prev Med Rep.* 2021;25:101669. Published 2021 Dec 16. doi:10.1016/j.pmedr.2021.101669
4. Indian Health. Vol 42 USC 13.; 2007. <https://www.govinfo.gov/app/details/CFR-2007-title42-vol1/CFR-2007-title42-vol1-part136>
5. Rosenberg M. Information on ThirdParty Collections and Processes to Procure Supplies and Services. United States Government Accountability Office. Published online March 2022. <https://www.gao.gov/assets/720/719433.pdf>
6. IHS Director recognizes traditional healing clinic with public health leadership award. Indian Health Service. Published online June 28, 2011.
7. Traditional, Complementary and Integrative Medicine. World Health Organization. https://www.who.int/health-topics/traditional-complementary-and-integrative-medicine#tab=tab_1. Accessed September, 12, 2022.
8. Straits, Kee. Native American Traditional Healing: Information and Ways to Collaborate for Western Medicine and Mental Health Providers. Published online at https://www.ihs.gov/sites/telebehavioral/themes/responsive2017/display_objects/documents/slides/education/traditionalhealing.pdf
9. Novins DK, Beals J, Moore LA, Spicer P, Manson SM; AI-SUPERPFP Team. Use of biomedical services and traditional healing options among American Indians: sociodemographic correlates, spirituality, and ethnic identity. *Med Care.* 2004;42(7):670-679.doi:10.1097/01.mlr.0000129902.29132.a6

10. Donna Grandbois (2005) STIGMA OF MENTAL ILLNESS AMONG AMERICAN INDIAN AND ALASKA NATIVE NATIONS: HISTORICAL AND CONTEMPORARY PERSPECTIVES, *Issues in Mental Health Nursing*, 26:10, 1001-1024, DOI: 10.1080/01612840500280661
11. Setzer W. The Phytochemistry of Cherokee Aromatic Medicinal Plants. MDPI. Published online November 12, 2018. <https://www.mdpi.com/2305-6320/5/4/121/htm>
12. Bersamin A, Izumi B, Nu J. Strengthening adolescents' connection to their traditional food system improves diet quality in remote Alaska Native communities: results from the Neqa Elicarvigmun Pilot Study. *Translational Behavioral Medicine*. 2019;9:952-961.
13. Crowshoe L, Dannenbaum D, Henderson R. Type 2 Diabetes and Indigenous Peoples. *Canadian Journal of Diabetes*. Published online April 1, 2018. [https://www.canadianjournalofdiabetes.com/article/S1499-2671\(17\)30832-8/fulltext](https://www.canadianjournalofdiabetes.com/article/S1499-2671(17)30832-8/fulltext)
14. Guide to Services at the Alaska Native Medical Center. Alaskan Native Medical Center. Published online April 2020. <https://anmc.org/files/guide-to-patient-services-April-2020.pdf>
15. IHS Director recognizes traditional healing clinic with public health leadership award. Indian Health Service. Published online June 28, 2011. <https://www.ihs.gov/newsroom/pressreleases/2011pressreleases/ihsdirectorrecognizestradditionalhealingclinicwithpublichealthleadershipaward/>
16. Esposito ML, Kahn-John M. How Should Allopathic Physicians Respond to Native American Patients Hesitant About Allopathic Medicine?. *AMA J Ethics*. 2020;22(10):E837-E844. Published 2020 Oct 1. doi:10.1001/amajethics.2020.837
17. Medicaid's Role in Health Care for American Indians and Alaska Natives (IssueBrief) Medicaid and CHIP Payment and Access Commission; Washington, D.C.: 2021. Advising Congress on Medicaid and CHIP Policy. Accessed August 27, 2022. <https://www.macpac.gov/wp-content/uploads/2021/02/Medicoids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf>
18. AHCCCS Reimbursement for Traditional Healing Services. Proposed AZ 1115 Waiver. Published online June 2021. Accessed August 27, 2022. <https://www.azahcccs.gov/AmericanIndians/Downloads/Consultations/Meetings/2016/TradditionalHealingWaiverLanguage.pdf>
19. Indian Health Care. United States Code 25. Chapter 18.§1544. Accessed August 27, 2022. https://www.ihs.gov/sites/ihsia/themes/responsive2017/display_objects/documents/home/USCode_Title25_Chapter%2018.pdf

RELEVANT AMA AND AMA-MSS POLICY

Indian Health Service H-350.977

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

care, through such mechanisms as agreements with tribal leaders or Indian Health Service contracts, as well as normal private practice relationships; and (d) Improvement in transportation to make access to existing private care easier for the American Indian population.

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

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

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

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

CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: Res. 233, 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 non reservation American Indians in an effort to improve their quality of life.

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

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

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

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

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

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

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

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

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

Unconventional Medical Care in the United States H-480.973

Our AMA: (1) encourages the National Center for Complementary and Integrative Health (NCCIH) of the National Institutes of Health (NIH) to determine by objective scientific evaluation the efficacy and safety of practices and procedures of unconventional medicine; and encourages its members to become better informed regarding the practices and techniques of such practices; and (2) utilizes the classification system of alternative medicine set forth by the NCCIH at the NIH, "Major Domains of Complementary and Alternative Medicine," in order to promote future discussion and research about the efficacy, safety, and use of alternative medicine.

BOT Rep. 15, A-94; Reaffirmed and Modified by Sub. Res. 514, I-95; Appended: Res. 505, A-00; Modified: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20

Physician Focused Alternative Payment Methods H-385.908

1. Our AMA encourages physicians to engage in the development of Physician-Focused Payment Models by seeking guidance and refinement assistance from the Physician-Focused Payment Model Technical Advisory Committee (PTAC).
2. Our AMA will continue to urge CMS to limit financial risk requirements to costs that physicians participating in an APM have the ability to influence or control.
3. Our AMA will continue to advocate for innovative ways of defining financial risk, such as including start-up investments and ongoing costs of participation in the risk calculation that would alleviate the financial barrier to physician participation in APMs.
4. Our AMA will work with CMS, the Office of the National Coordinator for Health Information Technology (ONC), PTAC, interested medical societies, and other organizations to pursue the following to improve the availability and use of health information technology (IT):
 - a. Continue to expand technical assistance;
 - b. Develop IT systems that support and streamline clinical participation;
 - c. Enable health IT to support bi-directional data exchange to provide physicians with useful reports and analyses based on the data provided;
 - d. Identify methods to reduce the data collection burden; and
 - e. Begin implementing the 21st Century Cures Act.
5. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to design risk adjustment systems that:
 - a. Identify new data sources to enable adequate analyses of clinical and non-clinical factors that contribute to a patient's health and success of treatment, such as disease stage and socio-demographic factors;
 - b. Account for differences in patient needs, such as functional limitations, changes in medical conditions compared to historical data, and ability to access health care services; and

- c. Explore an approach in which the physician managing a patient's care can contribute additional information, such as disease severity, that may not be available in existing risk adjustment methods to more accurately determine the appropriate risk stratification.
6. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve attribution methods through the following actions:
- a. Develop methods to assign the costs of care among physicians in proportion to the amount of care they provided and/or controlled within the episode;
 - b. Distinguish between services ordered by a physician and those delivered by a physician;
 - c. Develop methods to ensure a physician is not attributed costs they cannot control or costs for patients no longer in their care;
 - d. Explore implementing a voluntary approach wherein the physician and patient agree that the physician will be responsible for managing the care of a particular condition, potentially even having a contract that articulates the patient's and physician's responsibility for managing the condition; and
 - e. Provide physicians with lists of attributed patients to improve care coordination.
7. Our AMA will work with CMS, PTAC, interested medical societies, and other organizations to improve performance target setting through the following actions:
- a. Analyze and disseminate data on how much is currently being spent on a given condition, how much of that spending is potentially avoidable through an APM, and the potential impact of an APM on costs and spending;
 - b. Account for costs that are not currently billable but that cost the practice to provide; and
 - c. Account for lost revenue for providing fewer or less expensive services.
- CMS Rep. 10, A-17; Reaffirmed: CMS Rep. 03, I-18; Reaffirmed: CMS Rep. 10, A-19;
Reaffirmed: CMS Rep. 3, I-19; Reaffirmed: BOT Rep. 13, I-20

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 025
(I-22)

Introduced by: Paul Murdock, Anand Singh, Arsalan Ali, Bhavana Sreepad, Anne Burnett
Marion School of Medicine at Texas Christian University; Alicia Podwojniak,
Rowan School of Osteopathic Medicine; Priya Desai, Boston University
School of Medicine; Sritej Devineni, Northeast Ohio Medical University;
Chayton Fivecoat, Wayne State University School of Medicine; Dhruv Puri,
University of California San Diego School of Medicine; Anthony D'Angelo,
University of Texas Medical Branch John Sealy School of Medicine; Alex
Soltany, Wake Forest University School of Medicine

Subject: Studying Effects of Online Education on Medical Education Outcomes during
COVID-19 Pandemic

Sponsored by: Region 4 and Region 7

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Distance learning is a method of study in which teachers and students do not meet in
a classroom but use the Internet, email, online video conference, etc. to attend classes¹; and

Whereas, The COVID-19 pandemic disrupted the well-established, traditional structure of
medical education by forcing medical schools to transition to distance learning²; and

Whereas, The urgency of the pandemic required rapid and novel adaptations to existing medical
school curricula, functioning as a springboard for new innovations in medical education^{2,3}; and

Whereas, There were high levels of mental burden in medical students during the COVID-19
pandemic⁴; and

Whereas, 72% of medical students in a study during the COVID-19 pandemic reported anxiety
about performance on online exams⁵; and

Whereas, Medical knowledge self-efficacy among medical students during the COVID-19
pandemic was an important factor that influenced their desire to work⁶; and

Whereas, There is limited research surrounding the COVID-19 pandemic's impact on medical
students' mental health, standardized test scores, and student-perceived readiness; and

Whereas, There is no existing AMA or AMA-MSS policy supporting research on undergraduate
medical education outcomes during the COVID-19 pandemic; and

Whereas, Seventy-eight percent of medical schools switched to distance learning due to the
COVID-19 pandemic which may have been the catalyst for a new "online era" in medical
education⁷; therefore be it

- 1 RESOLVED, that our AMA support research on how distance learning impacted undergraduate
- 2 medical education outcomes including standardized test scores, mental health, and self-
- 3 efficacy.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Merriam-Webster's Collegiate Dictionary (11th ed.). Springfield, MA. *Merriam-Webster, Inc.* 2022. <https://www.merriam-webster.com/dictionary/distance%20learning>
2. Papapanou M, Routsis E, Tsamakidis K, et al. Medical education challenges and innovations during COVID-19 pandemic. *Postgraduate Medical Journal* Published Online First: 29 March 2021. doi: 10.1136/postgradmedj-2021-140032
3. Kim, J. W., Myung, S. J., Yoon, H. B., Moon, S. H., Ryu, H., & Yim, J. J. How medical education survives and evolves during COVID-19: our experience and future direction. *PLoS One*. 2020; 15(12), e0243958.
4. Perissotto T, Silva TCRPD, Miskulin FPC, et al. Mental health in medical students during COVID-19 quarantine: a comprehensive analysis across year-classes. *Clinics (Sao Paulo)*. 2021;76:e3007. Published 2021 Jul 5. doi:10.6061/clinics/2021/e3007
5. Abdulghani, H. M., Sattar, K., Ahmad, T., & Akram, A. (2020). Association of COVID-19 pandemic with undergraduate medical students' perceived stress and coping. *Psychology research and behavior management*, 13, 871.
6. Tempiski P, Arantes-Costa FM, Kobayasi R, Siqueira MAM, Torsani MB, et al. (2021) Medical students' perceptions and motivations during the COVID-19 pandemic. *PLOS ONE* 16(3): e0248627. <https://doi.org/10.1371/journal.pone.0248627>
7. Stoehr F, Müller L, Brady A, et al. How covid-19 kick-started online learning in medical education-the DigiMed study. *PLOS ONE*. <https://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0257394>. Published September 21, 2021. Accessed September 21, 2022.

RELEVANT AMA AND AMA-MSS POLICY

Update on the Uses of Simulation in Medical Education D-295.330

Our AMA will:

1. continue to advocate for additional funding for research in curriculum development, pedagogy, and outcomes to further assess the effectiveness of simulation and to implement effective approaches to the use of simulation in both teaching and assessment;
2. continue to work with and review, at five-year intervals, the accreditation requirements of the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and the Accreditation Council for Continuing Medical Education (ACCME) to assure that program requirements reflect appropriate use and assessment of simulation in education programs;
3. encourage medical education institutions that do not have accessible resources for simulation-based teaching to use the resources available at off-site simulation centers, such as online simulated assessment tools and simulated program development assistance;
4. monitor the use of simulation in high-stakes examinations administered for licensure and certification as the use of new simulation technology expands;
5. further evaluate the appropriate use of simulation in interprofessional education and clinical team building; and

6. work with the LCME, the ACGME, and other stakeholder organizations and institutions to further identify appropriate uses for simulation resources in the medical curriculum.

CME Rep. 8, A-09; Reaffirmed: CME Rep. 01, A-19

The Effect of the COVID-19 Pandemic on Graduate Medical Education D-310.946

Our AMA will: (1) work with relevant stakeholders to advocate for equitable compensation and benefits for residents and fellows who are redeployed to fulfill service needs that may be outside the scope of their specialty training; and (2) urge the Accreditation Council for Graduate Medical Education (ACGME) and specialty boards to consider reducing case numbers and clinic visits with revised holistic measures to recognize resident/fellow learning, given the drastic educational barriers confronted during the COVID-19 pandemic.

Res. 319, A-21

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 026
(I-22)

Introduced by: Alec Calac, University of California San Diego School of Medicine; Julia Seiberling, University of California Riverside School of Medicine; Shirley Tan, California University of Science and Medicine; Katie Wilson, University of Minnesota Medical School; Brianna Baldwin, University of Virginia School of Medicine; Lala Forrest, Frank H. Netter School of Medicine.

Subject: Special Diabetes Program for Indians

Sponsored by: Region 1, Region 7, Association of Native American Medical Students, American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

-
- 1 Whereas, in response to the diabetes and obesity epidemics among American Indians and
2 Alaska Natives (AI/AN), Congress established the Special Diabetes Program for Indians (SDPI)
3 in 1997¹; and
- 4 Whereas, this \$150 million annual grant program, coordinated by the Indian Health Service
5 (IHS) Division of Diabetes, with guidance from the Tribal Leaders Diabetes Committee, provides
6 funds for diabetes treatment and prevention to IHS, Tribal, and Urban Indian Health Programs
7 across the United States (U.S.)¹; and
- 8 Whereas, diabetes prevalence in AI/AN adults has decreased following the enactment of SDPI,
9 and has done so consistently, dropping from 15.4 percent in 2013 to 14.6 percent in 2017²; and
- 10 Whereas, diabetes-related mortality for AI/AN adults has decreased by 37 percent following the
11 enactment of SDPI, from 54.2 per 100,000 in 1999 to 34.4 per 100,000 in 2017¹; and
- 12 Whereas, diabetes-related kidney failure has dropped by 54 percent in AI/AN adults between
13 1996 (57.3 per 100,000) and 2013 (26.5 per 100,000) following the enactment of SDPI, a
14 greater decrease than for any other U.S. racial and ethnic group¹; and
- 15 Whereas, the IHS estimates that this decline in diabetes-related kidney failure among the AI/AN
16 adult population resulted in an estimated savings to Medicare of up to \$520 million over 10
17 years¹; and
- 18 Whereas, hospitalizations for uncontrolled diabetes among AI/AN adults has dropped 84
19 percent following the enactment of SDPI, from 57.9 per 100,000 in 2000 to 9.4 per 100,000 in
20 2015¹; and
- 21 Whereas, the prevalence of diabetic eye disease has decreased in AI/AN adults by more than
22 50 percent compared to reports from the 1980s and 1990s following the enactment of SDPI¹;
23 and
- 24 Whereas, in fiscal year (FY) 2020, there were 301 SDPI community-directed grant programs
25 serving more than 780,000 AI/AN children and adults in 35 states, of which, 254 are operated
26 by Tribes, 29 by Urban Indian Health Programs, and 18 by the IHS¹; and

Whereas, these community-directed grant programs support the implementation of diabetes clinical teams; diabetes patient registries; nutritional services; access to registered dietitians; access to physical activity specialists, access to culturally-tailored diabetes education materials; adult weight management services; nutrition services for children and youth, community-based physical activity services for children and youth; and physician activity for school-age youth¹; and

Whereas, this important public health program is subject to two-year appropriation cycles, creating continuity-of-care issues during prolonged Congressional budget negotiations; and

Whereas, the IHS is the only federal health program without advance appropriations, making it more difficult for SDPI grantees and IHS, Tribal, and Urban Indian Health Programs to hire new staff and maintain existing staffing levels during prolonged Congressional budget negotiations³; and

Whereas, SDPI funding has remained stagnant at \$150 million since 2004 with no adjustments for inflation, limiting expansion of the program to additional grantees and decreasing grant value⁴; and

Whereas, IHS funded programs have absorbed significant inflationary cost increases over the past twenty years, and federal and Tribal programs have difficulty managing resource losses associated with inadequate funding for inflationary costs⁵; and

Whereas, a review of other IHS grant programs, such as Indians Into Medicine (INMED), a five-year health professional grant, reported that INMED saw no regular funding increases, similar to SDPI⁶; therefore be it

RESOLVED, our AMA supports permanent reauthorization of the Special Diabetes Program for Indians; and be it further

RESOLVED, our AMA supports biannual inflationary increases for public health and health profession grants sponsored by the Indian Health Service.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Special Diabetes Program for Indians 2020 Report to Congress: Changing the Course of Diabetes: Charting Remarkable Progress [Internet]. Rockville (MD): Indian Health Service (US); 2020.
2. Bullock, A. et al. "Prevalence of diagnosed diabetes in American Indian and Alaska Native adults, 2006-2017." *BMJ open diabetes research & care* vol. 8,1 (2020): e001218.
3. Advance Appropriations. National Indian Health Board. Accessed September 22, 2022. https://www.nihb.org/legislative/advance_appropriations.php
4. National Clinical Care Commission. Report to Congress on Leveraging Federal Programs to Prevent and Control Diabetes and Its Complications. *Department of Health and Human Services*. Published 2021. Accessed August 31, 2022. <https://health.gov/sites/default/files/2022-01/NCCC%20Report%20to%20Congress.pdf>
5. FY 2023 National Tribal Budget Formulation Workgroup. *Indian Health Service*. Published February 12, 2021. Accessed September 22, 2022. https://www.ihs.gov/sites/budgetformulation/themes/responsive2017/display_objects/documents/FY2023NationalTribalBudgetFormulationWorkSessionMaterials.pdf

6. National Indian Health Board. Increasing Funding for the Indians Into Medicine (INMED) Program. Resolution 22-05. Published 2022. Accessed August 31, 2022.
[https://www.nihb.org/docs/02252022/22-05%20NIHB%20Resolution%20on%20Increasing%20Funding%20for%20the%20Indians%20Into%20Medicine%20\(INMED\)%20Program.pdf](https://www.nihb.org/docs/02252022/22-05%20NIHB%20Resolution%20on%20Increasing%20Funding%20for%20the%20Indians%20Into%20Medicine%20(INMED)%20Program.pdf)

RELEVANT AMA AND AMA-MSS POLICY

Improving Health Care of American Indians H-350.976

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

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

(3) State and local governments give special attention to the health and health-related needs of 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

Expansion of National Diabetes Prevention Program H-440.844

Our AMA: (1) supports evidence-based, physician-prescribed diabetes prevention programs, (2) supports the expansion of the NDPP to more CDC-certified sites across the country; and (3) will support coverage of the NDPP by Medicare and all private insurers.

Sub. Res. 911, I-12; Reaffirmed: CSAPH Rep. 1, A-22

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 027
(I-22)

Introduced by: Aarti Patel, Sara Kazyak, Pragathi Pathanjeli, Jovan Jande, Wayne State University School of Medicine; Jessyca Judge, Michigan State University College of Human Medicine; Shreya Mandava, University of Virginia School of Medicine

Subject: Recognition of the Disproportionate Impact of Infertility on Physicians

Sponsored by: Region 2, Region 5, American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, According to the CDC, infertility is formally defined as failure to achieve pregnancy after at least 12 months of regular unprotected sexual intercourse¹; and

Whereas, Nearly one in four female physicians attempting conception are diagnosed with infertility, demonstrating a rate nearly double that of the general public²; and

Whereas, In a study on infertility and pregnancy complications in US female surgeons, female surgeons had fewer children compared to male surgeons, were more likely to delay having children because of surgical training, and were more likely to use assisted reproductive technology³; and

Whereas, In a study on infertility and pregnancy complications in US female surgeons, 42% of female surgeons were found to face pregnancy loss, twice as likely as the general public, and more likely to face major pregnancy complications^{3,4}; and

Whereas, 25.5% of female physicians reported having fertility issues with the most cited factors in delaying having children being demands of training (72.9%) and long work hours (61.5%)⁵; and

Whereas, Sleep deprivation, poor diet, and lack of exercise associated with the demands of medical training have been found to impact a female physician's fertility⁶; and

Whereas, In a study amongst female residents and fellows, 50% of women reported being worried that having a child during their medical training would negatively impact their careers⁷; and

Whereas, More than one-third of physician mothers have reported discrimination related to pregnancy, maternity leave, or breastfeeding in the workplace, leading to higher rates of physician burnout for mothers in medicine and further contributing to delaying pregnancy⁸; and

Whereas, Among female physicians with infertility, when asked what they would do differently in retrospect, 28.6% would have attempted conception earlier, 17.1% would have gone into a different speciality²; and

Whereas, While 91% of female students/young professionals reported being aware of ovarian cryopreservation as an option, only 38.5% would consider it as an option, with the main barrier being cost⁹; and

Whereas, The majority of residents felt little to no support for fertility preservation options from their residency program, and 35% of surveyed residents reported stigma associated with their infertility¹⁰; and

Whereas, Over half of residency program directors are unaware if their trainees faced infertility, but many feel resources for trainees should be improved by creating policies for supporting resident's fertility needs¹¹; and

Whereas, While 78% of program directors support coverage of fertility preservation for their residents, only 6% of programs surveyed offer coverage for elective oocyte cryopreservation¹²; and

Whereas, Studies suggest that strategies to address physician infertility include increasing fertility education and awareness starting at the undergraduate medical education level and continuing throughout training and practice, providing insurance coverage for and access to fertility assessment and management, and offering support for those undergoing fertility treatments¹³; and

Whereas, The male is a major contributor in roughly 50% of infertility cases and male infertility is the sole contributor for a failure to conceive 20% of the time^{14,15}; and

Whereas, Male physicians face similar stressors to female physicians, including sleep deprivation, poor diet and exercise, and burnout, which may contribute to infertility^{16,17}; and

Whereas, Current research lacks an understanding of how sperm internal components contribute to male infertility, hindering the development of less invasive novel therapies to treat male infertility¹⁸; and

Whereas, There is a lack of concrete research into the prevalence of infertility among male physicians; however, shift work has been associated with infertility, hypogonadal symptoms, and poor semen parameters in men¹⁹; and

Whereas, Although AMA Policy H-420.952 recognizes infertility as a disease, there is no mention of the disproportionate burden that physicians, in particular, face compared to the general population; therefore be it

RESOLVED, Our AMA recognizes the disproportionately increased rates of infertility among female physicians in comparison to their non-physician counterparts; and be it further,

RESOLVED, Our AMA recognizes the contribution of rigorous medical training on family planning among physicians, particularly physicians of childbearing age; and be it further,

- 1 RESOLVED, Our AMA supports further research into the factors contributing to infertility in
- 2 physicians of all identities.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Carson SA, Kallen AN. Diagnosis and Management of Infertility: A Review. *JAMA*. 2021;326(1):65-76. doi:10.1001/jama.2021.4788
2. Stentz NC, Griffith KA, Perkins E, Jones RD, Jagsi R. Fertility and Childbearing Among American Female Physicians. *J Womens Health (Larchmt)*. 2016;25(10):1059-1065. doi:10.1089/jwh.2015.5638
3. Rangel EL, Castillo-Angeles M, Easter SR, et al. Incidence of Infertility and Pregnancy Complications in US Female Surgeons [published correction appears in *JAMA Surg*. 2021 Oct 1;156(10):991]. *JAMA Surg*. 2021;156(10):905-915. doi:10.1001/jamasurg.2021.3301
4. Anderson M, Goldman RH. Occupational Reproductive Hazards for Female Surgeons in the Operating Room. *JAMA Surgery*. 2020;155(3):243. doi:10.1001/jamasurg.2019.5420
5. Armijo PR, Flores L, Huynh L, Strong S, Mukkamala S, Shillcutt S. Fertility and Reproductive Health in Women Physicians. *J Womens Health (Larchmt)*. 2021;30(12):1713-1719. doi:10.1089/jwh.2020.8671
6. Female Physicians Face Higher Rates of Infertility and Pregnancy Complications. Ashpublications.org. Published November 24, 2021. Accessed August 26, 2022. <https://ashpublications.org/ashclinicalnews/news/1426/Female-Physicians-Face-Higher-Rates-of-Infertility?searchresult=1>
7. Kin C, Yang R, Desai P, Mueller C, Girod S. Female trainees believe that having children will negatively impact their careers: results of a quantitative survey of trainees at an academic medical center. *BMC Med Educ*. 2018 Nov 13;18(1):260. doi: 10.1186/s12909-018-1373-1. PMID: 30424762; PMCID: PMC6234638.
8. Chesak SS, Yngve KC, Taylor JM, Voth ER, Bhagra A. Challenges and Solutions for Physician Mothers: A Critical Review of the Literature. *Mayo Clinic Proceedings*. 2021;96(6):1578-1591. doi:10.1016/j.mayocp.2020.10.008
9. Hurley EG, Ressler IB, Young S, et al. Postponing Childbearing and Fertility Preservation in Young Professional Women. *Southern Medical Journal*. 2018 Apr;111(4):187-191. DOI: 10.14423/smj.0000000000000789. PMID: 29719026.
10. Aghajanova L, Hoffman J, Mok-Lin E, Herndon CN. Obstetrics and Gynecology Residency and Fertility Needs: National Survey Results. *Reproductive Sciences*. 2017;24(3):428-434. doi:10.1177/1933719116657193
11. Huynh M, Wang A, Ho J, Herndon CN, Aghajanova L. Fertility Preservation and Infertility Treatment in Medical Training: An Assessment of Residency and Fellowship Program Directors' Attitudes | Women's Health Reports. *Women's Health Reports*. Published December 8, 2021. Accessed August 26, 2022. <https://www.liebertpub.com/doi/abs/10.1089/whr.2021.0044>
12. Kim AS, Dhesi AS, Jabara SI, Baker MB. Care Gaps In Fertility Preservation Services for Resident Physicians: A Survey of Fertility Preservation Awareness and Insurance Coverage. *Fertility and Sterility*. 2020;114(3):e231. doi:10.1016/j.fertnstert.2020.08.647
13. Marshall AL, Arora VM, Salles A. Physician Fertility: A Call to Action. *Acad Med*. 2020;95(5):679-681. doi:10.1097/ACM.0000000000003079
14. Leslie SW, Siref LE, Soon-Sutton TL, Khan MAB. Male Infertility. In: StatPearls. StatPearls Publishing, Treasure Island (FL); 2021. PMID: 32965929.

15. Agarwal A, Baskaran S, Parekh N, et al. Male infertility. *The Lancet*. 2021;397(10271):319-333. doi:10.1016/s0140-6736(20)32667-2
16. Trockel MT, Menon NK, Rowe SG, et al. Assessment of Physician Sleep and Wellness, Burnout, and Clinically Significant Medical Errors. *JAMA Network Open*. 2020;3(12):e2028111. doi:10.1001/jamanetworkopen.2020.28111
17. Familoni OB. An overview of stress in medical practice. *Afr Health Sci*. 2008;8(1):6-7.
18. Turner KA, Rambhatla A, Schon S, et al. Male Infertility is a Women's Health Issue—Research and Clinical Evaluation of Male Infertility Is Needed. *Cells*. 2020;9(4):990. doi:10.3390/cells9040990
19. Muncey W, Jesse E, Loeb A, Thirumavalavan N. Infertility insurance: What coverage exists for physician trainees?. *Can Urol Assoc J*. 2021;15(7):E350-E355. doi:10.5489/cuaj.6824

RELEVANT AMA AND AMA-MSS POLICY

Recognition of Infertility as a Disease H-420.952

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

Res. 518, A-17

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.

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

Infertility Benefits for Veterans H-510.984

1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.

5. Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.

6. Our AMA will work with interested organizations to encourage TRICARE to cover: (1) fertility preservation procedures (cryopreservation of sperm, oocytes, or embryos) for medical indications, for active-duty military personnel and other individuals covered by TRICARE; and (2) gamete preservation for active-duty military personnel and activated reservist military personnel.

CMS Rep. 01, I-16; Appended: Res. 513, A-19; Appended: Res. 101, A-22

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.

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.

Resident and Fellow Access to Fertility Preservation H-310.902

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

Res. 302, A-22

Increased Education and Access to Fertility-Related Resources for U.S. Physicians 295.239MSS

AMA-MSS will (1) work with appropriate stakeholders to develop gender and sexuality inclusive educational initiatives for medical trainees of all levels to raise awareness about the high rate of physician infertility, family planning options including cryopreservation, and the financial implications of fertility management and (2) urge academic and private hospitals and employers to offer family planning resources and counseling for options such as gamete cryopreservation and in vitro fertilization, for medical residents, fellows, and physicians.

MSS Res. 014, A-22

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 028
(I-22)

Introduced by: Sandhya Sanapala, Elizabeth Suschana, University of Connecticut; Laura Knittig, Sam Houston State University; Christine Fasana, University of South Carolina Greenville; Dilpreet Kaeley, University of Toledo College of Medicine and Life Sciences

Subject: Including Gender Inclusive Language in Menstrual Healthcare

Sponsored by: Region 1, Region 2, Region 4, Region 7, PsychSIGN

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, 1.6% of all adults and 5% of young adults in the United States identify as a gender that is different than the sex they were assigned at birth¹; and

Whereas, “Gender-Inclusive Language”, as defined by the UN, is “speaking and writing in a way that does not discriminate against a particular sex, social gender or gender identity, and does not perpetuate gender stereotypes²; and

Whereas, Gender-inclusive language about menstruation creates a more welcoming clinical encounter and a stronger patient-provider relationship³; and,

Whereas, Since menstruation historically has been equated to womanhood, and this has created gender dysphoria in patients who menstruate⁴; and

Whereas, Gender-affirming care is a critical social determinant of the health and well-being of gender diverse communities, which encompasses the social, psychological, medical, and legal aspects of health, further, transgender patients face stigma and transphobia in the healthcare setting, which can be improved through gender affirmation to mitigate health disparities⁵; and,

Whereas, A study with transgender males and non-binary people who achieve menarche found that 93% of the participants experienced menstrual-related gender dysphoria and that transgender patients who menstruate are less likely to discuss menstruation with their doctors due to the stigma of their gender menstruating⁴; and

Whereas, Providers have been known to disregard correct pronouns and medical history and often are not sufficiently knowledgeable about transgender healthcare^{3,7}; and

Whereas, There is insufficient provider training to provide gender-affirming care to trans and non-binary patients who menstruate^{3,7}; and

Whereas, Studies show that in gender minorities, the prevalence of depression and anxiety symptoms meeting the clinical cut off was 52% and 38%, respectively, in comparison to non-gender minorities where the depression and anxiety rate was 27% and 30% in females and 25% and 14% in males respectively⁸; and

Whereas, Non-binary respondents had a decreased likelihood of receiving any mental health treatment and an increased likelihood of a positive AUDIT screen for dangerous alcohol use compared to their binary counterparts⁹; and

Whereas, Patients who identify as transgender and non-binary reported having a wide array of experiences when attempting to access healthcare, including discrimination and having to educate providers about their identity⁹; and

Whereas, The American College of Obstetricians and Gynecologists released a policy statement for inclusive language that reflects the broad spectrum of gender identities into ACOG guidance, resources, and communications in order to improve the quality of care for all patients, including those who identify as women and those who do not¹⁰; and

Whereas, Current AMA policy does not consistently use de-gendered language and references both menstrual care products and feminine hygiene products, which are not inclusive of trans and non-binary individuals who have a uterus and can menstruate; and therefore be it

RESOLVED, That our AMA supports gender-neutral language with regards to menstrual products in both practice and in training to ensure the needs of all individuals who menstruate are met; and be it further

RESOLVED, That our AMA amend current policy that includes de-gendered language to include transgender and non-binary individuals who have a uterus and can menstruate.

Considering Menstrual ~~Feminine Hygiene~~ Products as Medical Necessities, H-525.974

Our AMA: (1) encourages the Internal Revenue Service to classify ~~feminine hygiene products~~ menstrual products as medical necessities; (2) will work with federal, state, and specialty medical societies to advocate for the removal of barriers to ~~feminine hygiene products~~ menstrual products in state and local prisons and correctional institutions to ensure ~~incarcerated women~~ that menstrual products be provided free of charge, the appropriate type and quantity of ~~feminine hygiene products~~ menstrual products including tampons for their needs; and (3) encourages the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Brown A. About 5% of young adults in the U.S. say their gender is different from their sex assigned at birth. Pew Research Center. Accessed August 31, 2022. <https://www.pewresearch.org/fact-tank/2022/06/07/about-5-of-young-adults-in-the-u-s-say-their-gender-is-different-from-their-sex-assigned-at-birth/>
2. UNITED NATIONS Gender-inclusive language. Accessed August 31, 2022. <https://www.un.org/en/gender-inclusive-language/>.
3. Lane B, Perez-Brumer A, Parker R, Sprong A, Sommer M. Improving menstrual equity in the USA: perspectives from trans and non-binary people assigned female at birth and

health care providers. *Culture, Health & Sexuality*. 2021;0(0):1-15.
doi:[10.1080/13691058.2021.1957151](https://doi.org/10.1080/13691058.2021.1957151)

4. Frank SE. Queering Menstruation: Trans and Non-Binary Identity and Body Politics. *Sociological Inquiry*. 2020;90(2):371-404. doi:[10.1111/soin.12355](https://doi.org/10.1111/soin.12355)
5. Reisner SL, Radix A, Deutsch MB. Integrated and Gender-Affirming Transgender Clinical Care and Research. *J Acquir Immune Defic Syndr*. 2016;72(Suppl 3):S235-S242. doi:[10.1097/QAI.0000000000001088](https://doi.org/10.1097/QAI.0000000000001088).
6. Schwartz BI, Effron A, Bear B, et al. Experiences with Menses in Transgender and Gender Nonbinary Adolescents. *Journal of Pediatric and Adolescent Gynecology*. 2022;35(4):450-456. doi:[10.1016/j.jpaa.2022.01.015](https://doi.org/10.1016/j.jpaa.2022.01.015)
7. Kcomt L, Gorey KM, Barrett BJ, McCabe SE. Healthcare avoidance due to anticipated discrimination among transgender people: A call to create trans-affirmative environments. *SSM Popul Health*. 2020;11:100608. doi:[10.1016/j.ssmph.2020.100608](https://doi.org/10.1016/j.ssmph.2020.100608)
8. Reisner SL, Katz-Wise SL, Gordon AR, Corliss HL, Austin SB. Social epidemiology of depression and anxiety by gender identity. *J Adolesc Health*. 2016;59(2):203-208. doi:[10.1016/j.jadohealth.2016.04.006](https://doi.org/10.1016/j.jadohealth.2016.04.006)
9. Kattari SK, Bakko M, Hecht HK, Kattari L. Correlations between healthcare provider interactions and mental health among transgender and nonbinary adults. *SSM Popul Health*. 2019;10:100525. doi:[10.1016/j.ssmph.2019.100525](https://doi.org/10.1016/j.ssmph.2019.100525)
10. Inclusive Language. Accessed August 31, 2022. <https://www.acog.org/en/clinical-information/policy-and-position-statements/statements-of-policy/2022/inclusive-language>

RELEVANT AMA AND AMA-MSS POLICY

Considering Feminine Hygiene Products as Medical Necessities H-525.974

Our AMA: (1) encourages the Internal Revenue Service to classify feminine hygiene products as medical necessities; (2) will work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs; and (3) encourages the American National Standards Institute, the Occupational Safety and Health Administration, and other relevant stakeholders to establish and enforce a standard of practice for providing free, readily available menstrual care products to meet the needs of workers. Res. 218, A-18; Modified: Res. 209, I-21

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. Res. 212, I-16; Reaffirmed in

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 029
(I-22)

Introduced by: Kaye Dandrea, University of New England College of Osteopathic Medicine; Brandon Parker, Florida State University College of Medicine; Nicholas Bohannon, University of Nebraska College of Medicine; Gino Dettorre, Washington University School of Medicine in St. Louis; Matthew Linz, Rutgers New Jersey Medical School; Jacob Beiriger, Sidney Kimmel Medical College; Wyatt Lanik, University of Nebraska College of Medicine; John Slunecka, University of South Dakota Sanford School of Medicine; Udit Vyas, Indiana University School of Medicine; Chandana Kulkarni, Anne Burnett Marion School of Medicine at Texas Christian University

Subject: Naloxone Alternatives or Adjuncts to Combat Synthetic Opioid-Induced Respiratory Depression

Sponsored by: Region 1, Region 5, Region 6, PsychSIGN

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, In the United States, the opioid epidemic is a growing health crisis and has been declared a public health emergency¹; and

Whereas, Natural opioids are derived from the poppy plant, such as morphine and codeine, while synthetic opioids are artificially synthesized such as fentanyl, carfentanil, and methadone²; and

Whereas, Natural and synthetic opioid overdose-related deaths are a significant cause of death in the U.S., contributing to more than 100,000 deaths from April 2020 to April 2021, a 28.5% increase from the year prior^{3,4}; and

Whereas, Naloxone is a competitive antagonist with a high affinity for the mu-opioid receptor that can reverse opioid-induced respiratory depression and rescue opioid overdose, with a half-life of 30 to 120 minutes⁵; and

Whereas, The widespread distribution and use of naloxone has been shown to decrease opioid overdose-related deaths without significantly increasing the incidence of opioid use⁶⁻⁸; and

Whereas, Naloxone may precipitate withdrawal, which can lead to physical and psychological side effects for the patient, including mood changes, which may adversely affect bystanders or medical staff^{9,10}; and

Whereas, The need for large or repeated doses of naloxone to reverse synthetic opioid overdose further complicates medical management, adding to healthcare worker stress, especially in times of shortage¹¹; and

Whereas, Patients who overdosed on fentanyl-adulterated opioid tablets who received naloxone had recurrence of respiratory depression beyond the standard observation period for opioid overdose¹²; and

Whereas, Synthetic opioids have an increased potency compared to natural opioids, which frequently necessitates higher initial dosing or additional administrations to rescue respiratory depression in the setting of overdose¹³⁻¹⁵; and

Whereas, It has been estimated that nearly 80% of fatal opioid-related overdose deaths involved synthetic opioids¹⁶; and

Whereas, Between 2013 and 2019, synthetic opioid overdose-related deaths increased 1,040%, with more than 55,000 deaths related to synthetic opioid overdose in 2020 alone¹⁷⁻¹⁹; and

Whereas, A multi-agency meeting was held in 2019 to discuss the threat of synthetic opioids and urge the development of drugs aimed at rescuing respiratory depression and overdose caused by synthetic opioids specifically; among those present were representatives from the National Institutes of Health (NIH), the National Institute of Allergy and Infectious Diseases, the National Institute of Drug Abuse, the Food and Drug Administration (FDA), the Chemical Countermeasures Research Program, the Biomedical Advanced Research and Development Authority, and the Defense Threat Reduction Agency²⁰; and

Whereas, Respiratory stimulant drugs such as hypothalamic hormones, nicotinic receptor agonists, ampakines, serotonin agonists, antioxidants, and potassium channel blockers have been used in animal studies to reverse opioid-induced respiratory depression as alternatives to naloxone, but require further study before safe clinical use^{11,21,22}; and

Whereas, Preliminary studies of nalmeferene, a mu-opioid receptor antagonist more potent than nalcron, have shown potential reversal of opioid-induced respiratory depression²²; and

Whereas, Experimental drugs such as methocinnamox, an opioid receptor antagonist, have been shown to prevent respiratory depression following heroin exposure in Rhesus monkeys, but have not yet reached clinical trials²³; and

Whereas, AMA-MSS policy advocates for the prevention of fatal opioid overdose (100.007MSS) and increased access to reversal agents, yet this policy is specific to naloxone only and does not comment on concerns specific to synthetic opioids (100.010MSS); and

Whereas, AMA policy advocates for the prevention of drug-related overdose (D-95.987) and general opioid mitigation (D-95.964), but does not explicitly address the growing concern of synthetic opioids nor the limitations of naloxone; therefore be it

RESOLVED, That our AMA work with relevant stakeholders to increase research into the development of naloxone adjuncts or alternatives for use in combating synthetic opioid-induced respiratory depression and overdose.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Department of Health and Human Services. HHS Acting Secretary Declares Public Health Emergency to Address National Opioid Crisis. Accessed August 31, 2022. <https://public3.pagefreezer.com/browse/HHS.gov/31-12-2020T08:51/https://www.hhs.gov/about/news/2017/10/26/hhs-acting-secretary-declares-public-health-emergency-address-national-opioid-crisis.html>
2. CDC. Commonly Used Terms | Opioids | CDC. Published October 15, 2021. Accessed September 22, 2022. <https://www.cdc.gov/opioids/basics/terms.html>
3. Drug overdose deaths in the U.S. top 100,000 annually. U.S. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm. Published November 17, 2021. Accessed August 29, 2022.
4. National Institutes of Health. Overdose death rates. <https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates>. Published July 21, 2022. Accessed August 29, 2022.
5. Jordan MR, Morrisonponce D. Naloxone. In: StatPearls. StatPearls Publishing; 2022. Accessed August 29, 2022. <http://www.ncbi.nlm.nih.gov/books/NBK441910/>
6. Townsend T, Blostein F, Doan T, Madson-Olson S, Galecki P, Hutton DW. Cost-effectiveness analysis of alternative naloxone distribution strategies: First responder and lay distribution in the United States. *Int J Drug Policy*. 2020;75:102536. doi:10.1016/j.drugpo.2019.07.031
7. McClellan C, Lambdin BH, Ali MM, et al. Opioid-overdose laws association with opioid use and overdose mortality. *Addict Behav*. 2018;86:90-95. doi:10.1016/j.addbeh.2018.03.014
8. Stringfellow EJ, Lim TY, Humphreys K, et al. Reducing opioid use disorder and overdose deaths in the United States: A dynamic modeling analysis. *Science Advances*. 2022;8(25):eabm8147. doi:10.1126/sciadv.abm8147
9. Bateman JT, Saunders SE, Levitt ES. Understanding and countering opioid-induced respiratory depression [published online ahead of print, 2021 Jun 5]. *Br J Pharmacol*. 2021;10.1111/bph.15580. doi:10.1111/bph.15580
10. Chhabra N, Aks SE. Treatment of acute naloxone-precipitated opioid withdrawal with buprenorphine. *Am J Emerg Med*. 2020;38(3):691.e3-691.e4. doi:10.1016/j.ajem.2019.09.014
11. Dandrea KE, Cotten JF. A Comparison of Breathing Stimulants for Reversal of Synthetic Opioid-Induced Respiratory Depression in Conscious Rats. *J Pharmacol Exp Ther*. 2021;378(2):146-156. doi:10.1124/jpet.121.000675
12. Sutter ME, Gerona RR, Davis MT, et al. Fatal Fentanyl: One Pill Can Kill. *Acad Emerg Med*. 2017;24(1):106-113. doi:10.1111/acem.13034
13. Skolnick P. Treatment of overdose in the synthetic opioid era. *Pharmacol Ther*. 2022; 233:108019. doi:10.1016/j.pharmthera.2021.108019
14. Moss RB, Carlo DJ. Higher doses of naloxone are needed in the synthetic opioid era. *Subst Abuse Treat Prev Policy*. 2019;14(1):6. Published 2019 Feb 18. doi:10.1186/s13011-019-0195-4
15. Tuet WY, Pierce SA, Racine MC, et al. Changes in murine respiratory dynamics induced by aerosolized carfentanil inhalation: Efficacy of naloxone and naltrexone. *Toxicol Lett*. 2019;316:127-135. doi:10.1016/j.toxlet.2019.09.012
16. Ahmad, F., Rossen, L., & Sutton, P. (2021). Provisional drug overdose death counts. National Center for Health Statistics. <https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm>.
17. National Institutes of Health. Overdose death rates. <https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates>. Published July 21, 2022. Accessed August 29, 2022.

18. CDC. Synthetic Opioid Overdose Data | Drug Overdose | CDC Injury Center. Published June 6, 2022. Accessed September 22, 2022.
<https://www.cdc.gov/drugoverdose/deaths/synthetic/index.html>
19. Mattson CL, Tanz LJ, Quinn K, Kariisa M, Patel P, Davis NL. Trends and Geographic Patterns in Drug and Synthetic Opioid Overdose Deaths - United States, 2013-2019. *MMWR Morb Mortal Wkly Rep.* 2021;70(6):202-207. Published 2021 Feb 12.
doi:10.15585/mmwr.mm7006a4
20. Yeung DT, Bough KJ, Harper JR, Platoff GE Jr. National Institutes of Health (NIH) Executive Meeting Summary: Developing Medical Countermeasures to Rescue Opioid-Induced Respiratory Depression (a Trans-Agency Scientific Meeting)-August 6/7, 2019. *J Med Toxicol.* 2020;16(1):87-105. doi:10.1007/s13181-019-00750-x
21. Schrider R, Dahan JC, Boon M, et al. Advances in reversal strategies of opioid-induced respiratory toxicity. *Anesthesiology.* 2022;136:618-632.
<https://doi.org/10.1097/ALN.0000000000004096>
22. Krieter P, Gyaw S, Crystal R, Skolnick P. Fighting Fire with Fire: Development of Intranasal Nalmefene to Treat Synthetic Opioid Overdose. *J Pharmacol Exp Ther.* 2019;371(2):409-415. doi:10.1124/jpet.118.256115
23. Gerak LR, Maguire DR, Woods JH, Husbands SM, Disney A, France CP. Reversal and Prevention of the Respiratory-Depressant Effects of Heroin by the Novel μ -Opioid Receptor Antagonist Methocinnamox in Rhesus Monkeys. *J Pharmacol Exp Ther.* 2019;368(2):229-236. doi:10.1124/jpet.118.253286

RELEVANT AMA AND AMA-MSS POLICY

Opioid Mitigation D-95.964

Our AMA: (1) encourages relevant federal agencies to evaluate and report on outcomes and best practices related to federal grants awarded for the creation of Quick Response Teams and other innovative local strategies to address the opioid epidemic, and will share that information with the Federation; and (2) will update model state legislation regarding needle and syringe exchange to state and specialty medical societies. BOT Rep. 09, I-19

Treating Opioid Use Disorder in Hospitals D-95.967

1. Our AMA's Opioid Task Force will work together with the American Hospital Association and other relevant organizations to identify best practices that are being used by hospitals and others to treat opioid use disorder as a chronic disease, including identifying patients with this condition; initiating or providing opioid agonist or partial agonist therapy in inpatient, obstetric and emergency department settings; providing cognitive and behavioral therapy as well as other counseling as appropriate; establishing appropriate discharge plans, including education about opioid use disorder; and participating in community-wide systems of care for patients and families affected by this chronic medical disease; 2. Our AMA will advocate for states to evaluate programs that currently exist or have received federal or state funding to assist physicians, hospitals and their communities to coordinate care for patients with the chronic disease of opioid use disorder; 3. Our AMA will take all necessary steps to seek clarification of interpretations of 21 CFR 1306.07 by the DEA and otherwise seek administrative, statutory and regulatory solutions that will allow for (a) prescribers with the waiver permitting the prescribing of buprenorphine for opioid use disorder to be able to do so, when indicated, for hospitalized inpatients, using a physician order rather than an outpatient prescription, and (b) hospital inpatient pharmacies to be able to fill such authorizations by prescribers without this constituting a violation of federal regulations. Res. 223, A-18

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.

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.

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

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

95.023MSS Access to Naloxone for Vulnerable and Underserved Populations

AMA-MSS will support additional research on the most effective methods of naloxone distribution in emergency departments and solutions to overcome barriers to implementation. (MSS Res. 44, I-21)

100.007MSS Naloxone Administration and Opioid Overdose

AMA-MSS will ask the AMA to: (1) recognize the great burden that both prescription and non-prescription opioid use disorder places on patients and society alike and reaffirm its support for the compassionate treatment of patients with opioid use disorder; (2) monitor the progress of nasal naloxone studies and report back as needed; and (3) work to remove obstacles to physicians who wish to conduct ethical and needed research in the area of addiction medicine. (MSS Rep A, A-05; AMA Amended Res 526, A-06 Adopted [D-95.987]; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15; Amended and Reaffirmed: MSS GC Rep B, A-21)

100.010MSS Promoting Prevention of Fatal Opioid Overdose

AMA-MSS will ask the AMA to (1) encourage the establishment of new pilot programs directed towards heroin overdose treatment with naloxone; and (2) advocate for encourage the

education of health care workers and opioid users about the use of naloxone in preventing opioid overdose fatalities. (MSS Res 36, I-11; HOD Policy D-95.987 Amended in lieu of AMA Res 503, A-12; Reaffirmed: MSS GC Report A, I-16; Reaffirmed: MSS GC Report A, I21).

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 030
(I-22)

Introduced by: Jenna Gage, Kaci French, Roshaneh Ali, University of Texas Medical Branch
Galveston; Melanie Baker, University of Mississippi

Subject: Research of Plastic Use in Medicine

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

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Microplastics (MPs) are plastic particles smaller than 5mm and generated from the breakdown of plastic objects, clothing, car tires, and other everyday products¹; and

Whereas, The breakdown of an estimated 5 billion tons of existing plastic in landfills and the environment and the production of 400 million tons of plastic each year, a mass projected to more than double by 2050, account for the constantly rising levels of MPs²; and

Whereas, Wind has been shown to transport MPs in the atmosphere large distances and microplastics have been shown to be ubiquitous across various environments, including waste incineration, the textile industry, traffic emissions, and even remote mountain catchments and polar regions³; and

Whereas, MPs can enter the human body by inhalation, ingestion, and dermal contact⁴; and

Whereas, Humans could potentially be ingesting 0.1 to 5 g of microplastics per week and humans may accumulate several thousand microplastic particles in their lifetime^{2,5}; and

Whereas, There are significant microplastic concentrations contained in U.S. food, water supply and air (seafood = 1.48 MP particles/g, sugar = 0.44 MP particles/g, honey = 0.10 MP particles/g, salt = 0.11 MP particles/g, alcohol = 32.27 MP particles/L, bottled water = 94.37 MP particles/L, tap water = 4.23 MP particles/L, and air = 9.80 MP particles/m)⁶; and

Whereas, Microplastics may contain chemicals such as BPA, phthalates, heavy metals, flame retardants, and bisphenol A, that can disrupt endocrine function and have been linked to reproductive and developmental disorders including breast cancer, blood infection, early onset of puberty and genital defects^{1,7,8}; and

Whereas, Microplastics with a size of about 10 µm can cross cell membranes to organs including the liver, muscles, placenta, and even the blood-brain barrier⁸; and

Whereas, Microplastics can destabilize lipid membranes through mechanical stretching⁹; and

Whereas, MPs have been shown to induce damage to humans through inflammation, genotoxicity, and oxidative stress¹⁰; and

Whereas, Although research concerning the specific long term effects of MPs on the human body is limited, recent studies from 2021 identified for the first time the presence of MPs in human placentas and their ability to change the morphology of lung cells^{11,12}; and

Whereas, MPs have been shown to affect sperm quality in animal studies¹³; and

Whereas, It is difficult to determine the effects of MPs on human health because there is a lack of information on the risk of human exposure to this pollution⁴; and

Whereas, Healthcare facilities produce approximately 1.7 million tons of plastic in the U.S. and half of the plastic ever made was produced in the last 13 years, showing a growing problem^{14,15}; and

Whereas, Our AMA has no policy on plastic and has no policy in support of research in regards to reduction of medical waste specific to the medical sector; therefore be it

RESOLVED, That our AMA amend by addition as follows:

Stewardship of the Environment H-135.973

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages research into methods on the reduction of single-use plastic in medicine and the effects of microplastics on human health(14~~5~~) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15~~6~~) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16~~7~~) encourages expanded funding for environmental

1 research by the federal government; and (178) encourages family planning
2 through national and international support.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Prata JC, da Costa JP, Lopes I, Duarte AC, Rocha-Santos T. Environmental exposure to microplastics: An overview on possible human health effects. *Sci Total Environ.* 2020;702:134455. doi:10.1016/j.scitotenv.2019.134455
2. Lim X. Microplastics are everywhere - but are they harmful?. *Nature.* 2021;593(7857):22-25. doi:10.1038/d41586-021-01143-3
3. Chen G, Feng Q, Wang J. Mini-review of microplastics in the atmosphere and their risks to humans. *Sci Total Environ.* 2020;703:135504. doi:10.1016/j.scitotenv.2019.135504
4. Vethaak AD, Legler J. Microplastics and human health. *Science.* 2021 Feb 12;371(6530):672-4.
5. Senathirajah K, Attwood S, Bhagwat G, Carbery M, Wilson S, Palanisami T. Estimation of the mass of microplastics ingested - A pivotal first step towards human health risk assessment. *J Hazard Mater.* 2021;404(Pt B):124004. doi:10.1016/j.jhazmat.2020.124004
6. Cox KD, Covernton GA, Davies HL, Dower JF, Juanes F, Dudas SE. Human Consumption of Microplastics [published correction appears in *Environ Sci Technol.* 2020 Sep 1;54(17):10974]. *Environ Sci Technol.* 2019;53(12):7068-7074. doi:10.1021/acs.est.9b01517
7. Senathirajah K, Attwood S, Bhagwat G, Carbery M, Wilson S, Palanisami T. Estimation of the mass of microplastics ingested - A pivotal first step towards human health risk assessment. *J Hazard Mater.* 2021;404(Pt B):124004. doi:10.1016/j.jhazmat.2020.124004
8. Campanale C, Massarelli C, Savino I, Locaputo V, Uricchio VF. A Detailed Review Study on Potential Effects of Microplastics and Additives of Concern on Human Health. *International Journal of Environmental Research and Public Health.* 2020; 17(4):1212. <https://doi.org/10.3390/ijerph17041212>
9. Microplastics destabilize lipid membranes by mechanical stretching. *Proceedings of the National Academy of Sciences - PNAS,* 118(31). 2021. <https://doi.org/10.1073/pnas.2104610118>
10. Dybas CL. Silent scourge: Microplastics in water, food, and air. *BioScience.* 2020;70(12):1048-1055. doi:10.1093/biosci/biaa119
11. Goodman KE, Hare JT, Khamis ZI, Hua T, Sang QA. Exposure of Human Lung Cells to Polystyrene Microplastics Significantly Retards Cell Proliferation and Triggers Morphological Changes. *Chem Res Toxicol.* 2021;34(4):1069-1081. doi:10.1021/acs.chemrestox.0c00486
12. Ragusa A, Svelato A, Santacroce C, et al. Plasticenta: First evidence of microplastics in human placenta. *Environ Int.* 2021;146:106274. doi:10.1016/j.envint.2020.106274
13. D'Angelo S, Meccariello R. Microplastics: A Threat for Male Fertility. *Int J Environ Res Public Health.* 2021;18(5):2392. Published 2021 Mar 1. doi:10.3390/ijerph18052392

14. Scott M. Companies need to design in sustainability to products - and investors need to encourage them. Forbes.
<https://www.forbes.com/sites/mikescott/2018/07/30/companies-need-to-design-in-sustainability-to-products-and-investors-need-to-encourage-them/?sh=54505abc5c6f>.
 Published July 30, 2018. Accessed August 31, 2022.
15. Joseph B, James J, Kalarikkal N, Thomas S. Recycling of medical plastics. Advanced Industrial and Engineering Polymer Research. 2021 Jul 1;4(3):199-208.

RELEVANT AMA AND AMA-MSS POLICY

135.012MSS Toward Environmental Responsibility

AMA-MSS will ask the AMA to recognize the negative impact of climate change on global human health, particularly in the areas of infectious disease, the direct effects of heat, severe storms, food and water availability, and biodiversity. (MSS Amended Rep A, I-07) (AMA Res 607, A-08 Referred) (Modified: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

135.013MSS Statement of Sustainability Principles

AMA-MSS will (1) develop a model sustainability statement that medical schools can use as a template for creating institution-specific sustainability mission statements; and (2) encourage all medical schools to adopt mission statements which promote institutional sustainability initiatives such as consumption awareness, waste reduction, energy and water conservation, and the utilization of reusable/recyclable goods. (MSS Res 2, A-10) (Reaffirmed: MSS Res 10, I-11) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

135.014MSS Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability

AMA-MSS will ask that our AMA (1) amend policy H-135.949 by addition and deletion to read as follows:

Support of Clean Air and Reduction in Power Plant Emissions H-135.949

Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants, ~~substitution of natural gas in lieu of other carbon-based fossil fuels, and~~ continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.

(2) support the implementation of buffer zones between oil and gas development sites and residences, schools, hospitals, and religious institutions. (MSS Res 23, A-17)

135.015MSS AMA Policy on Investing in the Fossil Fuel Industry

AMA-MSS supports (1) the American Medical Association, Foundation, and any affiliated corporations, to work in a timely and fiscally responsible manner to end all financial investments or relationships with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; (2) the AMA, when fiscally responsible, to choose for its commercial relationships vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and (3) efforts of physicians and of other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators and government policy makers. (MSS Res 33, A-17)

135.017MSS Health Impact of Per- and Polyfluoroalkyl Substances (PFAS) Contamination in Drinking Water

AMA-MSS will ask the AMA to support legislation and regulation seeking to address contamination, exposure, classification, and clean-up of Per- and Polyfluoroalkyl substances. (MSS Res 02, A-19) (AMA Res. 901, Adopt Alternate Resolution in Lieu of Res. 901 and Res. 922 [H- 135.916], I-19)

135.018MSS Be the Change: Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership

AMA-MSS will ask the AMA to shift existing all-inclusive paper JAMA to opt-in paper JAMA subscriptions by the year 2020, still giving students an option to receive paper JAMA, while reducing AMA paper waste, supporting a green initiative, and saving cost. (MSS Res 45, I-18) (AMA Res 615, A-19, Referred) (BOT Report 8, Adopted, I-19)

135.019MSS Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room

AMA-MSS will ask the AMA to advocate for research into and development of intended multi-use operating room equipment and attire over devices, equipment and attire labeled for “single-use” with verified similar safety and efficacy profiles. (MSS Res. 42, I-19)

135.021MSS Environmental Contributors to Disease and Advocating for Environmental Justice

AMA-MSS will ask the AMA to amend Policy D-135.997, Research into the Environmental Contributors to Disease, by addition and deletion to read as follows:

Research into the Environmental Contributors to Disease and Advocating for Environmental Justice

Our AMA will (1) advocate for the greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as a priority public health issues; (3) encourage federal, state, and local agencies to address a remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

(MSS Res. 019, A-21)

Global Climate Change and Human Health H-135.938

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
 4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
 5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
 6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
- CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19

Global Climate Change - The "Greenhouse Effect" H-135.977

Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting;

(2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;

(3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity;

(4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and

(5) encourages humanitarian measures to limit the burgeoning increase in world population.

CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10;

Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14

AMA Advocacy for Environmental Sustainability and Climate H-135.923

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.

Res. 924, I-16; Reaffirmation: I-19

Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Health Care Leadership D-135.968

Our AMA will continue to explore environmentally sustainable practices for JAMA distribution.

BOT Rep. 8, I-19

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies D-135.969

Our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, 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.

BOT Rep. 34, A-18

Stewardship of the Environment H-135.973

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation; (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

Climate Change Education Across the Medical Education Continuum H-135.919

Our AMA: (1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education.

Support the Health Based Provisions of the Clean Air Act H-135.950

Our AMA opposes legislation to weaken the existing provisions of the Clean Air Act. Res. 417, A-03; Reaffirmation A-05; Reaffirmation I-11; Modified: CSAPH Rep. 1, A-21

Environmental Protection and Safety in Federal Facilities H-135.985

The AMA urges physicians to contribute to the solution of environmental problems by serving as knowledgeable and concerned consultants to environmental, radiation, and public health protection agencies of state and local governments.

BOT Rep. T, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07;
Reaffirmed: CSAPH Rep. 01, A-17

Clean Air H-135.991

- (1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.
- (2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.
- (3) The AMA endorses a more effective hazardous pollutant program to allow for efficient control of serious health hazards posed by airborne toxic pollutants.
- (4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.
- (5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health. Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health.

BOT Rep. R, A-82; Reaffirmed: CLRPD Rep. A, I-92; Amended: CSA Rep. 8, A-03;
Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation I-09; Reaffirmation A-14

Reducing Sources of Diesel Exhaust D-135.996

Our AMA will: (1) encourage the US Environmental Protection Agency (EPA) to set and enforce the most stringent feasible standards to control pollutant emissions from both large and small non-road engines including construction equipment, farm equipment, boats and trains; (2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from glider trucks and existing diesel engines; (3) call for all trucks traveling within the United States, regardless of country of origin, to be in compliance with the most stringent and current diesel emissions standards promulgated by US EPA; and (4) send a letter to US EPA Administrator opposing the EPA's proposal to roll back the "glider Kit Rule" which would effectively allow the unlimited sale of re-conditioned diesel truck engines that do not meet current EPA new diesel engine emission standards.

Res. 428, A-04; Reaffirmed in lieu of Res. 507, A-09; Reaffirmation A-11; Reaffirmation A-14;
Modified: Res. 521, A-18

Human and Environmental Health Impacts of Chlorinated Chemicals H-135.956

The AMA: (1) encourages the Environmental Protection Agency to base its evaluations of the potential public health and environmental risks posed by exposure to an individual chlorinated organic compound, other industrial compound, or manufacturing process on reliable data specific to that compound or process; (2) encourages the chemical industry to increase knowledge of the environmental behavior, bioaccumulation potential, and toxicology of their products and by-products; and (3) supports the implementation of risk reduction practices by the chemical and manufacturing industries.

Sub. Res. 503, A-94; Reaffirmation I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmation I-16

Assurance and Accountability for EPA's State Level Agencies H-135.924

Our AMA supports requiring that the United States Environmental Protection Agency (EPA) conduct regular quality assurance reviews of state agencies that are delegated to enforce EPA regulations.

Res. 221, A-16

Environmental Preservation H-135.972

It is the policy of the AMA to support state society environmental activities by:

- (1) identifying areas of concern and encouraging productive research designed to provide authoritative data regarding health risks of environmental pollutants;
- (2) encouraging continued efforts by the CSAPH to prepare focused environmental studies, where these studies can be decisive in the public consideration of such problems;
- (3) maintaining a global perspective on environmental problems;
- (4) considering preparation of public service announcements or other materials appropriate for public/patient education; and
- (5) encouraging state and component societies that have not already done so to create environmental committees.

Res. 52, A-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Green Initiatives and the Health Care Community H-135.939

Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of: Res. 504, A-16; Modified: Res. 516, A-18; Modified: Res. 923, I-19

Synthetic Gasification D-135.977

Our AMA will encourage the study the health effects of clean coal technologies including synthetic gasification plants.

Res. 514, A-12

Air Pollution and Public Health D-135.985

Our AMA: (1) promotes education among its members and the general public and will support efforts that lead to significant reduction in fuel emissions in all states; and (2) will declare the need for authorities in all states to expeditiously adopt, and implement effective air pollution control strategies to reduce emissions, and this position will be disseminated to state and specialty societies.

Res. 408, A-08; Reaffirmation A-14

Support of Clean Air and Reduction in Power Plant Emissions H-135.949

Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide;

and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.

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

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.

Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of: Res. 505, A-19

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.

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

AMA Position on Air Pollution H-135.998

Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.

(2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community.

(3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.

(4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control.

BOT Rep. L, A-65; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-14; Reaffirmation A-16; Reaffirmed: BOT Rep. 29, A-19

Protecting Public Health from Natural Gas Infrastructure H-135.930

Our AMA recognizes the potential impact on human health associated with natural gas infrastructure and supports legislation that would require a comprehensive Health Impact Assessment regarding the health risks that may be associated with natural gas pipelines.

Res. 519, A-15

Support Reduction of Carbon Dioxide Emissions D-135.972

Our AMA will (1) inform the President of the United States, the Administrator of the Environmental Protection Agency (EPA), and Congress that our American Medical Association supports the Administration's efforts to limit carbon dioxide emissions from power plants to protect public health; and (2) working with state medical societies, encourage state governors to support and comply with EPA regulations designed to limit carbon dioxide emissions from coal fired power plants.

Res. 421, A-14; Modified: Res. 506, A-15

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.

Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Appended: Res. 523, A-17

Clean Air H-135.979

Our AMA supports cooperative efforts with the Administration, Congress, national, state and local medical societies, and other organizations to achieve a comprehensive national policy and program to address the adverse health effects from environmental pollution factors, including air and water pollution, toxic substances, the "greenhouse effect," stratospheric ozone depletion and other contaminants.

Sub. Res. 43, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmed: CSAPH Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 031
(I-22)

Introduced by: Sara Kazyak, Aarti Patel, Wayne State University School of Medicine; Jara Crawford, Indiana University School of Medicine; Jessyca Judge, Michigan State University College of Human Medicine; Catriona Hong, Amanda Kahn, Vedika Karandikar, Julia Silverman, Elizabeth Suschana, University of Connecticut School of Medicine; Alec Calac, University of California San Diego School of Medicine; Rozena Shirvani, UT Rio Grande Valley School of Medicine; Kaye Dandrea, University of New England College of Osteopathic Medicine; Revati Gummaluri, Rowan University School of Osteopathic Medicine; Shreya Mandava, University of Virginia School of Medicine; Kira Szulborski, Tufts University School of Medicine; Haley Wymbs, University of South Carolina School of Medicine, Greenville; Mahima Goel, Carle Illinois College of Medicine

Subject: Expanding Inclusion of Diverse Mannequins Used in CPR and AED Training

Sponsored by: Region 1, Region 2, Region 3, Region 4, Region 5, Region 6, American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Out-of-hospital cardiac arrest (OHCA) results from a sudden circulatory collapse and it is fatal without rapid cardiopulmonary resuscitation (CPR) and/or defibrillation¹; and

Whereas, Bystander CPR is performed by a person who is not within the organized emergency-response system, and has been identified as a necessary intervention to improve out-of-hospital cardiac arrest survival²; and

Whereas, Every minute of delay in CPR results in a 10% decrease in survival rate, with OHCA being responsible for over 350,000 deaths per year in the United States with an estimated overall survival of 10%³⁻⁵; and

Whereas, Key strategies to improve survival include early recognition and activation of the Emergency Response System, early CPR, rapid defibrillation and an increase in rates of bystander CPR^{5,6}; and

Whereas, The American Heart Association (AHA) and supporting research recognize that women are less likely than men to receive CPR or AED application from a bystander, and even emergency medical services (EMS) are less likely to resuscitate women⁷⁻⁹; and

Whereas, Although OHCA rates are similar across genders, women have overall lower survival rates following CPR intervention or hospital discharge, which may be due to bystander hesitation to remove clothing items^{8,10,11}; and

Whereas, Concerns regarding accusations of sexual harassment or inappropriate touching, discomfort with breasts, and fears of injuring women are commonly cited by the public, particularly men, as reasons why women are less likely to receive bystander CPR in instances of OHCA, though delays in CPR intervention have been found to be more costly than concerns related to performing CPR^{12,13}; and

Whereas, While factors impacting CPR quality, such as clothing removal and hand placement, are impacted by the sex of the CPR mannequin utilized in training, 98.4% of almost 900 online CPR instructional videos use a male patient or mannequin without female anatomy, and none discussed female-specific barriers to CPR or defibrillation^{10,14}; and

Whereas, A study of the diversity of mannequins used across North and Latin America found only 12% were non-white, 6% represented women, <1% represented a non-lean body habitus, and 1% represented pregnant individuals¹⁵; and

Whereas, While CPR intervention during pregnancy does not differ from standard CPR intervention, other than manual left uterine displacement, studies show higher maternal mortality rates due to hesitancy of performing CPR due to concerns of inflicting harm on the patient¹⁶; and

Whereas, In a 2022 study performed in Australia, provider confidence for performing CPR on individuals with physical disabilities or abnormal chest shape was significantly improved by a supplemental training course¹⁷; and

Whereas, Though The International Liaison Committee on Resuscitation (ILCOR) recommends a depth of between 5cm and 6cm for adult chest compressions, the optimal chest compression depth recommended by ILCOR is unlikely to be sufficient when performing CPR on a patient with obesity¹⁸⁻²⁰; and

Whereas, Patients with body mass index classifications of “obese” or “underweight” are associated with higher rates of in-hospital mortality following out of hospital cardiac arrest²⁴; and

Whereas, There are still health disparities in OHCA survival rates due to a lack of competency in CPR and AED delivery for women, pregnant people, people with physical disabilities, and people with obesity^{8,10,11,16,17,21};

Whereas, Options for increasing diversity of CPR mannequins include the utilization of different skin colors, body types, and genders, or purchasing kits which can add breasts to a “male” chested mannequin on which a bra can be attached, though¹⁵; and

Whereas, Current cost-effective methods to diversify primarily male CPR mannequins include the Womanikin, an open-source design, or low-cost female accessory packs to add breasts to existing mannequins, indicating that existing mannequins can be modified to address current differences in OHCA survival following CPR intervention^{22,23}; and

Whereas, Options for CPR mannequins representing pregnant persons or persons with physical disabilities are not widely available; and

Whereas, While 2020 American Heart Association guidelines for CPR and emergency cardiovascular care states that it is reasonable to address barriers to bystander CPR for female

victims through educational training and public awareness efforts, it is clear additional action needs to be taken in order to address the disparities noted in OHCA CPR intervention²⁴; and

Whereas, Teaching materials used in American Heart Association Advanced Certified Life Support (ACLS) training have previously been found to insufficiently reflect races and gender at risk of requiring CPR²⁵; and

Whereas, AMA policy H-130.938 outlines guidelines CPR training for the American public, but it fails to address key healthcare inequities that exist in CPR education and intervention among minority groups; therefore, be it

RESOLVED, Our AMA supports use of diverse mannequins in CPR and AED training, including, but not limited to, mannequins with breasts, mannequins representing pregnant persons, mannequins representing persons with disabilities, and mannequins of varying body sizes; and be it further

RESOLVED, Our AMA supports the efforts of relevant stakeholders to develop diverse mannequins or modify current mannequins to reflect diverse patient populations, including, but not limited to, those representing pregnant persons or persons with physical disabilities; and be it further

RESOLVED, Our AMA will collaborate with relevant stakeholders to increase accessibility of CPR and AED training equipment representing diverse gender and body types in basic life support and advanced certified life support programs nationwide to ensure optimal competency for trainees of all education levels.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. 1. Uy-Evanado A, Chugh HS, Sargsyan A, et al. Out-of-hospital cardiac arrest response and outcomes during the COVID-19 pandemic. *JACC Clin Electrophysiol*. 2021;7(1):6-11. doi: S2405-500X(20)30729-5 [pii].
2. 2. Medical Dictionary. Bystander CPR. thefreedictionary.com. Accessed August 24, 2022. <https://medical-dictionary.thefreedictionary.com/bystander+CPR>.
3. 3. Benjamin EJ, Muntner P, Alonso A, Bittencourt MS, Callaway CW, Carson AP, Chamberlain AM, Chang AR, Cheng S, Das SR, et al. Heart disease and stroke statistics—2019 update: a report from the American Heart Association. *Circulation*. 2019; 139:e56–e528. DOI: 10.1161/CIR.0000000000000659.
4. 4. Williamson L. Why people fear performing CPR on women – and what to do about it. American Heart Association Website. <https://www.heart.org/en/news/2020/11/23/why-people-fear-performing-cpr-on-women-and-what-to-do-about-it>. Updated 2020. Accessed August 25, 2022.
5. 5. Chocron R, Jobe J, Guan S, et al. Bystander cardiopulmonary resuscitation quality: Potential for improvements in cardiac arrest resuscitation. *Journal of the American Heart Association*. 2021;10(6):e017930. doi: 10.1161/JAHA.120.017930.
6. 6. Yu Y, Meng Q, Munot S, Nguyen TN, Redfern J, Chow C. Assessment of Community Intervention for Bystander Cardiopulmonary Resuscitation in Out-of-Hospital Cardiac Arrest. *JAMA Netw Open*. 2020 Jul; 3(7): e209256. 10.1001/jamanetworkopen.2020.9256.

7. 7. Blewer AL, McGovern SK, Schmicker RH, et al. Gender Disparities Among Adult Recipients of Bystander Cardiopulmonary Resuscitation in the Public. *Circ Cardiovasc Qual Outcomes*. 2018;11(8):e004710. doi:10.1161/CIRCOUTCOMES.118.004710.
8. 8. Oving I, Blom MT, Tan HL. Sex differences in out-of-hospital cardiac arrest. *Aging (Albany NY)*. 2020 Apr 3;12(7):5588-5589. doi: 10.18632/aging.102980.
9. 9. Kiyohara K, Katayama Y, Kitamura T, et al. Gender disparities in the application of public-access AED pads among OHCA patients in public locations. *Resuscitation*. 2020;150:60-64. doi:10.1016/j.resuscitation.2020.02.038
10. 10. Kramer CE, Wilkins MS, Davies JM, Caird JK, Hallihan GM. Does the sex of a simulated patient affect CPR? *Resuscitation*. 2015;86:82-87. doi:10.1016/j.resuscitation.2014.10.016.
11. 11. Souers A, Zuver C, Rodriguez A, Van Dillen C, Hunter C, Papa L. Bystander CPR occurrences in out of hospital cardiac arrest between sexes. *Resuscitation*. 2021;166:1-6. doi:10.1016/j.resuscitation.2021.06.021.
12. 12. Perman SM, Shelton SK, Knoepke C, et al. Public perceptions on why women receive less bystander cardiopulmonary resuscitation than men in out-of-hospital cardiac arrest. *Circulation*. 2019;139(8):1060-1068. doi: 10.1161/CIRCULATIONAHA.118.037692.
13. 13. American Heart Association News. Worried about legal risks of doing CPR? Inaction is riskier. heart.org. Accessed August 26, 2022.<https://www.heart.org/en/news/2019/11/13/worried-about-legal-risk-of-doing-cpr-inaction-is-riskier>.
14. 14. Lynes CW, Toft LEB. Availability and Quality of Internet-Based Cardiopulmonary Resuscitation Training Films Featuring Women Experiencing Cardiac Arrest. *JAMA Cardiol*. 2020;5(12):1448–1449. doi:10.1001/jamacardio.2020.2871.
15. 15. Liblik K, Byun J, Lloyd-Kuzik A, et al. The DIVERSE study: Determining the importance of various genders, races, and body shapes for CPR education using manikins. *Curr Probl Cardiol*. 2022:101159. doi: <https://doi.org/10.1016/j.cpcardiol.2022.101159>.
16. 16. Jeejeebhoy FM, Zelop CM, Lipman S, et al. Cardiac Arrest in Pregnancy: A Scientific Statement From the American Heart Association. *Circulation*. 2015;132(18):1747-1773. doi:10.1161/CIR.0000000000000300.
17. 17. Deegan EM, Saunders A, Wilson NJ, McCann D. Cardio-pulmonary-resuscitation for people who use a wheelchair and/or have an atypical chest shape: an educational intervention. *Disabil Rehabil*. 2022;1-8. doi:10.1080/09638288.2022.2062464.
18. 18. Wyckoff MH, Singletary EM, Soar J, et. al. 2021 International Consensus on Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science With Treatment Recommendations: Summary From the Basic Life Support; Advanced Life Support; Neonatal Life Support; Education, Implementation, and Teams; First Aid Task Forces; and the COVID-19 Working Group. *Circulation*. 2021; 145(9):e645-e721. <https://doi.org/10.1161/CIR.0000000000001017>.
19. 19. Lee H, Oh J, Lee J, et al. Retrospective Study Using Computed Tomography to Compare Sufficient Chest Compression Depth for Cardiopulmonary Resuscitation in Obese Patients. *J Am Heart Assoc*. 2019;8(23):e013948. doi:10.1161/JAHA.119.013948.
20. 20. Secombe PJ, Sutherland R, Johnson R. Morbid obesity impairs adequacy of thoracic compressions in a simulation-based model. *Anaesth Intensive Care*. 2018;46(2):171-177. doi:10.1177/0310057X1804600205.
21. 21. Tellson A, Qin H, Erwin K, Houston S. Efficacy of acute care health care providers in cardiopulmonary resuscitation compressions in normal and obese adult simulation

- manikins. Proc (Bayl Univ Med Cent). 2017;30(4):415-418. doi:10.1080/08998280.2017.11930210.
22. 22. Joan Creative. Womanikin. joancreative.com. Accessed September 21, 2022. <https://www.joancreative.com/work/womanikin>
 23. 23. Heartsmart. PRESETAN Female Accessory 4-pack. heartsmart.com. Accessed September 21, 2022. https://www.heartsmart.com/prestan-female-accessory-4-pack-pp-fa-4-ms-ds-p?gclid=Cj0KCQjw7KqZBhCBARIsAI-fTKI2O8dZcd6NRRb-TURjD4PagHZ1Ew2BeX4d8NNVZHCYWfvxOja6qhQaAt7wEALw_wcB
 24. 24. Merchant RM, Topjian AA, Panchal AR, et al. Part 1: Executive Summary: 2020 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care. Circulation. 2020;142(16_suppl_2):S337-S357. doi:10.1161/CIR.0000000000000918.
 25. 25. Greenberg MR, Pierog JE. Evaluation of race and gender sensitivity in the american heart association materials for advanced cardiac life support. Gender Medicine. 2009;6(4):604-613. <https://www.sciencedirect.com/science/article/pii/S1550857909001181>. doi: <https://doi.org/10.1016/j.genm.2009.11.002>.

RELEVANT AMA AND AMA-MSS POLICY

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938

Our AMA:

- (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation;
- (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs;
- (3) encourages the American public to become trained in CPR and the use of automated external defibrillators;
- (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held;
- (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events;
- (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices;
- (7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel;
- (8) supports the development and use of universal connectivity for all defibrillators;
- (9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;
- (10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications;
- (11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and
- (12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.

Proficiency of Physicians in Basic and Advanced Cardiac Life Support H-300.945

Our AMA: (1) believes that all licensed physicians should become proficient in basic CPR and in advanced cardiac life support commensurate with their responsibilities in critical care areas; (2)

recommends to state and county medical associations that programs be undertaken to make the entire physician population, regardless of specialty or subspecialty interests, proficient in basic CPR; and (3) encourages training of cardiopulmonary resuscitation and basic life support be funded by medical schools and provided to first-year medical students, preferably during the first term or prior to clinical clerkships.

Disparities in Health Care E-8.5

Stereotypes, prejudice, or bias based on gender expectations and other arbitrary evaluations of any individual can manifest in a variety of subtle ways. Differences in treatment that are not directly related to differences in individual patients' clinical needs or preferences constitute inappropriate variations in health care. Such variations may contribute to health outcomes that are considerably worse in members of some populations than those of members of majority populations.

This represents a significant challenge for physicians, who ethically are called on to provide the same quality of care to all patients without regard to medically irrelevant personal characteristics.

To fulfill this professional obligation in their individual practices physicians should:

- (a) Provide care that meets patient needs and respects patient preferences.
- (b) Avoid stereotyping patients.
- (c) Examine their own practices to ensure that inappropriate considerations about race, gender identify, sexual orientation, sociodemographic factors, or other nonclinical factors, do not affect clinical judgment.
- (d) Work to eliminate biased behavior toward patients by other health care professionals and staff who come into contact with patients.
- (e) Encourage shared decision making.
- (f) Cultivate effective communication and trust by seeking to better understand factors that can influence patients' health care decisions, such as cultural traditions, health beliefs and health literacy, language or other barriers to communication and fears or misperceptions about the health care system.

The medical profession has an ethical responsibility to:

- (g) Help increase awareness of health care disparities.
- (h) Strive to increase the diversity of the physician workforce as a step toward reducing health care disparities.
- (i) Support research that examines health care disparities, including research on the unique health needs of all genders, ethnic groups, and medically disadvantaged populations, and the development of quality measures and resources to help reduce disparities.

AMA Principles of Medical Ethics: I,IV,VII,VIII,IX

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law. Issued: 2016

Inclusion of Women in Clinical Trials H-525.991

Our AMA: (1) encourages the inclusion of women, including pregnant women when appropriate, in all research on human subjects, except in those cases for which it would be scientifically irrational, in numbers sufficient to ensure that results of such research will benefit both men and women alike; (2) supports the National Institutes of Health policy requiring investigators to account for the possible role of sex as a biological variable in vertebrate animal and human studies; and (3) encourages translation of important research results into practice.

Res. 183, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 05, A-16; Reaffirmed: Res. 909, I-16

Use of Automatic External Defibrillators 130.002MSS

AMA-MSS will ask the AMA to support legislation for the increased use of automatic external defibrillators (AEDs) for the purpose of saving the life of another person in cardiac arrest provided that: (1) A person or entity who acquires an automatic external defibrillator ensures that: (A) Expected defibrillator users receive American Heart Association CPR and/or an equivalent nationally recognized course in defibrillator use and cardiopulmonary resuscitation; (B) The defibrillator is maintained and tested according to the manufacturer's operational guidelines; and (C) Any person who renders emergency care or treatment on a person in cardiac arrest by using an automatic defibrillator activates the emergency medical services system as soon as possible. (2) Any person or entity who acquires an automatic external defibrillator is encouraged to register the existence and location of the defibrillator with the emergency communications district or the ambulance dispatch center of the primary provider of emergency medical services where the automatic external defibrillator is to be located. (MSS Sub Res 12, A-98) (AMA Res 503, I-98 Referred) (BOT Rep 21, A-99 Adopted in Lieu of Res 503, I-98) (Reaffirmed: MSS Rep E, I-03) (Reaffirmed: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

Amending Policy H-525.988, "Sex and Gender Differences in Medical Research"

460.026MSS

RESOLVED, Our AMA amend Policy H-525.988, "Sex and Gender Differences in Medical Research," as follows

Sex and Gender Differences in Medical Research, H-525.988

Our AMA: (1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large;

(2) affirms the need to include all genders in studies that involve the health of society at large and publicize its policies;

(3) supports increased funding into areas of women's health and sexual and gender minority health research;

(4) supports increased research on women's health and sexual and gender minority health and the participation of women and sexual and gender minorities in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women and sexual and gender minorities from diverse cultural and ethnic groups, geographic locations, and socioeconomic status; and

(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative.

(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minorities (7) encourages the FDA to internally develop criteria for identifying medication and medical devices seeking FDA approval that were developed based on research that did not include adequate participation of women, and sexual and gender minorities. (MSS Res. 016, A-22)

Amending Policy H-130.938, "Cardiopulmonary Resuscitation (CPR) and Defibrillators"

440.117MSS

RESOLVED, That our AMA amend Policy H-130.938, "Cardiopulmonary Resuscitation (CPR) and Defibrillators," by addition to read as follows:

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938

Our AMA:

(1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation;

(2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs;

- (3) encourages the American public to become trained in CPR and the use of automated external defibrillators;
- (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held;
- (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events;
- (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices;
- (7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel; (8) supports the development and use of universal connectivity for all defibrillators;
- (9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use;
- (10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications;
- (11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and
- (12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.
- (13) encourages the distribution of Automated External Defibrillators in an equitable manner through the utilization of targeted placement strategies in order to increase availability and decrease disparities in areas where disproportionate rates of out-of-hospital cardiac arrest episodes exist. (MSS Res. 029, A-22)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 032
(I-22)

Introduced by: Anand Singh, Peter Park, Anne Burnett Marion School of Medicine at Texas Christian University; Sairandri Sathyanarayanan, McGovern Medical School at University of Texas Health

Subject: Addressing the Impact of Medicare Transition on Spousal Healthcare

Sponsored by: Region 3 and Region 7

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, The American population of individuals aged 65 and older is projected to increase from 54.1 million people in 2019 to 80.8 million people in 2040¹; and

Whereas, A study found that in 2021, one-fifth of older adults had to spend \$2000 out of pocket for healthcare in the past year²; and

Whereas, Medicare coverage is not a family plan and a spouse who is not 65 years old may not qualify for Medicare even if their partner is 65 and qualifies for Medicare, which can suddenly disrupt the insurance coverage of younger dependent spouses³; and

Whereas, A study found that insurance disruption that accompanies a spouse's Medicare transition showed female spouses under 65 had a 71% probability of experiencing a change in usual clinic/provider, 75% delaying filling or taking fewer medications than prescribed because of cost, and lower average mental health scores than women who did not experience an insurance disruption⁴; and

Whereas, A study found that spousal eligibility for Medicare results in the younger spouse having statistically significant worse insurance coverage and reduced access to health care services based on regression analysis⁵; and

Whereas, Medicare eligibility of older wives correlates with 3.49 percentage points increase in the number of younger husbands that are uninsured and younger wives experience 8.04 percentage decline in insurance coverage from a husband's employer after an older husband turns 65⁶; and

Whereas, No major Medicare reform has occurred to fix this issue despite multiple studies reporting that Medicare eligibility has adverse effects on spousal health insurance coverage and access to health care⁴⁻⁶; and

Whereas, There are limited options for insurance coverage for spouses who are not 65 years old with a partner who can qualify for Medicare, such as COBRA but it was associated with a high cost of an average annual health spending cost of \$11,695 versus \$6,144 for large group enrollees which can be prohibitively expensive⁷⁻⁸; and

Whereas, There is little current research looking into the impact that Medicare eligibility has on spousal health insurance coverage, health care utilization, and access to health care; and

Whereas, The American Medical Association has multiple policies (H-25.998, H-25.999, and H-295.981) that emphasize the importance of access to and the delivery of adequate health care of aging populations; therefore be it

RESOLVED, That our AMA work with appropriate stakeholders to improve spousal insurance coverage, access to healthcare, and healthcare utilization for those affected by Medicare transition; and be it further

RESOLVED, That our AMA encourages the Center for Medicare and Medicaid Services to explore the use of educational materials on health insurance coverage options for spouses of Medicare beneficiaries.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Projected future growth of older population. ACL Administration for Community Living. <https://acl.gov/aging-and-disability-in-america/data-and-research/projected-future-growth-older-population#:~:text=In%202019%2C%20there%20were%2054.1,and%2094.7%20million%20by%202060>. Published May 4, 2022. Accessed August 19, 2022.
2. Jacobson G, Cicchiello A, Shah A, Doty MM, Williams RD. When Costs Are Barrier to Health Care: Older Adults in 11 Countries. Commonwealth Fund. <https://www.commonwealthfund.org/publications/surveys/2021/oct/when-costs-are-barrier-getting-health-care-older-adults-survey>. Accessed August 19, 2022.
3. A younger spouse must wait until age 65 for Medicare. AARP. <https://www.aarp.org/health/medicare-qa-tool/qualify-for-medicare-at-age-63/>. Accessed August 19, 2022.
4. Schumacher JR, Smith MA, Liou JI, Pandhi N. Insurance disruption due to spousal Medicare transitions: implications for access to care and health care utilization for women approaching age 65. *Health Serv Res*. 2009 Jun;44(3):946-64. doi: 10.1111/j.1475-6773.2009.00952.x. Epub 2009 Mar 5. PMID: 19292774; PMCID: PMC2699916.
5. Dillender M, Mulligan K. The Effect of Medicare Eligibility on Spousal Insurance Coverage. *Health Econ*. 2016;25(5):591-605. doi:10.1002/hec.3175
6. Witman A. Public health insurance and disparate eligibility of spouses: The Medicare eligibility gap. *J Health Econ*. 2015;40:10-25. doi:10.1016/j.jhealeco.2014.10.007

7. Medicare coverage for non-working spouses. UnitedHealthcare. <https://www.uhc.com/news-articles/medicare-articles/medicare-coverage-for-non-working-spouses>. Accessed September 20, 2022.
8. Rae M, Pollitz K, Cox C, Kamal R, Fehr R, Young G. Key issues related to Cobra subsidies. KFF. <https://www.kff.org/private-insurance/issue-brief/key-issues-related-to-cobra-subsidies/>. Published May 28, 2020. Accessed September 20, 2022.

RELEVANT AMA AND AMA-MSS POLICY

Policy Recommendations in the Field of Aging H-25.998

1. It is the policy of the AMA that: (a) older individuals should not be isolated; (b) a health maintenance program is necessary for every individual; (c) more persons interested in working with the older people in medical and other professional fields are needed; (d) more adequate nursing home facilities are an urgent health need for some older people in many communities; (e) further development of service and facilities is required; (f) extension of research on both medical and socioeconomic aspects of aging is vital; (g) local programs for older persons, especially those which emphasize the importance of self-help and independence by the senior citizen, should be a major concern of medicine, both collectively and individually; and (h) local medical society committees along with other leaders in community service, should be equipped to appraise the advantage or disadvantage of proposed housing for older people.

2. Our AMA supports initiatives by the American Bar Association Commission on Law and Aging and other associations and agencies of the federal government to address elder abuse and to ensure consistent protection of elders' rights in all states.

(CMS Rep. A, I-60Reaffirmed: CLRPD Rep. C, A-88Reaffirmed: Sunset Report, I-98Reaffirmed: CSAPH Rep. 2, A-08Reaffirmed: CMS Rep. 01, A-18Appended: BOT Rep. 11, I-21)

Health Care for Older Patients H-25.999

The AMA: (1) endorses and encourages further experimentation and application of home-centered programs of care for older patients and recommends further application of other new experiments in providing better health care, such as rehabilitation education services in nursing homes, chronic illness referral centers, and progressive patient care in hospitals; (2) recommends that there be increased emphasis at all levels of medical education on the new challenges being presented to physicians in health care of the older person, on the growing opportunities for effective use of health maintenance programs and restorative services with this age group, and on the importance of a total view of health, embracing social, psychological, economic, and vocational aspects; (3) encourages continued leadership and participation by the medical profession in community programs for seniors; and (4) will explore and advocate for policies that best improve access to, and the availability of, high quality geriatric care for older adults in the post-acute and long term care continuum..

(Committee on Aging Report, I-60Reaffirmed: CLRPD Rep. C, A-88Reaffirmed: Sunset Report, I-98Reaffirmed: CSAPH Rep. 2, A-08Reaffirmation A-11Appended: Res. 709, A-13)

Geriatric Medicine H-295.981

1. Our AMA reaffirms its support for: (a) the incorporation of geriatric medicine into the curricula of medical school departments and its encouragement for further education and research on the

problems of aging and health care of the aged at the medical school, graduate and continuing medical education levels; and (b) increased training in geriatric pharmacotherapy at the medical student and residency level for all relevant specialties and encourages the Accreditation Council for Graduate Medical Education and the appropriate Residency Review Committees to find ways to incorporate geriatric pharmacotherapy into their current programs.

2. Our AMA recognizes the critical need to ensure that all physicians who care for older adults, across all specialties, are competent in geriatric care, and encourages all appropriate specialty societies to identify and implement the most expedient and effective means to ensure adequate education in geriatrics at the medical school, graduate, and continuing medical education levels for all relevant specialties.

(Res. 137, A-85Reaffirmed by CLRPD Rep. 2, I-95Appended: CSA Rep. 5, A-02Appended: Res. 301, A-10Reaffirmed: BOT Rep. 05, I-16)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 033
(I-22)

Introduced by: Dhruv Puri, Jessica Kim, University of California San Diego School of Medicine; Lynn Midani, University of New Mexico School of Medicine; Kristin Kohlmann, University of Wisconsin School of Medicine and Public Health; Eshani Kishore, Paul L. Foster School of Medicine; Caitlin Aguirre, University of Texas Medical Branch John Sealy School of Medicine; Rozena Shirvani, University of Texas Rio Grande Valley School of Medicine; Julia Houshmand, University of Miami Miller School of Medicine; Sanjana Mandilwar, Christine Fasana, University of South Carolina School of Medicine Greenville; Rodolfo Valentini, University of Connecticut School of Medicine

Subject: The Health Care Related Effects of Recent Changes to the US Mexico Border

Sponsored by: Region 6

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

1 Whereas, The U.S Mexico border extends 1980 miles from San Diego, California to Brownsville,
2 Texas with hundreds of thousands of undocumented immigrants entering the U.S illegally every
3 year¹; and
4

5 Whereas, On January 24th, 2017, President Trump signed the “Border Security and Immigration
6 Enforcement Improvements” Executive Order that resulted in an increase in the height of the
7 border wall from 17 to 30 feet and initiated the addition of 49 miles of new wall²; and
8

9 Whereas, The Biden administration halted all border wall construction initiated by the Trump
10 administration upon taking office but has recently been approving projects along the border to
11 continue construction ³⁻⁵; and;
12

13 Whereas, On March 20th, 2020, the Center for Disease Control under the Trump administration
14 issued a public health order, Title 42, a law that allows removals by the U.S. government of
15 persons who have recently been in a country where a communicable disease was present,
16 which effectively shut the border to asylum seekers⁶; and
17

18 Whereas, The US has to date expelled over 1.8 million individuals under Title 42, and the
19 border has experienced a significant increase in repeat and overall crossings at the border⁷; and
20

21 Whereas, Crossing the border for many results in injuries requiring medical assistance such as
22 physical trauma, rhabdomyolysis, dehydration, and death^{8,9}; and
23

Whereas, Study comparing cases of fatal injuries from falls sustained when climbing the US Mexico border wall determined that the implication of both lateral and vertical expansion of the wall is increased severity and cost of the trauma ^{10,11}; and

Whereas, A study found that 55% of migrants crossing the border experienced moderate to grave psychological suffering when screened by Doctors Without Borders¹²; and

Whereas, A study from Arizona described damage to the cranium and spine as a clinically prevalent and costly result of border wall crossing that needs to be addressed to decrease the detrimental impacts felt both by immigrants and surrounding health care systems ⁹; and

Whereas, One study of the San Diegan US - Mexico Border compared medical outcomes pre and post changes to the border by the Trump administration and saw a greater than fivefold increase in admissions, significantly increased hospital and scene mortality, as well as admissions costs in 2021 which exceeded 13 million USD¹¹; and

Whereas, A study on the Rio Grande Valley of 121 undocumented immigrants who were injured in their travels incurred a cost of 1.1 million USD to the healthcare system that provided care for this patient population¹³; and

Whereas, One study found the majority of deaths at the US-Mexico border were highly preventable¹⁴; therefore be it

RESOLVED, Our AMA recognizes the health related effects and humanitarian consequences of recent changes to the barriers between the US and Mexico on immigrant populations and increased burden to the US healthcare system.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Palacio, C.H., Cruz, B., Vanier, C. *et al.* The mechanism and pattern of injuries of undocumented immigrants crossing the Texas-Mexico border along the Rio Grande Valley. *Inj. Epidemiol.* 8, 58 (2021). <https://doi.org/10.1186/s40621-021-00341-x>
2. Border Security and Immigration Enforcement Improvements. <https://www.federalregister.gov/documents/2017/01/30/2017-02095/border-security-and-immigration-enforcement-improvements>. Published January 25, 2017. Accessed August 30, 2022.
3. Eferigue, J; Loo, N; Berlie, N. Work resumes on California border wall, threatening park. NewsNation. <https://www.newsnationnow.com/us-news/immigration/border-coverage/work-resumes-on-california-border-wall-threatening-park>. Published July 7, 2022. Accessed August 30, 2022.
4. Blankley B. Biden administration begins closing Arizona border wall gaps after pledging to not build 'another foot'. The Center Square. <https://www.thecentersquare.com/arizona/biden-administration-begins-closing-arizona->

- border-wall-gaps-after-pledging-to-not-build-another-foot/article_46a8b712-102a-11ed-b2de-3bbdb77bef6.html. Published July 30, 2022. Accessed September 21, 2022.
5. Devereaux R. Border Wall Construction Resumes Under President Joe Biden. The Intercept. Published September 1, 2022. Accessed September 21, 2022. <https://theintercept.com/2022/09/18/biden-trump-border-wall/>
 6. Laws and Regulations for the Medical Examination of Aliens. Centers for Disease Control and Prevention. <https://www.cdc.gov/immigrantrefugeehealth/laws-regulations.html>. Last updated December 16, 2019. Accessed August 30, 2022.
 7. Chishti M, Bolter J. *Controversial U.S. Title 42 Expulsions Policy Is Coming to an End, Bringing New Border Challenges*. Migration Policy Institute. 2022. <https://www.migrationpolicy.org/article/title-42-expulsions-policy>. Published March 31, 2022. Accessed August 30, 2022.
 8. Koleski J, Aldulaimi S, Moran E. From Dehydration to Fractures: Medical Issues Faced by People Crossing the United States: Mexico Border. *Journal of Immigrant and Minority Health*. 2019 Oct;21(5):1181-1184. DOI: 10.1007/s10903-018-0827-1. PMID: 30341478.
 9. Ramey WL, Walter CM, Zeller J, Dumont TM, Lemole GM, Hurlbert RJ. Neurotrauma From Border Wall Jumping: 6 Years at the Mexican-American Border Wall. *Neurosurgery*. 2019;85(3):E502-E508. doi:10.1093/neuros/nyz050
 10. Jackson NR, Lathrop S, Dvorscak L. Wall Falls: Blunt Trauma Sustained from Border Wall Crossings. *Am J Forensic Med Pathol*. 2021;42(3):243-247. doi:10.1097/PAF.0000000000000674
 11. Liepert AE, Berndtson AE, Hill LL, et al. Association of 30-ft US-Mexico Border Wall in San Diego With Increased Migrant Deaths, Trauma Center Admissions, and Injury Severity. *JAMA Surg*. 2022;157(7):633-635. doi:10.1001/jamasurg.2022.1885
 12. Russell, B. (2020, June 24). The Hidden Mental Health Crisis at Mexico's border. *Americas Quarterly*.
 13. Palacio CH, Cruz B, Vanier C, Cano J, Scott BG. The mechanism and pattern of injuries of undocumented immigrants crossing the Texas-Mexico border along the Rio Grande Valley. *Inj Epidemiol*. 2021;8(1):58. Published 2021 Oct 28. doi:10.1186/s40621-021-00341-x
 14. Sapkota S, Kohl HW 3rd, Gilchrist J, et al. Unauthorized border crossings and migrant deaths: Arizona, New Mexico, and El Paso, Texas, 2002-2003. *Am J Public Health*. 2006;96(7):1282-1287. doi:10.2105/AJPH.2005.075168.

RELEVANT AMA-MSS AND AMA POLICY

Financial Impact of Immigration on American Health System D-160.988

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

Res. 235, A-06Reaffirmation I-10Reaffirmed: BOT Rep. 04, A-20

Improving Healthcare of Hispanic Populations in the United States H-350.975

It is the policy of our AMA to: (1) Encourage health promotion and disease prevention through educational efforts and health publications specifically tailored to the Hispanic community. (2)

Promote the development of substance abuse treatment centers and HIV/AIDS education and prevention programs that reach out to the Hispanic community. (3) Encourage the standardized collection of consistent vital statistics on Hispanics by appropriate state and federal agencies. (4) Urge federal and local governments, as well as private institutions, to consider including Hispanic representation on their health policy development organization. (5) Support organizations concerned with Hispanic health through research and public acknowledgment of the importance of national efforts to decrease the disproportionately high rates of mortality and morbidity among Hispanics. (6) Promote research into effectiveness of Hispanic health education methods. (7) Continue to study the health issues unique to Hispanics, including the health problems associated with the United States/Mexican border.

CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 01, A-20

Patient and Physician Rights Regarding Immigration Status H-315.966

Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

Res. 018, A-17

Separation of Children From Their Caregivers at Border H-440.818

Our AMA will: (1) oppose the practice of separating migrating children from their caregivers in the absence of immediate physical or emotional threats to the child's well-being; and (2) urge the federal government to withdraw its policy of requiring separation of migrating children from their caregivers, and instead, give priority to supporting families and protecting the health and well-being of the children within those families.

Res. 253, A-18

Addressing and Banning Nonconsensual Medical Procedures Among Migrant Women at the Border D-350.978

Our AMA: (1) condemns the performance of nonconsensual, invasive medical procedures; (2) will advocate against forced sterilizations of any kind, including against migrant women in detention facilities, and advocate for appropriate associated disciplinary action (including license revocation); and (3) will advocate for safer medical practices and protections for migrant women.

Res. 016, A-22

270.041MSS: Supporting External Accountability for ICE and CBP

AMA-MSS promotes the health and well-being of immigrants and their families who are affected by immigration raids and/or held in detention by U.S. Immigration and Customs Enforcement or U.S. Customs and Border Protection. (MSS Res. 76, I-19) (Reaffirmed: MSS Res. 031, A-21)

350.015MSS: Patient and Physician Rights Regarding Immigration Status 350.015MSS

AMA-MSS will ask the AMA to support protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented. (MSS Res 15, A-17, Immediate Transmittal) (AMA Res 018, A-17 Adopted [H-315.966])

350.016MSS: Improving Medical Care in Immigration Detention Centers

AMA-MSS will ask that our AMA (1) issue a public statement urging U.S. Immigrations and Customs Enforcement Office of Detention Oversight to 1) revise its medical standards

governing the conditions of confinement at detention facilities to meet or exceed those set by the National Commission on Correctional Health Care, 2) take necessary steps to achieve full compliance with these standards, and 3) create a system to track complaints related to substandard healthcare quality filed by detainees; and (2) recommend the U.S. Immigrations and Customs Enforcement refrain from partnerships with private institutions whose facilities do not meet the standards of medical, mental, and dental care as guided by the National Commission on Correctional Health Care. (MSS Res 22, A-17, Immediate Transmittal) (AMA Res 017, A-17 Adopted as Amended [D-350.983])

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 034
(I-22)

Introduced by: Nikita Changlani, Texas Tech Health Sciences Center El Paso; Neha Siddiqui, Carle Illinois College of Medicine; Samantha Pavlock, Florida State University College of Medicine; Rajadhar Reddy, Baylor College of Medicine; Wilhelmina Tan, University of Texas Medical Branch at Galveston; Sayali Shelke, Texas A&M College of Medicine; Adrina Kocharian, University of Minnesota, Twin Cities.

Subject: Conservatorship and Guardianship Reform

Sponsored by: Region 2, Region 4, Region 6, PsychSIGN, American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, There are 1.3 million people currently under the care of court-appointed conservators or guardians, who control \$50 billion worth of these individuals' assets¹; and

Whereas, The number of elderly Americans is projected to nearly double by 2060, comprising over 20% of the total population, and dramatically increasing the number of people at risk of becoming subject to guardianships^{1,2}; and

Whereas, The vast majority of guardianships are permanent general guardianships, the most restrictive form of guardianships, which are difficult and costly to amend or terminate¹⁴; and

Whereas, Recent journalism, perspectives from lawyers, and high-profile legal proceedings on conservatorship and guardianship have raised additional questions over the paucity and decentralization of data, along with the potential for abuse and fraud in these systems⁴⁻¹¹; and

Whereas, Overly broad guardianships and the failure to consider less restrictive alternatives results in isolation and segregation of the conservatee, which has the potential to result in a violation of the Americans with Disabilities Act (ADA)¹⁵; and

Whereas, Physicians and other healthcare workers play a significant role in determining whether an individual is incapacitated, as these court proceedings often require the submission of evidence from a medical expert and a review of medical history, diagnoses, and/or psychological evaluation¹³; and

Whereas, Capacity determinations often lack scientific or evidentiary support, and heavily rely on a medical diagnosis and presumption of incapacity, rather than a functional approach and observed abilities¹³; and

Whereas, Elderly patients noted the importance of participating in their medical decision making and cited maintaining independence as a key measure of health outcomes^{16,17}; and

Whereas, In response to recent reports of guardianship abuse, The Senate Committee on Aging released a report in 2018, noting the impact of the guardianship system on the health and well-being of elderly and disabled populations, and the need for less restrictive alternatives¹; and

Whereas, Data on guardian abuse in elderly populations is limited, but reports indicate hundreds of cases of financial exploitation, physical abuse, and neglect^{1,21}; and

Whereas, Conservatoree's with intellectual disabilities/developmental disabilities (ID/DD) are at an increased risk of unfair treatment in guardianship proceedings and face several unique barriers, including overly restrictive guardianships, inadequate capacity determinations, and poor data collection and management¹⁸; and

Whereas, Guardianships are governed by state law, resulting in a wide degree of variation in legal standards and procedures^{19,20}; and

Whereas, Some states have significantly lower evidentiary standards for implementing guardianships and less protections on individual autonomy; for example, the New York legislature allows guardians to make any and all healthcare decisions for individuals with ID/DD, and does not require the consideration of the individual's preferences^{19,20}; and

Whereas, The majority of guardianship applications for individuals with intellectual or developmental disabilities are filed proactively, while many of these individuals are still minors and in school and before they have the opportunity to develop decision-making skills¹⁸;

Whereas, Limitations on autonomy and self-determination have a negative impact on physical and mental health, functional abilities, and general well-being²²; and

Whereas, Guardianships and capacity determinations can result in isolation and stigmatization, with self-reported feelings low-self esteem, helplessness, and inadequacy²³; and

Whereas, Individuals with ID/DD with greater self-determination reported a better quality of life, experienced better life outcomes, and developed a greater level of functional independence, including higher rates of productivity and employment²²; and

Whereas, Guardianships result in a drastic limitation of an individual's autonomy, civil liberties, and self-determination, and should be considered an option of last resort^{1,14}; and

Whereas, Supported Decision Making (SDM) is a new, less-restrictive alternative to guardianships, which preserves the autonomy and decision-making capacity of an individual while providing support from family, friends, and professionals²⁴; and

Whereas, Preliminary studies found that SDM leads to positive outcomes, including improved decision-making skills, greater levels of cognitive functioning, and stronger social support²⁴; and

Whereas, Additional data is needed on the relationship between SDM and improved life and health outcomes, particularly for individuals with mental illnesses and older adults with cognitive impairments^{1,14}; and

Whereas, Supported decision making is currently adopted in 12 states, several other countries, and model international guidelines^{14,25}; and

Whereas, Scientific research on SDM is limited, but indicates potential positive effects for patients living with mental illnesses²⁻³; and

Whereas, The medical and legal complexities of conservatorship and guardianship would benefit from detailed study; therefore be it

RESOLVED, That our AMA support federal and state efforts to collect anonymized data on guardianships and conservatorships to assess the effects on medical decision making and rates of abuse; and be it further

RESOLVED, That our AMA study the impact of supported decision making on medical decision making, health outcomes, and quality of life.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Senate Aging Committee Examines Ways to Strengthen Guardianship Programs. US Senate Committee on Aging. <https://www.aging.senate.gov/press-releases/senate-aging-committee-examines-ways-to-strengthen-guardianship-programs>. Published November 28, 2018. Accessed August 24, 2021.
2. Teasdale B, Daigle LE, Gann T. The contingent effect of guardianship on victimization: An examination of people with and without mental health problems. *J Interpers Violence*. 2021;36(11-12):5186-5208. <https://pubmed.ncbi.nlm.nih.gov/30303026>. Accessed August 24, 2021.
3. Page KS, Hinrichs KLM. Swimming against the tide: A case study on the removal of conservatorship and guardianship. <https://pubmed.ncbi.nlm.nih.gov/28452626>. Accessed August 24, 2021.
4. Kohn NA, English DM. Netflix's 'I Care a Lot' Should Worry You. *Hill*. February 24, 2021. Accessed August 24, 2021. <https://thehill.com/opinion/civil-rights/540212-netflixs-i-care-a-lot-should-worry-you>.
5. Aviv R. How the Elderly Lose Their Rights. *New Yorker*. October 2, 2017. Accessed August 24, 2021. <https://www.newyorker.com/magazine/2017/10/09/how-the-elderly-lose-their-rights>.
6. Eisenberg R. Beware the Con Game of Conservatorships. *Forbes*. May 15, 2015. Accessed August 24, 2021. <https://www.forbes.com/sites/nextavenue/2015/05/15/beware-the-con-game-of-conservatorships>.
7. Lapin N. #FreeBritney: The Truth About Conservatorships. *Forbes*. August 23, 2021. Accessed August 24, 2021. <https://www.forbes.com/sites/nicolelapin/2021/08/23/freebritney-the-truth-about-conservatorships/?sh=7090db857cf0>.
8. Farrow R, Tolentino J. Britney Spears' Conservatorship Nightmare. *New Yorker*. July 3, 2021. Accessed August 24, 2021. <https://www.newyorker.com/news/american-chronicles/britney-spears-conservatorship-nightmare>.
9. Day L, Stark S, Coscarelli J. Britney Spears Quietly Pushed for Years to End Her Conservatorship. June 22, 2021. Accessed August 24, 2021. <https://www.nytimes.com/2021/06/22/arts/music/britney-spears-conservatorship.html>.
10. Cahn N. Why conservatorships like the one controlling Britney Spears can lead to abuse. *Conversation*. July 19, 2021. Accessed August 24, 2021.

- <https://theconversation.com/why-conservatorships-like-the-one-controlling-britney-spears-can-lead-to-abuse-164617>.
11. ACLU, Disability Rights Orgs File Amicus Brief Urging Court to Allow Britney Spears to Select Her Attorney in Conservatorship Case. ACLU.org. <https://www.aclu.org/press-releases/aclu-disability-rights-orgs-file-amicus-brief-urging-court-allow-britney-spears>. Published July 13, 2021. Accessed August 24, 2021.
 12. An Aging Nation: The Older Population in the United States. United States Census Bureau. <https://time.com/wp-content/uploads/2015/01/p25-1140.pdf> Published May 2014.
 13. Representation and Investigation in Guardianship Proceedings. American Bar Association Commission on Law and Aging, 2021. https://www.americanbar.org/content/dam/aba/administrative/law_aging/chartrepresentationandinvestigation.authcheckdam.pdf
 14. Beyond Guardianship: Toward Alternatives That Promote Greater Self-Determination. National Council on Disability, 22 March 2018. https://ncd.gov/sites/default/files/NCD_Guardianship_Report_Accessible.pdf
 15. Guardianship: A Violation of the American with Disabilities Act and What We Can Do About It. University of St. Thomas Journal of Law and Public Policy 13 (2019): 117 <https://ir.stthomas.edu/cgi/viewcontent.cgi?article=1136&context=ustjlpp>
 16. Festen, Suzanne et al. "What matters to you?" Health outcome prioritisation in treatment decision-making for older patients." *Age and ageing* vol. 50,6 (2021): 2264-2269. doi:10.1093/ageing/afab160
 17. Wright MS. Dementia, Healthcare Decision Making, and Disability Law. *The Journal of Law, Medicine & Ethics*. 2019;47(4_suppl):25-33. doi:10.1177/1073110519898040
 18. Turning Rights Into Reality: How Guardianship and Alternatives Impact the Autonomy of People With Intellectual and Developmental Disabilities. National Council on Disability, 10 June 2019. https://ncd.gov/sites/default/files/NCD_Turning-Rights-into-Reality_508_0.pdf
 19. Margaret "Jenny" Hatch, Samantha Alexandra Crane, Jonathan G. Martinis; Unjustified Isolation Is Discrimination: The *Olmstead* Case Against Overbroad and Undue Organizational and Public Guardianship. *Inclusion* 1 June 2015; 3 (2): 65–74. doi: <https://doi.org/10.1352/2326-6988-3.2.65>
 20. Andreasian, Karen et al. Revisiting S.C.P.A. 17-A: Guardianship for people with Intellectual and Developmental Disabilities, CUNY Law review 18, no. 287 (2015): 335.
 21. Elder Abuse: The Extent of Abuse by Guardians is Unknown, but Some Measures Exist to Help Protect Older Adults. United States Government Accountability Office. November 2016, <https://www.gao.gov/assets/690/681088.pdf>.
 22. Shogren, Karrie A. et al. Relationships Between Self-Determination and Postschool Outcomes for Youth With Disabilities. *The Journal of Special Education*, Vol. 48, 2015, pp. 256-267.
 23. Kristin, Glen B. Supported Decision-Making and the Human Right of Legal Capacity. *Inclusion* 1 March 2015; 3 (1): 2–16. doi: <https://doi.org/10.1352/2326-6988-3.1.2>
 24. Peterson, Andrew et al. "Supported Decision Making With People at the Margins of Autonomy." *The American journal of bioethics : AJOB* vol. 21,11 (2021): 4-18. doi:10.1080/15265161.2020.1863507
 25. National Resource Center for Supported Decision-Making, In Your State, accessed March 10, 2022. <http://www.supporteddecisionmaking.org/states>

RELEVANT AMA AND AMA-MSS POLICY

National Guidelines for Guardianship 60.027MSS

AMA-MSS will ask the AMA to collaborate with relevant stakeholders to advocate for federal creation and adoption of national standards for guardianship programs, appropriate program funding measures, and quality control measures.
(MSS Res 55 I-18) (AMA Res 19, A-19, Referred)

Encouraging the Use of Advance Directives and Health Care Powers of Attorney H-140.845

Our AMA will: (1) encourage health care providers to discuss with and educate young adults about the establishment of advance directives and the appointment of health care proxies; (2) encourage nursing homes to discuss with resident patients or their health care surrogates/decision maker as appropriate, a care plan including advance directives, and to have on file such care plans including advance directives; and that when a nursing home resident patient's advance directive is on file with the nursing home, that advance directive shall accompany the resident patient upon transfer to another facility; (3) encourage all physicians and their families to complete a Durable Power of Attorney for Health Care (DPAHC) and an Advance Directive (AD); (4) encourage all medical schools to educate medical students and residents about the importance of having a DPAHC/AD before becoming severely ill and encourage them to fill out their own DPAHC/AD; (5) along with other state and specialty societies, work with any state that has technical problems with their DPAHC/AD to correct those problems; (6) encourage every state medical association and their member physicians to make information about Living Wills and health care powers of attorney continuously available in patient reception areas; (7) (a) communicate with key health insurance organizations, both private and public, and their institutional members to include information regarding advance directives and related forms and (b) recommend to state Departments of Motor Vehicles the distribution of information about advance directives to individuals obtaining or renewing a driver's license; (8) work with Congress and the Department of Health and Human Services to (a) make it a national public health priority to educate the public as to the importance of having a DPAHC/AD and to encourage patients to work with their physicians to complete a DPAHC/AD and (b) to develop incentives to individuals who prepare advance directives consistent with our current AMA policies and legislative priorities on advance directives; (9) work with the Centers for Medicare and Medicaid Services to use the Medicare enrollment process as an opportunity for patients to receive information about advance health care directives; (10) continue to seek other strategies to help physicians encourage all their patients to complete their DPAHC/AD; and (11) advocate for the implementation of secure electronic advance health care directives.

Code of Medical Ethics Opinion 2.1.2 Decisions for Adult Patients Who Lack Capacity

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

When a patient lacks decision-making capacity, the physician has an ethical responsibility to:

- (a) Identify an appropriate surrogate to make decisions on the patient's behalf:
 - (i) the person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or
 - (ii) a family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.
- (b) Recognize that the patient's surrogate is entitled to the same respect as the patient.
- (c) Provide advice, guidance, and support to the surrogate.

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

AMA Principles of Medical Ethics: I,III,VIII

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

Medical Care of Persons with Developmental Disabilities H-90.968

1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with disabilities including but not limited to physical, sensory, developmental, intellectual, learning, and psychiatric disabilities and chronic illnesses; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) education of physicians on how to provide and/or advocate for developmentally appropriate and accessible medical, social and living support for patients with disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with disabilities to implement priorities and quality improvements for the care of persons with disabilities.
2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with disabilities, and to increase the reimbursement for the health care of

these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with disabilities.

3. Our AMA entreats health care professionals, parents, and others participating in decision-making to be guided by the following principles: (a) All people with disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound disabilities, that there are resources available to them.

4. Our AMA will collaborate with appropriate stakeholders to create a model general curriculum/objective that (a) incorporates critical disability studies; and (b) includes people with disabilities as patient instructors in formal training sessions and preclinical and clinical instruction.

5. Our AMA recognizes the importance of managing the health of children and adults with developmental and intellectual disabilities as a part of overall patient care for the entire community.

6. Our AMA supports efforts to educate physicians on health management of children and adults with intellectual and developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with intellectual and developmental disabilities.

7. Our AMA encourages the Liaison Committee on Medical Education, Commission of Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement a curriculum on the care and treatment of people with a range of disabilities.

8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with a range of disabilities.

9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing programs that focus on the care and treatment of people with a range of disabilities.

10. Our AMA will advocate that the Health Resources and Services Administration include persons with disabilities as a medically underserved population.

11. Specific to people with developmental and intellectual disabilities, a uniquely underserved population, our AMA encourages: (a) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental and intellectual disabilities, to improve quality in clinical education; (b) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for individuals with developmental and intellectual disabilities; and (c) cooperation among physicians, health and human services professionals, and a wide variety of adults with intellectual and developmental disabilities to implement priorities and quality improvements for the care of persons with intellectual and developmental disabilities.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 035
(I-22)

Introduced by : Faith Portuphy, Marilynn Kanu, Daniel Nyancho, Bryan Ubanwa, Chioma Owo, Benjamin Akande, Paul Mpunga, Sam Oshoba, University of Texas Health San Antonio

Subject: Advocating for the Regulation of Waste Products in Industrialized Farming

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, An Industrial Farm, also known as Concentrated Animal Feeding Operation (CAFO), refers to a facility that keeps a large number of animals confined for more than 45 days in any 12-month period¹; and

Whereas, CAFOs produce vast amounts of manure containing contaminants like ammonia, antibiotics, and various types of bacteria, which typically accumulate in ground water, surface water, and air of surrounding communities²⁻³; and

Whereas, 53% of the population relies on groundwater for drinking water, and proximal communities are at higher risk for illnesses, such as nitrogen poisoning, which have been linked to high rates of stomach and esophageal cancer¹⁰; and

Whereas, Animals within these facilities are given high doses of antibiotics to promote the growth of animals and prevent bacterial infections⁶; and

Whereas, Excessive use of antibiotics in CAFOs has given rise to new antibiotic resistant strains of various bacteria (e.g. e.Coli and MRSA) which have been positively associated with outbreaks in surrounding communities⁹; and

Whereas, Communities in proximity to CAFOs are more likely to develop respiratory diseases, and around 12,700 deaths per year have been attributed to air pollution from these facilities²⁻³; and

Whereas, CAFOs produce large amounts of methane and nitrous oxide, which are greenhouse gases over 20 times more potent than carbon dioxide^{10,14}; and

Whereas, CAFOs disproportionately affect communities of color and low-income communities, which tend to be in isolated rural areas^{4,5,10}; and

Whereas, While pollution from CAFOs is regulated by the Environmental Protection Agency (EPA) under the 1972 Clean Water Act and Clean Air Act, there are several exceptions that lead to underreporting of pollutants released from their facilities³; and

Whereas, In 2019, the EPA signed an amendment stating CAFOs are exempt from the Emergency Planning and Community Right to Know Act (EPCRA) and the Comprehensive Environmental Response Compensation, and Liability Act (CERCLA), which are statutes requiring industries to report when high levels toxic chemicals are released into the environment³; and

Whereas, The Inflation Reduction Act of 2022 allocates money to the EPA specifically help combat climate change, environmental pollution, and environmental justice; and

Whereas, Existing policy H-135.996 states the AMA supports collaborative efforts with medical societies and other organizations to address adverse health effects from environmental pollution factors; therefore be it

RESOLVED, That our AMA recognizes Concentrated Animal Feeding Operations as a threat to public health; and be it further

RESOLVED, That our AMA encourage the EPA and appropriate stakeholders to remove the regulatory exemptions for CAFOs under EPCRA and CERCLA and tighten restrictions on pollution from CAFOs; and be it further

RESOLVED, That our AMA encourages the EPA and appropriate stakeholders to allocate funding toward the development and increased utilization of emerging technology in agricultural waste treatment.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Animal Feeding Operations (AFOs). EPA. <https://www.epa.gov/npdes/animal-feeding-operations-afos>.
2. Rogers S, Haines JR. Detecting and mitigating the environmental impact of fecal pathogens originating from confined animal feeding operations: Review. EPA. https://cfpub.epa.gov/si/si_public_record_report.cfm?Lab=NRMRL&dirEntryId=148645. 2005.
3. Gilliland N. Land Use Controls to Mitigate Environmental and Public Health Harms Caused by Concentrated Animal Feeding Operations. Southern California Interdisciplinary Law Journal. 2020;29(2):323-344.
4. USGCRP, Impacts of Climate Change on Human Health in the United States, 249 (2016); California's Fourth Climate Change Assessment, Climate Justice Summary Report 36-48 (2018)

5. Nicole W. CAFOs and environmental justice: the case of North Carolina [published correction appears in *Environ Health Perspect.* 2013 Jul;121(7):A210]. *Environ Health Perspect.* 2013;121(6):A182-A189. doi:10.1289/ehp.121-a182
6. Guo Y, Ryan U, Feng Y, Xiao L. Association of common zoonotic pathogens with concentrated animal feeding operations. *Frontiers in Microbiology.* 2022;12. doi:10.3389/fmicb.2021.810142
7. Kravchenko J, Rhew SH, Akushevich I, Agarwal P, Lyster HK. Mortality and Health Outcomes in North Carolina Communities Located in Close Proximity to Hog Concentrated Animal Feeding Operations. *N C Med J.* 2018 Sep-Oct;79(5):278-288. doi: 10.18043/ncm.79.5.278.
8. Hall J, Galarraga J, Berman I, Edwards C, Khanjar N, Kavi L, Murray R, Burwell-Naney K, Jiang C, Wilson S. Environmental Injustice and Industrial Chicken Farming in Maryland. *Int J Environ Res Public Health.* 2021 Oct 20;18(21):11039. doi: 10.3390/ijerph182111039.
9. Quist AJL, Holcomb DA, Fliss MD, Delamater PL, Richardson DB, Engel LS. Exposure to industrial hog operations and gastrointestinal illness in North Carolina, USA. *Sci Total Environ.* 2022 Jul 15;830:154823. doi: 10.1016/j.scitotenv.2022.154823. Epub 2022 Mar 25.
10. Understanding Concentrated Animal Feeding Operations and Their Impact on Communities. CDC.
https://www.cdc.gov/nceh/ehs/docs/understanding_cafos_nalboh.pdf
11. Castillo F, Mora AM, Kayser GL, Vanos J, Hyland C, Yang AR, Eskenazi B. Environmental Health Threats to Latino Migrant Farmworkers. *Annu Rev Public Health.* 2021 Apr 1;42:257-276. doi: 10.1146/annurev-publhealth-012420-105014. Epub 2021 Jan 4.
12. Zhou X, Zheng H, van der Hoek JP, Yu K, Cao Y. Recent applications of biological technologies for decontaminating hormones in livestock waste and wastewater. *Current Opinion in Environmental Science & Health.* 2021;24:100307. doi:10.1016/j.coesh.2021.100307
13. Gros M, Marti E, Balcázar JL, et al. Fate of pharmaceuticals and antibiotic resistance genes in a full-scale on-farm livestock waste treatment plant. *Journal of Hazardous Materials.* 2019;378:120716. doi:10.1016/j.jhazmat.2019.05.109
14. Sources of Greenhouse Gas Emissions. EPA.
<https://www.epa.gov/ghgemissions/sources-greenhouse-gas-emissions>

RELEVANT AMA AND AMA-MSS POLICY

Environmental Preservation H-135.972

It is the policy of the AMA to support state society environmental activities by:

- (1) identifying areas of concern and encouraging productive research designed to provide authoritative data regarding health risks of environmental pollutants;
- (2) encouraging continued efforts by the CSAPH to prepare focused environmental studies, where these studies can be decisive in the public consideration of such problems
- (3) maintaining a global perspective on environmental problems
- (4) considering preparation of public service announcements or other materials appropriate for public/patient education; and
- (5) encouraging state and component societies that have not already done so to create environmental committees.

Res. 52, A-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

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.

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.

Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of: Res. 505, A-19

Chemical Analysis Report of Public and Commercial Water D-440.999

Our AMA: (1) requests the appropriate federal agency to require analysis and appropriate labeling of the chemical content, including fluoride, of commercially bottled water, as well as of the water supplies of cities or towns; (2) urges the FDA to require that annual water quality reports from bottled water manufacturers be publicly accessible in a readily available format; and (3) urges the FDA to evaluate bottled water for changes in quality after typical storage conditions.

Res. 427, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Modified: CSAPH Rep. 3, A-12; Reaffirmed: CSAPH Rep. 1, A-22

Regulation of Endocrine Disrupting Chemicals H-135.920

Our American Medical Association will work with the federal government to pursue the following tenets:

- (1) Regulatory oversight of endocrine disrupting chemicals should be centralized such that regulations pass through a single office to ensure coordination among agencies, with the exception of pharmaceutical agents that are regulated by the Food and Drug Administration and are used for medical purposes
- (2) Policy should be based on comprehensive data covering both low-level and high-level exposures
- (3) Policy should be developed and revised under the direction of a collaborative group comprising endocrinologists, toxicologists, occupational/environmental medicine specialists, epidemiologists, and policymakers.

CSAPH Rep. 01, A-19

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. 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

Clean Air H-135.979

Our AMA supports cooperative efforts with the Administration, Congress, national, state and local medical societies, and other organizations to achieve a comprehensive national policy and program to address the adverse health effects from environmental pollution factors, including air and water pollution, toxic substances, the "greenhouse effect," stratospheric ozone depletion and other contaminants.

Sub. Res. 43, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmed: CSAPH Rep. 01, A-19

US Efforts to Address Health Problems Related to Agricultural Activities H-365.986

Our AMA supports the endeavors of the U.S. Surgeon General and the National Institute of Occupational Safety and Health of CDC to address health problems related to agricultural activities.

Res. 212, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: BOT Rep. 7, A-21

Antibiotic Use in Food-Producing Animals H-440.846

Our AMA supports: (1) federal efforts to ban antibiotic use in food-producing animals for growth promotion purposes, including through regulatory and legislative measures; (2) a strong federal requirement that antibiotic prescriptions for animals be overseen by a veterinarian knowledgeable of the place and intended use of these drugs, under a valid veterinarian-client-patient relationship (VCPR); and (3) efforts to expand FDA surveillance and data collection of antibiotic use in agriculture.

Res. 513, A-14; Reaffirmation A-15; Reaffirmed: CSAPH Rep. 3, I-15

Restriction of Non-Veterinary Antimicrobials in Commercial Livestock to Reduce Antibiotic Resistance D-100.976

Our AMA will work with interested partners to develop new, or improve existing, FDA guidelines concerning the prudent use of antibiotics in livestock and plants to protect patients from the dangers of antimicrobial-resistant pathogens.

Res. 530, A-08; Reaffirmed: CSAPH Rep. 01, A-20

Environmental Health Programs H-135.969

Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees.

Res. 124, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Green Initiatives and the Health Care Community H-135.939

Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of: Res. 504, A-16; Modified: Res. 516, A-18; Modified: Res. 923, I-19

Improving Rural Health H-465.994

1. Our AMA (a) supports continued and intensified efforts to develop and implement proposals for improving rural health care and public health, (b) urges physicians practicing in rural areas to be actively involved in these efforts, and (c) advocates widely publicizing AMA's policies and proposals for improving rural health care and public health to the profession, other concerned groups, and the public.

2. Our AMA will work with other entities and organizations interested in public health to:

- Encourage more research to identify the unique needs and models for delivering public health and health care services in rural communities.
- Identify and disseminate concrete examples of administrative leadership and funding structures that support and optimize local, community-based rural public health.
- Develop an actionable advocacy plan to positively impact local, community-based rural public health including but not limited to the development of rural public health networks, training of current and future rural physicians and public health professionals in core public health techniques and novel funding mechanisms to support public health initiatives that are led and managed by local public health authorities.
- Advocate for adequate and sustained funding for public health staffing and programs.

Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 433, A-19; Modified: CSAPH Rep. 2, A-22

Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies H-365.988

Our AMA supports: (1) the integration of occupational health and environmental health and injury prevention programs within existing health departments at the state and local level; (2) taking a leadership role in assisting state medical societies in implementation of such programs; and (3) working with federal agencies to ensure that "health" is the primary determinant in establishing environmental and occupational health policy.

Res. 1, A-89; Reaffirmed: Sunset Report, A-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

440.055MSS Oil and Gas Well-Stimulation Disclosure and Moratorium

AMA-MSS supports legislation and regulations that require the full disclosure of chemicals placed into the natural environment for petroleum, oil, and gas exploration and extraction. (MSS Res 48, A-15) (Reaffirmed: MSS GC Rep B, A-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 036
(I-22)

Introduced by: Madisen Faulkner, Faith Martin, Neha Agnihotri, University of South Carolina
School of Medicine Greenville

Subject: Emergency Anti-Epileptic Interventions

Sponsored by: Region 4, PsychSIGN

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Epilepsy requires public health action as it burdens individuals of all ages, races, and ethnic groups, especially impacting those of lower socioeconomic status¹; and

Whereas, In 2015, the Centers for Disease Control and Prevention (CDC) reported approximately 3.4 million people in the United States with active epilepsy, who often have comorbidities that may complicate their seizure management¹; and

Whereas, Costs of healthcare per year for people with epilepsy ranged from \$10-47,000 in 2013, increasing for those with uncontrolled seizures¹; and

Whereas, Most seizures are self-limiting, however they may occasionally be prolonged or recur without time for the person to recover in between²; and

Whereas, When a seizure lasts greater than or equal to 5 minutes, it is referred to as status epilepticus²; and

Whereas, Sequelae from status epilepticus includes permanent brain injury, cognitive impairment, psychiatric impairment, and death²; and

Whereas, Due to the timing and detrimental effects of status epilepticus, it is a medical emergency requiring urgent treatment²; and

Whereas, Studies show that status epilepticus is often not recognized in the prehospital setting, thereby delaying treatment^{2,3}; and

Whereas, In a 2017 study conducted by The American Academy of Neurology (AAN), the Neurocritical Care Society (NCS) and the NeuroHospitalist Society (NHS) it is concluded that rapid treatment of status epilepticus is associated with better patient outcomes and reduced morbidity and mortality⁴; and

Whereas, The Epilepsy Foundation supports the use of anti-epileptic rescue medications which can help avoid medical emergencies caused by seizures⁵; and

Whereas, A 2022 study found that benzodiazepines are a more effective method of seizure cessation than placebo reducing negative effects of seizures lasting longer than five minutes⁶; and

Whereas, Upon assessing the effectiveness of rescue medication other than intravenous benzodiazepines, intranasal diazepam is found to offer treatment of status epilepticus by nonmedical caregivers with easy administration, high bioavailability, a good safety profile, rapid onset of response, and social acceptability⁷; and

Whereas, The Food and Drug Administration (FDA) has approved the use of anti-epileptic drugs including rectal diazepam, nasal midazolam, and nasal diazepam in 1997, 2019, and 2020, respectively⁷; and

Whereas, According to the Epilepsy Foundation, approved intranasal rescue medications may work faster than orally administered medications, are a good alternative when the person cannot swallow, and are preferable to rectal medications in a public setting⁸; and

Whereas, The AMA nor the AMA-MSS bear policy addressing epilepsy or interventions for epilepsy; and

Whereas, The AMA supports early public intervention for medical emergencies such as cardiac arrest in our policy “Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938”; and

Whereas, The AMA has set precedent for support of the expansion of education and interventions of emergent conditions in the prehospital setting through policies such as, “Childhood Anaphylactic Reactions D-60.976” and “Expansion of Epinephrine Entity Stocking Legislation H-115.966”; therefore be it

RESOLVED, That our AMA support efforts in the recognition of status epilepticus and bystander intervention trainings; and be it further

RESOLVED, That our AMA encourage the distribution of home pharmacotherapy for status epilepticus by urging physicians to work with patients to develop an emergency anti-epileptic plan.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Zack, M. et al. National and State Estimates of the Number of Adults and Children with Active Epilepsy - United State, 2015. Centers for Disease Control and Prevention. 2017 Aug.; 66(31):821–5.

2. Sairanen, J. et al. Treatment delay in status epilepticus – more effective prehospital symptom recognition warranted. *Scandinavian Journal of Trauma, Resuscitation and Emergency Medicine*. 2019 Mar.; 27(28).
3. Maier, S. et al. Recognition and treatment of status epilepticus in the prehospital setting. *Seizure: European Journal of Epilepsy*. 2021 Jan.; 86: 1-5.
4. Josephson, S. et al. Quality improvement in neurology: Inpatient and emergency care quality measure set. *Neurology*. 2017 Aug.; 89 (7).
5. Hoerth M. et al. Seizure Rescue Therapies. Epilepsy Foundation. April 14, 2019.
6. Cruickshank Moira. Et al. Pre-hospital and emergency department treatment of convulsive status epilepticus in adults: an evidence synthesis. *Health Technol Assess*. 2022 Mar.; 26(20):1-76.
7. Cloyd J. et al. Overcoming the challenges of developing an intranasal diazepam rescue therapy for the treatment of seizure clusters. *Epilepsia*. 2021 Apr.; 62(4): 846-856.
8. Hoerth M. et al. Nasal Rescue Medicines. Epilepsy Foundation. April 18, 2020.

RELEVANT AMA AND AMA-MSS POLICY

Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938

Our AMA: (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation; (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs; (3) encourages the American public to become trained in CPR and the use of automated external defibrillators; (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held; (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events; (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices; (7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel; (8) supports the development and use of universal connectivity for all defibrillators; (9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use; (10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators (AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications; (11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and (12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim.

Childhood Anaphylactic Reactions D-60.976

Our AMA will: (1) urge all schools, from preschool through 12th grade, to: (a) develop Medical Emergency Response Plans (MERP); (b) practice these plans in order to identify potential barriers and strategies for improvement; (c) ensure that school campuses have a direct communication link with an emergency medical system (EMS); (d) identify students at risk for life-threatening emergencies and ensure these children have an individual emergency care plan that is formulated with input by a physician; (e) designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting families; (f) train school personnel in cardiopulmonary resuscitation; (g) adopt the School Guidelines for Managing Students with Food Allergies distributed by FARE (Food Allergy Research & Education); and (h) ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff are familiar with using this

equipment; (2) work to expand to all states laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis; (3) support increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis; (4) urge the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies; (5) urge physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan; and (6) work to allow all first responders to carry and administer epinephrine in suspected cases of anaphylaxis.

Food Allergic Reactions in Schools and Airplanes H-440.884

Our AMA recommends that all: (1) schools provide increased student and teacher education on the danger of food allergies; (2) schools have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the school administration be trained and certified in the indications for and techniques of their use; and (3) commercial airlines have a set of emergency food allergy guidelines and emergency anaphylaxis kits on the premises, and that at least one member of the flight staff, such as the head flight attendant, be trained and certified in the indications for and techniques of their use.

Res. 415, A-04; Reaffirmed: CSAPH Rep. 1, A-14

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 037
(I-22)

Introduced by: Carolyn Zichichi and Sravya Emmadi, Michigan State University College of Human Medicine; Evan Sitar, Loyola University of Chicago Stritch School of Medicine

Subject: Gender Pronoun Use in Medical Education

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Personal pronouns are pronouns that a person uses to identify themselves, which may evolve as an individual's dynamic identity evolves¹; and

Whereas, Gender affirmation through pronoun use allows patients and providers to build a trusting relationship to talk more openly about health, mitigating harm and promoting psychological safety^{2,3}; and

Whereas, Studies report creating inclusive norms and sharing pronouns in the professional setting helps to reduce bias and conditions for stigma, as well as decreases the burden on transgender and gender-nonconforming individuals to inform and educate others^{4,5,6,7}; and

Whereas, Misgendering occurs when a person is addressed or described using language (name, pronouns, or title) that does not match their gender identity⁸; and

Whereas, Studies found that unintentional misgendering was driven largely by knowledge deficits, particularly a lack of training or procedures for eliciting patients' gender, which result in emotional trauma, anticipation of stigma, and gender identity concealment^{7,9,10}; and

Whereas, Studies have shown that sexual and gender minority medical students reported bullying 1.5 times more than other students and having contemplating suicide 1.7 times more than others¹¹; and

Whereas, Cultural competence among health professionals and providing quality care when working with gender-diverse individuals is vital in addressing health disparities¹²; and

Whereas, Without inclusive procedures or protocols, healthcare workers must voluntarily seek specific knowledge about gender and sexuality above and beyond their training⁷; and

Whereas, Data demonstrates medical students and residents recognize improved patient care and empathy with education and consistent training, but gender pronouns have failed to make a significant appearance in curriculum^{12,13,14,15}; and

Whereas, Studies report inclusive procedures, such as a policy of asking all patients how they would like to be addressed as part of intake procedure, acted to reduce the conditions for stigma⁷; and

Whereas, Other professional organizations have made recommendations that providers routinely ask patients for gender identity and gender pronouns, as well as implemented inclusive practices such as inclusion of pronouns on email signatures, name badges, and social media^{16,17,18,19,20}; and

Whereas, Existing AMA policy has taken a stance supporting gender-neutral language in the clinical setting and on Medicaid documentation, supporting the medical care of LGBTQ populations, and education of sexual orientation and gender identity health issue in medical education (Pending Transmittal #53, H-315.967, H-160.991, H-295.878); therefore be it

RESOLVED, That our AMA encourage physician leaders of healthcare teams to support pronoun education for all members of their teams; and it be further

RESOLVED, That our AMA promote utilization of gender pronouns on email signatures, name badges, and virtual communications; and it be further

RESOLVED, That our AMA research best practices for implementation of pronouns in medical education curriculum and reduction of incidents of misgendering; and it be further

RESOLVED, That our AMA supports the routine collection of data on the inclusion of gender pronoun use in medical school curricula.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Luke Higgins, Mahima Poreddy, Richard Brach, Dr. Nathalie Feldman, Dana Kramer. Inclusive Learning Glossary for the Learning and Practice Environments. The University of Vermont: Larner College of Medicine. Retrieved from https://www.med.uvm.edu/docs/inclusivelanguageglossaryforthelearningandpracticeenvironments/medical-education-documents/student-affairs/inclusivelanguageglossaryforthelearningandpracticeenvironments.pdf?sfvrsn=da233ab9_2
2. Perelman School of Medicine University of Pennsylvania. Guidelines Relating to Transgender and Gender- Diverse Medical Students. Retrieved from <https://www.med.upenn.edu/student/guidelines-relating-to-transgender-and-gender-diverse-medical-students.html>
3. Westafer LM, Freiermuth CE, Lall MD, Muder SJ, Ragone EL, Jarman AF. Experiences of Transgender and Gender Expansive Physicians. JAMA Netw Open. 2022;5(6):e2219791. doi:10.1001/jamanetworkopen.2022.19791
4. Brown B. Pronoun visibility in health professions education - Mite MMC Institute ...<https://www.mitemmc.org/uploads/6.11.21-Pronoun-MITE-tip-Brown-June-2021.docx.pdf>. Accessed August 30, 2022.
5. Rider GN, McMorris BJ, Gower AL, Coleman E, Brown C, Eisenberg ME. Perspectives From Nurses and Physicians on Training Needs and Comfort Working With Transgender

- and Gender-Diverse Youth. *J Pediatr Health Care*. 2019;33(4):379-385. doi:10.1016/j.pedhc.2018.11.003
6. Najor AJ, Kling JM, Imhof RL, Sussman JD, Nippoldt TB, Davidge-Pitts CJ. Transgender Health Care Curriculum Development: A Dual-Site Medical School Campus Pilot. *Health Equity*. 2020;4(1):102-113. Published 2020 Apr 2. doi:10.1089/heq.2019.0106
 7. Sileo KM, Baldwin A, Huynh TA, et al. Assessing LGBTQ+ stigma among healthcare professionals: An application of the health stigma and discrimination framework in a qualitative, community-based participatory research study. *Journal of Health Psychology*. 2022;27(9):2181-2196. doi:10.1177/13591053211027652
 8. Dolan, I.J., Strauss, P., Winter, S. and Lin, A. (2020), Misgendering and experiences of stigma in health care settings for transgender people. *Med. J. Aust.*, 212: 150-151.e1. <https://doi-org.proxy2.cl.msu.edu/10.5694/mja2.50497>
 9. Goldberg AE, Kuvalanka KA, Budge SL, Benz MB, Smith JZ. Health Care Experiences of Transgender Binary and Nonbinary University Students. *The Counseling Psychologist*. 2019;47(1):59-97. doi:10.1177/0011000019827568
 10. Deutsch MB. Guidelines for the primary and gender-affirming care of transgender and gender nonbinary people. 2016 Jun 17. Accessed 2022 Aug 30.
 11. Madrigal, J., Rudasill, S., Tran, Z., Bergman, J., & Benharash, P. (n.d.). Sexual and gender minority identity in Undergraduate Medical Education: Impact on experience and career trajectory. *PLOS ONE*. Retrieved August 30, 2022, from <https://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0260387>
 12. Keeley D. Newsom, Gregory A. Carter, and Jessica J. Hille. Assessing Whether Medical Students Consistently Ask Patients About Sexual Orientation and Gender Identity as a Function of Year in Training. *LGBT Health*. Mar 2022. 142-147. <http://doi.org.proxy2.cl.msu.edu/10.1089/lgbt.2021.0109>
 13. Inn, Gabrielle M., Ballard, William, Politis, Marina and Brown, Megan EL 2021. It's not alphabet soup – supporting the inclusion of inclusive queer curricula in medical education. *The British Student Doctor Journal* 5 (2) , pp. 27-37. [10.18573/bsdj.276](https://doi.org/10.18573/bsdj.276)
 14. Jenkins, M. R., Herrmann, A., Tashjian, A., Ramineni, T., Ramakrishnan, R., Raef, D., ... & Shatzer, J. (2016). Sex and gender in medical education: a national student survey. *Biology of Sex Differences*, 7(1), 25-35.
 15. McGregor, A. J., Greenberg, M. R., Barron, R., Walter, L. A., Wolfe, J., Deutsch, A. L., ... & Beauchamp, G. A. (2020). Incorporating Sex and Gender-based Medical Education Into Residency Curricula. *AEM education and training*, 4, S82-S87.
 16. Lambda Legal. Professional Organization Statements Supporting Transgender People in Healthcare. Retrieved from https://www.lambdalegal.org/sites/default/files/publications/downloads/resource_trans-professional-statements_09-18-2018.pdf
 17. Morgan-Daniel J, Goodman XY, Franklin SG, Bartley K, Noe MN, Pionke JJ. Medical Library Association Diversity and Inclusion Task Force Report. *Journal of the Medical Library Association*. 2021;109(1). doi:10.5195/jmla.2021.1112
 18. Harbin, B. (2016). Teaching beyond the gender binary in the university classroom. Updated by Roberts, L.M. et al., (2020). *Vanderbilt Center for Teaching*. Retrieved from <https://cft.vanderbilt.edu/guides-sub-pages/teaching-beyond-the-gender-binary-in-the-university-classroom/>
 19. Medical Provider's Guide to gender pronouns - pride in practice. <https://www.prideinpractice.org/wp-content/uploads/2019/05/Medical-Provider-Guide-to-Gender-Pronouns-Pride-in-Practice.pdf>. Accessed August 31, 2022.
 20. Nye C, Anderson A. Transgender and Gender Diverse Nursing Care. *AJN, American Journal of Nursing*. 2021; 121 (10): 53-57. doi:10.1097/01.NAJ.0000794272.25624.e5.

RELEVANT AMA AND AMA-MSS POLICY

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

Promoting Inclusive Gender, Sex, Sexual Orientation Options on Medicaid Documentation H315.967

Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation, and preferred gender pronoun(s), preferred name, and an inventory of current 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: (MSS Res 36, A-19) (AMA Res. 004, Adopt as Amended [H-315.967], I-19) 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

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

Pending Transmittal # 53: Supporting the Use of Gender-Neutral Language (Formerly: Gender Neutral Language in AMA Policy - 65.040MSS)

RESOLVED, That our AMA (1) Recognize the importance of using gender-neutral language such as gender-neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity (2) Revise all relevant policies to utilize gender-neutral language in place of gendered language where such text inappropriately appears (3) Utilize gender-neutral language in future policies, internal communications, and external communications where gendered language does not specifically need to be used. (4) Encourage the use of gender-neutral language in public health and medical messaging (5) Encourage other professional societies to utilize gender-neutral language in their work (6) Support the use of gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse individuals

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 038
(I-22)

Introduced by: Neha Siddiqui, Carle Illinois College of Medicine; Samantha Pavlock, Florida State University College of Medicine; Rebecca Rishab Chawla, Medical College of Georgia; Anderson, University of Nebraska Medical Center; Rommel Morales, Northeast Ohio Medical University; Rajadhar Reddy, Baylor College of Medicine; Vineeth Amba, Rutgers Robert Wood Johnson Medical School; Catriona Hong, University of Connecticut School of Medicine; Justin Magrath, Tulane University College of Medicine; Rafay Nasir, Penn State College of Medicine; Kody Jones, Rush University College of Medicine

Subject: Studying Population-Based Payment Policy Disparities

Sponsored by: Region 5, Region 6, Region 7, Association of Native American Medical Students, PsychSIGN, American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

1 Whereas, Certain fields of medicine care for distinct patient populations, such as pediatrics,
2 obstetrics and gynecology (OBGYN), geriatrics, infectious disease, urology, addiction medicine,
3 sports medicine, etc; and
4

5 Whereas, Procedures performed for specialized patient populations such as gynecology patients
6 have been shown to be reimbursed at lower rates than those for other specialized patient
7 populations such as urology patients, despite being similar in nature¹; and
8

9 Whereas, The Medicare fee schedule is a leading cause of reimbursement imbalance between
10 specialties due to documented factors, such as discrepancies in valuation of surgical
11 intraoperative time, and different valuation of procedural and physical effort to cognitive effort²;
12 and
13

14 Whereas, There is evidence to suggest that current work Relative Value Units (RVUs) are
15 misvalued as changes in work RVUs have not reflected changes in technology in some
16 specialties with undervaluation in cognitive effort, such as the management of complex
17 conditions by primary care providers^{3,4}; and
18

19 Whereas, In comparison to higher paid specialties, lower paid specialties with a single physician
20 serving Medicare recipients are more likely to be completely absent in a given county, such that
21 92% of counties lack an addiction medicine physician and 80% of counties lack an infectious
22 disease specialist⁵; and
23

24 Whereas, Access to care for mental health has persisted as an issue due to provider availability
25 and reimbursement incentives⁶; and
26

Whereas, Documented racial disparities in reimbursement rates demonstrate statistically significant lower mean reimbursement per RVU for insured black patients within a tertiary hospital Emergency Department compared to their white counterparts, after adjusting for demographic and insurance factors⁷; and

Whereas, An analysis of RVUs reimbursed for gender-specific procedures revealed that procedures predominantly done on men were associated with higher RVUs and compensated at a rate 26.67% higher than procedures done predominantly on women¹; and

Whereas, Disparity in RVUs reimbursed for similar procedures performed predominantly on women versus men has minimally decreased from 1997 to 2015, with a study reporting 42 of 50 (84%) male-based urologic procedures compensated at a higher rate than the paired female urologic procedures¹; and

Whereas, OBGYN physicians work comparable hours and perform many surgical procedures similar in number and complexity to other surgical specialties, yet their pay is the lowest amongst all surgical specialties; leading to an estimated OBGYN physician shortage of 17% by 2030, 24% by 2040, and 31% by 2050^{8,9}; and

Whereas, Pediatric subspecialists are compensated at a significantly lower rate than that of internal medicine subspecialists, contributing to a high percentage of vacant seats across pediatric fellowship programs and a resulting shortage of pediatric subspecialists¹⁰⁻¹²; and

Whereas, The compensation of pediatric sub-specialists is lower than general pediatricians, de-incentivizing trainees to pursue fellowships in that realm, with a study finding the salary of pediatric endocrinologists to be 10% lower than that of general pediatricians¹³⁻¹⁵; and

Whereas, Pediatric infectious disease specialists experience the lowest compensation of all physicians, earning \$191,735 compared to \$265,000 earned by adult infectious disease specialists¹³⁻¹⁵; and

Whereas, Most pediatric subspecialty programs experience a significant fraction of unfilled seats; for example, 40.6% of pediatric nephrologist fellowship seats were not filled in 2019, indicating both trainee disinterest and a lack of provider availability, which can negatively impact access to care and contribute to longer wait times^{10,16}; and

Whereas, Medicare and Medicaid often function as a safety net for hospitals by reimbursing institutions for expenses of hospitalizations not paid by patients themselves, and often falls short of covering the hospitals' care-delivery costs^{17,18}; and

Whereas, Lower reimbursements for specialties that care for certain underserved patient populations may disincentivize physicians from entering those specialties and providing care for the corresponding patient populations, or disincentivize hospitals to provide such care^{19,20}; and

Whereas, Not only is the ratio of specialists to primary care physicians (PCP) higher in the U.S. than in other countries, it has been documented by studies as being due to U.S. ratio of specialist to PCP compensation rates exceeding other countries' specialist to PCP compensation rates²¹⁻²⁴; and

Whereas, An American College of Physicians position statement holds that "Medicare and other payers should adopt population-based, prospective payment models for primary and

1 comprehensive care that are structured and sufficient to ensure access to needed care and
2 address the needs of individuals experiencing health care disparities and inequities based on
3 personal characteristics and/or are disproportionately affected by social drivers of health. Hybrid
4 models combining fee-for-service with prospective payment should be made available and
5 should prioritize the needs of such individuals²⁵;

6
7 Whereas, The Center for Medicare Services' most recent publication of the Medicare payment
8 schedule came with an official solicitation for comments on how the agency can advance health
9 equity for people with Medicare²⁶; and

10
11 Whereas, The National Academy of Medicine Committee for Medicare recommends a potential
12 policy remedy to use reimbursements to incentivize care for underserved populations: a per-
13 patient payment adjustment for patients' social risks, deliberately connected to the quality of
14 patient outcomes; an approach that requires separate reporting of quality measures for
15 hospitals in different categories related to distinct levels of social risk in the populations they
16 serve and includes an additional financial incentive for quality improvement^{27,28}; and

17
18 Whereas, Financial incentives can reward hospitals for incremental improvements in quality
19 measures against their own historical benchmarks, and promote closing gaps in the quality of
20 care that may be worse among institutions primarily serving disadvantaged populations^{27,28}; and

21
22 Whereas, Anchor institutions are (organizations that commit themselves to hiring, procuring,
23 and investing in disadvantaged communities) and would earn enriched reimbursement for the
24 patients they serve from those same or similarly disadvantaged communities²⁹; and

25
26 Whereas, Another policy alternative to use reimbursement to promote care for underserved
27 populations is to promote hospitals that achieve certain metrics in key domains to be qualified
28 as anchor institutions²⁹; and

29
30 Whereas, A study found that the choice of a higher-income specialty was associated with lower
31 burnout (OR = 0.56, 95% CI 0.32-0.98)³⁰; and

32
33 Whereas, Medical students have indicated difficulty in completing loan repayments due to
34 increasing tuition rates and lack of financial compensation as deterrents to entering certain fields
35 and caring for certain populations^{25, 31}; and

36
37 Whereas, Nearly half (48%) of graduating medical students cite income as a strong or moderate
38 influence on their decision to pursue a certain specialty, and only 20% stated that it has no
39 influence on their decision of which specialty to choose²⁰; and

40
41 Whereas, Current AMA Policy H-65.961 states that the AMA "declares that compensation should
42 be equitable and based on demonstrated competencies and expertise and not based on personal
43 characteristics," which can include the type of population a physician serves or the specialty they
44 practice; therefore be it

45
46 RESOLVED, That our AMA study opportunities to incentivize health services predominantly
47 provided to underserved populations such as women, LGBTQ+ patients, children, elder
48 patients, patients with disabilities; and be it further

49
50 RESOLVED, That our AMA study the effects of differences in relative valuation and
51 reimbursement on subsequent trainee interest, institutional support, adequacy of workforce,

- 1 attrition, burnout, and income, especially in specialties that primarily care for underserved
2 populations.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Benoit MF, Ma JF, Upperman BA. Comparison of 2015 Medicare relative value units for gender-specific procedures: Gynecologic and gynecologic-oncologic versus urologic CPT coding. Has time healed gender-worth? *Gynecol Oncol.* 2017;144(2):336-342. doi.org/10.1016/j.ygyno.2016.12.006
2. Chan, David C., et al. "Accuracy of Valuations of Surgical Procedures in the Medicare Fee Schedule." *NEJM*, vol. 380, no. 16, 2019, pp. 1546–1554., doi.org/10.1056/NEJMs1807379
3. Zuckerman, Stephen, Katie Merrell, Robert A. Berenson, Susan Mitchell, Divvy Upadhyay, and Rebecca Lewis. 2016. Collecting Empirical Physician Time Data: Piloting an Approach for Validating Work Relative Value Units. Washington DC: Urban Institute.
4. Zuckerman, Stephen, Katie Merrell, Robert A. Berenson, Nicole Cafarella Lallemand, and Jonathan Sunshine. 2015. Realign Physician Payment Incentives in Medicare to Achieve Payment Equity among Specialties, Expand the Supply of Primary Care Physicians, and Improve the Value of Care for Beneficiaries. Washington DC: Urban Institute.
5. Goodson JD, Shahbazi S, Song Z. Physician payment disparities and access to services-a look across specialties. *J Gen Intern Med.* 2019;34(11):2649-2651. doi.org/10.1007/s11606-019-05133-0
6. <https://www.milliman.com/en/insight/Addiction-and-mental-health-vs-physical-health-Widening-disparities-in-network-use-and-p>
7. Venkat A, Onyekwere U, O'Neill JM, et al. Racial disparities in insurance reimbursement for physician professional services in the ED. *Am J Emerg Med.* 2014;32(9):1060-1067. doi.org/10.1016/j.ajem.2014.06.029
8. ACOG Continues Work to Stop 2021 Medicare Payment Cuts. The American College of Obstetricians and Gynecologists. <https://www.acog.org/news/news-articles/2020/06/acog-continues-work-to-stop-2021-medicare-payment-cuts>. Published July 2, 2020.
9. Vetter, M., Salani, R., Williams, T., Ellison, C., & Satiani, B. (2019). The Impact of Burnout on the Obstetrics and Gynecology Workforce. *Clinical Obstetrics and Gynecology*, 62(3), 444–454. doi.org/10.1097/grf.0000000000000452
10. 2019 Pediatric Specialties Match Results Statistics Report. National Resident Matching Program. <https://www.nrmp.org/fellowships/pediatrics-specialties-match/>. Published 2019.
11. Costill D, Ferkol TW, M.D., Burgert, Natasha L, M.D., F.A.A.P. Shortage of subspecialists, increased demand complicate future of pediatric care. *Infectious Diseases in Children.* 2016;29(6):1-12. <https://search.proquest.com/openview/af1ada96fd5cf3836b9b84191233e4d6/>
12. Singer NG, Onel KB. Challenges to practicing pediatric rheumatology. *Rheum Dis Clin North Am.* 2019;45(1):67-78. doi.org/10.1016/j.rdc.2018.09.011
13. Doximity 2019 Physician Compensation Report. Doximity. <https://blog.doximity.com/articles/doximity-2019-physician-compensation-report-d0ca91d1-3cf1-4cbb-b403-a49b9ffa849f>. Published March 2019.
14. Thiel, Bruce. Pediatric ID compensation 'just too low.' *Infectious Diseases in Children; Thorofare* Vol. 32, Iss. 3, (Mar 2019): 1,8-10. <https://search.proquest.com/openview/af1ada96fd5cf3836b9b84191233e4d6/>

15. Janet R Gilsdorf, Paul Spearman, Janet A Englund, Tina Q Tan, Kristina A Bryant, Pediatric Infectious Diseases Meets the Future, *Journal of the Pediatric Infectious Diseases Society*, Volume 8, Issue 1, March 2019, Pages 9–12, <https://doi.org/10.1093/jpids/piy042>
16. Pediatric workforce shortages persist. *Children's Hospital Association*. <https://www.childrenshospitals.org/Issues-and-Advocacy/Graduate-Medical-Education/Fact-Sheets/2018/Pediatric-Workforce-Shortages-Persist>. Published January 2018.
17. Colvin JD, Hall M, Berry JG, et al. Financial loss for inpatient care of Medicaid-insured children. *JAMA Pediatr*. 2016;170(11):1055-1062. doi:10.1001/jamapediatrics.2016.1639
18. Davis MM, Kan K. Medicaid and children's hospitals: a vital but strained double helix for children's health care. *JAMA Pediatr*. 2016;170(11):1043-1045. doi:10.1001/jamapediatrics.2016.2328
19. AAMC GSQ, and Davis MM, Kan K. Medicaid and children's hospitals: a vital but strained double helix for children's health care. *JAMA Pediatr*. 2016;170(11):1043-1045. doi:10.1001/jamapediatrics.2016.2328
20. American Association of Medical Colleges. Medical School Graduation Questionnaire. <https://www.aamc.org/media/55736/download> . Published July 2021.
21. Laugesen, M.J., Glied, S.A. (2011). Higher Fees Paid to US Physicians Drive Higher Spending for Physician Services Compared to Other Countries. *Health Affairs*, Vol 30(9). <https://www.healthaffairs.org/doi/10.1377/hlthaff.2010.0204>; Conover, Chris. (2013). Are U.S. Doctors Paid too Much? *Forbes*. <https://www.forbes.com/sites/theapothecary/2013/05/28/are-u-s-doctors-paid-too-much/#3c8df023d525> (See Table 2)
22. Anderson, G., Reinhardt, U., Hussey, P., Petrosyan, V. (2003). It's the Prices, Stupid: Why the United States is so Different from Other Countries. *Health Affairs* Vol 22(3). <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.22.3.89> OECD (2017). *Health at Glance 2017*:
23. OECD Indicators. <https://www.health.gov.il/publicationsfiles/healthataglance2017.pdf>
24. Knight V. American medical students less likely to choose to become primary care doctors. *Khn.org*. <https://khn.org/news/american-medical-students-less-likely-to-choose-to-become-primary-care-doctors/>. Published July 3, 2019.
25. Reforming Physician Payments to Achieve Greater Equity and Value in Health Care: A Position Paper of the American College of Physicians. Outland, BE, Erickson S, Doherty R, et al. *Annals of Internal Medicine*. 2022.
26. CMS Proposes Physician Payment Rule to Improve Health Equity, Patient Access. <https://www.cms.gov/newsroom/press-releases/cms-proposes-physician-payment-rule-improve-health-equity-patient-access>. Published July 13, 2021.
27. National Academies of Sciences, Engineering, and Medicine. *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*. Washington, DC: National Academies Press; 2016.
28. Casalino LP, Elster A, Eisenberg A, Lewis E, Montgomery J, Ramos D. Will pay-for-performance and quality reporting affect health care disparities? *Health Aff (Millwood)*. 2007;26(3):w405-w414. doi:10.1377/hlthaff.26.3.w405
29. Davis MM, Kan K. Adjusting Hospital Reimbursement to Account for Social Influences on Health. *JAMA Netw Open*. 2019;2(10):e1913630. doi:10.1001/jamanetworkopen.2019.13630
30. Davis MM, Kan K. Adjusting Hospital Reimbursement to Account for Social Influences on Health. *JAMA Netw Open*. 2019;2(10):e1913630. doi:10.1001/jamanetworkopen.2019.13630

31. National Residency Matching Program. NRMP program results 2015-2019: Main Residency Match. [https://mk0nrmp3oyqui6wqfm.kinstacdn.com/wp-content/uploads/2019/02/SMS Program Results 2015 2019.pdf](https://mk0nrmp3oyqui6wqfm.kinstacdn.com/wp-content/uploads/2019/02/SMS_Program_Results_2015_2019.pdf)

RELEVANT AMA AND AMA-MSS POLICY

Gender Discrimination in Medicine 9.5.5

Inequality of professional status in medicine among individuals based on gender can compromise patient care, undermine trust, and damage the working environment. Physician leaders in medical schools and medical institutions should advocate for increased leadership in medicine among individuals of underrepresented genders and equitable compensation for all physicians. Collectively, physicians should actively advocate for and develop family-friendly policies that:

- (a) Promote fairness in the workplace, including providing for:
 - (i) retraining or other programs that facilitate re-entry by physicians who take time away from their careers to have a family;
 - (ii) on-site child care services for dependent children;
 - (iii) job security for physicians who are temporarily not in practice due to pregnancy or family obligations.
- (b) Promote fairness in academic medical settings by:
 - (i) ensuring that tenure decisions make allowance for family obligations by giving faculty members longer to achieve standards for promotion and tenure;
 - (ii) establish more reasonable guidelines regarding the quantity and timing of published material needed for promotion or tenure that emphasize quality over quantity and encourage the pursuit of careers based on individual talent rather than tenure standards that undervalue teaching ability and overvalue research;
 - (iii) fairly distribute teaching, clinical, research, administrative responsibilities, and access to tenure tracks;
 - (iv) structuring the mentoring process through a fair and visible system.
- (c) Take steps to mitigate gender bias in research and publication. Issued: 2016

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.

BOT Rep. 27, A-19.

Advancing Gender Equity in Medicine D-65.989

1. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.

2. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.

3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.

4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

Res. 010, A-18; Modified: BOT Rep. 27, A-19.

Medical Care of Persons with Developmental Disabilities H-90.968

2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals.

Principles of and Actions to Address Primary Care Workforce H-200.949

1. Our patients require a sufficient, well-trained supply of primary care physicians--family physicians, general internists, general pediatricians, and obstetricians/gynecologists--to meet the nation's current and projected demand for health care services.
2. To help accomplish this critical goal, our American Medical Association (AMA) will work with a variety of key stakeholders, to include federal and state legislators and regulatory bodies; national and state specialty societies and medical associations, including those representing primary care fields; and accreditation, certification, licensing, and regulatory bodies from across the continuum of medical education (undergraduate, graduate, and continuing medical education).
3. Through its work with these stakeholders, our AMA will encourage development and dissemination of innovative models to recruit medical students interested in primary care, train primary care physicians, and enhance both the perception and the reality of primary care practice, to encompass the following components: a) Changes to medical school admissions and recruitment of medical students to primary care specialties, including counseling of medical students as they develop their career plans; b) Curriculum changes throughout the medical education continuum; c) Expanded financial aid and debt relief options; d) Financial and logistical support for primary care practice, including adequate reimbursement, and enhancements to the practice environment to ensure professional satisfaction and practice sustainability; and e) Support for research and advocacy related to primary care.

16. There should be increased financial incentives for physicians practicing primary care, especially those in rural and urban underserved areas, to include scholarship or loan repayment programs, relief of professional liability burdens, and Medicaid case management programs, among others. Our AMA will advocate to state and federal legislative and regulatory bodies, among others, for development of public and/or private incentive programs, and expansion and increased funding for existing programs, to further encourage practice in underserved areas and decrease the debt load of primary care physicians. The imposition of specific outcome targets should be resisted, especially in the absence of additional support to the schools.

17. Our AMA will continue to advocate, in collaboration with relevant specialty societies, for the recommendations from the AMA/Specialty Society RVS Update Committee (RUC) related to reimbursement for E&M services and coverage of services related to care coordination, including patient education, counseling, team meetings and other functions; and work to ensure that private payers fully recognize the value of E&M services, incorporating the RUC-recommended increases adopted for the most current Medicare RBRVS.

18. Our AMA will advocate for public (federal and state) and private payers to develop physician reimbursement systems to promote primary care and specialty practices in progressive, community-based models of integrated care focused on quality and outcomes such as the patient-centered medical home and the chronic care model consistent with current AMA Policies H-160.918 and H-160.919.

CME Rep. 04, I-18

Reimbursement to Physicians and Hospitals for Government Mandated Services H-240.966

(1) It is the policy of the AMA that government mandated services imposed on physicians and hospitals that are peripheral to the direct medical care of patients be recognized as additional practice cost expense.

(2) Our AMA will accelerate its plans to develop quantitative information on the actual costs of regulations.

(3) Our AMA strongly urges Congress that the RBRVS and DRG formulas take into account these additional expenses incurred by physicians and hospitals when complying with governmentally mandated regulations and ensure that reimbursement increases are adequate to cover the costs of providing these services.

(4) Our AMA will advocate to the CMS and Congress that an equitable adjustment to the Medicare physician fee schedule (or another appropriate mechanism deemed appropriate by CMS or Congress) be developed to provide fair compensation to offset the additional professional and practice expenses required to comply with the Emergency Medical Treatment and Labor Act.

Sub. Res. 810, I-92; Appended by CMS 10, A-98; Reaffirmation I-98; Reaffirmation A-02; Reaffirmation I-07; Reaffirmed in lieu of Res. 126, A-09; Reaffirmed: CMS Rep. 01, A-19.

Adequate Physician Reimbursement for Long-Term Care H-280.979

Our AMA supports: (1) continuing discussion with CMS to improve Medicare reimbursement to physicians for primary care services, specifically including nursing home and home care medical services;

(2) continued efforts to work with the Federation to educate federal and state legislative bodies about the issues of quality from the perspective of attending physicians and medical directors and express AMA's commitment to quality care in the nursing home;

(3) efforts to work with legislative and administrative bodies to assure adequate payment for routine visits and visits for acute condition changes including the initial assessment and ongoing monitoring of care until the condition is resolved; and

(4) assisting attending physicians and medical directors in the development of quality assurance guidelines and methods appropriate to the nursing home setting.

Res. 110, I-88; Res. 94, A-89; Res. 152, A-91; CMS Rep. 11, I-95; Reaffirmed: Sunset Report, I-98; Reaffirmation A-02; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16.

Fair Physician Contracts H-285.946

Our AMA will develop national (state) standards and model legislation for fair managed care/physician contracts, thereby requiring full disclosure in plain English of important information, including but not limited to: (1) AMA-MSS Digest of Policy Actions/ 183 disclosure of reimbursement amounts, conversion factors for the RBRVS system or other formulas if applicable, global follow-up times, multiple procedure reimbursement policies, and all other payment policies; (2) which proprietary "correct coding" CPT bundling program is employed; (3) grievance and appeal mechanisms; (4) conditions under which a contract can be terminated by a physician or health plan; (5) patient confidentiality protections; (6) policies on patient referrals and physician use of consultants; (7) a current listing by name and specialty of the physicians participating in the plan; and (8) a current listing by name of the ancillary service providers participating in the plan.

Res. 727, A-97; Amended by CMS Rep. 3, A-98; Reaffirmed: Res. 814, A-00; Reaffirmation A-06; Reaffirmation A-08; Reaffirmation I-08 Reaffirmed: CMS Rep. 01, A-18.

Cuts in Medicare and Medicaid Reimbursement H-330.932

(4) if the reimbursement is not improved, the AMA declares the Medicare reimbursement unworkable and intolerable, and seek immediate legislation to allow the physician to balance bill the patient according to their usual and customary fee; and

(5) supports a mandatory annual "cost-of-living" or COLA increase in Medicaid, Medicare, and other appropriate health care reimbursement programs, in addition to other needed payment increases.

Sub. Res. 101, A-97; Reaffirmation A-99 and Reaffirmed: Res. 127, A-99; Reaffirmation A-00; Reaffirmation I-00; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00; Reaffirmation A-01; Reaffirmation and Appended: Res. 113, A-02; Reaffirmation A-05; Reaffirmed in lieu of Res. 207, A-13.

Consultation Follow-Up and Concurrent Care of Referral for Principal Care H-390.917

- (1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation; and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; he/she may also have the patient referred for care and thus become the principal care physician. (2) The AMA communicate the appropriate use of consultation, evaluation and management, and office medical services codes to third party payers and advocate the appropriate reimbursement for these services in order to encourage high quality, comprehensive and appropriate consultations for patients.
- (2) Sub. Res. 42, A-90; Amended: BOT Rep. P, I-92; CMS Rep. 3, A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation I-08; Modified: CMS Rep. 01, A-18.

Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-Related Impairments H-390.835

Our AMA supports: (1) additional reimbursement for evaluation and management services for patients who require additional time and specialized equipment during medical visits due to severe mobility-related impairments; (2) that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law; (3) that primary and specialty medical providers be educated regarding the care of patients with severely impaired mobility to improve access to care; and (4) additional funding for payment for services provided to patients with mobility related impairments that is not through a budget neutral adjustment to the physician fee schedule. Res. 814, I-17.

RVS Updating H-400.969

Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3) encourages CMS to rely upon this process as it considers new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues; and (4) opposes changes in Relative Value Units that are in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC).

BOT Rep. O, I-92; Reaffirmed by BOT Rep. 8 - I-94; Reaffirmed by BOT Rep. 7, A-98; Reaffirmed: CMS Rep. 12, A-99; Reaffirmed: CMS Rep. 4, I-02; Reaffirmed: BOT Rep. 14, A-08; Reaffirmation I-10; Appended: Res. 822, I-12; Reaffirmation I-13; Reaffirmed: Sub. Res. 104, A-14; Reaffirmed in lieu of Res. 216, I-14; Reaffirmation A-15.

Guidelines for the Resource-Based Relative Value Scale H-400.991

- (1) The AMA reaffirms its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using: (a) an appropriate RVS based on the resource costs of providing physician services; (b) an appropriate monetary conversion factor; and (c) an appropriate set of conversion factor multipliers.
- (2) The AMA supports the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected and refined, would provide an acceptable basis for a Medicare indemnity payment system.

- (3) The AMA reaffirms its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing. (Reaffirmed: Sub. Res. 132, A-94)
- (4) The AMA reaffirms its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits.
- (5) The AMA promotes enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system.
- (6) The AMA supports expanding its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries.
- (7) The AMA reaffirms its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs.
- (8) The AMA believes that payment localities should be determined based on principles of reasonableness, flexibility and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan and nonmetropolitan areas within states) based on the availability of high quality data.
- (9) The AMA believes that, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented.
- (10) Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to: (a) partial completion of a residency plus time in practice; (b) local peer recognition; and (c) carrier analysis of practice patterns. A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years.
- (11) The AMA strongly opposes any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings.
- (12) The AMA believes that whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies.
- BOT Rep. AA, I-88; Reaffirmed: I-92; Reaffirmed and Modified: CMS Rep. 10, A-03; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16.

Non-Medicare Use of the RBRVS D-400.999

Our AMA will: (1) reaffirm Policy H-400.960 which advocates that annually updated and rigorously validated Resource Based Relative Value Scale (RBRVS) relative values could provide a basis for non-Medicare physician payment schedules, and that the AMA help to ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods;(2) reaffirm Policy H-400.969 which supports the use of the AMA/Specialty Society process as the principal method of refining and maintaining the Medicare relative value scale;(3) continue to identify the extent to which third party payers and other public programs modify, adopt, and implement Medicare RBRVS payment policies;(4) strongly oppose and protests the Centers for Medicare & Medicaid Services' Medicare multiple surgery reduction policy which reduces payment for additional surgical procedures after the first procedure by more

than 50%; and (5) encourage third party payers and other public programs to utilize the most current CPT codes updated by the first quarter of the calendar year, modifiers, and relative values to ensure an accurate implementation of the RBRVS.

CMS Rep. 12, A-99; Reaffirmation I-03; Reaffirmation I-07; Modified: BOT Rep. 22, A-17.

Decreasing Sex and Gender Disparities in Health Outcomes H-410.946

Our AMA: (1) supports the use of decision support tools that aim to mitigate **gender** bias in diagnosis and treatment; and (2) encourages the use of guidelines, treatment protocols, and decision support tools specific to biological sex for conditions in which physiologic and pathophysiologic differences exist between sexes.

Res. 005, A-18.

180.003MSS Equitable Reimbursement for Physicians' Cognitive Services

AMA-MSS supports the concept that third-party payors should provide more equitable reimbursement for physicians' cognitive services. MSS Sub Res 7, A-84; Reaffirmed: MSS COLRP Rep B, I-95; Reaffirmed: MSS Rep B, I-00; Reaffirmed: MSS Rep E, I-05; Reaffirmed: MSS GC Rep F, I-10; Reaffirmed: MSS GC Rep D, I-15.

525.011MSS Bridging the Gender Pay Gap

AMA-MSS (1) supports equitable compensation for all physicians with comparable experience performing equivalent work, and opposes gender-based discrimination in the workplace, and (2) supports efforts to address gender-based disparities in physician compensation including those that increase transparency during the hiring process, and internal reviews at the practice, department, or hospital system level that evaluate for gender-based discrimination pay gaps. MSS Res 30 I-18.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 039
(I-22)

Introduced by: Jenna Gage, Kaci French, University of Texas Medical Branch Galveston;
Katie McLaughlin, University of Minnesota

Subject: School-to-Prison Pipeline

Sponsored by: Region 4 and Region 6

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

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

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

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

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

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

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

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

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

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

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

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

RESOLVED, That our AMA amend by addition as follows:

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

Our AMA supports: (1) evidence-based frameworks in K-12 schools that focus on school-wide prevention and intervention strategies for student misbehavior; ~~and~~ (2) the consultation with school-based mental health professionals in the student discipline process; (3) efforts to address physical and mental trauma experienced by children in K-12 education by reducing punitive disciplinary actions in K-12 education and the involvement of law enforcement in student discipline; (4) ensuring that any law enforcement presence in K-12 schools focuses on maintaining student and staff safety and not on disciplining students; (5) transitions to restorative approaches that individually address students' medical, social, and educational needs, and; (6) efforts to prevent interactions between students and law enforcement as much as possible to avoid risk of incarceration.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. American Civil Liberties Union. School-to-prison pipeline. <https://www.aclu.org/issues/juvenile-justice/juvenile-justice-school-prison-pipeline>. Published April 4, 2022. Accessed August 30, 2022.
2. American University. Who is most affected by the school to prison pipeline? <https://soeonline.american.edu/blog/school-to-prison-pipeline>. Published February 24, 2021. Accessed September 21, 2022.
3. Global Health Center. We know the school-to-prison pipeline is a public health crisis, so why is restorative justice disparate from health justice? Institute for Public Health. <https://publichealth.wustl.edu/the-school-to-prison-pipeline/#:~:text=%2Dprison%20pipeline.%E2%80%9D-The%20school%2Dto%2Dprison%20pipeline%20is%20a%20public%20health%20crisis,discipline%20policies%20to%20impose%20order>. Published September 7, 2021. Accessed September 21, 2022.
4. Civil Rights Data Collection - Ed. <https://ocrdata.ed.gov/assets/downloads/CRDC-School-Discipline-Snapshot.pdf>. Accessed September 1, 2022.

5. Heise M, Nance P. "Defund the (school) police? bringing data to key school-to-prison pipeline claims. Published 2021. The Journal of Criminal Law & Criminology, 111(3), 717–772.
6. Jackson DB, Testa A. Household food insecurity and preschool suspension/expulsion in the United States. *Prev Med.* 2020;141:106283. doi:10.1016/j.ypmed.2020.106283
7. Hemez P, Brent JJ, Mowen TJ. Exploring the School-to-Prison Pipeline: How School Suspensions Influence Incarceration During Young Adulthood. *Youth Violence Juv Justice.* 2020;18(3):235-255. doi:10.1177/1541204019880945
8. Henry KK, Catagnus RM, Griffith AK, Garcia YA. Ending the School-to-Prison Pipeline: Perception and Experience with Zero-Tolerance Policies and Interventions to Address Racial Inequality [published online ahead of print, 2021 Aug 12]. *Behav Anal Pract.* 2021;1-10. doi:10.1007/s40617-021-00634-z
9. American Psychological Association Zero Tolerance Task Force. "Are Zero Tolerance Policies Effective in the Schools?: An Evidentiary Review and Recommendations." *American Psychologist* 63, no. 9 (December 2008): 852–62. <https://doi.org/10.1037/0003-066X.63.9.852>.
10. Bacher-Hicks A, By, Andrew Bacher-HicksStephen B. BillingsDavid J. Deming, et al. Proving the school-to-prison pipeline. *Education Next.* <https://www.educationnext.org/proving-school-to-prison-pipeline-stricter-middle-schools-raise-risk-of-adult-arrests/>. Published December 16, 2021. Accessed September 22, 2022.
11. School-to-prison pipeline. American Civil Liberties Union. <https://www.aclu.org/issues/juvenile-justice/juvenile-justice-school-prison-pipeline>. Published April 4, 2022. Accessed September 22, 2022.
12. Aronowitz SV, Kim B, Aronowitz T. A mixed-studies review of the school-to-prison pipeline and a call to action for school nurses. *J Sch Nurs.* 2021;37(1):51–60
13. Sinko L, He Y, Tolliver D. Recognizing the Role of Health Care Providers in Dismantling the Trauma-to-Prison Pipeline. *Pediatrics.* 2021;147(5):e2020035915. doi:10.1542/peds.2020-035915
14. Grayson AM; L.P.C.; B.C.-D.M.T.; N.C.C.. Addressing the Trauma of Racism from a Mental Health Perspective within the African American Community. *Dela J Public Health.* 2020;6(5):28-30. Published 2020 Nov 7. doi:10.32481/djph.2020.11.008
15. Heard-Garris NJ, Cale M, Camaj L, Hamati MC, Dominguez TP. Transmitting Trauma: A systematic review of vicarious racism and child health. *Soc Sci Med.* 2018;199:230-240. doi:10.1016/j.socscimed.2017.04.018
16. Morgan H. Restorative justice and the school-to-prison pipeline: A review of existing literature. *Education Sciences.* 2021 Mar 31;11(4):159.
17. Todić J, Cubbin C, Armour M, Rountree M, González T. Reframing school-based restorative justice as a structural population health intervention. *Health Place.* 2020;62:102289. doi:10.1016/j.healthplace.2020.102289
18. González T, Etow A, De La Vega C. Health Equity, School Discipline Reform, and Restorative Justice. *J Law Med Ethics.* 2019;47(2_suppl):47-50. doi:10.1177/1073110519857316
19. Velez G, Hahn M, Recchia H, Wainryb C. Rethinking Responses to Youth Rebellion: Recent Growth and Development of Restorative Practices in Schools. *Curr Opin Psychol.* 2020;35:36-40. doi:10.1016/j.copsyc.2020.02.011
20. Fronius, T.; Darling-Hammond, S.; Sutherland, H.; Guckenburg, S.; Hurley, H.; Petrosino, A. Restorative Justice in U.S. Schools: An Updated Research Review; The WestEd Justice & Prevention Research Center: San Francisco, CA, USA, 2019.

21. Gregory, A.; Evans, K.R. The Starts and Stumbles of Restorative Justice in Education: Where Do We Go from Here? National Education Policy Center: Boulder, CO, USA, 2020.

RELEVANT AMA AND AMA-MSS POLICY

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

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

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

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

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

Res. 008, A-22

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

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

Res. 404, A-17

Health Care While Incarcerated H-430.986

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

integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.

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

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

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

Medications for Opioid Use Disorder in Correctional Facilities H-430.987

1. Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated; and (b) medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.

2. Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.

3. Our AMA advocates for legislation, standards, policies, and funding that require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case managers, social workers, and pharmacies in the communities where patients, including individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment.

4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.

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

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

(1) Medical Testing and Care of Prisoners a) Federal and state correctional systems should provide comprehensive medical management for all entrants, which includes voluntary testing for HIV infection and mandatory testing for tuberculosis followed by appropriate treatment for those infected; b) During incarceration, prisoners should be tested for HIV infection as medically indicated or on their request; c) All inmates and staff should be screened for tuberculosis infection and retested at least annually. If an increase in cases of tuberculosis or HIV infection is noted, more frequent retesting may be indicated; d) Correctional institutions should assure that informed consent, counseling, and confidentiality procedures are in place to protect the patient, when HIV testing is appropriate; e) During their post-test counseling procedures, HIV-infected inmates should be encouraged to confidentially notify their sexual or needle-sharing partners; and f) Correctional medical care must, as a minimum, meet the prevailing standards of care for

HIV-infected persons in the outside community at large. Prisoners should have access to approved therapeutic drugs and generally employed treatment strategies. (2) HIV/AIDS Education and Prevention Our AMA: a) Encourages the inclusion of HIV-prevention information as a regular part of correctional staff and inmate education. AIDS education in state and federal prisons should stress abstinence from drug use and high-risk sexual practices, as well as the proper use of condoms as one way of decreasing the spread of HIV; b) Will pursue legislation that encourages state, local, and federal correctional institutions to make condoms available to inmates; and c) Urges medical personnel in correctional institutions to work closely with state and local health department personnel to control the spread of HIV/AIDS, tuberculosis, and other serious infectious diseases within and outside these facilities. (3) Prison-based HIV Partner Notification Program Our AMA: a) Urges state health departments to take steps to initiate with state departments of correctional services the development of prison-based HIV Partner Notification Programs for inmates convicted of drug-related crimes and their regular sexual partners; and b) Believes that all parties should recognize that maximum effectiveness in an HIV Partner Notification Program will depend on the truly voluntary participation of inmates and the strict observance of confidentiality at all levels.
CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13

Disease Prevention and Health Promotion in Correctional Institutions H-430.989

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, hepatitis, and other infectious diseases. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

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

Update on Tuberculosis H-440.931

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

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

Health Status of Detained and Incarcerated Youth H-60.986

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

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

(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.

(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system.

(CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res 917)

Reducing Racial and Ethnic Disparities in Health Care D-350.995

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:

(1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.

(2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.

(3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

BOT Rep. 4, A-03; Reaffirmation: A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

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.

Res. 408, 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 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

Policing Reform H-65.954

Our AMA: (1) recognizes police brutality as a manifestation of structural racism which disproportionately impacts Black, Indigenous, and other people of color; (2) will work with interested national, state, and local medical societies in a public health effort to support the elimination of excessive use of force by law enforcement officers; (3) will advocate against the utilization of racial and discriminatory profiling by law enforcement through appropriate anti-bias training, individual monitoring, and other measures; and (4) will advocate for legislation and regulations which promote trauma-informed, community-based safety practices.

Res. 410, I-20; Reaffirmed: CSAPH Rep. 2, A-21

AMA Support for Justice Reinvestment Initiatives H-95.931

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

Res. 205, A-16

Preventing Assault and Rape of Inmates by Custodial Staff H-430.981

Our AMA urges: (1) that all states have legislation that protects prisoners from sexual misconduct and assault; and (2) physicians who work within prisons to ensure procedures are followed for preventing sexual misconduct and assault of prisoners by staff and appropriately managing prisoners if abuse or assault does occur; the investigation of sexual misconduct should be confidential with information disclosed only to those individuals involved in the process.

CSAPH Rep. 01, A-20

Use of the Choke and Sleeper Hold in Prisons H-430.998

The AMA (1) does not regard the choke and sleeper holds as casually applied and easily reversible tranquilizers, but as the use of deadly force with the potential to kill; and (2) advocates that with all incidents involving the application of choke and sleeper holds there should be timely medical surveillance of the inmate.

Res. 3, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955

Our AMA:

1. Encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities.
 2. Affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health.
 3. Encourages the Centers for Disease Control and Prevention as well as state and local public health agencies to research the nature and public health implications of violence involving law enforcement.
 4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies.
 5. Encourages appropriate stakeholders, including, but not limited to the law enforcement and public health communities, to define “serious injuries” for the purpose of systematically collecting data on law enforcement-related non-fatal injuries among civilians and officers.
- Res. 406, A-16; Modified: BOT Rep. 28, A-18.

Police Chases and Chase-Related Injuries H-15.964

The AMA encourages (1) communities, aided by government officials and medical scientists, to develop guidelines on the use of police vehicles that indicate when, how, and how long pursuits should be carried out and to address other key aspects of police pursuit; and (2) responsible government agencies to develop, test, and use instruments and techniques with advanced technologies, for example, coding and tracking devices, to discourage, eliminate, or replace high-speed chases.

CSA Rep. C, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13

Mental Health Crisis Interventions H-345.972

Our AMA: (1) continues to support jail diversion and community based treatment options for mental illness; (2) supports implementation of law enforcement-based crisis intervention training programs for assisting those individuals with a mental illness, such as the Crisis Intervention Team model programs; (3) supports federal funding to encourage increased community and law enforcement participation in crisis intervention training programs; and (4) supports legislation and federal funding for evidence-based training programs by qualified mental health professionals aimed at educating corrections officers in effectively interacting with people with mental health and other behavioral issues in all detention and correction facilities.

Res. 923, I-15; Appended: Res. 220, I-18

Increased Use of Body-Worn Cameras by Law Enforcement Officers D-160.919

Our AMA: (1) will work with interested state and national medical specialty societies to support state legislation and/or regulation addressing implementation of body-worn camera programs for law enforcement officers, including funding for the purchase of body-worn cameras, training for officers and technical assistance for law enforcement agencies; (2) will continue to monitor privacy issues raised by body-worn cameras in health care settings; and (3) recommends that law enforcement policies governing the use of body-worn cameras in health care settings be developed and evaluated with input from physicians and others in the medical community and not interfere with the patient-physician relationship.

BOT Rep. 18, A-19

Use of Conducted Electrical Devices by Law Enforcement Agencies H-145.977

Our AMA: (1) recommends that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) that is modeled after available national guidelines; (2) encourages additional independent research involving actual field deployment of CEDs to better understand the risks and benefits under conditions of actual use. Federal, state, and local agencies should accurately report and analyze the parameters of CED use in field applications; and (3) policy is that law enforcement departments and agencies have a standardized protocol developed with the input of the medical community for the evaluation, management and post-exposure monitoring of subjects exposed to CEDs.

CSAPH Rep. 6, A-09; Modified: Res. 501, A-14

School Resource Officer Qualifications and Training H-60.902

Our AMA encourages: (1) an evaluation of existing national standards (and legislation, if necessary) to have qualifications by virtue of training and certification that includes child psychology and development, restorative justice, conflict resolution, crime awareness, implicit/explicit biases, diversity inclusion, cultural humility, and individual and institutional safety and others deemed necessary for school resource officers; and (2) the development of policies that foster the best environment for learning through protecting the health and safety of those in school, including students, teachers, staff and visitors.

Res. 926, I-19

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 040
(I-22)

Introduced by: Harinandan Sainath, Ashwin Varma, Long School of Medicine University of Texas Health San Antonio; Braxton Howell, University of South Carolina School of Medicine Greenville

Subject: Changing Medical School Drug Testing Policies

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Medical schools employ a wide range of drug testing policies which include mandatory pre-matriculation drug screenings, random drug tests, drug testing upon suspicion of impairment, and/or drug screening before clinical rotations¹⁻⁴; and

Whereas, Existing AMA policy H-95.985 states that physicians should understand the questions and objectives they want to answer prior to implementing drug testing programs⁵; and

Whereas, Most medical school drug testing policies state that their primary goals include protecting patient safety against impaired clinical care providers and to prevent the illegal use and distribution of alcohol and controlled substances^{2,4,6}; and

Whereas, Existing AMA policy. H-95.985 states that some limitations of drug testing are that they do not provide information about pattern of drug use, physical dependence, mental or physical impairments, or presence of substance use disorder⁵; and

Whereas, Negative drug tests results do not rule out recent substance abuse or presence of a substance use disorder, but rather suggest that substance use did not occur during the window of detection for each respective drug⁷; and

Whereas, Positive drug test results without any behavioral evidence of drug impairment do not give a clear indication of when impairment last occurred as the window of detection may last from 24 hours to 30 days depending on the type of drug, dosage, and frequency of use⁸⁻¹⁰; and

Whereas, Positive drug test results for certain drugs are not an indication of illegal substance use since alcohol use is legal at federal and state levels and recreational cannabis is legal in 19 states¹¹; and

Whereas, Drug testing cost has to be covered either by students individually or by the medical school as a whole, with urine immunoassay screening estimated to cost \$20 per test and further confirmatory testing estimated to cost between \$80-\$200¹²; and

Whereas, A recent survey of 49 U.S. medical schools shows that 91% of medical students consumed alcohol in the past year, 26% used marijuana, and 6% used amphetamines,

1 suggesting that the drug policies currently in place are not preventing substance use in
2 student¹³; and

3
4 Whereas, School-based counseling and resources to prevent substance abuse may be more
5 cost-effective and useful than implementing routine drug testing¹²; therefore be it

6
7 RESOLVED, our AMA-MSS will ask the AMA to 1) advise against the practice of pre-
8 matriculation drug screening and random drug testing in medical schools and 2) advocate that
9 reasonable suspicion of impairment is required to request a drug test for medical students.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Emory University School of Medicine. Criminal Background Checks and Drug Testing. Updated July 18, 2022. <https://med.emory.edu/education/programs/md/student-handbook/matriculation/criminal-background-check-drug-testing.html>
2. Perelman School of Medicine. Drug Screening Policy. PSOM Policies/Handbook. <https://www.med.upenn.edu/student/drug-screening-policy.html>
3. UTMB Health. School of Medicine School of Drug Testing Policy. Updated December 4, 2013. [https://www.utmb.edu/policies_and_procedures/IHOP/Supporting_Documents/IHOP%20-%2007.01.26%20-%20School%20of%20Medicine%20Drug%20Testing%20Policy.pdf#:~:text=The%20UTMB%20School%20of%20Medicine,%2C%20and%20phencyclidine%20\(PCP\).&text=Dru%20test%20results%20will%20remain%20separate%20from%20the%20academic%20record](https://www.utmb.edu/policies_and_procedures/IHOP/Supporting_Documents/IHOP%20-%2007.01.26%20-%20School%20of%20Medicine%20Drug%20Testing%20Policy.pdf#:~:text=The%20UTMB%20School%20of%20Medicine,%2C%20and%20phencyclidine%20(PCP).&text=Dru%20test%20results%20will%20remain%20separate%20from%20the%20academic%20record)
4. Vagelos College of Physicians and Surgeons. Alcohol and Other Drug Policy. <https://www.vagelos.columbia.edu/education/student-resources/honor-code-and-policies/vp-s-and-university-policies/alcohol-and-other-drug-policy>
5. AMA Policy Finder. Drug Testing H-95.985
6. UCSF School of Medicine. University of California Policy on Substance Abuse. UCSF Medical Student Policies. Updated July 30, 2019. <https://meded.ucsf.edu/policies-procedures/university-california-policy-substance-abuse>
7. McNeil SE, Cogburn M. Drug Testing. StatPearls. 2022 Jan. <https://www.ncbi.nlm.nih.gov/books/NBK459334/>
8. Hadland SE, Levy S. Objective Testing: Urine and Other Drug Tests. Child Adolesc Psychiatr Clin N Am. 2016;25(3):549-565. doi:10.1016/j.chc.2016.02.005
9. Eadie L, Lo LA, Christiansen A, Brubacher JR, Barr AM, Panenka WJ, MacCallum CA. Duration of Neurocognitive Impairment With Medical Cannabis Use: A Scoping Review. Frontiers in Psychiatry. 2021;12:638962. doi: 10.3389/fpsy.2021.638962
10. Berman SM, Kuczenski R, McCracken JT, London ED. Potential adverse effects of amphetamine treatment on brain and behavior: a review [published correction appears in Mol Psychiatry. 2010 Nov;15(11):1121]. Mol Psychiatry. 2009;14(2):123-142. doi:10.1038/mp.2008.90
11. Map of Marijuana Legality by State. DISA. August, 2022. <https://disa.com/map-of-marijuana-legality-by-state>

12. Levy S, Schizer M; Committee on Substance Abuse, American Academy of Pediatrics. Adolescent drug testing policies in schools. *Pediatrics*. 2015;135(4):e1107-e1112. doi:10.1542/peds.2015-0055
13. Ayala EE, Roseman D, Winseman JS, Mason HRC. Prevalence, perceptions, and consequences of substance use in medical students. *Med Educ Online*. 2017;22(1):1392824. doi:10.1080/10872981.2017.1392824

RELEVANT AMA AND AMA-MSS POLICY

Drug Testing H-95.985

Our AMA believes that physicians should be familiar with the strengths and limitations of drug testing techniques and programs:

1. Due to the limited specificity of the inexpensive and widely available non-instrumented devices such as point-of-care drug testing devices, acceptable clinical drug testing programs should include the ability to access highly specific, analytically acceptable confirmation techniques, which definitively establish the identities and quantities of drugs, in order to further analyze results from presumptive testing methodologies. Physicians should consider the value of data from non-confirmed preliminary test results, and should not make major clinical decisions without using confirmatory methods to provide assurance about the accuracy of the clinical data.
2. Results from drug testing programs can yield accurate evidence of prior exposure to drugs. Drug testing does not provide any information about pattern of use of drugs, dose of drugs taken, physical dependence on drugs, the presence or absence of a substance use disorder, or about mental or physical impairments that may result from drug use, nor does it provide valid or reliable information about harm or potential risk of harm to children or, by itself, provide indication or proof of child abuse, or neglect or proof of inadequate parenting.
3. Before implementing a drug testing program, physicians should: (a) understand the objectives and questions they want to answer with testing; (b) understand the advantages and limitations of the testing technology; (c) be aware of and educated about the drugs chosen for inclusion in the drug test; and (d) ensure that the cost of testing aligns with the expected benefits for their patients. Physicians also should be satisfied that the selection of drugs (analytes) and subjects to be tested as well as the screening and confirmatory techniques that are used meet the stated objectives.
4. Since physicians often are called upon to interpret results, they should be familiar with the disposition characteristics of the drugs to be tested before interpreting any results. If interpretation of any given result is outside of the expertise of the physician, assistance from appropriate experts such as a certified medical review officer should be pursued.

CSA Rep. J, I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: CSAPH Rep. 01, I-16; Reaffirmed: Res. 520, A-19

Issues in Employee Drug Testing H-95.984

The AMA (1) reaffirms its commitment to educate physicians and the public about the scientific issues of drug testing; (2) supports monitoring the evolving legal issues in drug testing of employee groups, especially the issues of positive drug tests as a measure of health status and potential employment discrimination resulting therefrom; (3) takes the position that urine alcohol and other drug testing of employees should be limited to (a) preemployment examinations of those persons whose jobs affect the health and safety of others, (b) situations in which there is reasonable suspicion that an employee's (or physician's) job performance is impaired by alcohol and/or other drug use, (c) monitoring as part of a comprehensive program of treatment and rehabilitation of substance use disorders, and (d) urine, alcohol and other drug testing of all physicians and appropriate employees of health care institutions may be appropriate under

these same conditions; and (4) urges employers who choose to establish alcohol and other drug testing programs to use confirmed, positive test results in employees primarily to motivate those employees to seek appropriate assistance with their alcohol or other drug problems, preferably through employee assistance programs.

CSA Rep. A, A-87; Reaffirmed: Sub. Res. 39, A-90, CSA Rep. D, I-90; BOT Rep. I, A-90; CSA Rep. 2, I-95; Reaffirmed: BOT Rep. 17, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: Res. 817, I-13

Cannabis Legalization for Medicinal Use D-95.969

Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) believes that cannabis for medicinal use should not be legalized through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; (5) believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions; (6) will, when necessary and prudent, seek clarification from the United States Justice Department (DOJ) about possible federal prosecution of physicians who participate in a state operated marijuana program for medical use and based on that clarification, ask the DOJ to provide federal guidance to physicians; and (7) encourages hospitals and health systems to: (a) not recommend patient use of non-FDA approved cannabis or cannabis derived products within healthcare facilities until such time as federal laws or regulations permit its use; and (b) educate medical staffs on cannabis use, effects and cannabis withdrawal syndrome.

CSAPH Rep. 05, I-17; Appended: Res. 211, A-18; Appended: CSAPH Rep. 3, I-19

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; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 041
(I-22)

Introduced by: Aila Rahman, Adrienne-Denise Bilbao, Daniel Domin, Sara Kayzak, Abhijay Kumar, Aarti Patel, Riley Wilstrom, Alexandra Yorks, Wayne State University

Subject: Supporting Research into Heat Response Plans

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, In 2021, The United Nations Intergovernmental Panel on climate change reported human activity has increased the temperature of the Earth by 1.1°C since the 1900s with a warning that it will rise further in the next 20 years¹; and

Whereas, The Environmental Protection Agency compiled heat wave data across 50 large metropolitans areas from 1961-2021 and found a statistically significant increase in heat wave frequency, intensity, and duration³; and

Whereas, Heat-related illnesses include heat strokes, exhaustion, and cramps with symptoms including headaches, dizziness, nausea, vomiting, and CNS dysfunction (specific to heat stroke only)²; and

Whereas, Each summer an average of 65,000 Americans visit the emergency room for acute heat-related illness, and around 700 heat related deaths are reported yearly with predicted increases in both²⁻⁴; and

Whereas, Heat exacerbates chronic illnesses particularly renal, respiratory, cardiovascular, and mental health disorders, leading to an increase in hospital admissions²⁻³; and

Whereas, People come to hospitals during extreme weather events not only for medical concerns but also access to air conditioning, electricity and a safe place to stay, contributing to a greater influx²⁻⁴; and

Whereas, Populations most vulnerable to heat include elderly persons, those with chronic diseases, pregnant persons, and outdoor workers, which greatly overlap with those most vulnerable to COVID-19 infection, placing further strains on hospitals and may require modifications to response plans^{1-3,8-9}; and

Whereas, Under normal conditions, hospitals derive energy primarily from the electrical distribution system, recently rated C- by the American Society of Civil Engineers in large part

1 due to its aging infrastructure and questionable ability to withstand extreme weather events¹²;
2 and

3
4 Whereas, A 2018 Lancet Report on health and climate change emphasizes a risk of systemic
5 hospital failure during heat events due to power outages, comprising patient care⁵; and

6
7 Whereas, Many equipment and medications, such as blood sugar monitors, insulin pumps, test
8 strips, and others require a certain temperature for storage and can be damaged during heat
9 waves¹⁰; and

10
11 Whereas, Hazard vulnerability analyses, often based on historical data, used by hospitals to
12 assess risk are likely inadequate for future preparation due to the acceleration of adverse
13 weather events from climate change⁶; and

14
15 Whereas, Current mitigation efforts for heat waves include public awareness of the harmful
16 effects of heat, protective measures like appropriate clothing, staying indoors, hydration, and
17 usage of cooling centers^{1-2,4,14}; and

18
19 Whereas, Despite public awareness efforts, a global survey conducted by the New England
20 Journal of Medicine revealed only 54% of patients are aware of the adverse effects of climate
21 change on health⁷; and

22
23 Whereas, Evidence suggests cooling centers are not used by vulnerable populations due to lack
24 of awareness of and knowledge about them, which can be mitigated by cooling center
25 education¹⁴; and

26
27 Whereas, A CDC report on heat response plans already contains resources, such as
28 infographics, handouts, and other educational materials on heat, heat-related illnesses, and
29 protective measures whose use is encouraged in healthcare facilities, such as hospitals,
30 outpatient clinics, and nursing homes²; and

31
32 Whereas, A recent CDC report on heat response plans indicates only 40% of health
33 departments from 30 states have a heat response plan and evaluation of such plans is a gap in
34 the literature despite evidence towards their effectiveness²; and

35
36 Whereas, A 2021 literature review of 756 articles on trends and gaps in climate change and
37 health research in North America identified a significant gap in mitigation and adaptation
38 strategies in response to climate change including heat waves¹¹; and

39
40 Whereas, Heat waves vary significantly from other disasters since they occur slower, over a
41 wider area, and harm to health involves consideration of existing health conditions, residence
42 and working conditions, therefore they warrant separate policy countermeasures from other
43 natural disasters like tornadoes, earthquakes, and tsunamis¹³; therefore be it

1 RESOLVED, Our AMA work with relevant stakeholders to support further research on the
 2 evaluation of heat response plans, including mitigation and adaptation strategies; and be it
 3 further
 4

5 RESOLVED, Our AMA supports the dissemination of pertinent education materials within
 6 healthcare facilities, including but not limited to upcoming heat waves, protective measures, and
 7 locations of local cooling centers.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Patel L, et al. Climate Change and Extreme Heat Events: How Health Systems Should Prepare. NEJM Catalyst. 2022;3(7).
2. Abbinett J, et al. Heat Response Plans: Summary of Evidence and Strategies for Collaboration and Implementation. CDC 2019.
3. US EPA. Climate Change Indicators: Heat Waves. US EPA. 2021.
4. Boyle P. Hurricanes, heat waves, fires, floods: Hospitals build defenses as climate change stirs the weather. AAMC. 2022.
5. Watts, N, et al. The 2018 Report of the Lancet Countdown on Health and Climate Change: Shaping the Health of Nations for Centuries to Come. The Lancet. 2018;392(10163):2479-2514.
6. Baugh J, et al. Beyond the Hazard Vulnerability Analysis: Preparing Health Systems for Climate Change. Rhode Island Medical Journal. 2021;104(9):55-59
7. Bees, J. How Health Care Leaders Respond to Climate Change. NEJM Catalyst. 2022;3(3).
8. Bose-O'Reilly S, et al. COVID 19-and Heat Waves: New Challenges for Healthcare Systems. Environmental Research. 2021;198:111153.
9. Fatima, SH, et al. Extreme Heat and Occupational Injuries in Different Climate Zones: A Systematic Review and Meta-Analysis of Epidemiological Evidence. Environ Int. 2021 Mar;148:106384.
10. CDC. Managing Diabetes in the Heat. Centers for Disease Control and Prevention. July 27 2022.
11. Harper, S.L., et al. Trends and Gaps in Climate Change and Health Research in North American. Environmental Research. 2021 Aug;199:111205.
12. American Society of Civil Engineers. 2021 Infrastructure Report Card. 2021.
13. Kim, DW, et al. Characteristics of Heat Waves from a Disaster Perspective. J Prev Med Public Health. 2020. Jan;53(1):26-28
14. Widerynski, S, et al. The Use of Cooling Centers to Prevent Heat-related Illness: Summary of Evidence and Strategies for Implementation. CDC. 2017

RELEVANT AMA AND AMA-MSS POLICY

Heat-Related Illness H-130.951

The AMA recognizes the significant public health threat imposed by heat-related emergencies, and provides the following policy: (1) Physicians should identify patients at risk for extreme heat-related illness such as the elderly, children, individuals with physical or mental disabilities, alcoholics, the chronically ill, and the socially isolated. Patients, family members, friends, and caretakers should be counseled about prevention strategies to avoid such illness. Physicians should provide patients at risk with information about cooling centers and encourage their use

during heat emergencies. (2) The AMA encourages patients at risk for heat-related illness to consider wearing appropriate medical identification.

CSA Rep. 10, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Hospital Disaster Plans and Medical Staffs H-225.941

Our AMA encourages: (1) appropriate stakeholders to examine the barriers and facilitators that medical staffs will encounter following a natural or other disaster; and (2) hospitals to incorporate, within their hospital disaster plans, workplace and personal preparedness efforts that reduce barriers to staff responses during a natural or other disaster, both within their institutions and across the community.

Res. 916, I-17

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.

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 MEDICAL STUDENT SECTION ASSEMBLY

Resolution 042
(I-22)

Introduced by: Rommel Morales, Megan Fainer, Madeline Foo, Northeast Ohio Medical University; Katherine Esser, Julianna Sim, University of Toledo; Maggie Stull, University of Kentucky; Christine Fasana, University of South Carolina

Subject: Advocating for Health Coverage Expansion for Post-COVID (Long-COVID) Conditions

Sponsored by: Region 4 and Region 5

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Known colloquially as Long-COVID or in literature as Post-Acute Sequelae of COVID (PASC), Post-COVID Conditions (PCC) as defined by the CDC consists of a diverse and seemingly disparate sequelae of symptoms following SARS CoV-2 infection longer than 12 weeks including, but not limited to, fluctuating and debilitating malaise, dyspnea, difficulty concentrating, GI symptoms, arthralgia, and myalgia¹⁻⁴; and

Whereas, The presentation of PCC can be episodic or sustained, with the presentation of novel symptoms, and or exacerbation of pre-existing conditions, such as cardiovascular, pulmonary, metabolic, and endocrine comorbidities⁵⁻⁶; and

Whereas, Reported instances of PCC currently affect or have affected an estimated 5.2 million people in the United States with many estimates, including those from John Hopkins and the CDC, being 3x-4x that rate when factoring unreported cases⁷; and

Whereas, PCC is especially prevalent among individuals under 65, Hispanics and Latinos, women, and non-college graduates⁸; and

Whereas, PCC can limit activities of daily living including but not limited to manual tasks, concentration, communication, caring for oneself, eating, and is classified as a disability under the Americans with Disabilities Act, Section 504 and Section 1557 in 2021⁹; and

Whereas, in adults with PCC who were employed prior to infection, 25% are now out of work, and 41% are working with reduced hours, disqualifying them from employee-sponsored health insurance¹⁰, and

Whereas, Among adults who have been disqualified from employee-sponsored health insurance, those who reside in one of the 12 states that have not adopted the Medicaid expansion may experience a significantly higher financial strain^{10,11}, and

Whereas, To qualify as having a disability for social security, a person must have "the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of no less than 12 months" - which can variably and inconsistently cover PCC dependent on the difficulties in and duration of diagnosis¹²; and

Whereas, Contingent on individual qualifications and geographical residence, patients on Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) have to wait anywhere from 1-3 years to qualify for social security and then health insurance, with an average acceptance rate of SSDI being 22% - thereby delaying financial support to patients with PCC¹³⁻¹⁵; and

Whereas, The variable symptomology of PCC compounds the cost burden to patients through the concurrent utilization of multiple specialists to solidify a PCC diagnosis and/or diagnose other underlying pathologies that PCC obfuscates (e.g. cancer, endocrine disorders, etc.), as well as delays in treatment due to the necessity of multiple specialists¹⁶⁻²¹; and

Whereas, Patients with PCC face complications regarding the diverse sequelae, spanning specialties such as pulmonology (dyspnea, cough), psychiatry (anxiety, depression, post-traumatic stress disorder), neurology (cognitive symptoms, "brain fog"), and cardiology (cardiac injury) - suggesting additive costs associated with these complications²²; and

Whereas, An estimate of more than 1 million Americans out of the workforce due to PCC would account for \$50 billion per year in lost wages, a projected \$9000 per year in medical treatments (when extrapolating from an analogous chronic fatigue syndrome), to an estimated economic cost of \$2.6 trillion²³⁻²⁴; and

Whereas, When subsidies for health care coverage under the American Rescue Plan expire after COVID, an estimated 3.7 million people would lose coverage benefits, 5 to 14 million people would be expelled from Medicaid, and 8 million will have premiums increase to at least double their current amount, and disadvantaged, minoritized groups who comprise the 42% of lower income enrollees would be disproportionately affected by these loss of benefits^{8,16,25}; and

Whereas, Current AMA policies, D-460.965 and D-70.943, that pertain to PCC center on the support of clinical study and education of post-viral or post-intensive care syndromes, rather than advocacy in healthcare access coverage; and

Whereas, AMA policy H-290.955, "Preventing Coverage Losses After the Public Health Emergency Ends", supports auto-transitions to alternate health insurance coverage, but does not explicitly include protections of expanded coverage currently in place under the American Rescue Plan; therefore be it

RESOLVED, That our AMA advocate to maintain coverage benefits for patients with Post-COVID Conditions (PCC) as expanded in the American Rescue Plan; and be it further

1 RESOLVED, that our AMA advocate for changing Social Security Disability Insurance and
 2 Supplemental Security Income qualification criteria to maximize Post-COVID Conditions (PCC)
 3 inclusion for disability benefits.
 4

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. PASC Fact Sheet. Recover - Researching COVID to Enhance Recovery. https://recovercovid.org/docs/pasc_initiative_fact_sheet.pdf. Accessed September 21, 2022.
2. Long COVID or Post-COVID Conditions. CDC. https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Flong-term-effects.html. Accessed August 31, 2022.
3. Long COVID - Your COVID Recovery. <https://www.yourcovidrecovery.nhs.uk/what-is-covid-19/long-covid/>. Accessed August 31, 2022.
4. Researching COVID to Enhance Recovery. *RECOVER* - Researching COVID to Enhance Recovery. <https://recovercovid.org/long-covid>. Accessed August 31, 2022.
5. Raveendran A.V., Jayadevan R., Sashidharan S. Long COVID: An overview. *Diabetes Metab Syndr*. 2021;15(3):869–875. doi: 10.1016/j.dsx.2021.04.007.
6. Fernández-de-Las-Peñas C., Florencio L.L., Gómez-Mayordomo V., Cuadrado M.L., Palacios-Ceña D., Raveendran A.V. Proposed integrative model for post-COVID symptoms [published online ahead of print, 2021 Jun 1] *Diabetes Metab Syndr*. 2021;15(4):102159. doi: 10.1016/j.dsx.2021.05.032.
7. CALCULATIONS & FORMULAS. Covid-19 Longhailer Advocacy Project. <https://www.longhailer-advocacy.org/calculations-formulas>. Accessed August 31, 2022.
8. Nearly One in Five American Adults Who Have Had COVID-19 Still Have “Long COVID.” https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/20220622.htm. Accessed August 31, 2022.
9. Guidance on “Long COVID” as a Disability Under the ADA, Section | HHS.gov. https://www.hhs.gov/civil-rights/for-providers/civil-rights-covid19/guidance-long-covid-disability/index.html#footnote10_0ac8mdc. Accessed August 31, 2022.
10. What are the Implications of Long COVID for Employment and Health Coverage? KFF. <https://www.kff.org/policy-watch/what-are-the-implications-of-long-covid-for-employment-and-health-coverage/>. Accessed August 31, 2022.
11. Phillips S, Williams MA. Confronting Our Next National Health Disaster — Long-Haul Covid. *N Engl J Med*. 2021;385(7):577-579. doi:10.1056/NEJMP2109285
12. Code of Federal Regulations § 404.1505. https://www.ssa.gov/OP_Home/cfr20/404/404-1505.htm. Accessed August 31, 2022.
13. Social Security Online - Medicare Information. <https://www.ssa.gov/disabilityresearch/wi/medicare.htm>. Accessed August 31, 2022.
14. Understanding SSI - SSI and Eligibility for Other Government and State Programs. <https://www.ssa.gov/ssi/text-other-ussi.htm>. Accessed August 31, 2022.
15. Annual Statistical Report on the Social Security Disability Insurance Program, 2017. Social Security Administration. https://www.ssa.gov/policy/docs/statcomps/di_asr/2017/di_asr17.pdf. Published October 2018. Accessed September 20, 2022.

16. Akpan N. How to get insurance coverage for long COVID as federal benefits get ready to expire. Gothamist. <https://gothamist.com/news/how-to-get-health-coverage-for-long-covid-as-pandemic-benefits-look-ready-to-expire>. Published June 15, 2022. Accessed August 31, 2022.
17. Raveendran AV, Misra A. Post COVID-19 Syndrome ("Long COVID") and Diabetes: Challenges in Diagnosis and Management. *Diabetes Metab Syndr*. 2021;15(5):102235. doi:10.1016/j.dsx.2021.102235
18. Mullangi S, Aviki EM, Chen Y, Robson M, Hershman DL. Factors Associated With Cancer Treatment Delay Among Patients Diagnosed With COVID-19. *JAMA Netw Open*. 2022;5(7):e2224296. doi:10.1001/jamanetworkopen.2022.24296
19. Taquet M, Dercon Q, Luciano S, Geddes JR, Husain M, Harrison PJ (2021) Incidence, co-occurrence, and evolution of long-COVID features: A 6-month retrospective cohort study of 273,618 survivors of COVID-19. *PLoS Med* 18(9): e1003773. <https://doi.org/10.1371/journal.pmed.1003773>
20. Nalbandian, A., Sehgal, K., Gupta, A. et al. Post-acute COVID-19 syndrome. *Nat Med* 27, 601–615 (2021). <https://doi.org/10.1038/s41591-021-01283-z>
21. Vance H, Maslach A, Stoneman E, et al. Addressing Post-COVID Symptoms: A Guide for Primary Care Physicians. *J Am Board Fam Med*. 2021;34(6):1229-1242. doi:10.3122/jabfm.2021.06.210254
22. DeMartino JK, Swallow E, Goldschmidt, Yang K, Viola M, Radtke T, Kirson N. Direct health care costs associated with COVID-19 in the United States. *J Manag Care Spec Pharm*, 2022 Sep;28(9):936-947.
23. Cutler DM, Summers LH. The COVID-19 Pandemic and the \$16 Trillion Virus. *JAMA*. 2020;324(15):1495–1496. doi:10.1001/jama.2020.19759
24. Cutler DM. The Costs of Long COVID. *JAMA Health Forum*. 2022;3(5):e221809. doi:10.1001/jamahealthforum.2022.1809
25. Cox C, Pollitz K, Ramirez G. How Marketplace Costs and Premiums will Change if Rescue Plan Subsidies Expire. Kaiser Family Foundation. <https://www.kff.org/policy-watch/how-marketplace-costs-premiums-will-change-if-rescue-plan-subsidies-expire/>. Published September 24, 2021. Accessed September 21, 2022.

RELEVANT AMA AND AMA-MSS POLICY

Call for Increased Funding, Research and Education for Post Viral Syndromes D-460.965

Our AMA: (1) supports the development of an ICD-10 code or family of codes to recognize Post-Acute Sequelae of SARS-CoV-2 infection ("PASC" or "Long COVID") and other novel post-viral syndromes as distinct diagnoses; (2) will advocate for legislation to provide funding for research, prevention, control, and treatment of post viral syndromes and long-term sequelae associated with viral infections, such as COVID-19; (3) will provide physicians and medical students with accurate and current information on post-viral syndromes and long-term sequelae associated with viral infections, such as COVID-19; and (4) will collaborate with other medical and educational entities to promote education among patients about post viral syndromes and long-term sequelae associated with viral infections, such as COVID-19, to minimize the harm and disability current and future patients face.

Alt. Res. 410, A-21

Increased Funding, Research and Education for Post-Intensive Care Syndrome D-70.943

Our AMA: (1) supports the development of an ICD-10 code or family of codes to recognize Post-Intensive Care Syndrome (PICS); and (2) will advocate for legislation to provide funding for research and treatment of PICS, including for those cases related to COVID-19.

Res. 121, A-22

Preventing Coverage Losses After the Public Health Emergency Ends H-290.955

1. Our AMA encourages states to facilitate transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate health insurance coverage for which the individual is eligible, and that auto-transitions meet the following standards:
 - a. Individuals must provide consent to the applicable state and/or federal entities to share information with the entity authorized to make coverage determinations.
 - b. Individuals should only be auto-transitioned 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.
 - c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-transitioned.
 - d. Individuals should not be penalized if they are auto-transitioned into coverage for which they are not eligible.
 - e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
 2. Our AMA supports coordination between state agencies overseeing Medicaid, Affordable Care Act marketplaces, and workforce agencies that will help facilitate health insurance coverage transitions and maximize coverage.
 3. Our AMA supports federal and state monitoring of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and uninsured rates.
- CMS Rep. 3, A-22

Status Report on Expanding Health Care Coverage to all Individuals, with an Emphasis on the Uninsured D-165.955

1. Our AMA will continue to: (1) place a high priority on expanding health insurance coverage for all; (2) pursue bipartisan support for individually selected and owned health insurance through the use of adequately funded federal tax credits as a preferred long-term solution for covering all; and (3) explore and support alternative means of ensuring health care coverage for all.
 2. Our AMA Board of Trustees will consider assisting Louisiana, and other Gulf Coast States if they should desire, in developing and evaluating a pilot project(s) utilizing AMA policy as a means of dealing with the impending public health crisis of displaced Medicaid enrollees and uninsured individuals as a result of the recent natural disasters in that region.
- CMS Rep. 1, I-05; Reaffirmed in lieu of Res. 101, A-13

Social Security Disability Medical Benefits D-330.961

Our AMA will continue to monitor future research and related developments on Medicare benefits for Social Security disability recipients, and will report and recommend further action to the House of Delegates as appropriate.

Sub Res. 101, A-03; Reaffirmed: CMS Rep. 4, A-13

Evaluation of the Principles of the Health Care Access Resolution 165.009MSS

- (1) AMA-MSS supports efforts to make health care more cost-effective by reducing administrative burdens, but only to such a degree that quality of care is not compromised; (2) AMA-MSS supports means of including both long-term care and prescription drug benefits into the guidelines for seeking affordable universal health care access and coverage; (3) AMA-MSS encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality of health care; and that our AMA-MSS supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons; (4) AMA-MSS will adopt policy to promote outcomes research as an effective mechanism to improve the quality of medical care for all persons and urge that the results of

such research be used only for educational purposes and for improving practice parameters; (5) AMAMSS will adopt policy to address the need to increase numbers of qualified health care professionals, practitioners, and providers in underserved areas to increase timely access to quality care; (6) AMA-MSS supports the inclusion of adequate and timely payments to physicians and other providers into any plan calling for affordable universal health care access; (7) AMA-MSS supports the inclusion of the principles of continuity of health insurance coverage and continuity of medical care into any plan calling for affordable universal health care access; (8) AMA-MSS supports the inclusion of the principle of consumer choice of healthcare providers and practitioners into any plan calling for affordable universal health care access; (9) AMA-MSS supports the inclusion of reducing health care administrative cost and burden into any plan calling for affordable universal health care access. (MSS Rep C, A-04) (Modified: MSS GC Rep B, I-09) (Modified: GC Rep A, I-16) (Reaffirmed: MSS GC Report A, I-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 043
(I-22)

Introduced by: Samuel Oshoba, Bryan Ubanwa, Benjamin Akande, Faith Portuphy, Daniel Nyancho, Chioma Owo, Ndanzia Mpunga, David Nweke, University of Texas Health San Antonio; Darby Billing, University of South Carolina School of Medicine Greenville

Subject: Researching New CCHD Screening Practices in Pigmented Neonates.

Sponsored by: Asian Pacific American Medical Student Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, CCHD refers to congenital heart defects that, when untreated, can present emergently within the first year of life with a large mortality risk without timely intervention¹; and

Whereas, Critical congenital heart disease (CCHD) is a common and serious birth defect, that affects an estimated 1/500 US newborns, and causes significant mortality in neonates^{2,3}; and

Whereas, CCHD emergently presents with shock, respiratory distress, and cyanosis¹; and

Whereas, Neonates with CCHD may have low blood oxygen levels, detected by pulse oximetry^{3,4}; and

Whereas, 20-30% of CCHD cases are not detected early (during neonatal hospitalization period)⁵; and

Whereas, The mortality rate for late detection is twice of those detected early⁵; and

Whereas, All 50 states have CCHD screening policies in place that primarily utilize pulse oximetry as their objective tool²; and

Whereas, While universal CCHD screening in the US allows many CCHDs to be detected, with a sensitivity of 42.86% in finding CCHD, pulse oximetry in isolation leaves opportunity for false negatives^{5,6}; and

Whereas, It has been noted that pulse oximetry has discrepancies in accuracy across racial groups of infants, with the odds ratio of occult hypoxemia being 2.16 for Black patients when compared with White patients^{7,8}; and

Whereas, It has been noted that pulse oximetry discrepancies exist for multiple pigmented groups, with oxygen saturation being overestimated by 2.1% for Asian patients, 1.4% for Black patients, and 0.8% for non-Black Hispanic patients⁷; and

Whereas, Echocardiography was associated with the highest detection rate for CCHD⁹; and

Whereas, The most common critical lesions that cause hypoxemia in newborns such as hypoplastic left heart syndrome, pulmonary atresia, tetralogy of Fallot, total anomalous pulmonary venous return, transposition of the great arteries, tricuspid atresia, and truncus arteriosus are all structurally identifiable by echocardiogram¹⁰; therefore be it

RESOLVED, That our AMA support the research of utilizing alternatives to pulse oximetry as a CCHD screening tool due to the overestimated oxygen saturation in pigmented individuals, such as echocardiography; and be it further

RESOLVED, That our AMA support the research of appropriate oxygen saturation targets variable by pigmentation in neonates to decrease the risk of occult hypoxemia in pigmented neonates.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Colombo J, Boyer P J, White S. Diagnosis and Management of Infants With Critical Congenital Heart Disease in the Emergency Department. Relias Media. 2019. Published 2019, December 1.
2. Glidewell J, Grosse SD, Riehle-Colarusso T, et al. Actions in Support of Newborn Screening for Critical Congenital Heart Disease - United States, 2011-2018. MMWR Morb Mortal Wkly Rep. 2019;68(5):107-111. Published 2019 Feb 8. doi:10.15585/mmwr.mm6805a3
3. Plana MN, Zamora J, Suresh G, Fernandez-Pineda L, Thangaratinam S, Ewer AK. Pulse oximetry screening for critical congenital heart defects. Cochrane Database Syst Rev. 2018;3(3):CD011912. Published 2018 Mar 1. doi:10.1002/14651858.CD011912.pub2
4. Martin GR, Ewer AK, Gaviglio A, et al. Updated strategies for pulse oximetry screening for critical congenital heart disease. Pediatrics. 2020;146(1). doi:10.1542/peds.2019-1650
5. Danworapong S, Nakwan N, Napapongsuriya C, Choksuchat D, Danworaphong S. Assessing the use of pulse oximetry screening for critical congenital heart disease in asymptomatic term newborns. Journal of Clinical Neonatology. 2019;8(1):28. doi:10.4103/jcn.jcn_79_18
6. Arvind B, Saxena A, Ramakrishnan S. Utility of pulse-oximetry screening in newborns with nonductus-dependent cyanotic congenital heart defects: A reason to alarm?. Ann Pediatr Cardiol. 2022;15(1):41-43. doi:10.4103/apc.apc_9_22

7. Andrist E, Nuppnau M, Barbaro RP, Valley TS, Sjoding MW. Association of race with Pulse Oximetry Accuracy in hospitalized children. JAMA Network Open. 2022;5(3). doi:10.1001/jamanetworkopen.2022.4584
8. Vesoulis, Z., Tims, A., Lodhi, H. et al. Racial discrepancy in pulse oximeter accuracy in preterm infants. J Perinatol 42, 79–85 2022. <https://doi.org/10.1038/s41372-021-01230-3>
9. Bradshaw EA, Martin GR. . Screening for critical congenital heart disease. Current Opinion in Pediatrics. 2012; 24 (5):603-608. doi: 10.1097/MOP.0b013e328357a843.
10. Oster ME, Aucott SW, Glidewell J, et al. Lessons Learned From Newborn Screening for Critical Congenital Heart Defects. Pediatrics. 2016;137(5):e20154573. doi:10.1542/peds.2015-4573

RELEVANT AMA AND AMA-MSS POLICY

Standardization of Newborn Screening Programs H-245.973

Our AMA:

- (1) recognizes the need for uniform minimum newborn screening (NBS) recommendations.
- (2) encourages continued research and discussions on the potential benefits and harms of NBS for certain diseases.
- (3) supports screening for critical congenital heart defects for newborns following delivery prior to hospital discharge.

CSAPH Rep. 9, A-06; Reaffirmed in lieu of Res. 502, A-09; Reaffirmed: CSAPH Rep. 01, A-19; Appended: Res. 511, A-19

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

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

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

which the proportion of women accepting HIV testing is low should evaluate their methods to determine how they can achieve greater success.

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

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

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

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

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

(10) Health care professionals should be educated about the benefits of universal HIV testing, with patient notification of the right of refusal, as a routine component of prenatal care, and barriers that may prevent implementation of universal HIV testing as a routine component of prenatal care should be addressed and removed. Federal funding for efforts to prevent perinatal HIV transmission, including both prenatal testing and appropriate care of HIV-infected women, should be maintained.

CSA Rep. 4, A-03; Reaffirmed: CEJA Rep. 3, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Preconception Care H-425.976

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

(1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan;

(2) Consumer awareness--increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts;

- (3) Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes;
 - (4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact);
 - (5) Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth);
 - (6) Pre-pregnancy checkup--offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy;
 - (7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception care;
 - (8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes;
 - (9) Research--increase the evidence base and promote the use of the evidence to improve preconception health; and
 - (10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor preconception health.
2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health.
3. Our AMA supports the use of pregnancy intention screening and contraceptive screening in appropriate women and men as part of routine well-care and recommend it be appropriately documented in the medical record.

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

Standardization of Newborn Screening Programs H-245.973

Our AMA:

- (1) recognizes the need for uniform minimum newborn screening (NBS) recommendations;
- (2) encourages continued research and discussions on the potential benefits and harms of NBS for certain diseases; and
- (3) supports screening for critical congenital heart defects for newborns following delivery prior to hospital discharge.

CSAPH Rep. 9, A-06; Reaffirmed in lieu of Res. 502, A-09; Reaffirmed: CSAPH Rep. 01, A-19; Appended: Res. 511, A-19

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 044
(I-22)

Introduced by: Alexandra Yorks, Amanda Paskavitz, Denise Bilbao, Alexander Eskandarian
Wayne State University School of Medicine; Hunter Kramer, Kansas City
University College of Osteopathic Medicine; Brittany Hodges, University of
Rochester School of Medicine and Dentistry; Amber Lockner, University of
Oklahoma Health Sciences Center; Jessyca Judge, Michigan State
University College of Human Medicine

Subject: Environmental Health Equity in Federally Subsidized Housing

Sponsored by: Region 4, Region 5, Association of Native American Medical Students

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

1 Whereas, In the 1980s, the government passed legislation known as the Comprehensive
2 Environmental Response, Compensation and Liability Act of 1980 (CERCLA) to assist the
3 Environmental Protection Agency (EPA) in identifying and remediating the country's most
4 dangerously contaminated sites by setting aside a 'Superfund' of money¹; and
5

6 Whereas, The Superfund set aside by CERCLA went bankrupt in 2003 leaving cleanup and
7 remediation projects, with estimated costs of \$15-100 million, to be funded solely through tax
8 revenue²; and
9

10 Whereas, Supreme Court rulings starting in 2008 with Burlington Northern v. the United States
11 have severely reduced the financial liability of polluters, stalling funding for the Superfund
12 program²; and
13

14 Whereas, CERCLA defines hazardous substances as elements and compounds which present
15 an imminent and substantial danger to the public health and welfare of living creatures and
16 waterfronts¹; and
17

18 Whereas, Hazardous substances defined by CERCLA include but are not limited to lead,
19 hexavalent chromium, radium, and polychlorinated biphenyl chemicals (PCBs), are known
20 hazards to human health, causing intellectual and behavioral delays, anemia, lung disease,
21 inflammatory diseases, cancers, adverse effects on fertility, and prenatal development^{3,4,5,6}; and
22

23 Whereas, The geographic areas identified through CERCLA contaminated with known
24 hazardous substances are commonly referred to as Superfund sites¹; and
25

Whereas, As of 2020, 73 million people live within 3 miles of a Superfund site which is roughly 22% of the U.S. population⁷; and

Whereas, Proximity to environmental hazards increases the risk for lifelong chronic mental and physical illnesses, including but not limited to cancer, congenital disabilities, and developmental disabilities⁹; and

Whereas, In Texas, East Houston's Fifth Ward, a community with proximity to three Superfund sites, there is a pediatric and adult cancer cluster with 43 percent of households reporting a cancer diagnosis¹⁰; and

Whereas, According to an evaluation performed by the Office of Inspector General in 2019, 18,158 properties owned, subsidized, or managed by the Department of Housing and Urban Development (HUD) are located within one mile of Superfund sites¹¹; and

Whereas, The majority of people living in federally subsidized housing belong to racial and ethnic minority groups, subjecting these groups to a disproportionate amount of environmental hazards exposure leading to inequitable health outcomes⁸; and

Whereas, Neither the EPA, the Department of Housing and Urban Development, states, cities, nor realtors are obligated to disclose proximity to Superfund sites upon purchase or lease agreement leaving citizens unaware of the health hazards they and their children face until they are grappling with long-term consequences¹²; and

Whereas, Those who rent their home are significantly less likely than homeowners to know that they live in close proximity to Superfund sites¹³; and

Whereas, There is often a disconnect between environmental protection organizations and community members near superfund sites, with residents of nearby communities often lacking adequate knowledge to assess the environmental hazards around them¹⁴; and

Whereas, A potential strategy for mitigating the lack of community knowledge of environmental exposures is to put communication processes in place to anticipate the potential for disconnect and seek regular feedback from community members¹⁴; and

Whereas, The Residential Lead-Based Paint Hazard Reduction Act of 1992 establishes guidelines to "educate the public concerning the hazards and sources of lead-based paint poisoning and steps to reduce and eliminate such hazards", demonstrating that the precedent for hazardous substance disclosure has already been established¹⁵; and

Whereas, The disclosures described in the Residential Lead-Based Paint Hazard Reduction Act of 1992, which include the explicit disclosure of lead-based paint in the property, a warning statement signed by both purchaser and seller, and a lead hazard information packet, do not extend to other environmental hazards which may be present at each site¹⁵; and

Whereas, The “right to know” principle applied to public health ethics allows for individual autonomy in decision making with respect to awareness of environmental hazard exposure¹⁶; and

Whereas, Disclosure of known environmental health risks would promote informed decision-making supporting individual autonomy.¹⁶; and

Whereas, The majority of those exposed to Superfund sites and living in federally subsidized housing are recipients of Medicaid or Medicare benefits, however, Medicare coverage is only available for Americans over the age of 65, with a few exceptions for those with chronic diseases such as end-stage renal failure and ALS or a disability¹⁷; and

Whereas, Section 1395rr-1 of the Social Security Act established a program to provide Medicare eligibility to those who have been exposed to environmental health hazards, however, this program is limited to individuals in Idaho, Montana, and Washington¹⁸; and

Whereas, Environmental health-related care includes but is not limited to blood hazardous substance screening, fertility, and prenatal testing, pediatric cognitive and behavioral delays screening, and prescriptions for heavy metal chelating drugs^{3,4,5,9}; and

Whereas, Planning and execution of a Superfund site cleanup may take years to decades as evidenced by the over 1,800 Superfund sites, as of January 4, 2022, that have been marked for clean-up for decades without completed remediation^{12,19}; and

Whereas, Communities residing on or near Superfund sites may have to wait years even after a clean-up project has been initiated for the toxin levels in their environment to reach levels acceptable for residential use¹⁹; and

Whereas, Although the EPA and community organizations work to remediate the Superfund sites fully, the EPA admits some sites may never reach environmental toxin levels safe for residential use²⁰; and

Whereas, Under CERCLA, the EPA maintains the right to establish Alternate Concentration Limits (CLs) for use in Superfund cleanups that may fall below the standards of widely used pollutant limits²⁰; and

Whereas, The EPA maintains the right to waive violations of other state and federal regulations on toxin levels due to “technical infeasibility” in order to approve a Superfund cleanup²⁰; and

Whereas, The current HUD-EPA agreement only requests yearly status reports on contaminant levels and environmental indicators at active Superfund sites, subject to the availability of the agency’s funding and manpower, and EPA guidelines suggest no follow-up or follow-up monitoring only every five years at deleted Superfund sites^{12, 21}; and

1 Whereas, The creation of new federally subsidized housing developments on land free of
2 environmental toxins provides immediate removal of communities from the environmental
3 hazards of older housing developed on or near Superfund sites²²; and
4

5 Whereas, Our AMA policy H-135.996 addresses the existence of environmental pollution and
6 supports research into its threat to human health; and
7

8 Whereas, Our AMA policy H-135.996 supports efforts to alert the American people to the
9 dangers of general environmental pollution, however, it does not go far enough to ask for
10 mandated disclosure to residents in known areas of environmental risk; and
11

12 Whereas, Our AMA policy H-135.996 does not directly address the need for expansion of
13 federally funded health insurance coverage of services to specifically address the health risk
14 associated with residing in or near polluted environments; and
15

16 RESOLVED, That our AMA advocate for federally mandated disclosure of Superfund site
17 proximity and potential threat assessments to those purchasing, leasing, or currently residing in
18 federally subsidized housing; and be it further
19

20 RESOLVED, That our AMA advocates for the expansion of Medicare and Medicaid to provide,
21 free of cost, environmental health-related care including but not limited to blood testing, prenatal
22 screening, intellectual delay screenings, and prescriptions for heavy metal chelating drugs; and
23 be it further
24

25 RESOLVED, That our AMA support efforts to expand Medicare and Medicaid eligibility to those
26 residing in housing in proximity to Superfund sites; and be it further
27

28 RESOLVED, That the AMA advocate for policies that expand the construction of new federally
29 subsidized housing properties on land proven to be free of known hazardous pollutants
30 including but not limited to lead, hexavalent chromium, radium, perfluorinated chemicals (PFCs),
31 and polychlorinated biphenyl chemicals (PCBs); and be it further
32

33 RESOLVED, That our AMA advocate for existing federally subsidized housing properties to be
34 vacated at the same rate as construction of new federally subsidized housing properties to
35 mitigate damage to current residents.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Comprehensive Environmental Response, Compensation, and Liability Act, 42 U.S.C. §9601 et seq. (1980)
2. Superfund. National Geographic Society. May 19, 2022.

3. Hessel EVS, et al. Occupational exposure to hexavalent chromium. Part I. Hazard assessment of non-cancer health effects. *Regul Toxicol Pharmacol.* 2021;126:105048.
4. Mitra P, et al. Clinical and molecular aspects of lead toxicity: An update. *Crit Rev Clin Lab Sci.* 2017;54(7-8):506-528.
5. Sanders T, et al. Neurotoxic effects and biomarkers of lead exposure: a review. *Rev Environ Health.* 2009;24(1):15-45.
6. Gómez-Roig MD, et al. Environmental exposure during pregnancy: Influence on prenatal development and early life: A comprehensive review. *Fetal Diagnosis and Therapy.* 2021;48(4):245-257.
7. U.S. EPA, Office of Land and Emergency Management 2020. Data collected includes: (1) Superfund site information from SEMS as of the end of FY2019 and site boundary data from FY 2014 FOIA Request; and (2) population data from the 2015-2018 American Community Survey.
8. "Resident Characteristics Report." Inventory Management System, Public and Indian Housing, 31 Aug. 2022, <https://hudapps.hud.gov/public/picj2ee/Mtcsrcl>.
9. Johnston J, et al. Chemical exposures, health, and environmental justice in communities living on the Fenceline of Industry. *Current Environmental Health Reports.* 2020;7(1):48-57.
10. IMPACT health Survey. <https://www.houstontx.gov/health/NewsReleases/IMPACT-health-survey-20200121.html>. Published January 21, 2020.
11. Office of Inspector General. *Contaminated Sites Pose Potential Health Risks to Residents at HUD Funded Properties.* 2019. OE-0003
12. Memorandum of Understanding between the U.S. Department of Housing and Urban Development and the U.S. Environmental Protection Agency regarding Improving Communication About HUD Public and Multifamily-Assisted Housing and Superfund Sites. March, 03, 2022.
13. Rhubart D, et al. The Right to Knowledge and the Superfund Program: A Fundamental Cause Approach to Disparities in Resident Awareness of Hazardous Waste Sites. *Environmental Justice.* Oct 2020. 181-188
14. Nagisetty R, et al. Environmental health perceptions in a superfund community, *Journal of Environmental Management*, Volume 261, 2020, 110151
15. Residential Lead-Based Paint Hazard Reduction Act, S.2341, (1992)
16. Lambert TW, et al. Ethical perspectives for public and environmental health: fostering autonomy and the right to know. *Environ Health Perspect.* 2003;111(2):133-137.
17. Department of Health and Human Services. *Picture Of Housing And Health: Medicare And Medicaid Use Among Older Adults In Hud-Assisted Housing.* 2014
18. Medicare coverage for individuals exposed to environmental health hazards, 42 U.S.C. 1395rr-1
19. EPA. <https://www.epa.gov/superfund/superfund-cleanup-process>. Accessed August 26, 2022.
20. United States Environmental Protection Agency. *Use of Alternate Concentration Limits (CLs) in Superfund Cleanups.* 2005
21. U.S. Finishing/Cone Mills Superfund Site slated for Partial Deletion from Superfund National Priorities List. August 2022. <https://www.epa.gov/newsreleases/us-finishingcone-mills-superfund-site-slated-partial-deletion-superfund-national#:~:text=When%20hazardous%20substances%20and%20pollutants,protect%20people%20and%20the%20environment>.
22. Caputo A, Lerner S. Thousands of public housing residents live near the most polluted places in the nation - and the government has done little to protect them. *American Public Media Reports.* <https://www.apmreports.org/story/2021/01/13/public-housing-near-polluted-superfund-sites>. Published May 4, 2022.

RELEVANT AMA AND AMA-MSS POLICY

Pollution Control and Environmental Health H-135.996

Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.

Sub. Res. 40, A-70Reaffirmed: CLRPD Rep. C, A-89Reaffirmed: Sunset Report, A-00Modified: CSAPH Rep. 1, A-10Reaffirmed: CSAPH Rep. 01, A-20

Modern Chemicals Policies H-135.942

Our AMA supports: (1) the restructuring of the Toxic Substances Control Act to serve as a vehicle to help federal and state agencies to assess efficiently the human and environmental health hazards of industrial chemicals and reduce the use of those of greatest concern; and (2) the Strategic Approach to International Chemicals (SAICM) process leading to the sound management of chemicals throughout their life-cycle so that, by 2020, chemicals are used and produced in ways that minimize adverse effects on human health and the environment.

Sub. Res. 404, A-08Reaffirmation A-10Reaffirmed: CSAPH Rep. 5, A-11Reaffirmation I-16Reaffirmed in lieu of: Res. 505, A-19

Research into the Environmental Contributors to Disease D-135.997

Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

Res. 402, A-03Appended: Res. 927, I-11Reaffirmed in lieu of: Res. 505, A-19

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 045
(I-22)

Introduced by: Manasvi Khullar, Megha Patel, Himani Aligireddy, Abby Ao, Touro University
California College of Osteopathic Medicine

Subject: Increase Resident Physician Pay

Sponsored by: American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Resident physicians are an integral part of the healthcare system, working alongside physicians, physician assistants, nurse practitioners, and other healthcare workers; and

Whereas, Upon completion of medical school, entering interns/residents have completed an average of 6,000 hours of clinical training¹; and

Whereas, Upon completion of a master's program or Doctor of Nursing Practice, Nurse Practitioners have completed 500-1,500 hours of clinical training¹; and

Whereas, Upon completion of a master's program, Physician Assistants have completed 1,600 hours of clinical training²; and

Whereas, The average medical resident earned \$64,200 annually in 2022 according to Medscape's Resident Salary and Debt Report³; and

Whereas, New graduate physician assistants were expected to earn between \$80,000 to \$84,200 in 2014⁴; and

Whereas, Nurse Practitioners with fewer than five years of experience earned around \$104,000 in 2019⁵; and

Whereas, The average medical school debt in 2021 is \$215,900 excluding premedical undergraduate and other educational debt that compounds during graduate medical training⁶; and,

Whereas, 76-89% of medical school graduates have educational debt⁶; and,

Whereas, The average physician assistant school debt is \$115,760 excluding premedical undergraduate and compound interest during educational years⁷; and,

Whereas, The average living wage in the United States for a family of four is \$100,498.60 in 2021⁸; and

Whereas, The consumer price index, a marker for inflation, rose 8.6 % from May of 2021 to May of 2022; the sharpest increase since 1981⁹; and

Whereas, 41 percent of residents and fellows have at least one child and 33 percent of those parents planned on having another during their current training program¹⁰; and

Whereas, The average cost of childcare has increased since pre-pandemic times by 41% to \$14,117¹¹; and

Whereas, Pay for first year internal medicine resident physicians was found to be poorly correlated with cost of living¹²; and,

Whereas, 1 in 5 residents work 70 hours per week or more and 62% of first year residents work 60+ hours per week¹³; and

Whereas, 58% of medical residents stated that they sometimes, often or always experienced feelings of burnout during their training¹⁴; and

Whereas, Compared to the general population, resident physicians are at a greater risk for burnout and depressive disorders^{15,16,17}; and

Whereas, 93% of residents listed earning a good income as very or somewhat concerning, compared to other concerns¹⁴; and

Whereas, 86% of residents were dissatisfied with compensation because of its poor reflection on the number of hours worked and the required skill level of the job¹⁸; and

Whereas, The AAMC predicted a physician shortage of 121,900 physicians by the year 2032¹⁹; and

Whereas, Resident pay is funded from a variety of sources such as Medicare funding for Graduate Medical Education which was capped in 1997 by the Balanced Budget Act, Medicaid, teaching hospitals, and private payers²⁰; and

Whereas, Although resident pay is determined by a variety of factors, teaching hospitals have the ability to increase resident salaries²⁰; and

Whereas, Residents increase the profits of hospital systems by billing more than they cost and by increasing patient load capabilities^{20,21}; and

Whereas, Our AMA already 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 via D-305.967; and

Whereas, Our AMA already supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians via H-305.988; and

Whereas, We propose the following changes to the existing resolution: Resident Bill of Rights H310.912; therefore be it

1 RESOLVED, that our AMA, to improve their commitment to representing all physician at all
2 points of their training, amend AMA amend policy H310.912 (Resident Bill of Rights):

3
4 **Resident Bill of Rights, H310.912**

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

6 (2) With regard to compensation, residents and fellows should receive: a.
7 Compensation for time at orientation; and b. Salaries commensurate with their
8 level of training and experience. Compensation should reflect cost of living
9 differences based on local economic factors, such as housing, transportation,
10 and energy costs (which affect the purchasing power of wages), and include
11 appropriate adjustments for changes in the cost of living, tied to the federal rate
12 of inflation as outlined by the U.S. Department of Labor.

13 and be it further

14
15 RESOLVED, that our AMA, to improve their commitment to representing all physician at all
16 points of their training, amend AMA policy H310.912 (Resident Bill of Rights):

17
18 **Resident Bill of Rights, H310.912**

19 10. Our AMA believes that healthcare trainee salary, benefits, and overall compensation
20 should, at minimum, reflect length of pre-training education, hours worked, and level of
21 independence and complexity of care allowed by an individual's training program ~~(for~~
22 ~~example when comparing physicians in training and midlevel providers at equal~~
23 ~~postgraduate training levels)~~ to be directly competitive with midlevel providers at equal
24 post-graduate training levels.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Compare the Education Gaps Between Primary Care Physicians and Nurse Practitioners. Texas Academy of Family Physicians.
<https://www.taftp.org/Media/Default/Downloads/advocacy/scope-education.pdf>. Accessed August 30, 2022.
2. Minimum clinical training requirements. Emory & Henry College.
<https://www.ehc.edu/live/profiles/3000-minimum-clinical-training-requirements>. Accessed August 30, 2022.
3. Robbins R. Medscape Residents Salary & Debt Report 2022. Medscape.
<https://www.medscape.com/slideshow/2022-residents-salary-debt-report-6015490?reg=1#2>. Published July 29, 2022. Accessed August 30, 2022.
4. AAPA salary report. American Academy of Physician Assistants.
https://www.aapa.org/wp-content/uploads/2016/12/2014_New_Graduate_Salary_Report.pdf. Published 2014. Accessed August 30, 2022.
5. Behring S, Hunt S, DeGarmo S. Nurse Practitioner Salary Guide. All Nursing Schools.
<https://www.allnursingschools.com/nurse-practitioner/salary/>. Published June 22, 2022. Accessed August 31, 2022.
6. Hanson M. Average Medical School Debt. Education Data Initiative.
<https://educationdata.org/average-medical-school-debt>. Published December 9, 2021. Accessed September 22, 2022.

7. Bruza-Augatis M, Hooker RS, Coombs JM. Financial Analysis of PA Lifetime earnings and debt. *Journal of the American Academy of Physician Assistants*. 2021;34(11):1-9. doi:10.1097/01.jaa.0000800020.12927.8c
8. Moser S, Swalina C. Living wage calculator. Living Wage Calculator. <https://livingwage.mit.edu/articles/99-a-calculation-of-the-living-wage>. Published May 19, 2022. Accessed September 22, 2022.
9. Cox J. Inflation rose 8.6% in May, highest since 1981. CNBC. <https://www.cnbc.com/2022/06/10/consumer-price-index-may-2022.html>. Published June 11, 2022. Accessed August 30, 2022.
10. Blair JE, Mayer AP, Caubet SL, Norby SM, O'Connor MI, Hayes SN. Pregnancy and Parental Leave During Graduate Medical Education. *Acad Med*. 2016;91(7):972-978. doi:10.1097/ACM.0000000000001006
11. Sherman R. The Childcare Conundrum. *Nurse Leader*. August 2022. doi:10.1016/j.mnl.2022.07.002
12. Pasha AS, Al Shabeeb R. Do Differences in Internal Medicine Resident Salaries Correlate with Variation in Regional Cost of Living? *J Gen Intern Med*. 2020Aug;35(8):2508-2509. doi: 10.1007/s11606-019-05471-z.
13. Landi H. Most medical residents are dissatisfied with their salaries. here's how much more they want to be paid. Fierce Healthcare. <https://www.fiercehealthcare.com/practices/most-medical-residents-dissatisfied-their-compensation-here-s-how-much-more-they-want-to>. Published August 25, 2020. Accessed September 22, 2022.
14. Hawkins M. 2021 - Merritt Hawkins Survey of Final Year Medical Residents. <https://www.merrithawkins.com/uploadedFiles/merritt-hawkins-2021-resident-survey.pdf>. Published May 2021. Accessed September 22, 2022.
15. Mata DA, Ramos MA, Bansal N, et al. Prevalence of Depression and Depressive Symptoms Among Resident Physicians: A Systematic Review and Meta-analysis. *JAMA*. 2015;314(22):2373-2383. doi:10.1001/jama.2015.15845
16. Dyrbye LN, West CP, Satele D, et al. Burnout among U.S. medical students, residents, and early career physicians relative to the general U.S. population. *Acad Med*. 2014;89(3):443-451. doi:10.1097/ACM.0000000000000134
17. West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences and solutions. *J Intern Med*. 2018;283(6):516-529. doi:10.1111/joim.12752
18. Ogawa R, Seo E, Maeno T, Ito M, Sanuki M, Maeno T. The relationship between long working hours and depression among first-year residents in Japan. *BMC Med Educ*. 2018 Mar 27;18(1):50. doi: 10.1186/s12909-018-1171-9. PMID: 29587738; PMCID: PMC5870810.
19. AAMC report reinforces mounting physician shortage. AAMC. <https://www.aamc.org/news-insights/press-releases/aamc-report-reinforces-mounting-physician-shortage>. Published June 11, 2021. Accessed August 31, 2022.
20. He K, Whang E, Kristo G. Graduate Medical Education Funding Mechanisms, challenges, and solutions: A narrative review. *The American Journal of Surgery*. 2021;221(1):65-71. doi:10.1016/j.amjsurg.2020.06.007
21. Feinstein AJ, Deckelbaum DL, Madan AK, McKenney MG. Unsupervised procedures by surgical trainees: a windfall for private insurance at the expense of graduate medical education. *J Trauma*. 2011;70(1):136-140. doi:10.1097/TA.0b013e3182014caf

RELEVANT AMA AND AMA-MSS POLICY

Residents' Salaries H-305.930

Our AMA supports appropriate increases in resident salaries.
Res. 307, A-05; Reaffirmed: CME Rep. 1, A-15

Residents and Fellows' Bill of Rights H-310.912

Residents and fellows have a right to:

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

(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.

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).

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

Resident Pay During Orientation D-310.967

Our AMA will advocate that all resident and fellow physicians should be compensated, and receive benefits, at a level commensurate with the pay that they will receive while in their training program, for all days spent in required orientation activities prior to the onset of their contractual responsibilities.

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

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.

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.

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

Cost and Financing of Medical Education and Availability of First-Year Residency Positions H-305.988

- 10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
 - 11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
 - 12. will advocate that resident and fellow trainees should not be financially responsible for their training.
- CME Rep. A, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Res. 313, I-95; Reaffirmed by CME Rep. 13, A-97; Modified: CME Rep. 7, A-05; Modified: CME Rep. 13, A-06; Appended: Res. 321, A-15; Reaffirmed: CME Rep. 05, A-16; Modified: CME Rep. 04, A-16; Reaffirmation: A-22

310.034 MSS Compensation for Resident/Fellow Physicians

The AMA-MSS recognizes the tremendous value of GME for patients and supports systems wherein adequate compensation is provided during GME training and supports the following AMA-MSS Digest of Policy Actions/ 175 principles regarding resident/fellow compensation: 1. The AMA-MSS supports reforming the current system of determining residents' salaries so that a resident's level of training, cost of living, whether or not they work in an underserved area, and other factors relevant to appropriate compensation of residents are taken into account. 2. The AMA-MSS asks that our AMA (a) work with the Accreditation Council for Graduate Medical Education and other appropriate agencies to assure that the terms of employment for resident physicians reflect the unique and extensive amount of education and experience acquired by physicians; (b) study the use of collective bargaining with residency programs participating in the Accreditation Council for Graduate Medical Education to ensure fair and equitable terms of employment for resident physicians; (c) study the creation of a body that would establish and monitor criteria for fair and equitable terms of employment for resident physicians. (MSS GC Rep A, I-16) (Reaffirmed: MSS GC Report A, I-21).

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 046
(I-22)

Introduced by: Alicia Podwojniak, Revati Gummaluri, Sohil Khanna, Neil Garg, Rowan University School of Osteopathic Medicine; Sherry Chen, University of South Carolina School of Medicine Greenville; Mahima Goel, Carle Illinois College of Medicine

Subject: Encouraging increased accessibility and utilization of occupational pulmonary lung disease screenings

Sponsored by: Region 4 and Region 6

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, The term “pneumoconiosis” summarizes a variety of incurable lung diseases that are caused by chronic exposure to various dusts, and can cause asbestosis, berylliosis, silicosis, coal miner’s pneumoconiosis and sillicatosis^{1,2}; and

Whereas, From 1999 to 2016, the average years of potential life lost due to pneumoconiosis has increased from 8.1 to 12.6 years lost³; and

Whereas, The resurgence of pneumoconiosis in recent years poses increased threats to a younger patient population, as it carries an advanced disease burden at the time of initial diagnosis and affects a growing collection of occupations such as metal miners, denim workers, pottery and ceramics workers, and stone masons⁴⁻⁸; and

Whereas, Miners and laborers constitute medically underserved, vulnerable, isolated and rural communities that are comprised of individuals of Hispanic descent, American-Indian descent, or individuals with less than a high school education^{9,10}; and

Whereas, The mining community represents an underserved medical community that was further abandoned during the COVID-19 pandemic, as many of the existing mobile health clinics and screening centers halted service¹⁰; and

Whereas, Current screening measures include the efforts by the National Institute for Occupational Safety (NIOSH) Health-administered Coal Workers’ Health Surveillance Program (CWHSP), which provides radiographic and spirometric screenings for US coal miners with increased efforts particularly in mobile clinics, that have resulted in a decrease in pneumoconiosis deaths among those who utilize them^{7,11}; and

Whereas, There are barriers that prevent workers from taking advantage of existing occupational pulmonary screenings, such as fear of reprisal, fear of diagnosis, and lack of access to alternative employment in the event of unfavorable diagnosis¹²; and

Whereas, Existing literature suggests that increased participation in occupational pulmonary screenings would allow better characterization of disease and be a useful early detection tool for these workers¹³; and

Whereas, Silicosis, and other pneumoconioses, are difficult to screen early and treat effectively, given the slow progression of lung disease with subsequent deterioration and advancement to fibrosis, necessitating early detection and accurate screening efforts among affected workers¹⁴; and

Whereas, The resurgences in pneumoconiosis deaths suggests that existing prevention and screening efforts are in need of improvement⁷; and

Whereas, AMA policy G-600.064 endorses screening and early treatment for persons with early disease rather than reactively treating following the onset of signs or symptoms with the goal of increasing favorable health outcomes; and

Whereas, AMA policy D-135.974 is limited in advocating for accessibility of occupational preventative health screenings, with existing policy stating that the AMA supports the proposed rule to establish a stricter standard of exposure assessments and medical surveillance requirements to identify adverse health effects in exposed populations of workers; and

Whereas, AMA Policy 365.988 promotes use of occupational disease prevention strategies, it fails to recognize and address barriers to existing programs, and fails to recognize other at-risk occupations; therefore be it

RESOLVED, That our AMA recognizes inequities in occupational health screenings for pulmonary lung disease and supports efforts to increase access to these screenings in marginalized communities; and be it further

RESOLVED, That our AMA amend Policy 365.988 "Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies" by insertion as follows:

Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies, H-365.988

Our AMA supports: (1) the integration of occupational health and environmental health and injury prevention programs within existing health departments at the state and local level; (2) taking a leadership role in assisting state medical societies in implementation of such programs; and (3) working with federal agencies to ensure that "health" is the primary determinant in establishing environmental and occupational health policy; (4) recognize barriers to accessibility and utilization of such programs; (5) encourages utilization of accessible screenings, such as those used in the NIOSH Coal Workers Health Surveillance Program, for other at risk occupational groups and utilization of these free screenings.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Blackley DJ, Halldin CN, Laney AS. Continued Increase in Prevalence of Coal Workers' Pneumoconiosis in the United States, 1970-2017. *Am J Public Health*. 2018;108(9):1220-1222. doi:10.2105/AJPH.2018.304517
2. Honma K, Abraham JL, Chiyotani K, et al. Proposed criteria for mixed-dust pneumoconiosis: definition, descriptions, and guidelines for pathologic diagnosis and clinical correlation. *Hum Pathol*. 2004;35(12):1515-1523. doi:10.1016/j.humpath.2004.09.008
3. Mazurek JM, Wood J, Blackley DJ, Weissman DN. Coal Workers' Pneumoconiosis-Attributable Years of Potential Life Lost to Life Expectancy and Potential Life Lost Before Age 65 Years - United States, 1999-2016. *MMWR Morb Mortal Wkly Rep*. 2018;67(30):819-824. Published 2018 Aug 3.
4. Qi, Xian-Mei¹; Luo, Ya¹; Song, Mei-Yue²; Liu, Ying¹; Shu, Ting¹; Liu, Ying³; Pang, Jun-Ling¹; Wang, Jing¹; Wang, Chen³. Pneumoconiosis: current status and future prospects. *Chinese Medical Journal*: April 20, 2021 - Volume 134 - Issue 8 - p 898-907 doi: 10.1097/CM9.0000000000001461
5. Blackley DJ, Crum JB, Halldin CN, Storey E, Laney AS. Resurgence of Progressive Massive Fibrosis in Coal Miners - Eastern Kentucky, 2016. *MMWR Morb Mortal Wkly Rep*. 2016;65(49):1385-1389. Published 2016 Dec 16. doi:10.15585/mmwr.mm6549a1
6. Rose C, Heinzerling A, Patel K, et al. Severe Silicosis in Engineered Stone Fabrication Workers - California, Colorado, Texas, and Washington, 2017-2019. *MMWR Morb Mortal Wkly Rep*. 2019;68(38):813-818. Published 2019 Sep 27. doi:10.15585/mmwr.mm6838a1
7. Bell JL, Mazurek JM. Trends in Pneumoconiosis Deaths - United States, 1999-2018. *MMWR Morb Mortal Wkly Rep*. 2020;69(23):693-698. Published 2020 Jun 12. doi:10.15585/mmwr.mm6923a1
8. Akgün M. Denim production and silicosis. *Curr Opin Pulm Med*. 2016;22(2):165-169. doi:10.1097/MCP.0000000000000249
9. Evans K, Lerch S, Boyce TW, et al. An Innovative Approach to Enhancing Access to Medical Screening for Miners using a Mobile Clinic with Telemedicine Capability. *J Health Care Poor Underserved*. 2016;27(4A):62-72. doi:10.1353/hpu.2016.0182
10. Sood A, Pollard C, Suer KL, Vlahovich K, Walker J. Caring for Miners During the Coronavirus Disease-2019 (COVID-19) Pandemic. *J Rural Health*. 2021;37(1):165-168. doi:10.1111/jrh.12444
11. Reynolds LE, Wolfe AL, Clark KA, et al. Strengthening the Coal Workers' Health Surveillance Program. *J Occup Environ Med*. 2017;59(4):e71. doi:10.1097/JOM.0000000000000993
12. Voelker R. Black Lung Resurgence Raises New Challenges for Coal Country Physicians. *JAMA*. 2019;321(1):17-19. doi:10.1001/jama.2018.15966
13. Laney AS, Blackley DJ, Halldin CN. Radiographic disease progression in contemporary US coal miners with progressive massive fibrosis. *Occup Environ Med*. 2017;74(7):517-520. doi:10.1136/oemed-2016-104249
14. Li T, Yang X, Xu H, Liu H. Early Identification, Accurate Diagnosis, and Treatment of Silicosis. *Can Respir J*. 2022;2022:3769134. Published 2022 Apr 25. doi:10.1155/2022/3769134

RELEVANT AMA AND AMA-MSS POLICY**295.068MSS Medical School and Occupational Exposure**

AMA-MSS encourages institutions to continually educate their students on occupational exposure protocols and encourage medical students to become well-informed and aware of the

relevant procedures. (MSS Rep E, I-95 Adopted in Lieu of Res 6, I-94) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Non-Physician Screening Tests H-425.968

1. AMA policy is that any wellness program vendor providing non-physician ordered screenings should adhere to the following principles: a. Must disclose for whom a screening test is indicated on the basis of accepted evidence-based guidelines; b. Must inform patients of the potential benefits and risks of performing a test and of the implications of positive or negative screening test results before a test is performed; c. Must disclose the qualifications of any persons in contact with the patient and of any persons interpreting the results of any screening test; d. Should use local physicians as medical directors or supervisors in the appropriate specialty with the requisite state licensure; e. Should send results of any screening to the individual patient and to the primary care physician or usual source of medical care, upon patient request; f. Should require a consultation with the patient's primary care physician or usual source of care if a screening test shows a positive or otherwise abnormal test result; g. If the test results are of a critical level or value, the patient should be contacted immediately and notified of the need for urgent or emergent medical evaluation.

2. Our AMA supports that physicians not be held liable for delayed or missed diagnoses indicated on wellness program vendor non-physician ordered screenings.
CMS Rep. 03, I-17

AMA Endorsement of Screening Tests or Standards G-600.064

(1) Delegates, state, or specialty societies submitting a resolution seeking endorsement or AMA adoption of specific screening tests must also submit an evidence-based review that determines the strength or quality of the evidence supporting their request, and that evaluates the degree to which the test satisfies the minimal criteria for validating the appropriateness of the screening test, which are: (a) the test must be able to detect the target condition earlier than without screening and with sufficient accuracy to avoid producing large numbers of false-positive and false-negative results; and (b) screening for and treating persons with early disease should improve the likelihood of favorable health outcomes compared with treating patients when they present with signs or symptoms of disease. (2) This review will be made available to the reference committee, which will either recommend to the House of Delegates that the resolution be referred or not be adopted.

Definitions of "Screening" and "Medical Necessity" H-320.953

(1) Our AMA defines screening as: Health care services or products provided to an individual without apparent signs or symptoms of an illness, injury or disease for the purpose of identifying or excluding an undiagnosed illness, disease, or condition.

(2) Our AMA recognizes that federal law (EMTALA) includes the distinct use of the word screening in the term "medical screening examination"; "The process required to reach, with reasonable clinical confidence, the point at which it can be determined whether a medical emergency does or does not exist."

(3) Our AMA defines medical necessity as: Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and

purchasers or for the convenience of the patient, treating physician, or other health care provider.

(4) Our AMA incorporates its definition of "medical necessity" in relevant AMA advocacy documents, including its "Model Managed Care Services Agreement." Usage of the term "medical necessity" must be consistent between the medical profession and the insurance industry. Carrier denials for non-covered services should state so explicitly and not confound this with a determination of lack of "medical necessity".

(5) Our AMA encourages physicians to carefully review their health plan medical services agreements to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.

(6) Our AMA urges private sector health care accreditation organizations to develop and incorporate standards that prohibit the use of definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness.

(7) Our AMA advocates that determinations of medical necessity shall be based only on information that is available at the time that health care products or services are provided.

(8) Our AMA continues to advocate its policies on medical necessity determinations to government agencies, managed care organizations, third party payers, and private sector health care accreditation organizations.

CMS Rep. 13, I-98; Reaffirmed: BOT Action in response to referred for decision Res. 724, A-99; Modified: Res. 703, A-03; Reaffirmation I-06; Reaffirmed: CMS Rep. 01, A-16

Commercialized Medical Screening H-480.956

AMA policy is that relevant specialty societies continue to evaluate the validity and clinical use of screening imaging procedures that are advertised directly to the public and make available to the broader physician community unbiased evaluations to help primary care physicians advise their patients of the risks and benefits of these procedures.

CSA Rep. 10, A-03; Reaffirmed: CSAPH Rep. 1, A-13

Clinical Preventive Services H-410.967

The AMA: (1) recommends the USPSTF guidelines to clinicians and medical educators as one resource for guiding the delivery of clinical preventive services. USPSTF recommendations should not be construed as AMA policy on screening procedures and should not take the place of clinical judgment and the need for individualizing care with patients; physicians should weigh the utility of individual recommendations within the context of their scope of practice and the situation presented by each clinical encounter; (2) will continue to encourage the adoption of practice guidelines as they are developed based on the best scientific evidence and methodology available; and (3) will continue to promote discussion, collaboration, and consensus among expert groups and medical specialty societies involved in preparation of practice guidelines.

CSA Rep. 1, A-97; Modified and Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Sub. Res. 517, A-12; Modified: CSAPH Rep. 1, A-

Value-Based Decision-Making in the Health Care System H-450.938

1. Physicians should encourage their patients to participate in making value-based health care decisions.

2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.

3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and usable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.
 4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.
 5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.
 6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life.
- CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 5, A-12; Reaffirmation I-14; Reaffirmation: I-17; Reaffirmed: CMS Rep. 06, A-19; Reaffirmed: CMS Rep. 2, I-21

Preventive Services H-425.997

Our AMA encourages the development of policies and mechanisms to assure the continuity, coordination and continuous availability of patient care, including professional preventive care and early-detection screening services, provided the services are cost effective.

2. It is the policy of the AMA that any preventive service that is being considered for inclusion in public or private sector insurance products have evidence-based data to demonstrate improved outcomes or quality of life and the cost effectiveness of the service.
 3. Our AMA believes that preventive care should ideally be coordinated by a patient's physician.
- BOT Rep. A, NCCMC Rec. 31, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report and Reaffirmed and Appended: CMS Rep. 7, A-00; Reaffirmed in lieu of Res. 104, A-06; Reaffirmation A-07; Modified and Reaffirmed: Sub. Res. 101, A-08; Reaffirmed: CMS Rep. 03, I-16; Reaffirmed: CMS Rep. 03, I-17; Reaffirmed: CMS Rep. 06, A-19

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

Occupational Safety and Health Administration Regulations H-365.983

The AMA (1) will work to modify the Occupational Safety and Health Administration regulations on Occupational Exposure to Bloodborne Pathogens to address its practicality and to make physician compliance possible; and (2) in conjunction with other national health provider groups, will work with Congress and other government regulatory agencies to ensure that all decisions regarding the regulation of medical practices be based upon scientific principles and/or fact.

Res. 242, I-92; Reaffirmed: BOT Rep. 28, A-03; Reaffirmed: BOT Rep. 28, A-13

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 047
(I-22)

Introduced by: Catherine Domingo, Michaela Stamper, Megan Fainer, Vissy Elad, Madeline Foo, Leslie Gonzalez, Maximilian Brockwell, Martha Solano, Northeast Ohio Medical University

Subject: Increasing Diversity in Stem Cell Biobanks and Disease Models

Sponsored by: Region 1, Region 4

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Despite racial and ethnic minorities composing almost 40% of the U.S. population, most biomedical and clinical research uses a largely homogenous population that is usually 79.7% White, with 98% of over 10,000 NIH-funded cancer clinical trials not meeting NIH's own criteria and goals for minority participation¹⁻³; and

Whereas, A principal component analysis of embryonic stem cell lines from the 1000 Genomes Project discovered 93 percent of 143 sequenced human embryonic stem cell lines clustered with reference samples of European ancestry⁴; and

Whereas, An analysis of 555 completed stem cell clinical trials showed only 45% documented information regarding patients' race and ethnicity, of which, Native American or Alaskan, Black, and Multiracial groups were underrepresented when compared to U.S. population data⁵; and

Whereas, Given that 72.6% of induced pluripotent stem cell lines (iPSCs) are Caucasian in origin, there is limited availability of racially and ethnically diverse iPSC biobanks and patient-derived disease models⁵⁻⁷;

Whereas, The availability of diverse iPSC lines has not kept pace with advances in iPSC disease models and technologies, leading to biased insights on disease mechanisms, disease susceptibility, and drug responses in population-specific genetic variants⁷⁻¹¹; and

Whereas, The history of research involving minorities has included questionable and harmful actions, such as the 1932 Tuskegee Syphilis Study, resulting in a greater unwillingness among minorities to participate in research studies¹²⁻¹³; and

Whereas, Recruitment materials used in U.S. biobanks are predominantly in English and above a fifth-grade reading level, limiting participation by underrepresented populations¹⁴; and

Whereas, Biobank recruitment strategies are often convenience-based, with hospital-based researchers recruiting patients not representative of those most afflicted by disease¹²; and

Whereas, Exclusion criteria in clinical trials often leads to participants with characteristics that are skewed, and the unnecessary exclusion of participants (e.g. non-English speakers, people with mental and physical disabilities), that better represent the actual demographic after treatment approval¹⁵⁻¹⁶; and

Whereas, Lack of diverse iPSC models for drug toxicity assessments fails to account for variations in metabolic activity, which leads to higher rates of adverse events in minority populations, resulting in patient harm and waste of resources^{9,17}; and

Whereas, Existing studies investigating the diversity of stem cell research encompass only major racial and ethnic groups (e.g. Asian or Latino), despite health disparities existing among specific subgroups (e.g. Cambodian or Colombian)^{6,18}; and

Whereas, An initiative by California's Stem Cell Agency addresses gaps in the diversity of stem cell lines through its publicly accessible iPSC Repository, with 2,600 iPSCs lines inclusive of minority populations including African, Hispanic, Native American, and East and South Asian populations¹⁹; and

Whereas, The NIH-sponsored All of Us Research Program endorses diversity as a core value and aims to build one of the largest diverse biobanks²⁰; and

Whereas, Our AMA supports the Diversity Trials Act that strives to ensure clinical trials focus on diseases disproportionately impacting underrepresented populations to discover scientific advances benefiting all communities²¹; and

Whereas, A recent study from the Stanford University Center for Biomedical Ethics (SCBE) recommends that reviewers and editors give priority to manuscripts that have significant minority group representation and to those that replicate prior studies that were primarily focused on White populations²²⁻²³; and

Whereas, A recent study SCBE recommends that race and/or ethnicity be included as variables in experiments requiring the use of stem cell lines such that potentially variable outcomes of intervention between racial or ethnic groups can be assessed²³⁻²⁴; and

Whereas, Our AMA is committed to supporting stem cell research and its diversification through a number of methodologies, as described in H-460.911, H-460.915, H-460.889, H-460.924, and 7.3.8 Research with Stem Cells²⁴⁻²⁶; therefore be it

RESOLVED, Our AMA encourages research institutions and stakeholders to (1) re-evaluate inclusion and exclusion criteria to increase minority participation in stem cell research, and (2) consider repeating prior experiments with cell lines from different populations; and be it further

1 RESOLVED, Our AMA amends Policy H-460.915, "Cloning and Stem Cell Research,"

2
3 **Cloning and Stem Cell Research, H-460.915**

4 Our AMA: (1) supports biomedical research on multipotent stem cells (including adult
5 and cord blood stem cells); (2) urges the use of stem cell lines from different ethnicities
6 in disease models; (3) supports the use of somatic cell nuclear transfer technology in
7 biomedical research (therapeutic cloning); (4) opposes the use of somatic cell nuclear
8 transfer technology for the specific purpose of producing a human child (reproductive
9 cloning); (5) encourages strong public support of federal funding for research involving
10 human pluripotent stem cells and (6) will continue to monitor developments
11 in stem cell research and the use of somatic cell nuclear transfer technology; and be it
12 further
13

14 RESOLVED, Our AMA strongly encourages institutional biobanks to collect racially and
15 ethnically diverse induced pluripotent stem cells and expand their accessibility such that future
16 disease models can better represent the population.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Oh SS, Galanter J, Thakur N, et al. Diversity in Clinical and Biomedical Research: A Promise Yet to Be Fulfilled. *PLOS Medicine*. 2015;12(12):e1001918. doi:10.1371/journal.pmed.1001918
2. Chen MS, Lara PN, Dang JHT, Paterniti DA, Kelly K. Twenty years post-NIH Revitalization Act: Enhancing minority participation in clinical trials (EMPaCT): Laying the groundwork for improving minority clinical trial accrual. *Cancer*. 2014;120:1091-1096. doi:10.1002/cncr.28575
3. Turner BE, Steinberg JR, Weeks BT, Rodriguez F, Cullen MR. Race/ethnicity reporting and representation in US clinical trials: A cohort study. *The Lancet Regional Health - Americas*. Published online April 2022:100252. doi:10.1016/j.lana.2022.100252
4. Merkle FT, Ghosh S, Genovese G, et al. Whole-genome analysis of human embryonic stem cells enables rational line selection based on genetic variation. *Cell Stem Cell*. 2022;29(3):472-486.e7. doi:10.1016/j.stem.2022.01.011
5. Parvanova I. Disparities in Racial and Ethnic Representation in Stem Cell Clinical Trials. Finkelstein J, ed. *Studies in Health Technology and Informatics*. 2020;272:358-361. doi:10.3233/SHTI200569
6. Guerrero S, López-Cortés A, Indacochea A, et al. Analysis of Racial/Ethnic Representation in Select Basic and Applied Cancer Research Studies. *Scientific Reports*. 2018;8(1). doi:10.1038/s41598-018-32264-x
7. Nehme R, Barrett LE. Using human pluripotent stem cell models to study autism in the era of big data. *Molecular Autism*. 2020;11(1). doi:10.1186/s13229-020-00322-9
8. Bisogno LS, Yang J, Bennett BD, et al. Ancestry-dependent gene expression correlates with reprogramming to pluripotency and multiple dynamic biological processes. *Science Advances*. 2020;6(47):eabc3851. doi:10.1126/sciadv.abc3851

9. Tegtmeier M, Nehme R. Leveraging the Genetic Diversity of Human Stem Cells in Therapeutic Approaches. *Journal of Molecular Biology*. 2022;434(3):167221. doi:10.1016/j.jmb.2021.167221
10. Horwitz R, Riley EAU, Millan MT, Gunawardane RN. It's time to incorporate diversity into our basic science and disease models. *Nature Cell Biology*. Published online November 29, 2021. doi:10.1038/s41556-021-00803-w
11. To Achieve Precision Medicine, Diverse Stem Cell Biobanks are Key. New York Stem Cell Foundation. Accessed August 30, 2022. <https://nyscf.org/resources/to-achieve-precision-medicine-diverse-stem-cell-biobanks-are-key/>
12. The Lack of Diversity in Biomedical Research has Deadly Consequences. New York Stem Cell Foundation. Accessed May 31, 2022. <https://nyscf.org/resources/the-lack-of-diversity-in-biomedical-research-has-deadly-consequences/>
13. Kumar G, Kim J, Farazi PA, Wang H, Su D. Disparities in awareness of and willingness to participate in cancer clinical trials between African American and White cancer survivors. *BMC Cancer*. 2022;22(1). doi:10.1186/s12885-022-10082-9
14. Cohn EG, Hamilton N, Larson EL, Williams JK. Self-reported race and ethnicity of US biobank participants compared to the US Census. *Journal of Community Genetics*. 2017;8(3):229-238. doi:10.1007/s12687-017-0308-6
15. U.S. Department of Health and Human Services, Food and Drug Administration, Center for Drug Evaluation and Research, Center for Biologics Evaluation and Research. Enhancing the Diversity of Clinical Trial Populations — Eligibility Criteria, Enrollment Practices, and Trial Designs Guidance for Industry.; 2020. https://www.fda.gov/media/127712/download?fbclid=IwAR3Rqx7gPsj5mBvdQK4tThMs3KL_TH-UYZup6AhDT8PPy_EsB1hDoO5ITwo
16. Nagamura F. The importance of recruiting a diverse population for stem cell clinical trials. *Current Stem Cell Reports*. 2016;2(4):321-327. doi:10.1007/s40778-016-0062-4
17. Fakunle ES, Loring JF. Ethnically diverse pluripotent stem cells for drug development. *Trends in Molecular Medicine*. 2012;18(12):709-716. doi:10.1016/j.molmed.2012.10.007
18. Konkel L. Racial and Ethnic Disparities in Research Studies: The Challenge of Creating More Diverse Cohorts. *Environmental Health Perspectives*. 2015;123(12). doi:10.1289/ehp.123-a297
19. McCormack K. Creating a New Model for Diversity in Scientific and Medical Research. California's Stem Cell Agency. Published November 29, 2021. Accessed August 30, 2022.
20. Biobank. National Institutes of Health: All of Us Research Program. Accessed August 30, 2022. <https://allofus.nih.gov/funding-and-program-partners/biobank>
21. Madara JL. Comment Letter to the U.S. House of Representatives. Published online May 4, 2022. <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2022-5-4-Letter-to-House-re-HR-5030-Diversifying-Investigations.zip%2F2022-5-4-Letter-to-House-re-HR-5030-Diversifying-Investigations.pdf>
22. Burchard EG, Oh SS, Foreman MG, Celedón JC. Moving Toward True Inclusion of Racial/Ethnic Minorities in Federally Funded Studies. A Key Step for Achieving Respiratory Health Equality in the United States. *American Journal of Respiratory and Critical Care Medicine*. 2015;191(5):514-521. doi:10.1164/rccm.201410-1944pp

23. Brothers KB, Bennett RL, Cho MK. Taking an antiracist posture in scientific publications in human genetics and genomics. *Genetics in Medicine*. 2021;23(6):1004-1007. doi:10.1038/s41436-021-01109-w
24. H-460.924 Race and Ethnicity as Variables in Medical Research. Accessed August 29, 2021. <https://policysearch.ama-assn.org/policyfinder/detail/race%20and%20ethnicity?uri=%2FAMADoc%2FHOD.xml-H-460.924.xml>
25. H-460.915 Cloning and Stem Cell Research. Accessed August 29, 2021. <https://policysearch.ama-assn.org/policyfinder/detail/stem%20cell?uri=%2FAMADoc%2FHOD.xml-0-4163.xml>
26. H-460.911 Increasing Minority Participation in Clinical Research. Accessed August 29, 2021. <https://policysearch.ama-assn.org/policyfinder/detail/minority%20research?uri=%2FAMADoc%2FHOD.xml-0-4159.xml>

RELEVANT AMA AND AMA-MSS POLICY

Increasing Minority Participation in Clinical Research H-460.911

1. Our AMA advocates that:
 - a. The Food and Drug Administration (FDA) conduct annual surveillance of clinical trials by gender, race, and ethnicity, including consideration of pediatric and elderly populations, to determine if proportionate representation of women and minorities is maintained in terms of enrollment and retention. This surveillance effort should be modeled after National Institute of Health guidelines on the inclusion of women and minority populations.
 - b. The FDA have a page on its web site that details the prevalence of minorities and women in its clinical trials and its efforts to increase their enrollment and participation in this research; and
 - c. Resources be provided to community level agencies that work with those minorities who are not proportionately represented in clinical trials to address issues of lack of access, distrust, and lack of patient awareness of the benefits of trials in their health care. These minorities include Hispanics, Asians/Pacific Islanders/Native Hawaiians, and Native Americans.
 2. Our AMA recommends the following activities to the FDA in order to ensure proportionate representation of minorities in clinical trials:
 - a. Increased fiscal support for community outreach programs; e.g., culturally relevant community education, community leaders' support, and listening to community's needs;
 - b. Increased outreach to female physicians to encourage recruitment of female patients in clinical trials;
 - c. Continued minority physician education on clinical trials, subject recruitment, subject safety, and possible expense reimbursements;
 - d. Support for the involvement of minority physicians in the development of partnerships between minority communities and research institutions; and
 - e. Fiscal support for minority recruitment efforts and increasing trial accessibility through transportation, child care, reimbursements, and location.
 3. Our AMA advocates that specific results of outcomes in all clinical trials, both pre- and post-FDA approval, are to be determined for all subgroups of gender, race and ethnicity, including consideration of pediatric and elderly populations; and that these results are included in publication and/or freely distributed, whether or not subgroup differences exist.
- BOT Rep. 4, A-08;n Reaffirmed: CSAPH Rep. 01, A-18

Cloning and Stem Cell Research H-460.915

Our AMA: (1) supports biomedical research on multipotent stem cells (including adult and cord blood stem cells); (2) supports the use of somatic cell nuclear transfer technology in biomedical

research (therapeutic cloning); (3) opposes the use of somatic cell nuclear transfer technology for the specific purpose of producing a human child (reproductive cloning); (4) encourages strong public support of federal funding for research involving human pluripotent stem cells; and (5) will continue to monitor developments in stem cell research and the use of somatic cell nuclear transfer technology.

CSA Rep. 5, A-03; Reaffirmed: CSAPH Rep. 1, A-13

Support of Embryonic/Pluripotent Stem Cell Research H-460.889

Our AMA will encourage strong public support of federal funding for research involving human pluripotent stem cells.

CSAPH Rep. 01, A-19

7.3.8 Research with Stem Cells

Human stem cells are widely seen as offering a source of potential treatment for a range of diseases and are thus the subject of much research. Clinical studies have validated the use of adult stem cells in a limited number of therapies, but have yet to confirm the utility of embryonic stem cells.

Physicians who conduct research using stem cells obtained from any source (established tissue, umbilical cord blood, or embryos) must, at a minimum:

- (a) Adhere to institutional review board (IRB) requirements.
- (b) Ensure that the research is carried out with appropriate oversight and monitoring.
- (c) Ensure that the research is carried out with appropriate informed consent. In addition to disclosure of research risks and potential benefits, at minimum, the consent disclosure should address:
 - (i) for a donor of cells to be used in stem cell research:
 - a. the process by which stem cells will be obtained;
 - b. what specifically will be done with the stem cells;
 - c. whether an immortal cell line will result; and
 - d. the primary and anticipated secondary uses of donated embryos and/or derived stem cells, including potential commercial uses.
 - (ii) for a recipient of stem cells in clinical research:
 - a. the types of tissue from which the stem cells derive (e.g., established tissue, umbilical cord blood, or embryos); and
 - b. unique risks posed by investigational stem cell products (when applicable), such as tumorigenesis, immunological reactions, unpredictable behavior of cells, and unknown long-term health effects.

The professional community as well as the public remains divided about the use of embryonic stem cells for either research or therapeutic purposes. The conflict regarding research with embryonic stem cells centers on the moral status of embryos, a question that divides ethical opinion and that cannot be resolved by medical science. Regardless whether they are obtained from embryos donated by individuals or couples undergoing in vitro fertilization, or from cloned embryos created by somatic cell nuclear transfer (SCNT), use of embryonic stem cells currently requires the destruction of the human embryo from which the stem cells derive.

The pluralism of moral visions that underlies this debate must be respected. Participation in research involving embryonic stem cells requires respect for embryos, research participants, donors, and recipients. Embryonic stem cell research does not violate the ethical standards of the profession. Every physician remains free to decide whether to participate in stem cell research or to use its products. Physicians should continue to be guided by their commitment to the welfare of patients and the advancement of medical science.

Physicians who conduct research using embryonic stem cells should be able to justify greater risks for subjects, and the greater respect due embryos than stem cells from other sources, based on expectations that the research offers substantial promise of contributing significantly to scientific or therapeutic knowledge.

AMA Principles of Medical Ethics: V

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

Issued: 2016

Race and Ethnicity as Variables in Medical Research H-460.924

Our AMA policy is that: (1) race and ethnicity are valuable research variables when used and interpreted appropriately; (2) health data be collected on patients, by race and ethnicity, in hospitals, managed care organizations, independent practice associations, and other large insurance organizations; (3) physicians recognize that race and ethnicity are conceptually distinct; (4) our AMA supports research into the use of methodologies that allow for multiple racial and ethnic self-designations by research participants; (5) our AMA encourages investigators to recognize the limitations of all current methods for classifying race and ethnic groups in all medical studies by stating explicitly how race and/or ethnic taxonomies were developed or selected; (6) our AMA encourages appropriate organizations to apply the results from studies of race-ethnicity and health to the planning and evaluation of health services; and (7) our AMA continues to monitor developments in the field of racial and ethnic classification so that it can assist physicians in interpreting these findings and their implications for health care for patients.

CSA Rep. 11, A-98; Appended: Res. 509, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 01, A-21

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 048
(I-22)

Introduced by: Katherine Kolp and Bridget Alley, University of Texas Health Sciences Center, San Antonio; Sereena Jivraj, Anne Burnett Marion School of Medicine at Texas Christian University; Jennifer Odoi and Adeola Ajijolaiya, University of Texas Medical Branch

Subject: Discussions on Elective Sterilization in Undergraduate Medical Education

Sponsored by: American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, One in three women aged 35-44 years in the United States rely on sterilization as their form of contraception, which includes procedures that permanently prevent pregnancy such as tubal ligation, bilateral salpingectomy, hysterectomy, etc.¹; and

Whereas, According to a National Review of Family Planning (NRFP) survey, of women who had a tubal ligation between 2015-2017, reasons for the procedure included family planning (68%), treatment for a medical condition (24.1%), and as an alternative to other previously used contraceptive methods with undesirable adverse effects (2.2%)²; and

Whereas, The NRFP survey from 2015-2017 found that about one in 20 women aged 20-29, one in five women aged 30-39, and nearly two in five women aged 40-49 relied on female sterilization for contraception²; and

Whereas, Aside from contraception purposes, a range of medical conditions may be treated with sterilization, such as hysterectomy, including: heavy menstrual cycles (caused by fibroids), pelvic pain (caused by adenomyosis or unsuccessfully treated pelvic inflammatory disease), uterine prolapse, or cancer of the uterus, cervix, or fallopian tubes³; and

Whereas, The NRFP survey from 2015-2017 found that of women aged 15-49 who received a hysterectomy, 96.6% of the procedures were for treatment of medical conditions, such as those previously listed²; and

Whereas, The decision in the *Dobbs v. Jackson Women's Health Organization* Supreme Court case has yielded an increased interest in permanent sterilization as a form of contraception⁴⁻⁸; and

Whereas, According to ACOG, "Respect for an individual woman's reproductive autonomy should be the primary concern guiding sterilization provision and policy"⁹; and

Whereas, The American College of Obstetrics and Gynecology (ACOG) recognizes that sterilization procedure discussions are particularly prone to biases from physicians based on the patient's culture, religion, gender, reproduction, sexuality, family, and parenting¹⁰; and

Whereas, ACOG also recognizes that the physician biases during discussions of sterilization lead to a disparity between women who could benefit from these procedures and those who can access them^{9,11}; and

Whereas, In the wake of the *Dobbs v. Jackson Women's Health Organization* Supreme Court decision, medical education and clinical experiences surrounding women's health will likely be restricted by state law, with only 29.23% of medical students nationwide training in states that protect the right to abortion¹²; and

Whereas, The Liaison Committee on Medical Education (LCME) currently lacks national standards on the specific content of medical education, including specific discussion around female sterilization; therefore, the sufficiency of instruction on this topic cannot be accurately assessed¹³; and

Whereas, The Association of American Medical Colleges (AAMC) reports that 90.19% of medical schools in the United States require an obstetrics and gynecology clerkship as a part of their medical curriculum, averaging 6.6 weeks in the 2019-2020 academic year; therefore, all medical students should be prepared for discussions about sterilization as both a contraceptive method and medical treatment prior to entering a clinical setting¹⁴; therefore be it

RESOLVED, That our AMA encourages the inclusion of female sterilization education as a part of medical school curricula; and be it further

RESOLVED, That our AMA develops guidelines and resources to support curricula that address physician bias in the topic of female sterilization in medical schools.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Stuart G, Ramesh S. Interval Female Sterilization. *Obstetrics & Gynecology*. 2018; 131(1): 117-124. doi: 10.1097/AOG.0000000000002376.4
2. NSFG - listing S - key statistics from the National Survey of Family Growth. Centers for Disease Control and Prevention. https://www.cdc.gov/nchs/nsfg/key_statistics/s-keystat.htm#sterilizationfemale.
3. Papadopoulos MS, Tolikas AC, Miliaras DE. Hysterectomy-current methods and alternatives for benign indications. *Obstet Gynecol Int*. 2010;2010:356740. doi:10.1155/2010/356740
4. Bolton A, Juhlin E. More people are opting to get sterilized - and some are being turned away. NPR. <https://www.npr.org/sections/health-shots/2022/07/29/1113573995/more-people-are-opting-to-get-sterilized-and-some-are-being-turned-away>. Published July 29, 2022. Accessed September 22, 2022.

5. Diaz A. 'frustrated' young women are trying to get sterilized after overturning of Roe. New York Post. <https://nypost.com/2022/07/13/young-women-trying-to-get-sterilized-after-overturning-of-roe/>. Published July 13, 2022. Accessed September 22, 2022.
6. More women are seeking sterilization since Roe vs. Wade was overturned. Los Angeles Times. <https://www.latimes.com/world-nation/story/2022-07-19/women-sterilization-ro-e-vs-wade>. Published July 19, 2022. Accessed September 22, 2022.
7. Venkataramanan M. Post-roe, more Americans want their tubes tied. it isn't easy. The Washington Post. <https://www.washingtonpost.com/health/2022/08/15/roe-tubal-sterilizations-barriers/>. Published August 17, 2022. Accessed September 22, 2022.
8. Weiner S, Writer SS. How the repeal of Roe v. Wade will affect training in abortion and Reproductive Health. AAMC. <https://www.aamc.org/news-insights/how-repeal-ro-e-v-wade-will-affect-training-abortion-and-reproductive-health>. Published June 24, 2022. Accessed September 22, 2022.
9. Committee Opinion No. 695: Sterilization of Women: Ethical Issues and Considerations. *Obstet Gynecol*. 2017;129(4):e109-e116. doi:10.1097/AOG.0000000000002023
10. Informed consent and shared decision making in obstetrics and gynecology. *Obstetrics & Gynecology*. 137(2). <https://doi.org/10.1097/aog.0000000000004247>
11. Kimport K, Dehlendorf C, Borrero S. Patient-provider conversations about sterilization: A qualitative analysis. *Contraception*. 2017;95(3):227-233. doi:10.1016/j.contraception.2016.10.009
12. Traub AM, Mermin-Bunnell K, Pareek P, et al. The implications of overturning Roe v. Wade on medical education and future physicians. The Lancet Regional Health – Americas. [https://www.thelancet.com/journals/lanam/article/PIIS2667-193X\(22\)00151-X/fulltext](https://www.thelancet.com/journals/lanam/article/PIIS2667-193X(22)00151-X/fulltext). Published July 20, 2022. Accessed September 22, 2022.
13. Functions and Structure of a Medical School. LCME. <https://lcme.org/publications/#Standards>. Published July 19, 2016. Accessed September 21, 2022.
14. Clinical course required weeks by discipline. Curriculum Reports. <https://www.aamc.org/data-reports/curriculum-reports/interactive-data/clinical-course-required-weeks-discipline>. Accessed September 21, 2022.

RELEVANT AMA AND AMA-MSS POLICY

Healthcare and Organizational Policies and Cultural Changes to Prevent and Address Racism, Discrimination, Bias and Microaggressions H-65.951

Our AMA adopted the following guidelines for healthcare organizations and systems, including academic medical centers, to establish policies and an organizational culture to prevent and address systemic racism, explicit and implicit bias and microaggressions in the practice of medicine:

GUIDELINES TO PREVENT AND ADDRESS SYSTEMIC RACISM, EXPLICIT BIAS AND MICROAGGRESSIONS IN THE PRACTICE OF MEDICINE

Health care organizations and systems, including academic medical centers, should establish policies to prevent and address discrimination including systemic racism, explicit and implicit bias and microaggressions in their workplaces.

An effective healthcare anti-discrimination policy should:

- Clearly define discrimination, systemic racism, explicit and implicit bias and microaggressions in the healthcare setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias and microaggressions.

- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the healthcare system.
- Prioritize safety in both reporting and corrective actions as they relate to discrimination, systemic racism, explicit and implicit bias and microaggressions.
- Create anti-discrimination policies that:
 - Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
 - Define expected and prohibited behavior.
 - Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias, and microaggressions.
 - Ensure privacy and confidentiality to the reporter.
 - Provide a confidential method for documenting and reporting incidents.
 - Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.
- These policies should include:
 - Taking every complaint seriously.
 - Acting upon every complaint immediately.
 - Developing appropriate resources to resolve complaints.
 - Creating a procedure to ensure a healthy work environment is maintained for complainants and prohibit and penalize retaliation for reporting.
 - Communicating decisions and actions taken by the organization following a complaint to all affected parties.
 - Document training requirements to all the members of the healthcare system and establish clear expectations about the training objectives.

In addition to formal policies, organizations should promote a culture in which discrimination, including systemic racism, explicit and implicit bias, and microaggressions are mitigated and prevented. Organized medical staff leaders should work with all stakeholders to ensure safe, discrimination-free work environments within their institutions.

Tactics to help create this type of organizational culture include:

- Surveying staff, trainees, and medical students, anonymously and confidentially to assess:
 - Perceptions of the workplace culture and prevalence of discrimination, systemic racism, explicit and implicit bias, and microaggressions.
 - Ideas about the impact of this behavior on themselves and patients.
- Integrating lessons learned from surveys into programs and policies.
- Encouraging safe, open discussions for staff and students to talk freely about problems and/or encounters with behavior that may constitute discrimination, including racism, bias, or microaggressions.
- Establishing programs for staff, faculty, trainees and students, such as Employee Assistance Programs, Faculty Assistance Programs, and Student Assistance Programs, that provide a place to confidentially address personal experiences of discrimination, systemic racism, explicit or implicit bias or microaggressions.
- Providing designated support person to confidentially accompany the person reporting an event through the process.

Res. 003, A-21

Medicolegal, Political, Ethical and Economic Medical School Course H-295.961

(1) The AMA urge every medical school and residency program to teach the legal, political, ethical and economic issues which will affect physicians. (2) The AMA will work with state and county medical societies to identify and provide speakers, information sources, etc., to assist with the courses. (3) An assessment of professional and ethical behavior, such as exemplified in the AMA Principles of Medical Ethics, should be included in internal evaluations during medical

school and residency training, and also in evaluations utilized for licensure and certification. (4) The Speaker of the HOD shall determine the most appropriate way for assembled physicians at the opening sessions of the AMA House of Delegates Annual and Interim Meetings to renew their commitment to the standards of conduct which define the essentials of honorable behavior for the physician, by reaffirming or reciting the seven Principles of Medical Ethics which constitute current AMA policy. (5) There should be attention to subject matter related to ethics and to the doctor-patient relationship at all levels of medical education: undergraduate, graduate, and continuing. Role modeling should be a key element in helping medical students and resident physicians to develop and maintain professionalism and high ethical standards. (6) There should be exploration of the feasibility of improving an assessment of ethical qualities in the admissions process to medical school. (7) Our AMA pledges support to the concept that professional attitudes, values, and behaviors should form an integral part of medical education across the continuum of undergraduate, graduate, and continuing medical education. Res 189, A-90; Modified by CME Rep. 1, I-95; Appended: Res. 318, I-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed in lieu of Res. 902, I-13; Reaffirmation I-15

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 049
(I-22)

Introduced by: Nivan Wadhawan, Shilpa Rajagopal, Joshua Fernandez de la Vega,
University of Texas Medical Branch John Sealy School of Medicine

Subject: Amend Civil and Human Rights H-65.959 to Increase Protections

Sponsored by: PsychSIGN

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Outing is defined as “exposing someone’s lesbian, gay, bisexual, transgender or gender non-binary identity to others without their permission”¹; and

Whereas, Mandatory reporting can “out” LGBTQ+ individuals and those questioning their sexual orientation and/or gender identity²; and

Whereas, Protection of LGBTQ+ and questioning individuals from being “outed” prevents additional physical safety risks, stress, mental health degradation, and discrimination^{3,4}; and

Whereas, There has been a recent wave of directives, resolutions, and laws in states such as Texas and Florida that require mandated reporters, including physicians, to disclose an individual’s gender identity and/or sexual orientation to outside entities^{5,6,7,8}; therefore be it

RESOLVED, That our AMA amend Policy H-65.959, “Opposing Mandated Reporting of People Who Question Their Gender Identity” as follows:

Opposing Mandated Reporting of People Who Question Their Gender Identity, H-65.959

Our AMA opposes mandated reporting of individuals who identify as part of the LGBTQ+ community and those who question or express interest in exploring their gender identity and/or sexual orientation.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. HRC Foundation. Human Rights Campaign. Glossary of terms. Available at: <https://www.hrc.org/resources/glossary-of-terms>. Accessed August 30, 2022.
2. Lippy C, Burk C, Hobart M. There’s no one I can trust: The impact of mandatory reporting on the help-seeking and well-being of domestic violence survivors. Seattle: National LGBTQ DV Capacity Building Learning Center, 2016. Available at:

[http://www.ncdsv.org/Natl-LGBTQ-DV-](http://www.ncdsv.org/Natl-LGBTQ-DV-CBLC_There%27s+No+One+I+Can+Trust_2016.pdf)

[CBLC_There%27s+No+One+I+Can+Trust_2016.pdf](#). Accessed August 30, 2022.

3. National Center for HIV, Viral Hepatitis, STD, and TB Prevention. Centers for Disease Control and Prevention. Gay and bisexual men's health: Mental health. Available at: <https://www.cdc.gov/msmhealth/mental-health.htm>. Accessed August 30, 2022.
4. Brown TNT, Herman JL. Intimate partner violence and abuse among LGBT people: A review of existing research. Los Angeles: The Williams Institute, 2015. Available at: <https://ncmedr.org/wp-content/uploads/2017/09/Intimate-Partner-Violence-and-Sexual-Abuse-among-LGBT-People.pdf>. Accessed August 30, 2022.
5. Yurcaba J. Texas governor calls on citizens to report parents of Transgender Kids For AbuseJo. NBC News. <https://www.nbcnews.com/nbc-out/out-politics-and-policy/texas-governor-calls-citizens-report-parents-transgender-kids-abuse-rcna17455>. Published February 23, 2022. Accessed September 21, 2022.
6. Jones K. LGBTQ youth: Who decides what is age-appropriate? Close Up Washington, D.C. <https://www.closeup.org/lgbtq-youth-who-decides-what-is-age-appropriate/>. Published March 16, 2022. Accessed September 21, 2022.
7. Yang J, Joseph E. How Florida's 'don't say gay' law regulates school lessons on gender, sexual orientation. PBS News Hour. <https://www.pbs.org/newshour/show/how-floridas-dont-say-gay-law-regulates-school-lessons-on-gender-sexual-orientation>. Published March 30, 2022. Accessed September 21, 2022.
8. Office of the Attorney General of Texas. Whether certain medical procedures performed on children constitute child abuse. 2022. Opinion No. KP-0401. Accessed September 21, 2022. <https://gov.texas.gov/uploads/files/press/O-MastersJaime202202221358.pdf>

RELEVANT AMA AND AMA-MSS POLICY

Opposing Mandated Reporting of People Who Question Their Gender Identity H-65.959

Our AMA opposes mandated reporting of individuals who question or express interest in exploring their gender identity.

Res. 015, A-19

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.

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.

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

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.

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

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information

from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

Opposing Mandated Reporting of People who Question their Gender Identity 65.029MSS

AMSMSS will ask the AMA to oppose mandated reporting of youth who question or express interest in exploring their gender identity. (MSS Res 18, I-18) (AMA Res 015, A-19, Adopted [H-65.959])

Nondiscrimination Based on Sexual Orientation 65.002MSS

AMA-MSS continues to support its positions that nondiscrimination policies are a means for protecting the rights of those that suffer from prejudice. (AMA Res 12, A-89 Adopted [H-295.969]) (Reaffirmed: MSS Rep D, I-99) (Modified: MSS GC Rep A, I-16)

Nondiscriminatory Policy for the Health Care Needs of the LGBTQ+ Community 65.008MSS

AMA-MSS will ask the AMA to (1) encourage physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or

employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement; and (2) encourage individual physicians to display for patient and staff awareness-as one example: "This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or gender identity." (MSS Res 27, A03) (AMA Res 414, A-04 Adopted [D-65.996]) (Amended: MSS Rep E, I-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19) (Amended: LGBTQ+ Affairs Report A, A-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 050
(I-22)

Introduced by: Region 2; Charlie Adams; Kansas City University College of Osteopathic Medicine; Region 5, Jara Crawford, Indiana University School of Medicine

Subject: Waste Receptacles in All Restroom Stalls for Menstrual Product Disposal

Sponsored by: Region 4, Region 5, Region 7, and PsychSIGN

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, In-install waste receptacles are a key feature in women's restrooms across the United States and are widely recognized to be an important part of maintaining a sanitary public facility¹²; and

Whereas, Lack of in-install waste receptacles is a significant barrier to managing menstruation safely and accessibly for transgender and nonbinary people¹⁰; and

Whereas, Thirty-one percent of transgender people who are out in places of public accommodation experience negative treatment due to their gender identity⁶, and some transmasculine people fear changing their menstrual products in a public restroom may out them^{2,10}; and

Whereas, Some transmasculine individuals' physical appearance makes using the women's restroom more dangerous than using the men's restroom in which menstrual product receptacles are not universally available¹⁰; and

Whereas, Two-thirds of transmasculine people feel unsafe using the men's restroom during menstruation¹; and

Whereas, Fifty-nine percent of transgender people sometimes avoid public restrooms for fear of confrontation and discrimination⁴; and

Whereas, Twelve percent of transgender people are verbally harassed in public restrooms and one percent of transgender people are physically or sexually assaulted in public restrooms⁴; and

Whereas, Nearly one-third of trans people have limited the amount they ate or drank in order to avoid using the restroom⁶; and

Whereas, Poor menstrual hygiene has been linked to an increase in urinary and reproductive tract infections and a long-term increase in infertility⁵, and eight percent of transgender people fight a urinary tract infection, kidney infection, or another kidney-related problem due to avoiding restrooms⁶;

Whereas, Menstruating trans and nonbinary people sometimes hide used menstrual products in their sleeves or pockets to avoid disposing of them in public and risking outing themselves¹⁰; and

Whereas, Menstruation, gendered association with menstruation, and use of menstrual products are sources of distress for many transgender people^{1,9,13}; and being forced to carry a used menstrual product is dehumanizing and worsens the gender dysphoria and social stigma that contributes to the forty-one percent suicide attempt rate for transgender people³; and

Whereas, Non-lined sanitary receptacles yield ten times more microbial contamination than other bathroom surfaces, and thus hiding used menstrual products in pockets poses a serious health threat⁸; and

Whereas, Non-hygienic handling of used menstrual products poses a serious health risk of Hepatitis B and C exposure⁸; and thus the U.S. Occupational Safety and Health Administration (OSHA) requires sanitary disposal bins be lined by a plastic or wax bag and workers be provided gloves to prevent physical contact with used menstrual products⁷; and

Whereas, Transgender people may still be accommodated within existing binary restrooms in places that lack gender-neutral restrooms for such reasons as cost-prohibitiveness and building structure¹⁰; and

Whereas, The AMA has a history of advocating for people to use the restroom that aligns with their gender identity¹¹, and AMA resolution H-65.964 advocates for policies that promote safe access to public facilities, including restrooms, for transgender individuals, however, does not include how to make exclusionary binary restroom facilities more inclusive; therefore be it

RESOLVED, That our AMA amend H-65.964 “Access to Basic Human Services for Transgender Individuals” as follows:

Access to Basic Human Services for Transgender Individuals H-65.964

1. Our AMA (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one’s gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one’s gender identity, including the addition of waste receptacles in men’s restroom stalls for safe and discreet disposal of used menstrual products by transgender men and non-binary people.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Chrisler, J. et al. Queer periods: attitudes towards and experiences with menstruation in the masculine of centre and transgender community. *Culture, Health & Sexuality*, 18(11), 1238—1250. April 2016.
2. Fahs, Breanne. *Out for Blood: Essays on Menstruation and Resistance*. Albany: State University of New York Press. 2016.
3. James SE, et al. Executive Summary of the Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality, 2016.

4. Treating urinary incontinence after prostate surgery. University of Utah Health. <https://healthcare.utah.edu/healthfeed/postings/2021/11/urinary-incontinence.php> November 2021.
5. World Bank Group. Menstrual Health and hygiene. World Bank. <https://www.worldbank.org/en/topic/water/brief/menstrual-health-and-hygiene#:~:text=Poor%20menstrual%20hygiene%2C%20however%2C%20can,as%20hepatitis%20B%20and%20thrush.> May 2022.
6. James, S. E., et al. The Report of the 2015 U.S. Transgender Survey. Washington, DC: National Center for Transgender Equality. 2016.
7. Clark, P. *Feminine Hygiene Products*. U.S. Department of Labor. April 1992. <https://www.osha.gov/laws-regs/standardinterpretations/1992-04-17-0>
8. Germanow, A. *Take care when emptying sanitary disposal units in women's restrooms*. Cleaning & Maintenance Management. December 2019 from <https://cmmonline.com/articles/sanitary-disposal-units-in-womens-restrooms>
9. Lowik, A. J. "Just Because I Don't Bleed, Doesn't Mean I Don't Go Through It": Expanding Knowledge on Trans and Non Binary Menstruators." *International Journal of Transgender Health* 22:113–113. 2021.
10. Lane, B., et al. Improving menstrual equity in the USA: Perspectives from trans and non-binary people assigned female at birth and health care providers. *Culture, Health & Sexuality*. 2021.
11. Henry, T. *Exclusionary bathroom policies harm transgender students*. American Medical Association. April 2019. <https://www.ama-assn.org/delivering-care/population-care/exclusionary-bathroom-policies-harm-transgender-students>
12. Maroko AR, et al. Public restrooms, periods, and people experiencing homelessness: An assessment of public toilets in high needs areas of Manhattan, New York. *PLoS One*. June 2021.
13. Frank, S. E. 2020. "Queering Menstruation: Trans and Non-Binary Identity and Body Politics." *Sociological Inquiry* 90:371–404.

RELEVANT AMA AND AMA-MSS POLICY

Nondiscriminatory Policy for the Health Care Needs of the LGBTQ+ Community

65.008MSS

AMA-MSS will ask the AMA to (1) encourage physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement; and (2) encourage individual physicians to display for patient and staff awareness-as one example: "This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or gender identity." MSS Res 27, A- 03; AMA Res 414, A-04 Adopted [D-65.996]; Amended: MSS Rep E, I-08; Reaffirmed: GC Rep B, I-13; Reaffirmed: MSS GC Rep A, I-19; Amended: LGBTQ+ Affairs Report A, A-21

Protection of Transgender Individuals' Right to Use Public Facilities in Accordance with Their Gender Identity 65.022MSS

AMA-MSS supports transgender individuals' right to use public facilities in accordance with their gender identity to mitigate harms. MSS Res 01, A-17

Access to Basic Human Services for Transgender Individuals H-65.964

1. Our AMA (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one's gender identity, including, but not limited

to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one's gender identity. Res. 010, A-17

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 051
(I-22)

Introduced by: Senila Yasmin, Tufts University School of Medicine; Raisa Rauf, Boston University School of Medicine; Neha [Aliya] Siddiqui, Vish Vijayakumar, Carle Illinois College of Medicine, University of Illinois Urbana Champaign; Nooralhuda Alhashim, Northeast Ohio Medical University College of Medicine; Elhaam Jawadi, Penn State College of Medicine.

Subject: Providing Modest Attire Options at Hospitals for Patients and Employees

Sponsored by: Region 5, Region 7, Asian Pacific American Medical Student Association, American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, There is a lack of inclusivity in the hospital and operating rooms when it comes to the availability of modest professional uniforms and hospital gowns;^{1,2} and

Whereas, Wearing modest or hijab-compliant professional attire is religiously obligatory for Muslim women observing hijab and a critical part of Muslim identity;³ and

Whereas, Members of the medical care team or other patients who do not identify as Muslims may also want to wear more modest clothing, due to spiritual, personal, or even medical reasons; and

Whereas, Certain practicing Mormons, Amish, Orthodox Jews, and Christians use modest apparel;⁴ and

Whereas, A 2020 study found that 4.5% of the total US physician workforce consists of physicians who are international medical graduates of Muslim-majority nations, and this number does not include Muslim physicians born in the United States so the total number of US Muslim physicians is likely higher;⁵ and

Whereas, The Institute for Social Policy and Understanding's (ISPU) *American Muslim Poll 2022: A Politics and Pandemic Status Report* found that Muslims were the most likely religious group to experience discrimination in institutional settings, especially when seeking healthcare services;⁶ and

Whereas, A national survey of American Muslim physicians in 2013 found that 24% of Muslims surveyed experience religious discrimination on the job;⁷ and

Whereas, There are many accounts of hijab-wearing Muslim women who state that their medical duties are hindered due to a lack of modest attire, such as wearing an N-95 respirator over a hijab;⁸ and

Whereas, Modest or ‘halal’ scrub options and medical hijabs exist, but are not laundered by hospitals or supplied by hospital-approved third parties, and therefore are not allowed into the operating room per hospital policy;⁸⁻¹⁰ and

Whereas, A 2018 study found wearing long sleeves while prepping a patient in the operating room decreases airborne contaminants;¹¹ and

Whereas, The Association of Perioperative Registered Nurses (AORN) released guidelines in 2015 that require individuals who are scrubbed to wear long-sleeves in the operating room;¹² and

Whereas, Despite concerns that long-sleeves can cause increased surgical site infections, a study found that the implementation of AORN’s guidelines about wearing long-sleeves in the operating room did not affect the frequency of surgical site infections;¹³ and

Whereas, A 2021 systematic review of 59 articles from 2000-2019 found no correlation between what was worn in the operating room and the incidence of surgical site infections;¹⁴ and

Whereas, A 2021 systematic review found that research studying the association between clothing in the operating room and surgical site infections is lacking, despite guidelines like those of AORN’s that stipulate operating room attire requirements;¹⁴ and

Whereas, The U.S. Equal Employment Opportunity Commission states, “...employers are required by federal law to make exceptions to their usual rules or references to permit employees to observe religious dress and grooming practices,” and that hospitals with restrictive policies could be liable for denial of accommodation without evidence that religious garb and grooming pose a workplace risk or hazard;¹⁵ and

Whereas, Modest, hospital-provided scrubs can serve as professional, clean and functional attire;⁸ and

Whereas, According to OSHA, personal protective equipment (PPE) is any equipment that is worn by an individual whose purpose is to protect against exposures to hazardous materials that can cause bodily harm in the workplace;¹⁶ and

Whereas, According to OSHA, PPE should “fit comfortably, encouraging worker use” but hijab observers often need to sacrifice comfort and ease of access for modesty;^{9,16} and

Whereas, According to OSHA, scrubs are considered “street clothing”, not PPE, and therefore should be covered under gowns, aprons, and laboratory coats in the operating room;¹⁷ and

Whereas, Before entering the operating room at most institutions, scrubs must be covered by an additional sterile gown after a healthcare provider properly scrubs in, covering anything they may be wearing below, including hospital laundered scrubs;¹⁸ and

Whereas, The American Hospital Association promotes the enhancement of cultural competency because cultural competency is recognized as an essential means of reducing racial and ethnic disparities in health care;¹⁹ and,

Whereas, Cultural competence is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients;^{20,21} and

Whereas, Cultural competence in the healthcare setting includes incorporating culture-specific attitudes and values into health promotion tools and willingness to make clinical settings more accessible to patients;^{20,21} and

Whereas, Lack of cultural competence may lead to patient dissatisfaction;^{20,21} and,

Whereas, Hospitals should provide modest scrubs for employees and hospital attire options for patients as well to promote cultural and religious inclusivity;^{2,6} and

Whereas, Some patients require modesty in interactions and in clothing during clinical encounters and procedures;^{2,22} and

Whereas, failure to provide modest accommodations for patients who require it is a predictor of delayed healthcare in certain patient populations;²³ and

Whereas, One approach of the AMA's 2021-2023 Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity is to build alliances and share power with physicians and stakeholders who have been historically marginalized & minoritized to "develop structures and processes to consistently center [their] experiences and ideas."²⁴ and

Whereas, Policy H-440.856 states that the AMA encourages all physicians to wear clean, appropriate attire, and research into textile transmission of infections;²⁵ and

Whereas, Policy H-440.810 states that the AMA encourages diverse PPE designs to fit all healthcare professional's body types, cultural expressions, and practices, but this policy fails to consider the religious obligations of modesty that some may follow and the fact that scrubs are not considered PPE according to OSHA;²⁶ and

Whereas, Policy H-65.949 states that the AMA encourages healthcare institutions to provide PPE that takes both patient safety and healthcare worker's natural hair/hairstyles or cultural headwear into account, but does not explicitly state whether this applies to religious and cultural modest clothing;²⁷ therefore be it

RESOLVED, Our AMA support the provision of safe, modest operating room scrubs and hospital attire options for both patients and employees.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Kishawi D. A Guide to Hijab in the Operating Room. Hijab in the OR. Published 2022. Accessed September 22, 2022. <https://hijabintheor.com/>
2. Attum B, Hafiz S, Malik A, Shamoon Z. Cultural Competence in the Care of Muslim Patients and Their Families. In: StatPearls. StatPearls Publishing; 2022. Accessed September 22, 2022. <http://www.ncbi.nlm.nih.gov/books/NBK499933/>

3. Is Hijab Compulsory in Islam? Islam Question & Answer. Published May 22, 2010. Accessed September 22, 2022. <https://islamqa.info/en/answers/47569/is-hijab-compulsory-in-islam>
4. Conan N. Modesty And Faith Connected In Many Religions. NPR. <https://www.npr.org/templates/story/story.php?storyId=126672354>. Published May 10, 2010. Accessed August 31, 2022.
5. Boulet JR, Duvivier RJ, Pinsky WW. Prevalence of International Medical Graduates From Muslim-Majority Nations in the US Physician Workforce From 2009 to 2019. JAMA Network Open. 2020;3(7):e209418. doi:10.1001/jamanetworkopen.2020.9418
6. Mogahed D, Ikramullah E, Chouhoud Y. American Muslim Poll 2022: A Politics and Pandemic Status Report. Institute for Social Policy and Understanding. Published August 23, 2022. Accessed September 22, 2022. <https://www.ispu.org/american-muslim-poll-2022-1/>
7. Mohamed B. New estimates show U.S. Muslim population continues to grow. Pew Research Center. Published January 3, 2018. Accessed August 10, 2022. <https://www.pewresearch.org/fact-tank/2018/01/03/new-estimates-show-u-s-muslim-population-continues-to-grow/>
8. Jacoby A. The First Medical Hijab For Muslim Women In Medicine. Medelita. Published March 7, 2019. Accessed August 31, 2022. <https://www.medelita.com/blog/medelita-medical-hijab-womens-day/>
9. Avicenna Scrubs. Avicenna Scrubs. Accessed September 18, 2022. <https://avicennascrubs.com/>
10. Long Sleeve Scrub Sethigh Quality Stretch Fabricembroider - Etsy. Accessed August 10, 2022. https://www.etsy.com/listing/1228836317/long-sleeve-scrub-sethigh-quality?ga_order=most_relevant&ga_search_type=all&ga_view_type=gallery&ga_search_query=halal+scrubs&ref=sr_gallery-1-10&pro=1&frs=1&organic_search_click=1
11. Markel TA, Gormley T, Greeley D, Ostojic J, Wagner J. Wearing long sleeves while prepping a patient in the operating room decreases airborne contaminants. American Journal of Infection Control. 2018;46(4):369-374. doi:10.1016/j.ajic.2017.10.016
12. Cowperthwaite L, Holm RL. Guideline Implementation: Surgical Attire. AORN Journal. 2015;101(2):188-197. doi:10.1016/j.aorn.2014.12.003
13. Elmously A, Gray KD, Michelassi F, et al. Operating Room Attire Policy and Healthcare Cost: Favoring Evidence over Action for Prevention of Surgical Site Infections. Journal of the American College of Surgeons. 2019;228(1):98-106. doi:10.1016/j.jamcollsurg.2018.06.010
14. Svetanoff WJ, Dekonenko C, Briggs KB, et al. Debunking the Myth: What You Really Need to Know about Clothing, Electronic Devices, and Surgical Site Infection. Journal of the American College of Surgeons. 2021;232(3):320-331.e7. doi:10.1016/j.jamcollsurg.2020.11.032
15. EEOC. Religious Garb and Grooming in the Workplace: Rights and Responsibilities. U.S. Equal Employment Opportunity Commission (EEOC). Published March 6, 2014. Accessed August 31, 2022. <https://www.eeoc.gov/laws/guidance/religious-garb-and-grooming-workplace-rights-and-responsibilities>
16. OSHA. Personal Protective Equipment. Occupational Safety and Health Administration. Accessed August 31, 2022. <https://www.osha.gov/personal-protective-equipment>
17. OSHA. Enforcement Procedures for the Occupational Exposure to Bloodborne Pathogens Standard, 29 CFR 1910.1030. Occupational Safety and Health Administration. Accessed August 31, 2022. <https://www.osha.gov/enforcement/directives/cpl-2-244c>

18. TeachMe Surgery. Scrubbing, Gowning, and Gloving. TeachMe Surgery. Published March 18, 2019. Accessed August 31, 2022. <https://teachmesurgery.com/skills/theatre-basics/scrubbing-gowning/>
19. Health Research & Educational Trust. Becoming a culturally competent health care organization. Health Research & Educational Trust. Published June 2013. Accessed September 22, 2022. <https://www.aha.org/system/files/hpoe/Reports-HPOE/becoming-culturally-competent-health-care-organization.PDF>
20. Liu J, Gill E, Li S. Revisiting cultural competence. The Clinical Teacher. 2021;18(2):191-197. doi:10.1111/tct.13269
21. Cultural Competence in Health Care: Is it important for people with chronic conditions? Health Policy Institute. Accessed September 22, 2022. <https://hpi.georgetown.edu/cultural>
22. Lawrence P, Rozmus C. Culturally sensitive care of the Muslim patient. J Transcult Nurs. 2001;12(3):228-233. doi:10.1177/104365960101200307
23. Vu M, Azmat A, Radejko T, Padela AI. Predictors of Delayed Healthcare Seeking Among American Muslim Women. Journal of Women's Health. 2016;25(6):586-593. doi:10.1089/jwh.2015.5517
24. AMA. The AMA's strategic plan to embed racial justice and advance health equity. American Medical Association. Accessed August 31, 2022. <https://www.ama-assn.org/about/leadership/ama-s-strategic-plan-embed-racial-justice-and-advance-health-equity>
25. H-440.856 Hospital Dress Codes for the Reduction of Health Care. AMA PolicyFinder. Published 2010. Accessed September 22, 2022. <https://policysearch.ama-assn.org/policyfinder/detail/Hospital%20Dress%20Codes%20for%20the%20Reduction%20of%20Health%20Care-Associated%20Infection%20Transmission%20of%20Disease%20H-440.856?uri=%2FAMADoc%2FHOD.xml-0-3872.xml>
26. H-440.810 Availability of Personal Protective Equipment (PPE). AMA PolicyFinder. Published 2021. Accessed September 18, 2022. <https://policysearch.ama-assn.org/policyfinder/detail/440.810?uri=%2FAMADoc%2FHOD.xml-H-440.810.xml>
27. H-65.949 Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism. AMA PolicyFinder. Published 2022. Accessed September 18, 2022. <https://policysearch.ama-assn.org/policyfinder/detail/Combating%20Natural%20Hair%20and%20Cultural%20Headwear%20Discrimination%20in%20Medicine%20and%20Medical%20Professionalism%20H-65.949?uri=%2FAMADoc%2FHOD.xml-H-65.949.xml>

RELEVANT AMA AND AMA-MSS POLICY

Availability of Personal Protective Equipment (PPE) H-440.810

1. Our AMA affirms that the medical staff of each health care institution should be integrally involved in disaster planning, strategy and tactical management of ongoing crises.
2. Our AMA supports evidence-based standards and national guidelines for PPE use, reuse, and appropriate cleaning/decontamination during surge conditions.
3. Our AMA will advocate that it is the responsibility of health care facilities to provide sufficient personal protective equipment (PPE) for all employees and staff, as well as trainees and contractors working in such facilities, in the event of a pandemic, natural disaster, or other surge in patient volume or PPE need.
4. Our AMA supports physicians and health care professionals and other workers in health care facilities in being permitted to use their professional judgement and augment institution-provided

PPE with additional, appropriately decontaminated, personally-provided personal protective equipment (PPE) without penalty.

5. Our AMA supports the rights of physicians and trainees to participate in public commentary addressing the adequacy of clinical resources and/or health and environmental safety conditions necessary to provide appropriate and safe care of patients and physicians during a pandemic or natural disaster.

6. Our AMA will work with the HHS Office of the Assistant Secretary for Preparedness and Response to gain an understanding of the PPE supply chain and ensure the adequacy of the Strategic National Stockpile for public health emergencies.

7. Our AMA encourages the diversification of personal protective equipment design to better fit all body types, cultural expressions and practices among healthcare personnel.

Res. 412, I-20; Appended: Res. 414, A-21; Modified: Res. 410, I-21

Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism H-65.949

Our AMA: (1) recognizes that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination; (2) opposes discrimination against individuals based on their hair or cultural headwear in health care settings; (3) acknowledges the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace; (4) encourages medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace; and (5) encourages healthcare institutions to provide adequate protective equipment in accordance with appropriate patient safety for healthcare workers with natural hair/hairstyles or cultural headwear.

Res. 006, A-22

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.

BOT Rep. 3, A-10; Reaffirmation A-15

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 052
(I-22)

Introduced by: Nathan Hendryx, Michaela Stamper, Olivia Safady, Michael Massey,
Saaleha Shamsi, Natasha Salmen, Caleigh Hitchcock, Diana Arredondo,
Luis Pozo, Nicholas Ventigan, Northeast Ohio Medical University

Subject: Improving Cardiovascular Screenings By Including Lipoprotein(a) (Lp(a))

Sponsored by Region 5

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Lipoprotein A (Lp(a)), a variant of low-density lipoprotein (LDL) with apolipoprotein(a) covalently bound to apolipoprotein-B100, can accumulate, promoting atherosclerosis and thrombosis;¹⁻⁹ and

Whereas, Elevated Lp(a) is genetically inherited on the LPA gene locus and is relatively independent of age, gender, and diet;^{1,7,9,10-13} and

Whereas, An estimated one in five people have elevated levels of Lp(a);^{1,2,9,13-16} and

Whereas, Lp(a) is a direct, risk factor for cardiovascular disease, independent of total cholesterol, High Density Lipoprotein-Cholesterol (HDL-C), triglycerides, and Low Density Lipoprotein-Cholesterol (LDL-C);^{7,9,13,15-17, 26} and

Whereas, Lp(a) is not traditionally included on lipid panel screening, as current guidelines suggest screening only in those with early atherosclerotic cardiovascular disease (ASCVD) or family history of early ASCVD;^{9,18,19} and

Whereas, Adult levels of Lp(a) are reached by the age of two, therefore Lp(a) screening can begin as early as childhood;²⁰ and

Whereas, Serum concentration of Lp(a) can be measured through a simple blood draw;^{1,8,21} and

Whereas, Lp(a) screening is a low cost test, ranging from \$11-\$179 before insurance;^{22,23} and

Whereas, Elevated Lp(a) would only require a one-time screening test to detect;^{1,9,24} and

Whereas the American Heart Association (AHA) and American College of Cardiology (ACC) call for an increase in Lp(a) screening and research based on the link between Lp(a) and ASCVD;^{2,25} and

1 Whereas, The European Society of Cardiology and European Atherosclerosis Society suggests
2 measurement of Lp(a) levels at least once in each adult lifetime;²⁰ and

3
4 Whereas, Lp(a) screening is not currently covered by Medicare as a biomarker for
5 cardiovascular risk assessment panel, which currently includes a basic lipid panel consisting of
6 total cholesterol, HDL-C, triglycerides, and LDL-C;^{2Mis6} and

7
8 Whereas, Testing of Lp(a) is more frequently conducted in non-Hispanic white patients and
9 those with private insurance; indicating potential barriers in access;²⁷ and

10
11 Whereas, 2018 AHA analysis found individuals of low socioeconomic status (SES), particularly
12 those with low income, have a heavier CVD burden and are more likely to face increased
13 cardiovascular event rates and poorer outcomes;³⁴ and

14
15 Whereas, Medicaid, by definition, provides health coverage to low-income families and
16 individuals, and the most recent Medicare beneficiary enrollment trends indicate Medicare and
17 Medicare Advantage enrollees are disproportionately lower-income;^{35, 36} and

18
19 Whereas, ASCVD is a major cause of mortality, hence risk factors such as elevated Lp(a)
20 should be detected early in order to initiate preventative care methodologies including lowering
21 LDL levels via pharmacological intervention, lifestyle and diet changes;^{1,2,8,9,28-30} and

22
23 Whereas, Recommendations have been made for the lab cut off values of Lp(a) which are
24 considered "elevated" to be lower in the African American population in comparison to other
25 groups due to direct correlation to ASCVD events, making accessible preventative screening an
26 even greater priority in this specific community;^{31,32} and

27
28 Whereas, No current FDA approved medications directly address Lp(a) levels, yet promising
29 candidates are currently undergoing clinical trials, providing a potential for future direct Lp(a)
30 pharmacological treatment options;^{1,9} and

31
32 Whereas, Addition of Lp(a) to preventative screening panels will provide a more accurate
33 estimation of Lp(a) prevalence and increase the number of potential participants in future clinical
34 trials evaluating potential treatments;³³ and

35
36 Whereas, By Lp(a) testing every patient enrolled in their cardiac prevention program for over 10
37 years, the Cleveland Clinic has built a sample of over 25,000 patients, from which they have
38 corroborated the cardiovascular event and direct cardiovascular mortality rate increase
39 associated with Lp(a);³³ and

40
41 Whereas, The Cleveland Clinic screening initiative may serve as an example of what nationwide
42 efforts could resemble and provide in terms of predictive value and resource allocation;^{33,37} and

Whereas, Current AMA policy calls for cholesterol management and emphasizes the need for preventative strategies in promoting the reduction of heart disease; therefore, be it

RESOLVED, Our AMA advocates medical providers add a one time screening for Lp(a) to one lipid panel run on each patient when deemed beneficial under their clinical judgment as it pertains to current literature; and be it further

RESOLVED, Our AMA urges the Centers for Medicare and Medicaid Services (CMS) to extend coverage of cardiovascular risk assessment to include Lp(a) screening when deemed clinically beneficial.

RESOLVED, That our AMA amend H-425.990 by addition:

Prevention of Coronary Artery Disease H-425.990

The AMA believes that (1) total serum cholesterol, High Density Lipoprotein-Cholesterol (HDL-C), triglycerides, and Low Density Lipoprotein-Cholesterol (LDL-C) should be measured under supervision of a physician, with proper safeguards for quality assurance and (2) when serum cholesterol levels are excessive, appropriate measures should be taken to educate the patient concerning methods to improve serum lipids and thereby reduce the risk of coronary heart disease and, additionally, (3) serum Lipoprotein (a) should be measured when deemed beneficial for prevention of future coronary events under the supervising physician's clinical judgment.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Elevated lipoprotein(a) - National Lipid Association Online.
https://www.lipid.org/sites/default/files/elevated_lipoprotein_a.pdf. Accessed August 29, 2022.
2. Lipoprotein(a) in clinical practice. American College of Cardiology.
<https://www.acc.org/latest-in-cardiology/articles/2019/07/02/08/05/lipoproteina-in-clinical-practice>. Accessed August 31, 2022.
3. Farzam K, Senthilkumaran S. Lipoprotein A. PubMed. Published 2021.
<https://www.ncbi.nlm.nih.gov/books/NBK570621/>
4. Vasquez N, Joshi PH. Lp(a): Addressing a Target for Cardiovascular Disease Prevention. Curr Cardiol Rep. 2019;21(9):102. Published 2019 Jul 31.
doi:10.1007/s11886-019-1182-0
5. Jang AY, Han SH, Sohn IS, Oh PC, Koh KK. Lipoprotein(a) and Cardiovascular Diseases - Revisited. Circ J. 2020;84(6):867-874. doi:10.1253/circj.CJ-20-0051

6. Gu J-X, Huang J, Li S-S, et al. Elevated lipoprotein(a) and genetic polymorphisms in the LPA gene may predict cardiovascular events. *Scientific reports*. 2022;12(1):3588. doi:10.1038/s41598-022-07596-4
7. Reyes-Soffer G, Gissette Reyes-Soffer Search for more papers by this author, Ginsberg HN, et al. Lipoprotein(a): A genetically determined, causal, and prevalent risk factor for atherosclerotic cardiovascular disease: A scientific statement from the American Heart Association. *Arteriosclerosis, Thrombosis, and Vascular Biology*. https://www.ahajournals.org/doi/10.1161/ATV.000000000000147?utm_campaign=science-news21-22&utm_source=science-news&utm_medium=phd-link&utm_content=phd-10-14-21. Published October 14, 2021. Accessed August 28, 2022.
8. Cegla J, France M, Marcovina SM, Neely RDG. Lp(a): When and how to measure it. *Ann Clin Biochem*. 2021;58(1):16-21. doi:10.1177/0004563220968473
9. Thanassoulis G. Screening for High Lipoprotein(a). *Circulation*. 2019;139(12):1493-1496. doi:10.1161/CIRCULATIONAHA.119.038989
10. Clarke R, Peden JF, Hopewell JC, et al. Genetic variants associated with Lp(a) lipoprotein level and coronary disease. *New England Journal of Medicine*. 2009;361(26):2518-2528. doi:10.1056/nejmoa0902604
11. Enas EA, Varkey B, Dharmarajan TS, Pare G, Bahl VK. Lipoprotein(a): An independent, genetic, and causal factor for cardiovascular disease and acute myocardial infarction. *Indian Heart Journal*. 2019;71(2):99-112. doi:10.1016/j.ihj.2019.03.004
12. Schmidt K, Noureen A, Kronenberg F, Utermann G. Structure, function, and genetics of lipoprotein (a). *Journal of Lipid Research*. 2016;57(8):1339-1359. doi:10.1194/jlr.r067314
13. Cho L. Why would my doctor order a lipoprotein(a) blood test? Cleveland Clinic. <https://health.clevelandclinic.org/why-would-my-doctor-order-a-lipoproteina-blood-test/>. Published December 10, 2021. Accessed August 26, 2022.
14. Brandt EJ, Mani A, Spatz ES, Desai NR, Nasir K. Lipoprotein(a) levels and association with myocardial infarction and stroke in a nationally representative cross-sectional US cohort. *J Clin Lipidol*. 2020;14(5):695-706.e4. doi:10.1016/j.jacl.2020.06.010
15. Lipoprotein(a), Cardiovascular Disease, and Contemporary Management. Jacobson, Terry A. *Mayo Clinic Proceedings*, Volume 88, Issue 11, 1294-1311
16. Burgess S, Ference BA, Staley JR, et al. Association of LPA Variants With Risk of Coronary Disease and the Implications for Lipoprotein(a)-Lowering Therapies: A Mendelian Randomization Analysis. *JAMA Cardiol*. 2018;3(7):619-627. doi:10.1001/jamacardio.2018.1470
17. Nordestgaard BG, Chapman MJ, Ray K, et al. Lipoprotein(a) as a cardiovascular risk factor: current status. *Eur Heart J*. 2010;31(23):2844-2853. doi:10.1093/eurheartj/ehq386
18. Arnett DK, Blumenthal RS, Albert MA, Buroker AB, Goldberger ZD, Hahn EJ, Himmelfarb CD, Khera A, Lloyd-Jones D, McEvoy JW, Michos ED, Miedema MD, Muñoz D, Smith SC Jr, Virani SS, Williams KA Sr, Yeboah J, Ziaeian B. 2019 ACC/AHA guideline on the primary prevention of cardiovascular disease: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Circulation*. 2019;140:e596–e646. DOI: 10.1161/ CIR.0000000000000678

19. Lipid panel: What it is, purpose, preparation & results. Cleveland Clinic. Updated November 9, 2021. Accessed August 26, 2022.
<https://my.clevelandclinic.org/health/diagnostics/17176-lipid-panel#:~:text=A%20lipid%20panel%20is%20a,a%20measurement%20of%20your%20triglycerides.>
20. Kohn B, Ashraf AP, Wilson DP. Should lipoprotein(a) be measured in youth? *The Journal of Pediatrics*. 2021;228:285-289. doi:10.1016/j.jpeds.2020.08.042
21. Lipoprotein (a) Blood Test. MedlinePlus. Accessed August 28, 2022.
<https://medlineplus.gov/lab-tests/lipoprotein-a-blood-test/>
22. Pearson A. Opinion: What about testing for lipoprotein(a)? *Medical News*.
<https://www.medpagetoday.com/opinion/skeptical-cardiologist/85423>. Published March 14, 2020. Accessed August 31, 2022.
23. Lipoprotein(a). Find Lab Tests Online. <https://www.findlabtest.com/lab-test/blood-tests-for-heart-disease/lipoprotein-a-labcorp-120188>. Published August 26, 2022. Accessed August 31, 2022.
24. Saeedi R, Frohlich J. Lipoprotein (a), an independent cardiovascular risk marker. *Clin Diabetes Endocrinol*. 2016;2:7. Published 2016 Mar 31. doi:10.1186/s40842-016-0024-x
25. Lipoprotein(a): A genetically determined, causal, and prevalent risk factor for atherosclerotic cardiovascular disease. *professional.heart.org*.
<https://professional.heart.org/en/science-news/lipoprotein-a-a-genetically-determined-causal-and-prevalent-risk-factor-for-ascvd/Commentary>. Published July 20, 2022. Accessed August 31, 2022.
26. MolDX: Biomarkers in cardiovascular risk assessment. CMS.gov Centers for Medicare & Medicaid Services. <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=36358>. Accessed August 31, 2022.
27. Michelle Kelsey, Courtney Page, Brooke Alhanti, Shannon L. Rhodes, Shia T. Kent, Eric Peterson, Neha Pagidipati, Lipoprotein(a) Testing Patterns in a Large Health System, *The American Journal of Cardiology*, Volume 153, 2021, pages 43-50, ISSN 0002-9149, <https://doi.org/10.1016/j.amjcard.2021.05.018>.
28. Ellulu MS, Patimah I, Khaza'ai H, Rahmat A, Abed Y, Ali F. Atherosclerotic cardiovascular disease: a review of initiators and protective factors. *Inflammopharmacology*. 2016;24(1):1-10. doi:10.1007/s10787-015-0255-y
29. Schmitz G, Orsó E. Lipoprotein(a) hyperlipidemia as cardiovascular risk factor: pathophysiological aspects. *Clin Res Cardiol Suppl*. 2015;10(Suppl 1):21-25. doi:10.1007/s11789-015-0074-0
30. Hill MF, Bordonni B. Hyperlipidemia - StatPearls - NCBI Bookshelf.
<https://www.ncbi.nlm.nih.gov/books/NBK559182/>. Published February 8, 2022. Accessed August 29, 2022.
31. Guan W, Cao J, Steffen BT, et al. Race is a key variable in assigning lipoprotein(a) cutoff values for coronary heart disease risk assessment: the Multi-Ethnic Study of Atherosclerosis. *Arterioscler Thromb Vasc Biol*. 2015;35(4):996-1001. doi:10.1161/ATVBAHA.114.304785
32. Virani SS, Brautbar A, Davis BC, et al. Associations between lipoprotein(a) levels and cardiovascular outcomes in black and white subjects: the Atherosclerosis Risk in

- Communities (ARIC) Study. *Circulation*. 2012;125(2):241-249.
doi:10.1161/CIRCULATIONAHA.111.045120
33. Leahy DR. The need to simplify lipoprotein(A) testing guidelines: Test everyone. *The Cardiology Advisor*.
<https://www.thecardiologyadvisor.com/home/topics/metabolic/lipoprotein-a-testing-guidelines-atherosclerotic-cardiovascular-disease-ascvd-cas/>. Published January 7, 2022. Accessed August 31, 2022.
34. Schultz WM, Kelli HM, Lisko JC, et al. Socioeconomic status and cardiovascular outcomes. *Circulation*. 2018;137(20):2166-2178. doi:10.1161/circulationaha.117.029652
35. Policy basics: Introduction to Medicaid. Center on Budget and Policy Priorities.
<https://www.cbpp.org/research/health/introduction-to-medicaid>. Published April 14, 2020. Accessed September 20, 2022.
36. Assistant Secretary For Planning and Evaluation, Tarazi W, Welch WP, et al.; 2022.
<https://aspe.hhs.gov/sites/default/files/documents/f81aafbba0b331c71c6e8bc66512e25d/medicare-beneficiary-enrollment-ib.pdf>. Accessed September 20, 2022.
37. Preventive Cardiology & Rehabilitation. Cleveland Clinic.
<https://my.clevelandclinic.org/departments/heart/depts/preventive-cardiology-rehabilitation#programs-clinics-tab>. Accessed September 20, 2022.

RELEVANT AMA AND AMA-MSS POLICY

Prevention of Coronary Artery Disease H-425.990

The AMA believes that (1) total serum cholesterol should be measured under supervision of a physician, with proper safeguards for quality assurance and (2) when serum cholesterol levels are excessive, appropriate measures should be taken to educate the patient concerning methods to improve serum lipids and thereby reduce the risk of coronary heart disease. Res. 165, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Combating Obesity and Health Disparities H-150.944

Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful dairy and nondairy beverages in school lunches and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of foods and beverages low in fat, added sugars, and cholesterol. Res. 413, A-07; Reaffirmation A-12; Reaffirmation A-13; Modified: CSAPH Rep. 03, A-17

Heart Disease in Women H-525.975

1. Our AMA supports increased awareness and education on preventive measures for heart disease in women and encourages comprehensive care of heart disease in women.
 2. Our AMA urges research to address the gaps in knowledge related to coronary pathophysiology and diagnostic, treatment, and interventional strategies for heart disease in women; and to better understand the role of demographic, socioeconomic, and psychological factors in the onset of heart disease in women.
- Res. 506, A-16

Clinical Preventive Services H-425.984

Implications for Adolescent, Adult, and Geriatric Medicine: (1) Prevention should be a philosophy that is espoused and practiced as early as possible in undergraduate medical schools, residency training, and continuing medical education, with heightened emphasis on the theory, value, and implementation of both clinical preventive services and population-based preventive medicine. (2) Practicing physicians should become familiar with authoritative clinical preventive services guidelines and routinely implement them as appropriate to the age, gender, and individual risk/environmental factors applicable to the patients in the practice at every opportunity, including episodic/acute care visits. (3) Where appropriate, clinical preventive services recommendations should be based on outcomes-based research and effectiveness data. Federal and private funding should be increased for further investigations into outcomes, application, and public policy aspects of clinical preventive services.

CSA Rep. D, I-92; Reaffirmed by CME Rep. 5, I-95; Reaffirmed and Modified: CSA Rep. 8, A-05; Reaffirmed: BOT Rep. 8, I-06; Reaffirmed: CSAPH Rep. 01, A-16

Value of Preventive Services H-460.894

Our AMA: (1) encourages committees that make preventive services recommendations to: (a) follow processes that promote transparency and clarity among their methods; (b) develop evidence reviews and recommendations with enough specificity to inform cost-effectiveness analyses; (c) rely on the very best evidence available, with consideration of expert consensus only when other evidence is not available; (d) work together to identify preventive services that are not supported by evidence or are not cost-effective, with the goal of prioritizing preventive services; and (e) consider the development of recommendations on both primary and secondary prevention; (2) encourages relevant national medical specialty societies to provide input during the preventive services recommendation development process; (3) encourages comparative-effectiveness research on secondary prevention to provide data that could support evidence-based decision making; and (4) encourages public and private payers to cover preventive services for which consensus has emerged in the recommendations of multiple guidelines-making groups.

CMS-CSAPH Rep. 01, A-17

Preventive Services H-425.997

1. Our AMA encourages the development of policies and mechanisms to assure the continuity, coordination and continuous availability of patient care, including professional preventive care and early-detection screening services, provided the services are cost effective.

2. It is the policy of the AMA that any preventive service that is being considered for inclusion in public or private sector insurance products have evidence-based data to demonstrate improved outcomes or quality of life and the cost effectiveness of the service.

3. Our AMA believes that preventive care should ideally be coordinated by a patient's physician. BOT Rep. A, NCCMC Rec. 31, A-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report and Reaffirmed and Appended: CMS Rep. 7, A-00; Reaffirmed in lieu of Res. 104, A-06; Reaffirmation A-07; Modified and Reaffirmed: Sub. Res. 101, A-08; Reaffirmed: CMS Rep. 03, I-16; Reaffirmed: CMS Rep. 03, I-17; Reaffirmed: CMS Rep. 06, A-19

8.11 Health Promotion and Preventive Care

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

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

(b) Educate patients about relevant modifiable risk factors.

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

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

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

AMA Principles of Medical Ethics: V,VII

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

AMA Endorsement of Screening Tests or Standards G-600.064

(1) Delegates, state, or specialty societies submitting a resolution seeking endorsement or AMA adoption of specific screening tests must also submit an evidence-based review that determines the strength or quality of the evidence supporting their request, and that evaluates the degree to which the test satisfies the minimal criteria for validating the appropriateness of the screening test, which are: (a) the test must be able to detect the target condition earlier than without screening and with sufficient accuracy to avoid producing large numbers of false-positive and false-negative results; and (b) screening for and treating persons with early disease should improve the likelihood of favorable health outcomes compared with treating patients when they present with signs or symptoms of disease. (2) This review will be made available to the reference committee, which will either recommend to the House of Delegates that the resolution be referred or not be adopted.

Preventive Medicine Services H-425.987

1. Our AMA supports (A) continuing to work with the appropriate national medical specialty societies in evaluating and coordinating the development of practice parameters, including those for preventive services; (B) continuing to actively encourage the insurance industry to offer products that include coverage for general preventive services; and (C) appropriate reimbursement and coding for established preventive services.

2. Our AMA will seek legislation or regulation so that evidence-based screenings are paid for separately when provided as part of a comprehensive well-patient examination/review.

CMS Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-07; Reaffirmed and Appended: Res. 804, I-11; Reaffirmed in lieu of Res. 107, A-12; Reaffirmed: Res. 123, A-17

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 053
(I-22)

Introduced by: Aliah McCalla, Halimah Hamidu-Egiebor, Central Michigan University
College of Medicine

Subject: Ensuring Basic Ophthalmology Training in Medical Education

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Recent studies have shown that in the United States, there are approximately 12 million people who are 40 years or older who have a vision impairment, 1 million individuals who are blind, and 8 million patients who are visually impaired because they have uncorrected refractive error¹; and

Whereas, As of 2018, 10.5% of the population had diabetes and one in twenty-nine (4.1 million) Americans have diabetic retinopathy²⁻⁴; and

Whereas, Furthermore, in 2018, there was a reported crude annual glaucoma prevalence rate of 29.76%, 22.74%, 19.89%, and 18.04% in patients self-described as Black, Asian, Hispanic and North American Natives respectively³; and

Whereas, Eye disease and vision loss significantly impact the quality of life in patients due to the potential loss of the independence, ability to work, socialize and potential impact on patients mental health and because there is also a higher prevalence of diabetic retinopathy and glaucoma in underserved populations it is extremely imperative that we as physicians are equipped with the skillset and knowledge required to screen patients^{2,4,5-7}; and

Whereas, The detection of diabetic retinopathy and glaucoma can be achieved via a simple in office diagnostic techniques such as tonometry and ophthalmoscopy⁴; and

Whereas, Through effective diagnostic ophthalmic glaucoma and diabetic retinopathy screening education, medical students, regardless of their specialty could help screen patients for common oculopathies that have the potential to cause irreversible vision loss ^{2,4}; and

Whereas, There is a formidable reduction in the amount of ophthalmic education received by medical students, because ophthalmology clinical rotations are no longer a mandatory component of medical education and only 30% of institutions have implemented a mandatory ophthalmology clinical education requirement^{8,9}; and

Whereas, In 2018 the Association of University Professors of Ophthalmology (AUPO) conducted a study on the practice of ophthalmic education in medicine which suggested that the implementation of a dedicated director of medical student education in the schools ophthalmic department resulted in more curricular time dedicated ophthalmology education^{9, 11-13}; and

Whereas, institutions that required students to be exposed to ophthalmology during their pre-clinical medical education had significantly better baseline primary care ophthalmologic skills which is especially important because analysis of graduating medical students suggests that an estimated 70% of medical student's graduates are unable to use an ophthalmoscope properly^{5,9,10}; and

Whereas, Many underserved populations have barriers to healthcare access and may encounter challenges in attending ophthalmology specialists; therefore to avoid the dire consequences of patients being unable to attend an ophthalmologist for routine oculopathies such as glaucoma and diabetic retinopathy, there is a greater importance for primary care physicians to be trained as to how to perform initial ocular screenings^{8,9,10}; and

Whereas, there currently is no relevant AMA policy related to increasing ophthalmology medical education; therefore be it

RESOLVED, That our AMA will work with stakeholders to promote education in ophthalmology and supports integrating training in ophthalmology in medical education, to promote competency in screenings for oculopathies.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

- 1.National Diabetes Statistics Report 2020. Estimates of diabetes and its burden in the United States. Published online 2020:32.
- 2.The Prevalence of Diabetic Retinopathy Among Adults in the United States | Diabetic Retinopathy | JAMA Ophthalmology | JAMA Network. Accessed August 18, 2022. <https://jamanetwork.com/journals/jamaophthalmology/fullarticle/416212>
- 3.Glaucoma | Examination-Based Studies | Information on Data Sources | Vision & Eye Health Surveillance System | Vision Health Initiative (VHI) | CDC. Accessed August 18, 2022. <https://www.cdc.gov/visionhealth/vehss/data/studies/glaucoma.html>
- 4.Glaucoma and the Primary Care Physician | 2000-07-10 | AHC Media:.... Accessed August 18, 2022. <https://www.reliasmedia.com/articles/54940-glaucoma-and-the-primary-care-physician>
- 5.Committee on Public Health Approaches to Reduce Vision Impairment and Promote Eye Health, Board on Population Health and Public Health Practice, Health and Medicine Division, National Academies of Sciences, Engineering, and Medicine. Making Eye Health a Population Health Imperative: Vision for Tomorrow. (Teutsch SM, McCoy MA, Woodbury RB, Welp A, eds.). National Academies Press; 2016:23471. doi:10.17226/23471
- 6.Chou CF, Frances Cotch M, Vitale S, et al. Age-Related Eye Diseases and Visual Impairment Among U.S. Adults. American Journal of Preventive Medicine. 2013;45(1):29-35. doi:10.1016/j.amepre.2013.02.018
- 7.Carter K, Miller KM. Ophthalmology inpatient consultation. Ophthalmology. 2001;108(8):1505-1511. doi:10.1016/S0161-6420(01)00630-3
- 8.Grewal D. Emotional Intelligence and Graduate Medical Education. JAMA. 2008;300(10):1200. doi:10.1001/jama.300.10.1200

9.Moxon NR, Goyal A, Giaconi JA, et al. The State of Ophthalmology Medical Student Education in the United States: An Update. *Ophthalmology*. 2020;127(11):1451-1453. doi:10.1016/j.ophtha.2020.05.001

10.Allison K, Patel D, Alabi O. Epidemiology of Glaucoma: The Past, Present, and Predictions for the Future. *Cureus*. Published online November 24, 2020. doi:10.7759/cureus.11686

11.Flexner A. Medical education in the United States and Canada. From the Carnegie Foundation for the Advancement of Teaching, Bulletin Number Four, 1910. *Bulletin of the World Health Organization*. 2002;80(7):594.

12.Gilmour G, McKivigan J. Evaluating medical students; proficiency with a handheld ophthalmoscope: a pilot study. *AMEP*. 2016;Volume 8:33-36. doi:10.2147/AMEP.S119440

13.Selvendran S, Biswas S, Aggarwal N. Improving medical students; proficiency in ophthalmoscopy. *AMEP*. 2017;Volume 8:219-220. doi:10.2147/AMEP.S133314

RELEVANT AMA AND AMA-MSS POLICY

65.010MSS Promoting Awareness and Education of LGBTQ+ Health Issues on Medical School Campuses

Promoting Awareness and Education of LGBTQ+ Health Issues on Medical School Campuses
AMA-MSS (1) supports medical student interest groups to organize and congregate under the auspices of furthering their medical education or enhancing patient care by improving their knowledge and understanding of various communities – without regard to their gender, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students who wish to conduct on-campus educational seminars and workshops on health issues in LGBTQ+ communities; (3) encourages the LCME to require all medical schools to incorporate GLBT LGBTQ+ health issues in their curricula; and (4) reaffirms its opposition to discrimination against any medical student on the basis of sexual orientation.

(MSS Amended Res 28, A-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Amended: LGBTQ+ Affairs Report A, A-21)

295.029MSS Medical Student Legislative Awareness

AMA-MSS will recommended that: (1) medical students actively encourage state medical societies to sponsor legislative awareness workshops for students and that MSS chapters should establish a dialogue between medical society legislative personnel; and (2) all medical students register to vote, keep abreast of legislators' positions on issues that affect physicians, and actively contact legislators for their support of such issues. (COLRP Rep A, A-91) (AMA Res 14, A-91 Adopted [H-295.953]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

Channeling of Eye Examinations to Optometrists H-35.976

The AMA advocates to all third party payers organized medicine's strong opposition to: (a) channeling enrollees to optometrists and other non-physicians; (b) designating optometrists as primary eye care providers; (c) shifting patients from ophthalmologists to optometrists; and (d) excluding ophthalmologists from performing refractive eye examinations, routine eye examinations, or primary eye care. The AMA, state medical societies, and national medical specialty societies seek introduction of legislation prohibiting third party payers from mandating that routine and refractive examinations be performed by optometrists rather than by ophthalmologists.

Res. 213, A-98; Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: BOT Rep. 09, A-19

Encouraging Vision Screenings for Schoolchildren H-425.977

Our AMA: (1) encourages and supports outreach efforts to provide vision screenings for school-age children prior to primary school enrollment; (2) encourages the development of programs to improve school readiness by detecting undiagnosed vision problems; and (3) supports periodic pediatric eye screenings based on evidence-based guidelines with referral to an ophthalmologist for a comprehensive professional evaluation as appropriate.

Res. 430, A-05; Modified: CSAPH Rep. 1, A-15

Use of Protective Eyewear by Athletes H-10.970

Our AMA supports the use of protective eyewear for sports participants who have had intraocular surgery or eye trauma, or are functionally one-eyed individuals, and for all other sports participants engaged in high-risk eye injury sports, as advocated by the American Academy of Pediatrics and the American Academy of Ophthalmology.

Res. 404, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18

VA Technology-Based Eye Care Services H-510.982

Our AMA encourages the Department of Veterans Affairs to continue to explore telemedicine approaches that increase access to quality health care to U.S. veterans, including the Technology-Based Eye Care Services (TECS) program; and will work with Congress to ensure that U.S. veterans can access eye care through the TECS program.

Res. 111, A-17

Prescribing Eye Medications H-120.996

Our AMA (1) reaffirms its policy that only physicians licensed to practice medicine and surgery are qualified to prescribe or apply eye medications; and (2) continues to urge that state medical societies oppose legislation or administrative attempts to give optometrists a license to prescribe or apply medications or to diagnose disease or injury or to diagnose the absence of disease or injury.

Sub. Res. 76, A-76; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation A-99; Reaffirmed: BOT Rep. 23, A-09; Reaffirmed: BOT Rep. 09, A-19

Eye Exams for the Elderly H-25.990

Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings.

Res. 813, I-05; Reaffirmed: CSAPH Rep. 1, A-15

Evaluation of Iridology H-175.998

Our AMA believes that iridology, the study of the iris of the human eye, has not yet been established as having any merit as a diagnostic technique.

CSA Rep. F, A-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21

Advancing Gender Equity in Medicine D-65.989

1. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral criteria; (c) encourage a

specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.

2. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.

3. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.

4. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

5. Our AMA will: (a) require all members elected and appointed to national and regional AMA leadership positions to complete AMA Code of Conduct and anti-harassment training, with continued evaluation of the training for effectiveness in reducing harassment within the AMA; and (b) work with the Women Physicians Section, American Medical Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer to leadership.

Res. 010, A-18; Modified: BOT Rep. 27, A-19; Appended: Res. 615, A-22

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.

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

Creating an Effective Environment for Medical Student Education H-295.900

1. The AMA encourages the development of a model student orientation program that includes workshops that address health awareness for students and standards of behavior for teachers and learners.

2. Our AMA will: (A) ask the Liaison Committee on Medical Education to ensure that medical schools have policies to protect medical students from retaliation based on reporting incidents of mistreatment; and (B) through the Learning Environment Study, conduct research and disseminate findings on the medical education learning environment including the positive and negative elements of that environment that impact the teacher-learner relationship; and (C) encourage the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine to identify best practices and strategies to assure an appropriate learning environment for medical students.

CME Rep. 9, A-98; Reaffirmed: CME Rep. 2, A-08; Appended: CME Rep. 9, A-13

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.. Our AMA will encourage adding educational webinars, workshops and other didactics via remote learning formats to enhance the educational needs of smaller training programs.

CME Rep. C, I-90; Reaffirmation A-00; Reaffirmation A-01; Reaffirmation I-01; Reaffirmed: CME Rep. 1, I-08; Reaffirmed: CEJA Rep. 06, A-18; Appended: Res. 956, I-18; Appended: Res. 318, A-19; Modified: CME Rep. 3, I-21

Encouraging Health Activism by Physicians H-425.989

Our AMA encourages physicians to participate in educational workshops designed to help physicians incorporate the techniques of primary prevention and health promotion in their daily practices.

Res. 14, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 054
(I-22)

Introduced by: Alec Calac, University of California San Diego School of Medicine; Sarah Mae Smith, University of California Irvine School of Medicine; Camille Adajar, University of Nevada Las Vegas School of Medicine; Julia Seiberling, University of California Riverside School of Medicine; Cecily Negri, Southern Illinois University School of Medicine; Druv Bhagavan, Washington University in St. Louis School of Medicine; Adrienne Nguyen, Des Moines University College of Osteopathic Medicine; Renato Guerrieri, McGovern Medical School at University of Texas Health; Caitlin Aguirre, University of Texas Medical Branch John Sealy School of Medicine; Aparna Kanjhlia, Medical College of Georgia; Allie Conry, University of South Carolina School of Medicine Greenville; Jara Crawford, Indiana University School of Medicine; Rommel Morales, Northeast Ohio Medical University; Leah Knox, University of Toledo College of Medicine and Life Sciences; Matthew Swanson, Frank H Netter MD School of Medicine; Krishna Channa, University of Connecticut School of Medicine

Subject: Expanded Housing Voucher Anti-Discrimination Protections

Sponsored by: Region 1, Region 2, Region 4, Region 5, Region 6, Region 7, Association of Native American Medical Students, Asian Pacific American Medical Student Association, PsychSIGN, American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Adequate, safe, and affordable housing is an important social determinant of health, yet studies on subsidized housing and health are limited in number and scope¹; and

Whereas, Individuals in need of federal housing assistance and subsidized housing may bear a greater burden of mental and physical illness, physical violence and economic hardship than the general population¹⁻²; and

Whereas, The US Department of Health and Human Services and Housing Urban Development (HUD) entered into a partnership in 2021 to expand affordable housing access, along with services that address social determinants of health among vulnerable populations³; and

Whereas, The federal housing choice voucher program, commonly referred to as "Section 8" is a federal housing program for tenants experiencing economic and related hardships^{2,4}; and

Whereas, 2 in 3 voucher households are not protected by anti-discrimination laws at the local, state, or federal level, allowing for landlords to discriminate against and refuse the use of the Section 8 vouchers by prospective tenants⁵; and

Whereas, Over two-thirds of HUD beneficiaries (Section 8 or related program) are racial and ethnic minorities, with 45% identifying as Black or African American⁷; and

Whereas, Racial and ethnic minorities are less likely to be homeowners due to disparate intergenerational wealth compared to the non-Hispanic white population⁸⁻⁹;

Whereas, Our AMA recognizes that generational wealth gaps experienced by Black or African American, American Indian or Alaska Native, and Hispanic families are a consequence of structural racism and a barrier to achieving racial health equity (D-60.965); and

Whereas, Families' length of stay in the Section 8 Housing Choice Voucher program is increasing and rate of success in finding suitable low-income housing to utilize the voucher has been decreasing since the 1980s, both largely due to rising housing costs, stagnant incomes, and insufficient federal funding¹⁰; and

Whereas, The increasing wait times in Section 8 reinforce existing housing insecurity and homelessness that track among disparities in race, especially in the difficulty of finding and maintaining employment, and increasing childhood adverse events, leading to cognitive and mental health problems, respiratory diseases, accidental and intentional injuries, and diminished educational outcomes¹¹; therefore be it

RESOLVED, our AMA support local, state, and federal policies requiring landlords to accept Section 8 and related housing vouchers as valid sources of individual and family income; and be it further

RESOLVED, our AMA support local, state, and federal policies preventing landlords from discriminating against individuals and families who utilize public assistance.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Pomeroy ML, Johnson E, Weinstein AA. Subsidized Housing and Health: An Exploratory Study Examining Resident Perspectives on Community Health and Access to Care. J Health Care Poor Underserved. 2021;32(3):1415-1432. doi:10.1353/hpu.2021.0141
2. Jayasundara DS, Legerski EM, Danis FS, Ruddell R. Oil Development and Intimate Partner Violence: Implementation of Section 8 Housing Policies in the Bakken Region of North Dakota and Montana. J Interpers Violence. 2018;33(21):3388-3416. doi:10.1177/0886260518798359
3. HHS and HUD announce expanded partnership, new housing and services resource center. Published December 8, 2021. Accessed September 22, 2022. https://www.hud.gov/press/press_releases_media_advisories/hud_no_21_201
4. Housing Choice Vouchers Fact Sheet. U.S. Department of Housing and Urban Development. Accessed September 22, 2022. https://www.hud.gov/topics/housing_choice_voucher_program_section_8
5. Bell, A., Sard, B., Koepnick, B. Prohibiting Discrimination Against Renters Using Housing Vouchers Improves Results. Center on Budget and Policy Priorities. Last Updated December 20, 2018. Accessed September 22, 2022. <https://www.cbpp.org/research/housing/prohibiting-discrimination-against-renters-using-housing-vouchers-improves-results>

6. Ellen, I., O'Regan, K., Harwood, K. Advancing Choice in the Housing Choice Voucher Program: Source of Income Protections and Locational Outcomes. *Housing Policy Debate*. 2022. DOI: 10.1080/10511482.2022.2089196
7. Public Housing Statistics. *iProperty Management*. Last Updated May 9, 2022. Accessed September 22, 2022. <https://ipropertymanagement.com/research/public-housing-statistics>
8. Fenton, R. Unaffordable housing: cost-burdened housing estimates for South Carolina's minority population. *South Carolina State Library*. Published August 9, 2022. Accessed September 22, 2022. <https://dc.statelibrary.sc.gov/handle/10827/45438>
9. Eldemire, A., Luchtenberg, K., Wynter, M. Does Homeownership Reduce Wealth Disparities for Low-Income and Minority Households? *The Review of Corporate Finance Studies*. Volume 11, Issue 3. August 2022: Pages 465–510, <https://doi.org/10.1093/rcfs/cfac016>
10. Section 8 Family Data. *Section 8 Information*. Published March 24, 2020. Accessed August 28, 2022. <https://section8-information.org/section-8-statistics/>
11. Acosta S, Gartland E. Families Wait Years for Housing Vouchers Due to Inadequate Funding. Center on Budget and Policy Priorities. <https://www.cbpp.org/research/housing/families-wait-years-for-housing-vouchers-due-to-inadequate-funding>. Published July 22, 2021. Accessed September 18, 2022.

RELEVANT AMA AND AMA-MSS POLICY

Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data H-350.953

Our AMA will: (1) oppose policies that enable racial housing segregation; and (2) advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool.

Res. 405, A-18

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; and

(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.

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 055
(I-22)

Introduced by: Victoria Panwala, Washington State University School of Medicine; Andrea Zhang, University of Miami Miller School of Medicine; Preetham Bachina, Johns Hopkins University School of Medicine

Subject: Advocating for access to safer smoking kits as part of harm reduction services

Sponsored by: PsychSIGN

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

1 Whereas, Fentanyl, a synthetic opioid which has become the main contributor to the opioid
2 overdose epidemic in the United States is more often reported to be smoked than injected^{9 1,8};
3 and
4

5 Whereas, People who smoked fentanyl instead of injecting opioids reported improved health,
6 fewer financial constraints, fewer abscesses, reduced stigma and not needing to purchase
7 fentanyl as often as supplies last longer when smoked rather than injected¹⁰; and
8

9 Whereas, Providing safer smoking supplies at syringe service programs provides individuals
10 with a safer alternative to injection drug use, thus reducing risk of overdose, soft tissue
11 infections and endocarditis, and risk of infectious disease transmission from injection drug use<sup>1-
12 4,18,19</sup>; and
13

14 Whereas, Safer smoking supplies consist of but are not limited to glass stems and pipes, plastic
15 mouthpieces for burn prevention, screens, wooden push sticks, and alcohol wipes¹; and
16

17 Whereas, Safer smoking supplies reduce the risk of transmission of Hepatitis C and HIV from
18 people sharing smoking equipment^{1,2}; and
19

20 Whereas, Providing safer smoking supplies has been shown to reduce risky smoking
21 behaviors^{7,8}; and
22

23 Whereas, Lack of access to new pipes is a reported reason why people who use drugs use
24 damaged pipes, report sharing pipes, or use self-made pipes^{5,20}; and
25

26 Whereas, Self-made pipes increase risk for injury and chemical burns inside the mouth and
27 near the lips since materials such as plastic bottles or tin cans can give off toxic vapors and
28 cause respiratory damage^{6,17}; and

Whereas, A 2008 study by Leonard et al in the *International Journal of Drug Policy* that involved people who inject drugs in Canada reported a 25% increase in smoking instead of injection of crack 6 months after they had access to clean smoking equipment¹²; and

Whereas, A 2017 study by Prangnell et al in the *BMC Public Health* journal evaluated rates of health problems associated with crack smoking during the expansion of safer smoking kit distribution in Vancouver, Canada, and found that study participants who obtained safer smoking kits were significantly less likely to report health problems from smoking crack than participants who made their own pipes or acquired them elsewhere²¹; and

Whereas, A pilot program of safer smoking supply distribution at the Tacoma Needle Exchange showed a 64% increase in new individuals coming to the SSP for the first time, proving both the demand for this service, and the increased opportunity to engage new individuals in harm reduction¹; and

Whereas, A pilot program of safer smoking supply distribution at the Tacoma Needle Exchange distributed safer smoking supplies in 94% of encounters at the site, thus illustrating the demand for safer smoking supplies¹; and

Whereas, International studies elsewhere in North America and abroad demonstrate the harm reduction efficacy of safer smoking kits^{14-17,21}; and

Whereas, The sale, import, and export of safer smoking supplies is illegal under Title 21 U.S. Code 863 – Drug paraphernalia, which prevents syringe service programs and other harm reduction programs from distributing them, and prevents the allocation of public funds for their distribution^{1,8,11}; therefore be it

RESOLVED, Our AMA will produce an informational press release or infographic codifying its support for the distribution of safer smoking kits and detailing evidence in favor of their distribution; and be it further

RESOLVED, That our AMA amend Policy D-95.987 by addition to read as follows; and be it further

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 or distribution of “drug paraphernalia” designed for harm reduction from drug use, including but not limited to drug contamination testing, safer smoking kit materials, and injection drug preparation, use, and disposal supplies.

5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.

6. Our AMA will advocate for the decriminalization of distribution of “drug paraphernalia” for harm reduction purposes at both a state and federal level.

RESOLVED, That our AMA amend Policy H-95.989 by addition to read as follows; and be it further

Drug Paraphernalia H-95.989

The AMA opposes the manufacture, sale and use of drug paraphernalia except as it pertains to harm reduction materials such as but not limited to safer smoking kit materials, sterile syringes, and drug contamination testing materials.

RESOLVED, That our AMA amend Policy H-95.958 by addition to read as follows; and be it further

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 and other harm reduction materials including safer smoking kits.

RESOLVED, That our AMA collaborate with state and local medical societies and other relevant stakeholders to advocate for the distribution of safer smoking kits at all syringe exchange/harm reduction programs; and be it further

RESOLVED, That our AMA collaborate with state and local medical societies and other relevant stakeholders to allocate public funding for distribution of safer smoking kits and to eliminate barriers to the use of public funding for such distribution.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Singh S, Banta-Green C, Kingston S. *Distribution of Safer Drug Smoking Supplies as a Public Health Strategy*. 2022. January 2022. <https://adai.uw.edu/safer-smoking/>
2. *Issue Brief: Smoking Supplies for Harm Reduction*. https://www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/IssueBrief_SmokingSupplies_Web_ADA.pdf
3. Leonard L, DeRubeis E, Pelude L, Medd E, Birkett N, Seto J. "I inject less as I have easier access to pipes": Injecting, and sharing of crack-smoking materials, decline as safer crack-smoking resources are distributed. *International Journal of Drug Policy*. 2008/06/01/ 2008;19(3):255-264. doi:<https://doi.org/10.1016/j.drugpo.2007.02.008>
4. Pizzey R, Hunt N. Distributing foil from needle and syringe programmes (NSPs) to promote transitions from heroin injecting to chasing: An evaluation. *Harm Reduction Journal*. 2008/07/21 2008;5(1):24. doi:10.1186/1477-7517-5-24
5. Cheng T, Wood E, Nguyen P, Montaner J, Kerr T, DeBeck K. Crack pipe sharing among street-involved youth in a Canadian setting. *Drug Alcohol Rev*. May 2015;34(3):259-66. doi:10.1111/dar.12180
6. Porter J, Bonilla L. Crack users' cracked lips: an additional HIV risk factor. *Am J Public Health*. 1993 Oct;83(10):1490-1. doi: 10.2105/ajph.83.10.1490-a. PMID: 8214248; PMCID: PMC1694867.
7. Frankeberger J, Cepeda A, Natera-Rey G, Valdez A. Safer Crack Kits and Smoking Practices: Effectiveness of a Harm Reduction Intervention among Active Crack Users in Mexico City. *Subst Use Misuse*. 2019;54(4):592-600. doi:10.1080/10826084.2018.1528460
8. Wohlfeil S. Experts say safe smoking supplies could reduce harm of fentanyl. *Inlander*. March 17, 2022. <https://www.inlander.com/spokane/experts-say-safe-smoking-supplies-could-reduce-harm-of-fentanyl/Content?oid=23459408>
9. Issue brief: Nation's drug-related overdose and death epidemic continues to worsen. American Medical Association; February 15, 2022. <https://www.ama-assn.org/system/files/issue-brief-increases-in-opioid-related-overdose.pdf>
10. Kral AH, Lambdin BH, Browne EN, et al. Transition from injecting opioids to smoking fentanyl in San Francisco, California. *Drug Alcohol Depend*. 2021;227:109003. doi:10.1016/j.drugalcdep.2021.109003.
11. Drug paraphernalia. 21 United States Code § 863. 2010. <https://www.govinfo.gov/app/details/USCODE-2010-title21/USCODE-2010-title21-chap13-subchapl-partD-sec863/summary>
12. Leonard L, DeRubeis E, Pelude L, Medd E, Birkett N, Seto J. "I inject less as I have easier access to pipes": injecting, and sharing of crack-smoking materials, decline as safer crack-smoking resources are distributed. *Int J Drug Policy*. 2008;19(3):255-264. doi:10.1016/j.drugpo.2007.02.008
13. Goldman JE, Wayne KM, Periera KA, Krieger MS, Yedinak JL, Marshall BDL. Perspectives on rapid fentanyl test strips as a harm reduction practice among young

- adults who use drugs: a qualitative study. *Harm Reduction Journal*. 2019/01/08 2019;16(1):3. doi:10.1186/s12954-018-0276-0
14. Miskovic, M. et al. Distribution of Harm Reduction Kits in a Specialty HIV Hospital. *Am. J. Public Health*. 2018
 15. Ivsins, A. Uptake, benefits of and barriers to safer crack use kit (SCUK) distribution programmes in Victoria, Canada--a qualitative exploration. *Int. J. Drug Policy* . 2011
 16. Frankenberger, J. Safer Crack Kits and Smoking Practices: Effectiveness of a Harm Reduction Intervention among Active Crack Users in Mexico City. *Subst. Use. Misuse*. 2019
 17. Harris M. An urgent impetus for action: safe inhalation interventions to reduce COVID-19 transmission and fatality risk among people who smoke crack cocaine in the United Kingdom. *Int J Drug Policy*. 2020;83:102829. doi:10.1016/j.drugpo.2020.102829
 18. Macías J, Palacios RB, Claro E, et al. High prevalence of hepatitis C virus infection among noninjecting drug users: association with sharing the inhalation implements of crack. *Liver Int*. 2008;28(6):781-786. doi:10.1111/j.1478-3231.2008.01688.x
 19. Shannon K, Ishida T, Morgan R, et al. Potential community and public health impacts of medically supervised safer smoking facilities for crack cocaine users. *Harm Reduct J*. 2006;3:1. Published 2006 Jan 10. doi:10.1186/1477-7517-3-1
 20. Ti L, Buxton J, Wood E, Zhang R, Montaner J, Kerr T. Difficulty accessing crack pipes and crack pipe sharing among people who use drugs in Vancouver, Canada. *Subst Abuse Treat Prev Policy*. 2011;6:34. Published 2011 Dec 30. doi:10.1186/1747-597X-6-34
 21. Prangnell A, Dong H, Daly P, Milloy MJ, Kerr T, Hayashi K. Declining rates of health problems associated with crack smoking during the expansion of crack pipe distribution in Vancouver, Canada. *BMC Public Health*. 2017;17(1):163. Published 2017 Feb 3. doi:10.1186/s12889-017-4099-9.

RELEVANT AMA AND AMA-MSS Policy

Prevention of Drug-Related Overdose D-95.987

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

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the 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.

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

Drug Paraphernalia H-95.989

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

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

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.

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.

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 056
(I-22)

Introduced by: Frank F. Zhou, David Geffen School of Medicine at University of California
Los Angeles; Julia Houshmand, Miami Miller School of Medicine

Subject: Ensuring Fair Opportunities for International Medical Students

Sponsored by: Region 1

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, International students make up more than 10% of the United States graduate student population but only 0.6% of matriculants to United States medical schools¹⁻³; and

Whereas, Only 50 out of 171 United States allopathic medical schools and 19 out of 45 United States osteopathic medical schools currently consider international applicants for admission^{4,5}; and

Whereas, Only 17% of international applicants to allopathic programs are accepted to at least one program while 38% of domestic applicants are accepted to at least one program^{6,7}; and

Whereas, The cost of applying to and attending medical school is a significant financial barrier that prevents talented students from entering a career in medicine⁸; and

Whereas, International medical students face additional financial barriers to domestic students, given that international students are ineligible for federal financial aid, require a American co-signer to take out private loans, and may be required to deposit up to four years of tuition upfront into an escrow account prior to matriculation^{7,9,10}; and

Whereas, Many, if not most national medical student scholarships, including the AMA Physicians of Tomorrow scholarship, the Tylenol Future Care scholarship, and the National Medical Fellowships awards, are restricted to domestic students only¹¹⁻¹³; and

Whereas, International medical students offer valuable diversity of thought, cultural perspectives, and unique life experiences that enrich the educational environment of medical school campuses^{9,14}; and

Whereas, Accepting applications from international students allows medical schools and the United States to attract and retain the best and brightest future doctors from around the world¹⁵; and

Whereas, International medical students can complement efforts to improve physician workforce diversity by better mirroring an increasingly cosmopolitan United States patient population⁹; and

Whereas, The AMA already affirms the participation of international students at United States medical schools, advocates for admissions processes that focus primarily on personal qualities, and believes that cost should not be a barrier towards medical education; therefore be it

RESOLVED, That our AMA will encourage additional medical schools to consider applications from and to admit international students to their programs alongside domestic students; and be it further

RESOLVED, That our AMA will amend policy H-255.968 “Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools”; and be it further

Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools H-255.968

Our AMA:

1. supports the autonomy of medical schools to determine optimal tuition requirements for international students;
2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance;
3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); and
4. encourages medical schools to minimize the use of prepayment requirements, such as escrow accounts, unless deemed truly necessary; and
5. encourages medical schools that continue to require prepayment to consider requesting only one year of prepayment at a time, rather than all four years at once; and
- 4- 6. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, for four years for covering the costs of medical school.

RESOLVED, That our AMA will urge organizations that administer medical student scholarships to also allow international medical students to apply for those scholarships.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Open Doors. IIE Open Doors / Academic Level. IIE Open Doors / Academic Level. Accessed September 22, 2022. <https://opendoorsdata.org/data/international-students/academic-level/>
2. National Center for Education Statistics. The Integrated Postsecondary Education Data System. Accessed September 22, 2022. <https://nces.ed.gov/ipeds/search/ViewTable?tableId=29448>
3. AAMC. Matriculants to U.S. MD-Granting Medical Schools by State of Legal Residence, 2012-2013 through 2021-2022. <https://www.aamc.org/media/6011/download?attachment>
4. Medical School Admission Requirements. Accessed August 30, 2022. <https://mec.aamc.org/msar-ui/#/landing>
5. American Association of Colleges of Osteopathic Medicine. Choose DO Explorer. Choose DO. Accessed September 22, 2022. <https://choosedo.org/explorer/>
6. Table A-7.2: Applicants, First-Time Applicants, Acceptees, and Matriculants to U.S. MD-

- Granting Medical Schools by Sex, 2012-2013 through 2021-2022.
7. Docs A. Applying to Medical School as an International Applicant. AAMC Students & Residents. Accessed August 30, 2022. <https://students-residents.aamc.org/applying-medical-school/applying-medical-school-international-applicant>
 8. National Academies of Sciences E, Division H and M, Practice B on PH and PH. *Financial Barriers to Medical Education*. National Academies Press (US); 2018. Accessed August 30, 2022. <https://www.ncbi.nlm.nih.gov/books/NBK518880/>
 9. Datta J, Miller BM. International students in United States' medical schools: does the medical community know they exist? *Med Educ Online*. 2012;17:10.3402/meo.v17i0.15748. doi:10.3402/meo.v17i0.15748
 10. Virji AZ. As a non-U.S. citizen, I faced hurdles applying to U.S. medical schools. Now that I've made it, I want to help others like me. AAMC. Accessed September 22, 2022. <https://www.aamc.org/news-insights/non-us-citizen-i-faced-hurdles-applying-us-medical-schools-now-i-ve-made-it-i-want-help-others-me>
 11. AMA Physicians of Tomorrow Scholarship. AMA Foundation. Accessed August 30, 2022. <https://amafoundation.org/programs/scholarships/>
 12. Tylenol Future Care Scholarship FAQ. https://www.tylenol.com/sites/tylenol_us/files/22-23_tylenolr_future_care_scholarship_faq.pdf
 13. National Medical Fellowships. Scholarships and Awards. Published June 28, 2021. Accessed August 30, 2022. <https://nmfonline.org/scholarships-programs/scholarships-and-awards/>
 14. Krislov M. Why International Students Are Good For Colleges, Universities And America. Forbes. Accessed August 30, 2022. <https://www.forbes.com/sites/marvinkrislov/2019/03/22/why-international-students-are-good-for-colleges-universities-and-america/>
 15. Retaining U.S. International Student Graduates Could Help Fill Millions of Critical Job Openings. FWD.us. Accessed August 30, 2022. <https://www.fwd.us/news/us-international-students/>

RELEVANT AMA AND AMA-MSS POLICY

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
 2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
 3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
 4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
 5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
 6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.
- Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22

Progress in Medical Education: the Medical School Admission Process H-295.888

1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.
 2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school.
- CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11; Reaffirmed: CME Rep. 1, A-21

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.

7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring

that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that

individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 057
(I-22)

Introduced by: Jordyn Lee, Florida Atlantic University Schmidt College of Medicine;
Madeline Holt, Rachel Donaldson, University of South Carolina School of
Medicine Greenville; Matthew Alwyn, Sam Houston State University College
of Osteopathic Medicine; Ariana Maleki, University of Texas Health San
Antonio

Subject: Use of ICD and CPT Codes to Improve Response to Human Trafficking

Sponsored by: American Medical Women's Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, studies estimate that up to 88% of human trafficking victims had contact with a healthcare provider while being trafficked, highlighting the important role a provider can have in identifying and treating victims of human trafficking¹; and

Whereas, In June of 2018, the Centers for Disease Control and Prevention (CDC) introduced new codes in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) to describe human trafficking (HT), which included codes for both suspected and confirmed cases of HT in pediatric and adult patients²; and

Whereas, The use of these new ICD-10 codes for HT can improve continuity of care for trafficked persons, identify potential risk factors for HT, facilitate criminal prosecution of trafficking cases, and highlight the healthcare needs of victims³⁻⁵; and

Whereas, The use of ICD codes provides a source of epidemiological data that can be used to track incidence and/or reoccurrence of sexual or labor exploitation of individuals, inform public policy and HT prevention efforts, and facilitate development of services and resources for victims^{3,4}; and

Whereas, Preliminary reports suggest that the use of ICD codes for HT is not uniform or widespread, and does not appropriately reflect the volume of HT victims that access healthcare services⁶⁻⁸; and

Whereas, Low utilization of HT ICD codes may be attributed to (1) failure to identify HT victims, (2) lack of awareness of the new ICD codes and their appropriate use, and/or (3) concerns regarding patient privacy and safety when suspected or confirmed HT is documented in the EHR^{3,7-9}; and

Whereas, Consistent identification and clinical documentation of HT with ICD codes is critical to develop effective response strategies and protocol in clinical settings that provide resources to victims beyond the National Human Trafficking Hotline or notification of law enforcement⁴; and

Whereas, Continued education of healthcare providers regarding recognition and treatment of HT victims, along with education of providers and coding professionals regarding documentation of suspected or confirmed HT in the EHR using ICD codes, would promote increased utilization of these codes¹⁰; and

Whereas, Concerns regarding patient safety and/or stigmatization related to documentation of suspected or confirmed HT within the EHR should be addressed through implementation of innovative privacy standards, such as data segmentation that allows differential access to sensitive health information^{9,11}; and

Whereas, A precedent for appropriate use of HT ICD codes exist in the form of interpersonal violence (IPV) ICD codes, which include child abuse, elder abuse, and domestic violence, and which have been in use since the early 2000s⁷, which can inform the development of educational materials and protocols regarding HT ICD coding; and,

Whereas, Increased documentation of HT in the EHR could promote subsequent development of Current Procedural Terminology (CPT) codes which describe anti-trafficking efforts such as screening, identification, reporting, and intervention, to allow for physician reimbursement of these important services⁴; and

Whereas, Current AMA policy H-65.966: Physicians Response to Victims of Human Trafficking, and directive D-170.992: Human Trafficking / Slavery Awareness emphasize education of physicians regarding recognition and reporting of HT in clinical settings; and

Whereas, Current AMA policy does not address the documentation of suspected or confirmed human trafficking in the EHR and appropriate use of HT ICD codes by providers and coding professionals, or the reimbursement of anti-trafficking efforts; therefore be it

RESOLVED, That our AMA supports increased utilization of the International Classification of Diseases (ICD) codes that describe suspected and confirmed cases of human trafficking; and be it further

RESOLVED, That our AMA supports the use of electronic health record data which references suspected or confirmed human trafficking by relevant stakeholders in the development of targeted services and resources to address the needs of victims; and be it further

RESOLVED, That our AMA study the development of physician reimbursement models that support anti-trafficking efforts including victim identification, intervention, and referral.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. McAmis NE, Mirabella AC, McCarthy EM, et al. Assessing healthcare provider knowledge of human trafficking. *PLoS One*. 2022;17(3):e0264338. Published 2022 Mar 9. doi:10.1371/journal.pone.0264338
2. Kerr PL, Bryant G. Use of ICD-10 Codes for Human Trafficking: Analysis of Data From a Large, Multisite Clinical Database in the United States. *Public Health Reports*. 2022;137(1_suppl):83S-90S. doi:10.1177/00333549221095631
3. American Hospital Association. ICD-10-CM Coding for Human Trafficking. September 2018. Retrieved from: <https://www.aha.org/system/files/2018-09/icd-10-code-human-trafficking.pdf>
4. Macias-Konstantopoulos, WL. Diagnosis codes for human trafficking can help assess incidence, risk factors, and comorbid illness and injury. December 2018. Retrieved from: <https://journalofethics.ama-assn.org/article/diagnosis-codes-human-trafficking-can-help-assess-incidence-risk-factors-and-comorbid-illness-and/2018-12>
5. Lederer, L., Wetzel, C. A. The Health Consequences of Sex Trafficking and Their Implications for Identifying Victims in Healthcare Facilities.” *Annals of Health Law*, Volume 23, Issue 1, 61-91. 2014
6. Medical journeys of victims of exploitation and trafficking: a retrospective cohort study using a large multi-state dataset and new ICD-10 codes Kezban Yagci Sokat, Alexander Gutfraind, Guido Muscioni, Sami Alahmadi, Jonathan Hudlow, Ronald Hershow, Beau Norgeot
medRxiv 2022.05.02.22274579; doi: <https://doi.org/10.1101/2022.05.02.22274579>
7. Kerr PL, Bryant G. Use of ICD-10 Codes for Human Trafficking: Analysis of Data From a Large, Multisite Clinical Database in the United States. *Public Health Reports*. 2022;137(1_suppl):83S-90S. doi:10.1177/00333549221095631
8. Garg A, Panda P, Malay S, Slain KN. Human Trafficking ICD-10 Code Utilization in Pediatric Tertiary Care Centers Within the United States. *Front Pediatr*. 2022;10:818043. Published 2022 Feb 18. doi:10.3389/fped.2022.818043
<https://www.frontiersin.org/articles/10.3389/fped.2022.818043/full>
9. Greenbaum J, Garrett A, Chon K, Bishop M, Luke J, Stoklosa H. Principles for Safe Implementation of ICD Codes for Human Trafficking. *Journal of Law, Medicine & Ethics*. 2021;49(2):285-289. doi:10.1017/jme.2021.40
10. Monestime JP, Mayer RW, Blackwood A. Analyzing the ICD-10-CM Transition and Post-implementation Stages: A Public Health Institution Case Study. *Perspect Health Inf Manag*. 2019;16(Spring):1a. Published 2019 Apr 1.
11. International Center for Missing and Exploited Children. Documenting ICD codes and other sensitive information in electronic health records. January 2011. Retrieved from: <https://www.aha.org/system/files/media/file/2021/03/documenting-icd-10-codes-other-sensitive-information-in-electronic-health-record.pdf>

RELEVANT AMA AND AMA-MSS POLICY**Physicians Response to Victims of Human Trafficking H-65.966**

1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.

Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.

The US Department of State defines human trafficking as an activity in which someone obtains

or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

The Polaris Project -

In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:

- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
 - a. An assessment tool for health care professionals
 - b. Online training in recognizing and responding to human trafficking in a health care context
 - c. Speakers and materials for in-person training
 - d. Links to local resources across the country

The Rescue & Restore Campaign -

The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.

BOT Rep. 20, A-13; Appended: Res. 313, A-15

Human Trafficking / Slavery Awareness D-170.992

Our AMA will study the awareness and effectiveness of physician education regarding the recognition and reporting of human trafficking and slavery.

Res. 015, A-18

The Identification and Protection of Human Trafficking Victims 515.008MSS

AMA-MSS

- (1) supports the development of educational initiatives to train medical students, residents and physicians to understand their role in treating and screening for human trafficking in suspected patients;
- (2) supports AMA encouragement of editors and publishers of medical training literature to include indications that a patient might be a victim of human trafficking and suggested screening questions as created by Department of Health and Human Services;
- (3) Supports the AMA working with the Department of Health and Human Services, and law enforcement agencies to develop guidelines for use in hospital and office settings in order to better identify victims of human trafficking and to provide a conduit to resources that can better address all of the victim's medical, legal and social needs; and
- (4) encourages physicians to act as first responders in addressing human trafficking. (MSS Res 19, A-12) (Reaffirmed: MSS GC Report A, I-17)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 058
(I-22)

Introduced by: Chandana Kulkarni, Peter Park, Anne Burnett Marion School of Medicine at Texas Christian University; John Slunecka, University of South Dakota Sanford School of Medicine; Mohamed Jimale, University of Texas Medical Branch; Emily Smith, Carle Illinois College of Medicine; Preston Wilson Louisiana State University Health Shreveport; Udit Vyas, Indiana University School of Medicine; Gino Dettorre, Victoria Mityul, Washington University School of Medicine in St. Louis; Kaye Dandrea, University of New England College of Osteopathic Medicine; Brandon Parker, Florida State University College of Medicine; Wyatt Lanik, University of Nebraska College of Medicine; Jacob Beiriger, Sidney Kimmel Medical College

Subject: Artificial Intelligence-Integrated Software for Image Manipulation Detection

Sponsored by: Region 4 and Region 6

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

1 Whereas, Up to one-fifth of published life-sciences papers contain at least one digitally altered
2 image¹⁻⁴; and
3

4 Whereas, A 2016 independent investigation found that 784 papers of the 20,621 screened in 40
5 scientific journals had evidence of manipulated Western blot images prompting dozens of
6 retractions, and overall, 3.8% of published papers contained problematic figures, with at least
7 half exhibiting features suggestive of deliberate manipulation^{1,2,5,6,18}; and
8

9 Whereas, A 2018 study investigating 960 papers found 59 papers (6%) showed inappropriate
10 image duplication in papers published in American Society of Microbiology's "*Molecular and*
11 *Cellular Biology*" over a 7 year period^{3,5-7}; and

12 Whereas, A 2022 investigation published in *Science* found that a canonical study done in 2006
13 at the University of Minnesota, cited more than 2,200 times in other academic papers, reported
14 the oligomer A β *56 as a culprit in causing the dementia phenotype seen in Alzheimer's Disease
15 (AD), but this conclusion was based on hundreds of tampered images⁸⁻¹⁰; and
16

17 Whereas, *Elsevier*, *JAMA*, *Wiley*, *Springer*, and *Nature* published a new guide on the preprint
18 server Open Science Framework, outlining best-practice recommendations for detecting image
19 manipulation, and how publishers could use review software across hundreds of thousands of
20 papers^{1,5,11}; and
21

22 Whereas, Reports from December 2021 show that publishers, like the *American Association for*
23 *Cancer Research (AACR)*, utilize artificial intelligence (AI) software to spot duplications and
24 partial duplications before publication¹²; and
25

Whereas, The publisher *Frontiers* developed an AI-image combing tool called *AIRA (Artificial Intelligence Review Assistant)* to run automated checks on all submitted manuscripts, of which only 10% require follow-up from the human integrity team^{1,13,14}; and

Whereas, Firms like *LPIXEL* in Tokyo and *Proofig* in Rehovot, Israel both provide customized automated software for detection of image duplication or manipulation that can be purchased by researchers or publishers to quickly analyze images that have been duplicated, rotated, flipped, stretched, filtered, or otherwise manipulated^{11,15,16}; and

Whereas, Image-integrity specialists agree that it is difficult to evaluate software products already on the market as they have not been publicly compared using standardized tests, due to the lack of a database against which they could test the tool^{12,13,17,18}; and

Whereas, Image integrity guidelines must be further standardized, enforced and integrated with AI and Machine Learning (ML) software in order to curb further academic misconduct and prevent patient mistrust in medical research and innovations^{2,4-7,12,17-21}; and

Whereas, AMA policy urges medical schools and biomedical research institutions to implement the mechanisms for preventing scientific fraud (H-460.966), supports the peer review process and encourages scientific collaboration between academic institutions (H-460.972), there is no comment on automating these mechanisms for further efficiency of manuscript review; and

Whereas, AMA policy advocates for AI-integration into healthcare (H-480.939), there is no existing AMA or AMA-MSS policy supporting further research into the creation or establishment of standardized affordable AI-integrated software program engineered for review of scientific image integrity; therefore be it

RESOLVED, That our AMA work with relevant stakeholders to promote the creation of a nationally collaborative database of images from retracted publications to provide a test bank for researchers developing automated image screening tools.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Publishers unite to tackle doctored images in research papers. Accessed August 15, 2022. <https://www.nature.com/articles/d41586-021-02610-7>
2. Bik EM, Casadevall A, Fang FC. The Prevalence of Inappropriate Image Duplication in Biomedical Research Publications. *mBio*. 2016;7(3):e00809-16. doi:10.1128/mBio.00809-16
3. Else H, Van Noorden R. The fight against fake-paper factories that churn out sham science. *Nature*. 2021;591(7851):516-519. doi:10.1038/d41586-021-00733-5
4. Baker M. Problematic images found in 4% of biomedical papers. *Nature*. Published online April 22, 2016. doi:10.1038/nature.2016.19802
5. Bik EM, Fang FC, Kullas AL, Davis RJ, Casadevall A. Analysis and Correction of Inappropriate Image Duplication: the Molecular and Cellular Biology Experience. *Mol Cell Biol*. 2018;38(20):e00309-18. doi:10.1128/MCB.00309-18
6. Study: 35,000 Papers May Have Retraction-Worthy Image Duplication. The Scientist Magazine®. Accessed September 17, 2022. <https://www.the-scientist.com/news-opinion/study--35-000-papers-contain-retraction-worthy-image-duplication--64430>

7. Eye for Manipulation: A Profile of Elisabeth Bik. The Scientist Magazine®. Accessed September 17, 2022. <https://www.the-scientist.com/news-opinion/eye-for-manipulation--a-profile-of-elisabeth-bik-65839>
8. Potential fabrication in research images threatens key theory of Alzheimer's disease. Accessed August 15, 2022. <https://www.science.org/content/article/potential-fabrication-research-images-threatens-key-theory-alzheimers-disease>
9. Grimes DR. What an Alzheimer's Controversy Reveals About the Pressures of Academia. The Atlantic. Published July 29, 2022. Accessed August 15, 2022. <https://www.theatlantic.com/science/archive/2022/07/alzheimers-disease-data-fraud-sylvain-lesne/670995/>
10. Mamo J. What allegations of Alzheimer's research fraud mean for patients. The Conversation. Accessed August 15, 2022. <http://theconversation.com/what-allegations-of-alzheimers-research-fraud-mean-for-patients-187911>
11. Van Noorden R. Publishers launch joint effort to tackle altered images in research papers. *Nature*. Published online May 13, 2020. doi:10.1038/d41586-020-01410-9
12. Van Noorden R. Journals adopt AI to spot duplicated images in manuscripts. *Nature*. 2021;601(7891):14-15. doi:10.1038/d41586-021-03807-6
13. Communications F. Artificial Intelligence to help meet global demand for high-quality, objective peer-review in publishing - Science & research news | Frontiers. Published July 1, 2020. Accessed September 17, 2022. <https://blog.frontiersin.org/2020/07/01/artificial-intelligence-to-help-meet-global-demand-for-high-quality-objective-peer-review-in-publishing/>
14. Communications F. Research Integrity: Identifying and tackling peer review fraud - Science & research news | Frontiers. Published August 10, 2021. Accessed September 17, 2022. <https://blog.frontiersin.org/2021/08/10/research-integrity-identifying-and-tackling-peer-review-fraud/>
15. Image Proofing & Integrity | Proofing LTD. | Software for. proofing. Accessed September 7, 2022. <https://www.proofing.com>
16. Quach K. Publishers use AI to catch bad scientists doctoring data. Accessed September 17, 2022. https://www.theregister.com/2022/09/12/academic_publishers_are_using_ai/
17. Butler D. Researchers have finally created a tool to spot duplicated images across thousands of papers. *Nature*. 2018;555(7694):18-18. doi:10.1038/d41586-018-02421-3
18. Publisher uses artificial intelligence software to detect fraud in scientific data • Registry. Time News. Published September 12, 2022. Accessed September 17, 2022. <https://time.news/publisher-uses-artificial-intelligence-software-to-detect-fraud-in-scientific-data-registry/>
19. Acuna DE, Brookes PS, Kording KP. Bioscience-scale automated detection of figure element reuse. Published online February 23, 2018;269415. doi:10.1101/269415
20. Williams CL, Casadevall A, Jackson S. Figure errors, sloppy science, and fraud: keeping eyes on your data. *J Clin Invest*. 129(5):1805-1807. doi:10.1172/JCI128380
21. Gu J, Wang X, Li C, et al. AI-enabled image fraud in scientific publications. *Patterns*. 2022;3(7):100511. doi:10.1016/j.patter.2022.100511

RELEVANT AMA AND AMA-MSS POLICY

Scientific Fraud and Misrepresentation H-460.966

Our AMA: (1) urges medical schools and biomedical research institutions to implement the guidelines set forth in Framework for Institutional Policies and Procedures to Deal With Fraud in Research; (2) urges the Liaison Committee on Medical Education to require the programs that it accredits to have in place a formal process for dealing with alleged instances of scientific fraud;

and (3) urges medical schools and biomedical research institutions to install a mechanism for promoting structured discussions of ethics in research and clinical practice with required participation by medical students, graduate students, and research fellows.

Joint Report CSA & CEJA, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CEJA Rep. 6, A-10; Reaffirmed: CEJA Rep. 01, A-20

Fraud and Misrepresentation in Science H-460.972

The AMA:

- (1) supports the promotion of structured discussions of ethics that include research, clinical practice, and basic human values within all medical school curricula and fellowship training programs;
- (2) supports the promotion, through AMA publications and other vehicles, of (a) a clear understanding of the scientific process, possible sources of error, and the difference between intentional and unintentional scientific misrepresentation, and (b) multidisciplinary discussions to formulate a standardized definition of scientific fraud and misrepresentation that elaborates on unacceptable behavior;
- (3) supports the promotion of discussions on the peer review process and the role of the physician investigator;
- (4) supports the development of specific standardized guidelines dealing with the disposition of primary research data, authorship responsibilities, supervision of research trainees, role of institutional standards, and potential sanctions for individuals proved guilty of scientific misconduct;
- (5) supports the sharing of information about scientific misconduct among institutions, funding agencies, professional societies, and biomedical research journals; and
- (6) will educate, at appropriate intervals, physicians and physicians-in-training about the currently defined difference between being an "author" and being a "contributor" as defined by the Uniform Requirements for Manuscripts of the International Committee of Medical Journal Editors, as well as the varied potential for industry bias between these terms.

CSA Rep. F, I-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-03; Appended: Res. 311, A-11; Reaffirmed: CEJA Rep. 1, A-21

Augmented Intelligence in Health Care H-480.939

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

- 1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
- 2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
- 3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on (a) clinical validation; (b) alignment with clinical decision-making that is familiar to physicians; and (c) high-quality clinical evidence.
- 4. Payment and coverage for health care AI systems must (a) be informed by real world workflow and human-centered design principles; (b) enable physicians to prepare for and

transition to new care delivery models; (c) support effective communication and engagement between patients, physicians, and the health care team; (d) seamlessly integrate clinical, administrative, and population health management functions into workflow; and (e) seek end-user feedback to support iterative product improvement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Augmented Intelligence in Health Care H-480.940

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

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
 2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
 3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:
 - a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
 - b. is transparent;
 - c. conforms to leading standards for reproducibility;
 - d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
 - e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
 4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
 5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI.
- BOT Rep. 41, A-18

Ethically Sound Innovation in Clinical Practice E-1.2.11

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

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

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

- (a) Innovate on the basis of sound scientific evidence and appropriate clinical expertise.
- (b) Seek input from colleagues or other medical professionals in advance or as early as possible in the course of innovation.
- (c) Design innovations so as to minimize risks to individual patients and maximize the likelihood of application and benefit for populations of patients.
- (d) Be sensitive to the cost implications of innovation.
- (e) Be aware of influences that may drive the creation and adoption of innovative practices for reasons other than patient or public benefit.

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

- (f) Base recommendations on patients' medical needs.

- (g) Refrain from offering such services until they have acquired appropriate knowledge and skills.
- (h) Recognize that in this context informed decision making requires the physician to disclose:
 - (i) how a recommended diagnostic or therapeutic service differs from the standard therapeutic approach if one exists;
 - (ii) why the physician is recommending the innovative modality;
 - (iii) what the known or anticipated risks, benefits, and burdens of the recommended therapy and alternatives are;
 - (iv) what experience the professional community in general and the physician individually has had to date with the innovative therapy;
 - (v) what conflicts of interest the physician may have with respect to the recommended therapy.
- (i) Discontinue any innovative therapies that are not benefiting the patient.
- (j) Be transparent and share findings from their use of innovative therapies with peers in some manner. To promote patient safety and quality, physicians should share both immediate or delayed positive and negative outcomes.

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

- (k) Ensure that innovative practices or technologies that are made available to physicians meet the highest standards for scientifically sound design and clinical value.
- (l) Require that physicians who adopt innovations into their practice have relevant knowledge and skills.
- (m) Provide meaningful professional oversight of innovation in patient care.
- (n) Encourage physician-innovators to collect and share information about the resources needed to implement their innovations safely, effectively, and equitably.

AMA Principles of Medical Ethics: V,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; Amended: 2021 Amended: 2022

480.027MSS Encouraging Collaboration between Physicians and Industry in AI Development

Our AMA-MSS will ask the AMA to augment the existing Physician Innovation Network (PIN) through the creation of advisors to specifically link physicians members of AMA and its associated specialty societies with companies or individuals working on augmented intelligence (AI) research and development, focusing on: (a) expanding recruitment among AMA physician members; (b) advising AMA physician members who are interested in healthcare innovation/AI without knowledge or proper channels to pursue their ideas; (c) increasing outreach from AMA to industry leaders and companies to both further promote the PIN and to understand the needs of specific companies; (d) facilitating communication between companies and physicians with similar interests; (e) matching physicians to projects early in their design and testing stages; (f) decreasing the time and workload spent by individual physicians on finding projects themselves; and (g) above all, boosting physician-centered innovation in the field of AI research and development. Our AMA-MSS will ask the AMA to support selection of PIN advisors through an application process where candidates are screened by PIN leadership for interpersonal skills, problem solving, networking abilities, objective decision making, and familiarity with industry. (MSS Res. 121, Nov. 2020)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 059
(I-22)

Introduced by: Victoria Mousa, Erin Ladine, Kimberly Ibarra, Kelsey Hu, Radhika Patel, Kim Chi Dang, Laura Knitting, Claire Schumann, Sam Houston State University; Leonard Wang, University of Texas Medical Branch, Praneet Paidisetty, McGovern Medical School

Subject: Support for Medicare Expansion to Wheelchair Accessibility Home Modifications as Durable Medical Equipment

Sponsored by: Region 3

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, The 2010 United States Census reported that 3.6 million individuals utilize a wheelchair and 11.6 million used a cane, crutches or walker to assist with ambulation¹; and

Whereas, A report from the U.S. Department of Housing and Urban Development Office of Policy Development and Research reports that 89.2% of persons with disability live in inaccessible housing²; and

Whereas, Over 50% of households with a resident reliant on wheeled mobility equipment have homes with stairs at the front entrance that may inhibit their ability to freely enter their home²; and

Whereas, The United Nations Convention on the Rights of Persons with Disabilities, Article 9 safeguards the right of persons with disabilities to live in an accessible environment⁵; and

Whereas, A Joint Statement by the Department of Justice and Department of Housing and Urban Development on the Fair Housing Act requires that passage into and within all premises of covered dwellings may have an accessible route for wheelchair users¹⁴; and

Whereas, The Fair Housing Act also require usable kitchen and bathrooms such that an individual using a wheelchair can maneuver about and use this space¹⁴; and

Whereas, One study noted that 16% of injuries from wheelchair accidents from falls required medical intervention, most commonly for fractures and concussions³; and

Whereas, A study that employed wheeled mobility device users found that 90% of participants reported that their participation was limited when surfaces higher than their wheeled device were encountered, indicating the value that wheelchair ramps can provide¹²; and

Whereas, Researchers at the National Disability Institute found that on average households containing an adult with a physical disability, 28% more income, or an additional \$17,690 a year to obtain the same standard of living^{4,11}; and

Whereas, Medicare Part B covers medically necessary equipment defined as Durable Medical Equipment including wheelchairs, scooters, traction equipment, however not including wheelchair ramps as medically necessary¹³; and

Whereas, A single-blind randomized controlled trial in New Zealand found a 31% reduction in the rate of fall injuries at home per year following home stairs modification intervention compared with households in the control group without home modification⁷; and

Whereas, A study that assessed the factors that influence the risk of falling after spinal cord injury found lack of necessary home modification to be a major determinant⁹; and

Whereas, Spinal cord injury patient participants in the 2020 BMJ Open study noted that “egregious cost of home modifications” are reason for lack of proper accommodations and increased incidence of fall⁹; and

Whereas, Independence in mobility, as provided by necessary wheelchair home modifications, has been deemed a key factor in preserving function and maintaining life satisfaction among wheelchair users^{6,8,10}; and

RESOLVED, That our AMA amend current policy Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs D-330.899 to state the following

Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs D-330.899

Our AMA: (1) will request that the Centers for Medicare and Medicaid Services render a benefit category determination that establishes that the seat elevation, standing features of power wheelchairs, and installation of wheelchair ramps are primarily medical in nature and qualify under the definition of durable medical equipment when used in a power wheelchair.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Brault MW. Americans With Disabilities: 2010. *United States Census Bureau*. July 2012
2. Greiman, L., Ravesloot, C., Goddard, K., Ward, B. Effects of a consumer driven home modification intervention on community participation for people with mobility disabilities. *Disabilities and Health*, 2022; 15(1).
3. Berg, K., Hines, M., Allen, S. Wheelchair users at home: few home modifications and many injurious falls. *American Journal of Public Health*, 2002;92(1), 48.
4. Chan, L., Beaver, S., MacLehose, R. F., Jha, A., Maciejewski, M., & Doctor, J. N. Disability and health care costs in the Medicare population. *Archives of physical medicine and rehabilitation*, 2002; 83(9), 1196-1201.
5. Convention of the Rights of Persons with Disabilities Article 9 – Accessibility Enable. Department of Economic and Social Affairs.
6. Koontz AM, Ding D, Jan YK, de Groot S, Hansen A. Wheeled mobility. *Biomed Res Int*. 2015;2015:138176. doi:10.1155/2015/138176

7. Keall, M., et al. Home modifications to prevent home fall injuries in houses with Māori occupants (MHIPI): a randomized controlled trial. *The Lancet Public Health*. 2021;6(9), e631-e640.
8. Yarfi C, Ashigbi EYK, Nakua EK. Wheelchair accessibility to public buildings in the Kumasi metropolis, Ghana. *Afr J Disabil*. 2017;6:341. Published 2017 Sep 28. doi:10.4102/ajod.v6i0.341
9. Singh H, Scovil CY, Yoshida K, et al. Factors that influence the risk of falling after spinal cord injury: a qualitative photo-elicitation study with individuals that use a wheelchair as their primary means of mobility. *BMJ Open*. 2020;10(2):e034279. Published 2020 Feb 25. doi:10.1136/bmjopen-2019-034279
10. Requejo PS, Furumasu J, Mulroy SJ. Evidence-Based Strategies for Preserving Mobility for Elderly and Aging Manual Wheelchair Users. *Top Geriatr Rehabil*. 2015;31(1):26-41. doi:10.1097/TGR.0000000000000042
11. Morris ZA, McGarity SV, Goodman N, Zaidi A. The extra costs associated with living with a disability in the United States. *Journal of Disability Policy Studies*. 2021;104420732110435. doi:10.1177/10442073211043521
12. Koontz AM, Bass SR, Kulich HR. Accessibility facilitators and barriers affecting independent wheelchair transfers in the community. *Disabil Rehabil Assist Technol*. 2021;16(7):741-748. doi:10.1080/17483107.2019.1710771
13. Traction equipment. Traction Equipment Coverage. <https://www.medicare.gov/coverage/traction-equipment>. Accessed September 22, 2022.
14. US Department of Justice, US Department of Housing and Urban Development. Accessibility (Design and Construction) Requirements for Covered Multifamily Dwellings Under the Fair House Act. Accessed September __, 2022

RELEVANT AMA AND AMA-MSS POLICY

Support for Housing Modification Policies H-160.890

Our AMA: (1) 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.

Res. 806, I-19

Protect Medicare Beneficiary Access to Complex Rehabilitation Wheelchairs D-330.907

Our AMA: (1) encourages the Centers for Medicare and Medicaid Services (CMS) to refrain from implementing policies on January 1, 2016 that would curtail access to complex rehabilitation technology (CRT) wheelchairs and accessories by applying competitively bid prices to these specialized devices. In the event that CMS does not refrain from implementing policies limiting access to CRT wheelchairs, our AMA will encourage Congress to support legislation (e.g. H.R. 3229) that would provide a technical correction to federal law to clarify that CMS cannot apply Medicare competitive bidding pricing to CRT wheelchairs.

Res. 816, I-15

Protecting Patient Access to Seat Elevation and Standing Features in Power Wheelchairs D-330.899

Our AMA: (1) will request that the Centers for Medicare and Medicaid Services render a benefit category determination that establishes that the seat elevation and standing features of power wheelchairs are primarily medical in nature and qualify under the definition of durable medical equipment when used in a power wheelchair.

Res. 808, I-19

Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-Related Impairments H-390.835

Our AMA supports: (1) additional reimbursement for evaluation and management services for patients who require additional time and specialized equipment during medical visits due to severe mobility-related impairments; (2) that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law; (3) that primary and specialty medical providers be educated regarding the care of patients with severely impaired mobility to improve access to care; and (4) additional funding for payment for services provided to patients with mobility related impairments that is not through a budget neutral adjustment to the physician fee schedule.

Res. 814, I-17

Community Mobility Devices H-90.978

The AMA urges physicians, who treat patients with impaired mobility outside the home, to work with state medical associations and appropriate medical specialty societies to identify state agencies and community service organizations that provide local transportation assistance to disabled individuals, and that such information be made readily accessible to disabled patients. CMS Rep. 10, A-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 060
(I-22)

Introduced by: Taseen Haque, Keck School of Medicine of University Southern California;
Madisen Faulkner, University of South Carolina School of Medicine
Greenville; Shefali Jain, Medical College of Georgia; Dhruv Puri, University
of California San Diego School of Medicine; Michael Head, University of
California Irvine School of Medicine; Abby Ao, Touro University California
College of Osteopathic Medicine

Subject: Elective Personal Finance Curriculum in Medical Education

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

1 Whereas, Personal finance classes in medical school have been shown to be effective at
2 addressing the lack of financial knowledge prevalent among medical students¹; and
3

4 Whereas, Medical students, residents and fellows have been shown to have low levels of
5 personal financial literacy²⁻³; and
6

7 Whereas, Personal finance has no singular definition and terms used within definitions of
8 personal finance, such as “income generation”, “protection” and so on can vary widely
9 depending on the profession of an individual⁴⁻⁵; and
10

11 Whereas, Cultivation of financial literacy is associated with an improved sense of self and well-
12 being among medical trainees^{4,6,7}; and
13

14 Whereas, The pillars of personal finance according to the American College of Surgeons
15 includes (1) Basics of savings, investment and taxes (2) Disability and life insurance information
16 (3) Contract negotiation and (4) Typical compensation structures⁸; and
17

18 Whereas, Medical trainees have been shown to have gaps in education on topics including
19 disability insurance, retirement, estate planning, and taxes and have high interest in learning
20 about retirement planning and investing^{3,9,10}; and
21

22 Whereas, In addition to student loan debt, many medical trainees also carry credit card debt³;
23 and
24

25 Whereas, Residents are least comfortable with estate planning, asset protection, and salary
26 negotiation with a future employer¹¹; and

Whereas, Resident physicians state they received little or no formal finance education in medical school and express a shared interest in financial curriculum during residency training¹¹; and

Whereas, Our AMA has articles tagged as “personal finance” on their website, but the offerings are isolated and organized in a manner that may not be approachable for those without background knowledge on the subject¹²⁻¹³; and

Whereas, There is a demonstrable racial gap in financial literacy education¹⁴; and

Whereas, Our AMA encourages teaching institutions to offer residents and fellows personal finance education, but does not define “personal finance education” or mention medical students (H-310.912); and

Whereas, Our AMA supports education for medical students about medical debt management, but does not comment on encouraging education on critical aspects of personal finance that many medical students do not gain exposure to(305.089MSS); therefore be it

RESOLVED, That our AMA define “Personal Finance Education” as education on topics including, but not limited to: (1) Practice models and contract negotiations; (2) Risk management and insurance; (3) Financial principles; (4) Savings and Investments; (5) Debt Management; (6) Retirement Planning; (7) Estate Planning; (8) Budgeting; and (9) Use of Credit scores and Credit Cards; and be it further

RESOLVED, That Our AMA develop high-quality self-directed resources, such as but not limited to CME courses or other online modules, on Personal Finance Education for medical students, medical schools, residents, and fellows to use; and be it further

RESOLVED, That our AMA work with the LCME or other appropriate stakeholders to encourage medical schools to offer elective courses on Personal Finance Education.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Grewal K, Sweeney MJ. An Innovative Approach to Educating Medical Students About Personal Finance. *Cureus*. 2021;13(6):e15579. Published 2021 Jun 10. doi:10.7759/cureus.15579
2. Hays R. Peer Review Report For: Personal Financial Literacy Among U.S. Medical Students [version 1]. MedEdPublish 2017, 6:35 (<https://doi.org/10.21956/mep.19446.r28626>)
3. Ahmad FA, White AJ, Hiller KM, Amini R, Jeffe DB. An assessment of residents' and fellows' personal finance literacy: an unmet medical education need. *Int J Med Educ*. 2017;8:192-204. Published 2017 May 29. doi:10.5116/ijme.5918.ad11
4. Cawyer CR, Blanchard C, Kim KH. Financial Literacy and Physician Wellness: Can a Financial Curriculum Improve an Obstetrician/Gynecologist Resident and Fellow's Well-Being?. *AJP Rep*. 2022;12(1):e64-e68. Published 2022 Feb 4. doi:10.1055/s-0041-1742268

5. Personal finance. PERSONAL FINANCE | Cambridge English Dictionary. <https://dictionary.cambridge.org/us/dictionary/english/personal-finance>. Accessed September 20, 2022.
6. Bar-Or YD, Fessler HE, Desai DA, Zakaria S. Implementation of a Comprehensive Curriculum in Personal Finance for Medical Fellows. *Cureus*. 2018 Jan 1;10(1):e2013. doi: 10.7759/cureus.2013.
7. Payne, J., Haller, S., Flores, L. E., Baxter, J., Payton, W., , Nelson, K. Personal Finance Skills Among Health Professionals: Piloting A Student-Led Finance Curriculum And A Review Of The Current Landscape. *Graduate Medical Education Research Journal*. 2020 Dec 09; 2(2). <https://digitalcommons.unmc.edu/gmerj/vol2/iss2/3>
8. Chapman et al. The Pillars of Personal Financial Success: Filling a critical gap in surgical education. *The Bulletin*. <https://bulletin.facs.org/2018/09/the-pillars-of-personal-financial-success-filling-a-critical-gap-in-surgical-education/>. Published August 30, 2018. Accessed September 17, 2022.
9. Bar-Or YD, Fessler HE, Desai DA, Zakaria S. Implementation of a Comprehensive Curriculum in Personal Finance for Medical Fellows. *Cureus*. 2018;10(1):e2013. Published 2018 Jan 1. doi:10.7759/cureus.2013
10. Huebinger RM, Hussain R, Tupchong K, Walia S, Fairbrother H, Rogg J. Survey-based Evaluation of Resident and Attending Financial Literacy. *West J Emerg Med*. 2021;22(6):1369-1373. Published 2021 Nov 5. doi:10.5811/westjem.2021.8.53016
11. Wang, A., et al. Nationwide Needs Assessment Survey of Financial Literacy Among Psychiatry Residents. *Acad Psychiatry*. 2022; 46, 401–402.
12. Medical Student Personal Finance. American Medical Association. <https://www.ama-assn.org/topics/medical-student-personal-finance>. Accessed September 20, 2022.
13. Medical Residency Personal Finance. American Medical Association. <https://www.ama-assn.org/medical-residents/medical-residency-personal-finance>. Accessed September 20, 2022.
14. Al-Bahrani A, Weathers J, Patel D. Racial Differences in the Returns to Financial Literacy Education. *The Journal of consumer affairs*. 2019;53(2):572-599. doi:10.1111/joca.12205

RELEVANT AMA AND AMA-MSS 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

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.

2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.

3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.

4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.

5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.

6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.

7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.

8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.
13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the "cost of attendance"; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to "lock in" a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts

from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.

15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.

16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.

17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.

18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.

19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.

20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician participation in the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the employer's PSLF program qualifying status; (f) Advocate that the profit status of a physician's training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes; (j) Monitor the denial rates for physician applicants to the PSLF; (k) Undertake expanded federal advocacy, in the event denial rates for physician applicants are unexpectedly high, to encourage release of information on the basis for the high denial rates, increased transparency and streamlining of program requirements, consistent and accurate communication between loan servicers and borrowers, and clear expectations regarding oversight and accountability of the loan servicers responsible for the program; (l) Work with the United States Department of Education to ensure that applicants to the PSLF and its supplemental extensions, such as Temporary Expanded Public Service Loan Forgiveness (TEPSLF), are provided with the necessary information to successfully complete the program(s) in a timely manner; and (m) Work with the United States Department of Education to ensure that individuals who would otherwise qualify for PSLF and its supplemental extensions, such as TEPSLF, are not disqualified from the program(s).

21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.
 22. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.
- 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

Residents' Salaries H-305.930

Our AMA supports appropriate increases in resident salaries.
Res. 307, A-05; Reaffirmed: CME Rep. 1, A-15

Funding for Teaching Health Center Graduate Medical Education Program D-305.955

Our American Medical Association will encourage Congress to reauthorize the Teaching Health Center Graduate Medical Educational Program to its full and ongoing funding needs to continue the training of primary providers in community based health centers in underserved areas to assure a continuing supply of primary providers and dentists for the underserved populations.
Res. 214, A-15

Cost and Financing of Medical Education and Availability of First-Year Residency Positions H-305.988

Our AMA:

1. believes that medical schools should further develop an information system based on common definitions to display the costs associated with undergraduate medical education;
2. in studying the financing of medical schools, supports identification of those elements that have implications for the supply of physicians in the future;
3. believes that the primary goal of medical school is to educate students to become physicians and that despite the economies necessary to survive in an era of decreased funding, teaching functions must be maintained even if other commitments need to be reduced;
4. believes that a decrease in student enrollment in medical schools may not result in proportionate reduction of expenditures by the school if quality of education is to be maintained;
5. supports continued improvement of the AMA information system on expenditures of medical students to determine which items are included, and what the ranges of costs are;
6. supports continued study of the relationship between medical student indebtedness and career choice;
7. believes medical schools should avoid counterbalancing reductions in revenues from other sources through tuition and student fee increases that compromise their ability to attract students from diverse backgrounds;
8. supports expansion of the number of affiliations with appropriate hospitals by institutions with accredited residency programs;
9. encourages for profit-hospitals to participate in medical education and training;
10. supports AMA monitoring of trends that may lead to a reduction in compensation and benefits provided to resident physicians;
11. encourages all sponsoring institutions to make financial information available to help residents manage their educational indebtedness; and
12. will advocate that resident and fellow trainees should not be financially responsible for their training.

CME Rep. A, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Res. 313, I-95; Reaffirmed by CME Rep. 13, A-97; Modified: CME Rep. 7, A-05; Modified: CME Rep. 13, A-06; Appended: Res. 321, A-15; Reaffirmed: CME Rep. 05, A-16; Modified: CME Rep. 04, A-16; Reaffirmation: A-22

The Ecology of Medical Education: The Infrastructure for Clinical Education H-305.942

The AMA recommends the following to ensure that access to appropriate clinical facilities and faculty to carry out clinical education is maintained: (1) That each medical school and residency program identify the specific resources needed to support the clinical education of trainees, and should develop an explicit plan to obtain and maintain these resources. This planning should include identification of the types of clinical facilities and the number and specialty distribution of full-time and volunteer clinical faculty members needed. (2) That affiliated health care institutions and volunteer faculty members be included in medical school and residency program resource planning for clinical education when appropriate. (3) That medical school planning for clinical network development include consideration of the impact on the education program for medical students and resident physicians. (4) That accrediting bodies for undergraduate and graduate medical education be encouraged to adopt accreditation standards that require notification of changes in clinical affiliations, in order to ensure that changes in the affiliation status of hospitals or other clinical sites do not adversely affect the education of medical students and resident physicians.

CME Rep. 13, A-97; Modified: CME Rep. 2, I-05; Reaffirmed: CME Rep. 1, A-15

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 publicly 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.

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

305.062MSS: Industry Support of Professional Education in Medicine

AMA-MSS encourages aggressively decreasing reliance on industry support for medical education and supports alternative funding mechanisms to finance quality medical education. (MSS Res Late 4, A-08) (Reaffirmed: GC Rep B, I-13) (Reaffirmed: MSS GC Rep A, I-19)

305.087MSS Voluntary Service-Payback and Loan Repayment Programs

The AMA-MSS supports the following principles regarding voluntary service-payback and loan repayment programs:

1. The AMA-MSS will ask the AMA to support legislation to continue the National Health Service Corps scholarship and field programs and support the development of other voluntary programs that finance medical students through their undergraduate training in exchange for their service in underserved areas.

2. The AMA-MSS will ask the AMA to advocate for the inclusion of physicians trained in preventive medicine among those who qualify for participation in the National Health Service Corps Loan Repayment Program. (MSS GC Rep A, I-17)

305.090MSS Medical Student Loan Forgiveness

The AMA-MSS supports the following principles regarding student loan forgiveness:

1. That the AMA-MSS will ask the AMA to support the development of realistic loan forgiveness programs as a means of effectively addressing the urgent financial needs of medical students.

2. That the AMA-MSS will ask the AMA to oppose the reduction and support that expansion of medical student and physician benefits and eliminate requirements for qualification under Public Service Loan Forgiveness.

3. That the AMA-MSS will ask the AMA to study the feasibility and utility of loan forgiveness programs for the private sector including, but not limited to, the offering of tax credits and/or benefits to employers who pay the remaining balance of medical school loans when hiring physicians following completion of residency.
(MSS GC Rep A, I-17)

305.089MSS Medical Student Debt Management Education

The AMA-MSS supports the following principles regarding financial management and debt education of medical students:

1. That the AMA-MSS will ask the AMA to encourage medical school financial aid offices to educate medical students in medical debt management and provide financial and tax counseling.

2. That the AMA-MSS will ask the AMA to assist medical school financial aid offices in implementing debt management, financial, and tax counseling and education services.

3. That the AMA-MSS will encourage medical school financial aid officers to counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation.

4. That the AMA-MSS will ask the Association of American Medical Colleges and American Association of Colleges of Osteopathic Medicine to require greater transparency in financial aid information provided to medical students and applicants.

5. That the AMA-MSS ask the Association of Medical Colleges and American Association of Colleges of Osteopathic Medicine to encourage medical colleges to provide additional data to students and applicants including by not limited to: (1) average debt incurred in medical school for graduation students with federal aid assistance, separated by instate and out of state students, reported in quartiles, (1) percent of current students receiving financial aid other than loans, and (3) the amount and types of available non-loan aid such as scholarships, interest free loans, or grants available from the institution

(MSS GC Rep A, I-17)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 061
(I-22)

Introduced by: Kody Jones and Natalia Whitney, Rush Medical College; Mollie Marr, Oregon Health and Science University; Shefali Jain, Medical College of Georgia; Jara Crawford, Indiana University School of Medicine; Neha Siddiqui, Carle Illinois College of Medicine

Subject: Increasing Access to Gender-Affirming Procedures Through Expanded Training and Equitable Reimbursement

Sponsored by: Region 2, Region 4, Region 5

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Gender-affirming care is an important and potentially life-saving aspect of health care for transgender and gender diverse individuals^{1,2}; and

Whereas, Gender-affirming procedures represent an important component of gender-affirming care with numerous benefits for transgender and gender diverse individuals^{3,4}; and

Whereas, Demand for gender-affirming procedures continues to increase^{5,6}; and

Whereas, A barrier to patients receiving gender-affirming procedures is the limited number of providers trained to perform them^{6,7}; and

Whereas, Only 1 in 4 plastic surgery residency programs incorporate structured training for gender-affirming procedures⁸; and

Whereas, Centers for Medicare and Medicaid Services determines reimbursement rates for procedures based on “relative value units” which are influenced by recommendations from the AMA/Specialty Society RVS Update Committee⁹; and

Whereas, Since 2014, health insurance reimbursement for gender-affirming procedures has lagged considerably behind inflation¹⁰; and

Whereas, Lack of equitable reimbursement further limits the number of providers and institutions willing to perform gender-affirming procedures due to lack of financial sustainability¹¹; and

Whereas, Lack of equitable reimbursement has led to providers and institutions being unwilling to accept particular health insurances, which creates an additional barrier to patients with these insurances receiving gender-affirming procedures¹¹; and

Whereas, Existing AMA policy (H-185.927) states our AMA will “advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria”, but does not address instances of gender-affirming care for individuals who do not have gender dysphoria nor

1 structured training for gender-affirming procedures nor reimbursement for said procedures by
2 health insurance providers¹²; and

3
4 Whereas, Existing AMA policy (H-185.950) states our AMA “supports public and private health
5 insurance coverage for treatment of gender dysphoria as recommended by the patient’s
6 physician”, but does not address instances of gender-affirming care for individuals who do not
7 have gender dysphoria nor reimbursement for gender-affirming procedures by health insurance
8 providers¹³; and

9
10 Whereas, Existing AMA policy (D-295.312) states our AMA will “advocate for policies
11 addressing the medical spectrum of gender identity to ensure access to quality health care”, but
12 does not address structured training for gender-affirming procedures nor reimbursement for said
13 procedures by health insurance providers¹⁴; and

14
15 Whereas, Existing AMA policy (H-160.991) states our AMA “is committed to taking a leadership
16 role in...encouraging the development of educational programs in LGBTQ Health”, thus
17 indicating that this policy is an extension of previously expressed values¹⁵; and

18
19 Whereas, Existing AMA policy (D-385.968) states our AMA will “oppose any attempts...to
20 restrict reimbursement for procedures and services based on physician specialty”, thus
21 indicating that this policy is an extension of previously expressed values¹⁶; therefore be it

22
23 RESOLVED, Our AMA advocate for expanded structured training for gender-affirming
24 procedures by working with relevant stakeholders including but not limited to the Accreditation
25 Council for Graduate Medical Education; and be it further

26
27 RESOLVED, Our AMA advocate for equitable reimbursement of gender-affirming procedures by
28 health insurance providers, including public and private insurers, which at minimum equates to
29 the cost of performing these procedures.

30
Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Feldman JL, Luhur WE, Herman JL, Poteat T, Meyer IH. Health and health care access in the US transgender population health (TransPop) survey. *Andrology (Oxford)*. 2021;9(6):1707-1718. doi:10.1111/andr.13052
2. Stranix JT, Bluebond-Langner R. Improving Access to Genital Gender-Affirming Surgery-The Need for Comprehensive Gender Health Centers of Excellence. *JAMA surgery*. Published online 2022. doi:10.1001/jamasurg.2022.2644
3. American Psychiatric Association; Diagnostic and statistical manual of mental disorders;3rd edition. Author, Washington, DC.1980.
4. Thomas, T.N. Overview of Surgery for Transgender Patients. In Comprehensive Care of the Transgender Patient, 1st ed.; Ferrando, C.A., Ed.; Elsevier: Philadelphia, PA, USA, 2020; pp. 48–58.
5. Nolan IT, Kuhner CJ, Dy GW. Demographic and temporal trends in transgender identities and gender confirming surgery. *Transl Androl Urol*. 2019;8(3):184-190. doi:10.21037/tau.2019.04.09
6. Peters B. Opinion: The long overdue rise of gender-affirming care. MedPage Today. <https://www.medpagetoday.com/opinion/second->

opinions/93186#:~:text=There%20has%20been%20much%20written%20recently%20about%20the,to%20then%20have%20the%20need%20for%20gender-affirming%20care.

Published June 19, 2021. Accessed September 18, 2022.

7. Cohen W, Maisner RS, Mansukhani PA, Keith J. Barriers To Finding A Gender Affirming Surgeon. *Aesthetic Plast Surg.* 2020;6:2300-2307.
8. Ha M, Ngaage LM, Finkelstein E, et al. P109. TEACHING AND TRAINING IN GENDER-AFFIRMING PROCEDURES IN US ACADEMIC PLASTIC SURGERY RESIDENCY PROGRAMS. *Plast Reconstr Surg Glob Open.* 2022;10(4 Suppl):101-102. Published 2022 Apr 1. doi:10.1097/01.GOX.0000828784.57368.95
9. RVS Update Committee (RUC). American Medical Association. <https://www.ama-assn.org/about/rvs-update-committee-ruc/rvs-update-committee-ruc>. Accessed September 18, 2022.
10. Siotos C, Underhill J, Sykes J, Jones K, Hamidian A. Trends in Medicare Reimbursement for Gender Affirmation Procedures. Paper presented at: Rush University Division of Plastic and Reconstructive Surgery Research Day; June 29, 2022; Chicago, IL.
11. Stein S, Brady C. Medicare pay uncertainty limits gender reassignment surgery (corrected). *Bloomberg Law.* <https://news.bloomberglaw.com/health-law-and-business/medicare-pay-uncertainty-limits-gender-reassignment-surgery-corrected>. Published July 26, 2018. Accessed August 31, 2022.
12. *Clarification of Medical Necessity for Treatment of Gender Dysphoria*, Resolution 05-A16 AMA Annual Meeting. June 2016.
Adopted AMA Resolution—June 2016
13. *Removing Financial Barriers to Care for Transgender Patients*, Resolution 122-A08 AMA Annual Meeting. June 2008.
Adopted AMA Resolution—June 2008
14. *Medical Spectrum of Gender*, Resolution 003-A17 AMA Annual Meeting. June 2017.
Adopted AMA Resolution—June 2017
15. *Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations*, Resolution, CSA Rep. C, I-81 AMA Interim Meeting. November 1981.
Adopted AMA CSA Rep—November 1981
16. *Support for Appropriate Billing and Payment Procedures by Physicians*, BOT Rep. 32-A08 AMA Annual Meeting. June 2008.
Adopted AMA BOT Rep—June 2008

RELEVANT AMA AND AMA-MSS POLICY

Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927

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

AMA Res. 05, A-16 Modified: Res. 015, A-21

Removing Financial Barriers to Care for Transgender Patients H185.950

Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient's physician.

Res. 122A-08 Modified: Res. 05, A-16 Reaffirmed: Res. 012, A-22

Medical Spectrum of Gender D-295.312

Given the medical spectrum of gender identity and sex, our AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual's genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth.

Res. 003, A-17; Modified: Res. 005, I-18

Support for Appropriate Billing and Payment Procedures by Physicians D-385.968

Our AMA will oppose any attempts by federal and state legislatures, regulatory bodies, hospitals, private and government payers, and others to restrict reimbursement for procedures and services based on physician specialty.

BOT Rep. 32, A-08; Reaffirmed: CMS Rep. 01, A-18

Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

CSA Rep. C, I-81 Reaffirmed: CLRPD Rep. F, I-91 CSA Rep. 8 - I-94 Appended: Res. 506, A-00 Modified and Reaffirmed: Res. 501, A-07 Modified: CSAPH Rep. 9, A-08 Reaffirmation A-12 Modified: Res. 08, A-16 Modified: Res. 903, I-17 Modified: Res. 904, I-17 Res. 16, A-18 Reaffirmed: CSAPH Rep. 01, I-18

Sexual Orientation and/or Gender Identity as Health Insurance Criteria H-180.980

The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity.

Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97; Reaffirmed: CMS Rep. 9, A-07; Modified: BOT Rep. 11, A-07; Reaffirmed: CMS Rep. 01, A-17

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

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

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

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

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

2. This task force, which will serve at the direction of our AMA Board of Trustees, will inform the Board to help guide organized medicine's response to bans and restrictions on abortion, prepare for widespread criminalization of other evidence-based care, implement relevant AMA policies, and identify and create implementation-focused practice and advocacy resources on issues including but not limited to: a. Health equity impact, including monitoring and evaluating the consequences of abortion bans and restrictions for public health and the physician workforce and including making actionable recommendations to mitigate harm, with a focus on the disproportionate impact on under-resourced, marginalized, and minoritized communities; b. Practice management, including developing recommendations and educational materials for addressing reimbursement, uncompensated care, interstate licensure, and provision of care, including telehealth and care provided across state lines; c. Training, including collaborating with interested medical schools, residency and fellowship programs, academic centers, and clinicians to mitigate radically diminished training opportunities; d. Privacy protections, including best practice support for maintaining medical records privacy and confidentiality, including under HIPAA, for strengthening physician, patient, and clinic security measures, and countering law enforcement reporting requirements; e. Patient triage and care coordination, including identifying and publicizing resources for physicians and patients to connect with referrals, practical support, and legal assistance; f. Coordinating implementation of pertinent AMA policies, including any actions to protect against civil, criminal, and professional liability and retaliation, including criminalizing and penalizing physicians for referring patients to the care they need; and g. Anticipation and preparation, including assessing information and resource gaps and creating a blueprint for preventing or mitigating bans on other appropriate health care, such as gender affirming care, contraceptive care, sterilization, infertility care, and management of ectopic pregnancy and spontaneous pregnancy loss and pregnancy complications.

Res. 621, A-22

Patient-Reported Outcomes in Gender Confirmation Surgery 65.032 MSS

AMA-MSS will ask the AMA to: (1) support initiatives and research to establish standardized protocols for patient selection, surgical management, and pre-operative and post-operative care for transgender patients undergoing gender affirming surgeries; and (2) support development and implementation of standardized tools, such as questionnaires to evaluate outcomes of gender affirming surgeries.

(MSS Res 26, I-17) (AMA Res 004,A-18, Adopted [H-460.893]) (Amended: LGBTQ+ Affairs Report A, A-21)

Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions 65.042 MSS

(1) Our AMA-MSS will ask our AMA to amend policy H-185.990, by addition as follows: INFERTILITY AND FERTILITY PRESERVATION INSURANCE COVERAGE, H-185.990 It is the policy of the AMA that (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, 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; and (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. (2) Our AMA-MSS will ask our AMA to amend policy H185.950 by addition as follows: REMOVING FINANCIAL BARRIERS TO CARE FOR TRANSGENDER PATIENTS, H-185.950 Our AMA supports public and private health insurance coverage for medically necessary treatment of gender dysphoria as recommended by the patient's physician, including gender-affirming hormone therapy and gender-affirming surgery. (MSS Res. 042, Nov. 2020)

Opposing Efforts that would Prevent Transgender or Questioning Youth from Being Prescribed Puberty-Suppressing Medications by Physicians 60.034 MSS

AMA-MSS opposes efforts that would prevent transgender or questioning youth from being prescribed puberty-suppressing medications by physicians.

(MSS Res. 73, I-19)

Removing Barriers to Care for Transgender Patients 65.012 MSS

AMA-MSS will ask the AMA to (1) support public and private health insurance coverage for treatment of gender dysphoria in adolescents and adults; and (2) oppose categorical exclusions of coverage for treatment of gender dysphoria in adolescents and adults when prescribed by a physician.

(MSS Amended Res 11, I-07) (AMA Res 122, A-08 Adopted as Amended in Lieu of AMA Res 114 and 115 [H-185.950]) (Reaffirmed: MSS GC Report C, I-12) (Reaffirmed: MSS GC Report A, I-17)

Improving Inclusiveness of Transgender Patients within Electronic Medical Record Systems 65.026 MSS

AMA-MSS will ask the AMA to amend policy H-315.967, Promoting Gender, Sex, Sexual Orientation Options on Medicaid Documentation by insertion as follows: Promoting Gender, Sex, Sexual Orientation Options on Medicaid Documentation H315.967 Our AMA: (1) supports the voluntary inclusion of a patient's biological sex, current gender identity, sexual orientation,

and preferred gender pronoun(s), preferred name, and an inventory of current 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.
(MSS Res 36, A-19) (AMA Res. 004, Adopt as Amended [H-315.967], I-19)

Opposition to the Criminalization and Undue Restriction of Evidence-Based Gender Affirming Care for Transgender and Gender-Diverse Individuals 65.041 MSS

Our AMA-MSS will ask our AMA to amend policy H-185.927, Clarification of Medical Necessity for Treatment of Gender Dysphoria by addition and deletion as follows: CLARIFICATION OF MEDICAL NECESSITY FOR TREATMENT OF GENDER DYSPHORIA, H185.927 Our AMA:

(1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by AMA-MSS Digest of Policy Actions/ 30 generally-accepted standards of medical and surgical practice; and (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria; and (3) opposes efforts that criminalize or otherwise restrict evidence-based gender-affirming care or place an undue burden on individuals seeking access to this care.

(MSS Res. 027, Nov. 2020)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 062
(I-22)

Introduced by: Cesar Ramirez and Imaan Ali, Sam Houston College of Osteopathic Medicine; Dieu Thao Nguyen, Carla Wyatt-Ingram, and Sanjana Mandilwar, University of South Carolina School of Medicine Greenville

Subject: Increased Inclusivity and Admission Policies Clarification for DACA Medical School and Residency Applicants

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, The Deferred Action for Childhood Arrivals (DACA) policy has existed since 2012, as a policy established by a memorandum from the Secretary of Homeland Security, granting individuals who entered the United States before June 15, 2007 and, resided in the United States continuously through June 15, 2012, deferred action from removal proceedings, lawful presence (but not lawful status), and employment authorization for a two year period, provided that they entered the United States when they were under the age of 16, and met certain criteria; and¹

Whereas, The DACA policy is on track to become codified as a federal regulation, with a final rule taking effect on October 31, 2022; and²

Whereas, given the uncertainty of the upcoming political landscape it is important that the AMA works to support DACA students².

Whereas, As of March 2022 there are 611,270 DACA recipients in the United States, with an estimate of 1,159,000 considered immediately eligible without actively awarded DACA status; and³

Whereas, The American Association of Medical Colleges (AAMC) estimates that over the first eight years since DACA was established, only about 200 DACA-status individuals, representing less than 0.1% of all DACA recipients, have trained in US medical schools and residency programs; and⁴

Whereas, For the 2022-2023 school year, 70 medical institutions are listed on the AAMC website as accepting DACA-status eligible applicants, 5 fewer than in 2020; and^{4, 5}

Whereas, Despite institutions knowing what DACA was, only 58% were familiar with their DACA admission policies; and⁴

1 Whereas, The Federal government permits DACA recipients to rotate through medical facilities
2 operated by the Department of Veterans Affairs (VA), and certain states (including New York
3 and California) have expanded licensure eligibility to include DACA recipients, many states
4 restrict licensure for non-U.S. citizens who are not “qualified aliens”, excluding DACA recipients
5 from licensure; and⁷

6
7 Whereas, DACA students have reported acceptance to several institutions only to have their
8 offers rescinded due to their status, despite being transparent about their DACA status from the
9 start of the admission process; and⁶

10
11 Whereas, DACA-status students are ineligible for Federal Student Aid and must resort to private
12 student loans; and⁶

13
14 Whereas, The median debt of a medical school graduate is \$200,000 as of 2020, and there are
15 programs available for loan forgiveness through Public Service Loan Forgiveness, or service to
16 rural communities through the National Health Service Corps Rural Community Loan
17 Repayment Program; and⁶

18
19 Whereas, DACA recipients are ineligible for such loan forgiveness programs, despite being
20 more likely to serve in underserved and/or rural communities than the general population; and^{2,6}

21
22 Whereas, Less than ten percent of schools reserved funds for DACA students, and some
23 required proof of payment for all four years for matriculation; and⁴

24
25 Whereas, Half of US states allow for public schools to charge DACA students out-of-state
26 tuition, despite eligibility for in-state tuition if documented; and⁶

27
28 Whereas, DACA recipients are hired through the same procedure as US Citizens or Permanent
29 Residents using the federal I-9 process; and⁷

30
31 Whereas, DACA recipients and their households pay about \$5.6 billion in annual Federal taxes
32 and about \$3.1 billion in annual State and local taxes; and²

33
34 Whereas, DACA individuals are considered resident aliens for federal and state tax purposes,
35 they do not qualify for government assistance programs such as Supplemental Nutrition
36 Assistance Program (SNAP), Medicaid, Supplemental Security Income (SSI), Temporary
37 Assistance for Needy Families (TANF), health insurance subsidies under the Affordable Care
38 Act (ACA), or any other federal, state, or local benefit as defined by 8 U.S.C 1611 and 8 U.S.C
39 1621; and^{8, 9}

40
41 Whereas, The AMA supports efforts to increase the applicant pool of qualified minority students
42 (H-350.979); and¹⁰

Whereas, The AMA supports medical schools should be explicit in publications of their admissions requirements and the methods they employ in the selection of students (H-295.995); and¹¹

Whereas, The AMA supports the efforts of the AAMC increasing transparency in the medical school application process for international students (H-255.968); and¹²

Whereas, The AMA has no policy encouraging medical schools to provide transparency on admissions requirements in the selection of DACA eligible applicants; and

Whereas, The AMA supports legislation that provides targeted financial aid to financially disadvantaged students at both collegiate and medical school levels (H-350.979); and¹⁰

Whereas, There currently exists no similar policy for DACA-eligible medical school applicants; and

Whereas, During the COVID-19 pandemic over 200,000 DACA recipients were working essential positions, at least 29,000 of whom were health care workers; and¹³

Whereas, DACA healthcare workers increase diversity of the medical field and contribute to the learning of fellow medical students to the culture of immigrant patients, broadening access to care for underserved populations; and¹⁴

Whereas, Family Educational Rights and Privacy Act (FERPA) protects the immigration or citizenship status of a student attending any school that receives funds from the U.S. Department of Education and this information cannot be disclosed to a third party, including ICE or any federal agency, unless the student provides consent or the school is mandated to do so by a judicial order or subpoena; and¹⁵

Whereas, United States Citizenship and Immigration Services (USCIS) currently has access to the personal information of DACA recipients, including names and addresses, and has been found to have shared this information with other agencies of the Federal Government, including ICE, despite promises made by previous administrations that such information would be kept from federal agencies; and¹⁶

Whereas, DACA recipients who are healthcare workers are more likely to work in underserved communities, helping to alleviate a particularly dire shortage of healthcare professionals in these areas; and^{2, 17};

Whereas, Each DACA recipient in the healthcare field will care for an average of between 1,533 and 4,600 patients a year. Together, over the course of their careers, they will impact the lives of 1.7 to 5.1 million U.S. patients¹⁷; therefore be it

1 RESOLVED, That our AMA provide support and encourage the Association of American
 2 Medical Colleges, individual medical schools, and residency programs to establish criteria that
 3 institutions must meet to declare themselves “Deferred Action for Childhood Arrivals-friendly”,
 4 including transparency in the admissions process and favorable financial aid policies; and be it
 5 further

6
 7 RESOLVED, That AMA encourages transparency from institutions in the medical school and
 8 residency application process by making certain data publicly accessible, in order to guide
 9 DACA applicants on their medical school and residency options including, at minimum: (1) the
 10 number of Deferred Action for Childhood Arrivals applicants, (2) the number of accepted
 11 Deferred Action for Childhood Arrivals applicants, (3) the number of matriculated Deferred
 12 Action for Childhood Arrivals students, (4) financial aid options available for Deferred Action for
 13 Childhood Arrivals applicants, (5) and the form of financial aid received, or payment provided,
 14 by accepted Deferred Action for Childhood Arrivals students.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Napolitano SJ. Exercising prosecutorial discretion with respect to individuals who came to the United States as children and with respect to certain individuals who are the parents of U.S. citizens or permanent residents. Exercising Prosecutorial Discretion with Respect to Individuals Who Came to the United States as Children and with Respect to Certain Individuals Who Are the Parents of U.S. Citizens or Permanent Residents | Homeland Security. <https://www.dhs.gov/publication/exercising-prosecutorial-discretion-respect-individuals-who-came-united-states-children>. Published June 15, 2012. Accessed August 30, 2022.
2. The Federal Register. Federal Register :: Request Access. <https://www.federalregister.gov/documents/2022/08/30/2022-18401/deferred-action-for-childhood-arrivals>. Published August 30, 2022. Accessed August 30, 2022.
3. Deferred Action for Childhood Arrivals (DACA) Data Tools. Migration Policy Institute. <https://www.migrationpolicy.org/programs/data-hub/deferred-action-childhood-arrivals-daca-profiles>. Published July 21, 2022. Accessed August 29, 2022.
4. Carranco, S., Carrasquillo, O., Young, B. et al. Is Medicine Just a DREAM for DACA Students? DACA Practices and Policies Among U.S. Medical Schools. J Immigrant Minority Health 24, 300–303 (2022). <https://doi.org/10.1007/s10903-021-01211-w>
5. Association of American Medical Colleges. (n.d.). Deferred action for childhood arrivals (DACA) 2023 - students & residents. Medical School Admission Requirements™ (MSAR®) Report for Applicants and Advisors Deferred Action for Childhood Arrivals (DACA). Retrieved August 30, 2022, from <https://students-residents.aamc.org/media/7031/download>
6. Gillezeau, C., Lieberman-Cribbin, W., Bevilacqua, K. et al. Deferred Action for Childhood Arrivals (DACA) medical students – an examination of their journey and experiences as medical students in limbo. BMC Med Educ 21, 358 (2021). <https://doi.org/10.1186/s12909-021-02787-5>
7. Nakae S, Rojas Marquez D, Di Bartolo IM, Rodriguez R. Considerations for Residency Programs Regarding Accepting Undocumented Students Who Are DACA Recipients.

- Acad Med. 2017 Nov;92(11):1549-1554.
<https://doi.org/10.1097/ACM.0000000000001731>. PMID: 28562450.
8. Buchholz , L. (2017, August 22). Daca and the Affordable Care Act. H&R Block. Retrieved August 29, 2022, from <https://www.hrblock.com/tax-center/healthcare/daca-and-affordable-care-act/>
 9. Fact sheet: Immigrants and public benefits. National Immigration Forum. (2021, November 1). Retrieved August 29, 2022, from <https://immigrationforum.org/article/fact-sheet-immigrants-and-public-benefits/>
 10. Increase the Representation of Minority and Economically Disadvantaged Populations in the Medical Profession H-350.979. AMA. <https://policysearch.ama-assn.org/policyfinder/detail/medical%20school%20admissions?uri=%2FAMADoc%2FHOD.xml-0-3029.xml>. Published 2018. Accessed August 30, 2022.
 11. Recommendations for Future Directions for Medical Education H-295.995. AMA. <https://policysearch.ama-assn.org/policyfinder/detail/medical%20school%20admissions?uri=%2FAMADoc%2FHOD.xml-0-2294.xml>. Published 2018. Accessed August 28, 2022.
 12. Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools H-255.968. AMA. <https://policysearch.ama-assn.org/policyfinder/detail/international%20medical%20students?uri=%2FAMADoc%2FHOD.xml-0-1770.xml>. Published 2022. Accessed August 29, 2022.
 13. Svajlenka, N. P. (2021, November 7). A demographic profile of DACA recipients on the frontlines of the coronavirus response. Center for American Progress. Retrieved August 29, 2022, from <https://www.americanprogress.org/article/demographic-profile-daca-recipients-frontlines-coronavirus-response/>
 14. Kuczewski MG. Addressing Systemic Health Inequities Involving Undocumented Youth in the United States. AMA Journal of Ethics. 23(2):146-155.
<https://doi.org/10.1001/amajethics.2021.146>
 15. Legislation affecting dreamers. Legislation Affecting DREAMers // Diversity and Inclusion // Marquette University. <https://www.marquette.edu/diversity/undocumented-student-legislation.php>. Accessed September 20, 2022.
 16. Lind D. Ice has access to DACA recipients' personal information despite promises suggesting otherwise, internal emails show. ProPublica.
<https://www.propublica.org/article/ice-has-access-to-daca-recipients-personal-information-despite-promises-suggesting-otherwise-internal-emails-show>. Published April 21, 2020. Accessed September 20, 2022.
 17. Department of Homeland Security, et. al v. Regents of the University of California, et. al, Nos. 18-587 18-588 and 18-589 U.S 3 (9th Cir. 2019)

RELEVANT AMA AND AMA-MSS POLICY

Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages D-350.986

1. Our American Medical Association will study the issue of Deferred Action for Childhood Arrivals-eligible medical students, residents, and physicians and consider the opportunities for their participation in the physician profession and report its findings to the House of Delegates.
2. Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrivals recipients.

Res. 305, A-15; Appended: Late Res. 1001, I-16; Reaffirmation: A-19

Advance Tuition Payment Requirements for International Students Enrolled in US Medical Schools H-255.968

Our AMA:

1. supports the autonomy of medical schools to determine optimal tuition requirements for international students;
2. encourages medical schools and undergraduate institutions to fully inform international students interested in medical education in the US of the limited options available to them for tuition assistance;
3. supports the Association of American Medical Colleges (AAMC) in its efforts to increase transparency in the medical school application process for international students by including school policy on tuition requirements in the Medical School Admission Requirements (MSAR); and
4. encourages medical schools to explore alternative means of prepayment, such as a letter of credit, for four years of medical school.

CME Rep. 5, A-12; Reaffirmed: CME Rep. 1, A-22

Impact of Immigration Barriers on the Nation's Health D-255.980

1. Our AMA recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.
2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.
3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.
4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.
5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.
6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

Alt. Res. 308, A-17; Modified: CME Rep. 01, A-18; Reaffirmation: A-19; Reaffirmed: CME Rep. 4, A-21; Reaffirmed: Res. 234, A-22

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.

CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08; Reaffirmed: CME Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 063
(I-22)

Introduced by: Yusuf Mufti, University of Texas Medical School at San Antonio; Archita Goyal, Tufts University School of Medicine; Jacob Rha, Tufts University School of Medicine; Alex Soltany, Wake Forest University School of Medicine; Katie McLaughlin, University of Minnesota Medical School, Duluth Campus

Subject: Ground Ambulance Services and Surprise Billing

Sponsored by: Region 3, Region 4, Region 7

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Emergency Medical Services (EMS) and ground ambulance services play a critical role in the network of healthcare in each community¹; and

Whereas, People insured under Medicare or Medicaid are not at risk for surprise billing²; and

Whereas, Ten percent of emergency room visits for privately insured individuals require an ambulance ride to the hospital³; and

Whereas, Anywhere from 71-86% of ground ambulance rides involve potential surprise bills with patients being charged an aggregate of \$129 million per year due to out-of-network charges^{1,4}; and

Whereas, 39% of Americans would struggle to cover an unexpected expense of just \$400⁵; and

Whereas, Eight percent of all medical debt stems from ambulance charges⁶; and

Whereas, Medical debt disproportionately impacts poor and minority communities, with 80% of medical debt being held by households with zero or negative net worth, and 27% of Black households holding medical debt compared to only 17% of non-black households⁷; and

Whereas, EMS and ambulance service reimbursement from governmental sources is inadequate and subject to significant year-to-year fluctuations⁴; and

Whereas, Patients bear a disproportionate and unintentional financial burden due to out-of-network ambulance service charges⁸; and

Whereas, Financial concerns have been linked to reduced utilization of ground ambulance services, increasing risk of morbidity and mortality⁹; and

Whereas, Low-income patients are 160% more likely to utilize emergency medical services when cost concerns are eliminated¹⁰; and

Whereas, Only Colorado, Delaware, Florida, Illinois, Maine, Maryland, New York, Ohio, Vermont, West Virginia have protections against ground ambulance surprise billing¹¹; and
 Whereas, The No Surprises Act supplements existing state surprise billing laws to protect patients from receiving surprise medical bills by requiring private health plans to cover eligible out-of-network costs, and by prohibiting covered healthcare providers from billing more than the in-network cost-sharing amount¹²⁻¹⁴; and

Whereas, The No Surprises Act called for the creation of a “Ground Ambulance and Patient Billing” advisory committee in January 2022 to develop recommendations on how to address surprise billing in the context of ground ambulance services, but has neither chosen representing members nor published a meeting date^{11,15}; and

Whereas, The No Surprises Act addresses air ambulance services by including “medical transport by helicopter” and “medical transport by airplane”, but does not include ground ambulance services¹⁶⁻¹⁷; therefore be it

RESOLVED, That our AMA oppose surprise billing practices for ground ambulance services.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Sun EC, Mello MM, Moshfegh J, Baker LC. Assessment of out-of-network billing for privately insured patients receiving care in in-network hospitals. *JAMA Intern Med*. 2019;179(11):1543. doi:10.1001/jamainternmed.2019.3451
2. No Surprises: Understand your rights against surprise medical bills. Centers for Medicare & Medicaid Services . Published January 3, 2022. Accessed September 22, 2022. <https://www.cms.gov/newsroom/fact-sheets/no-surprises-understand-your-rights-against-surprise-medical-bills>
3. Ground ambulance rides and potential for surprise billing. Peterson-KFF Health System Tracker. Published June 24, 2021. Accessed September 22, 2022. <https://www.healthsystemtracker.org/brief/ground-ambulance-rides-and-potential-for-surprise-billing/>
4. Chhabra KR, McGuire K, Sheetz KH, Scott JW, Nuliyalu U, Ryan AM. Most patients undergoing ground and air ambulance transportation receive sizable out-of-network bills: an analysis of the prevalence and financial impact of out-of-network billing for ground and air ambulance transportation. *Health Affairs*. 2020;39(5):777-782. doi:10.1377/hlthaff.2019.01484
5. Report on the Economic Well-Being of U.S. Households in 2018. Published May 23, 2019. Accessed September 22, 2022. <https://www.federalreserve.gov/publications/files/2018-report-economic-well-being-us-households-201905.pdf>
6. Giovanetti E. Nearly 1 in 4 Americans have medical-related debt. LendingTree. Published June 27, 2022. Accessed September 22, 2022. <https://www.lendingtree.com/personal/medical-debt-survey/>
7. Perry A, Crear-Perry J, Romer C, Adjeiwaa-Manu N. The racial implications of medical debt: How moving toward universal health care and other reforms can address them. Brookings Institute. Published October 5, 2021. Accessed September 22, 2022.

- <https://www.brookings.edu/research/the-racial-implications-of-medical-debt-how-moving-toward-universal-health-care-and-other-reforms-can-address-them/>
8. Duffy E, Trish E, Adler L. Surprise medical bills increase costs for everyone, not just for the people who get them. Brookings Institute. Published October 2, 2020. Accessed September 22, 2022. <https://www.brookings.edu/opinions/surprise-medical-bills-increase-costs-for-everyone-not-just-for-the-people-who-get-them/>
 9. Siepmann, D. B., et al. "Association between Prepayment Systems and Emergency Medical Services Use among Patients with Acute Chest Discomfort Syndrome. For the Rapid Early Action for Coronary Treatment (REACT) Study." *Annals of Emergency Medicine*, vol. 35, no. 6, June 2000, pp. 573–78.
 10. Smolderen, Kim G., et al. "Health Care Insurance, Financial Concerns in Accessing Care, and Delays to Hospital Presentation in Acute Myocardial Infarction." *JAMA*, vol. 303, no. 14, Apr. 2010, pp. 1392–400. PubMed, <https://doi.org/10.1001/jama.2010.409>.
 11. O'Brien M, Hoadley J, Kona M. Protecting consumers from surprise ambulance bills. *The Commonwealth Fund*. Published online November 15, 2021. doi:10.26099/KJ08-MZ71
 12. Pollitz K. No surprises act implementation: what to expect in 2022. Kaiser Family Foundation. Published December 10, 2021. Accessed September 22, 2022. <https://www.kff.org/health-reform/issue-brief/no-surprises-act-implementation-what-to-expect-in-2022/>
 13. Ending surprise medical bills. Center for Medicare and Medicaid Services. Published January 14, 2022. Accessed September 22, 2022. <https://www.cms.gov/nosurprises/Ending-Surprise-Medical-Bills>
 14. Federal independent dispute resolution (IDR) process guidance for disputing parties. US Department of Health and Human Services. Published April 13, 2022. Accessed September 22, 2022. <https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Revised-IDR-Process-Guidance-Disputing-Parties.pdf>
 15. Biden-Harris administration announces steps to protect consumers and improve ground ambulance billing practices through no surprises act implementation. Center for Medicare and Medicaid Services. Published November 19, 2021. Accessed September 22, 2022. <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-announces-steps-protect-consumers-and-improve-ground-ambulance-billing>
 16. Mitchell S. Ambulance rides still aren't protected from surprise billing — and subscriptions do little to help. *The Intercept*. Published August 8, 2022. Accessed September 22, 2022. <https://theintercept.com/2022/08/08/ambulance-ems-subscription-bills/>
 17. The No Surprises Act's Prohibitions on Balancing Billing. Center for Medicare and Medicaid Services. Accessed September 22, 2022. <https://www.cms.gov/files/document/a274577-1a-training-1-balancing-billingfinal508.pdf>

RELEVANT AMA AND AMA-MSS POLICY

Out-of-Network Care H-285.904

1. Our AMA adopts the following principles related to unanticipated out-of-network care:
 - A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
 - B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
 - C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.

D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.

2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.

3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges.

Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, I-18; Reaffirmation: A-19; Reaffirmed: Res. 210, A-19; Appended: Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 236, A-22

Billing Procedures for Emergency Care H-130.978

(1) Our AMA urges physicians rendering emergency care to ensure that the services they provide are accurately and completely described and coded on the appropriate claim forms. (2) In the interest of high quality care, patients who seek medical attention on an emergency basis should have the benefit of an immediate evaluation of any indicated diagnostic studies. The physician who provides such evaluation is entitled to adequate compensation for his or her services. When such evaluations are provided as an integral part of and in conjunction with other routine services rendered by the emergency physician, ideally an inclusive charge, commensurate with the services provided, should be made. Where the carrier collapses or eliminates CPT-4 coding for payment purposes, the physician may be left with no realistic alternative other than to itemize. Such an itemized bill should not be higher than the amount which would be paid if the appropriate inclusive charge were recognized. The interpretation of diagnostic procedures by a consulting specialist, as a separate and independent service provided the emergency patient, is equally important to good patient care. Physicians who provide such interpretations are also entitled to adequate compensation for their services. (3) Our AMA encourages state and local organizations representing the specialty of emergency medicine to work with both private and public payers in their area to implement payment practices and coding procedures which assure that payment to physicians rendering emergency care adequately reflects the extent of services provided.

CMS Rep. J, I-86; Reaffirmed by Res. 118, I-95; Reaffirmation A-00; Reaffirmed: BOT Rep. 6, I-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 808, I-15

Advocacy Efforts to Persuade All Health Payers to Pay for EMTALA-Mandated Services D-130.975

Our AMA will incorporate into any existing or future legislative efforts regarding EMTALA and/or balance billing, language which would require all insurers to assign payments directly to any health care provider who has provided EMTALA-mandated emergency care, regardless of in-network and out-of-network status.

BOT Rep. 2, I-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17

Balance Billing for All Physicians D-380.996

1. Our AMA will devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to introduce legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interferes with patient access to care.

2. This national legislation will be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician contracts.

3. Our AMA will develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician's right to balance bill any insured patient.

4. Our AMA Board of Trustees will report back to our AMA House of Delegates electronically by March 15, 2008 and at every HOD meeting its progress toward the completion of all of these goals.

Res. 925, I-07; Reaffirmed: BOT Rep. 22, A-17

Medicare Balance Billing D-390.986

Our American Medical Association: (1) advocate that physicians be allowed to balance bill Medicare recipients to the full amount of their normal charge with the patient responsible for the difference between the Medicare payment and the physician charges; (2) seek introduction of national legislation to bring about implementation of balance billing of Medicare recipients; and (3) further advocate that such federal laws and regulations pre-empt state laws that prohibit balance billing.

Res. 713, I-02; Reaffirmation A-04; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: BOT Rep. 9, A-22

Balance Billing H-385.991

Our AMA supports the right of the physician to balance bill a patient for any care given, regardless of method of payment, where permissible by law or contractual agreement.

Sub. Res. 128, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 704, A-01; Reaffirmation A-04; Reaffirmation A-05; Reaffirmation A-06; Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06; Reaffirmed: CMS Rep. 01, A-16

Freedom of Choice H-390.854

(1) The AMA will seek appropriate cases to challenge the legality and constitutionality of Medicare restrictions on non-participating physicians' medical practice and on patient freedom of choice by such mechanisms as limitations on balance billing and prohibitions on private "opt out" arrangements between physicians and patients. (2) The AMA will strongly resist such restrictions being extended to other payers in national health care reform legislation.

Res. 117, I-92; Reaffirmed: CMS Rep. 10, A-03; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-06; Reaffirmed: CMS Rep. 01, A-16

Medicare's Ambulance Service Regulations H-240.978

(1) The AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to the most appropriate facility based on the patient's needs and the determination made by physician medical direction; and expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the onsite evaluation and physician medical direction.

(2) The AMA will work with the Centers for Medicare & Medicaid Services (CMS) to pay emergency medical services providers for the evaluation and transport of patients to the most appropriate site of care not limited to the current CMS defined transport locations.

Res. 37, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Modified: Res. 124, A-17

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 064
(I-22)

Introduced by: Bryan Ubanwa, Ndanzia Mpunga, Benjamin Akande, Chioma Owo, Faith Portuphy, Sam Oshoba, and Daniel Nyancho, University of Texas Health San Antonio Long School of Medicine

Subject: Encouraging Universal Return-to-Play Protocols for Common Sport Injuries in Collegiate and Professional Athletes

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Collegiate and professional athletes are at a heightened risk of experiencing a musculoskeletal sports injury due to the intense physical demands at elite levels of play¹; and

Whereas, Female athletes are more likely to experience overuse injuries, common in collegiate and professional sports, at higher rates than their male counterparts²; and

Whereas, Repetitive trauma to the head, which occurs commonly in contact-sport athletes, can lead to chronic neurobehavioral abnormalities which span from full recovery to persistent cognitive dysfunction³; and

Whereas, Musculoskeletal sports injuries are linked to decreased physical activity and a number of comorbidities such as obesity, cardiovascular disease, and posttraumatic arthritis⁴; and

Whereas, Sports injuries are associated with depression, anxiety, and low self-esteem in athletes, especially those suffering from serious injuries⁵; and

Whereas, The largest risk factor for injury is previous injury due to abnormal changes in the kinematic chain of function including altered proprioception, range of motion, and scar tissue build-up⁶; and

Whereas, Athletes who sustain sports injuries experience excessive direct and indirect costs of care for treatment and rehabilitation post-injury which can lead to early retirement from play⁴; and

Whereas, There is a large mixture of both accelerated rehabilitation programs and 9-12 month full return-to-play protocols in the literature, creating non-uniformity in criteria for return after anterior cruciate ligament reconstruction post-surgically^{7,8}; and

Whereas, In a study on appropriate recovery time for post-traumatic brain injury athletes, 96% of patients demonstrated clinical recovery by 8 weeks after injury where only around 45% of patients demonstrated similar recovery within the recommended 10-14 day window⁹; and

Whereas, strict adherence to a return-to-play protocol has been shown to be effective in the management of athletes following acute isolated posterior cruciate ligament injury, as 91.5% of were able to play at the same or higher level two years after injury and nearly 70% were still playing at the same or higher level five years after the injury¹⁰; and

Whereas, Requiring states to develop an evidence based concussion information sheet including “the procedures needed for allowing a student athlete to return to athletic activity” is consistent with already existing AMA policy H-970-959; and

Whereas, There is a gap in coverage of common musculoskeletal sports injuries at collegiate and professional level in AMA policy H.470.954, which has previously stated support for the “adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations”; therefore be it

RESOLVED, That our AMA encourages interested parties to: (a) establish a standard, universal protocol for return-to-play recovery for collegiate and professional athletes; (b) promote additional evidence-based studies on the effectiveness of a universal protocol for evaluation and post-injury management course at collegiate and professional level; (c) support national and state efforts to minimize the consequences of inadequate recovery windows for collegiate and professional athletes; and be it further

RESOLVED, That our AMA encourage: (a) proper evaluation of mental readiness and medical fitness of college and professional athletes before allowing them to return to competitive play; (b) promotion of further research into the most effective method and protocol for return-to-play at the collegiate and professional level; (c) identification and abstention from harmful practices in sports training of college and professional athletes.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Schallmo, M. et. al. Return-to-Play and Performance Outcomes of Professional Athletes in North America After Hip Arthroscopy From 1999 to 2016. *The American Journal of Sports Medicine*. 2018 May; 46(8): 1959-1969.
2. Carter, C. et. al. Sex-based Differences in Common Sports Injuries. *Journal of the American Academy of Orthopaedic Surgeons*. 2018 July; 26(13): 447-454.
3. Singla, A. et. al. The anatomy of concussion and chronic traumatic encephalopathy: A comprehensive review. *Clinical Anatomy*. 2018 Nov; 32(1): 310-318.
4. Lemoyne, J. et. al. Analyzing injuries among university-level athletes: prevalence, patterns and risk factors. *Journal of Canadian Chiropractic Association*. 2017 Aug; 61(2): 88-95.
5. Gennarelli, S.M. et. al. Psychosocial interventions help facilitate recovery following musculoskeletal sports injuries: a systematic review. *The Physician and Sportsmedicine*. 2020 Mar; 48(4): 370-377.
6. Fulton, J. et. al. Injury Risk is Altered by Previous Injury: A Systematic Review of the Literature and Presentation of Causative Neuromuscular Factors. *International Journal of Sports Physical Therapy*. 2014 Oct; 9(5): 583-595.

7. Schrock, J. et. al. Evolving Treatment Patterns of NFL Players by Orthopaedic Team Physicians Over the Past Decade, 2008-2016. *Sports Health: Sage Journals*. 2018 Feb; 10(5): 453-461.
8. Flagg, K. et. al. Current criteria for return to play after anterior cruciate ligament reconstruction: an evidenced-based review. *Annals of Translational Medicine*. 2019 Oct; 7: S252.
9. Kara, S. et. al. Less Than Half of Patients Recover Within 2 Weeks of Injury After a Sports-Related Mild Traumatic Brain Injury: A 2-Year Prospective Study. *Clinical Journal of Sport Medicine*. 2020 March; 30(2): 96-101.
10. Agolley, D. et. al. Successful return to sports in athletes following non-operative management of acute isolated posterior cruciate ligament injuries. *The Bone & Joint Journal*. 2017 Jun; 99(6): 774-778.

RELEVANT AMA AND AMA-MSS POLICY

Athletic Preparticipation Examinations for Adolescents H-470.971

To promote the health and safety of adolescents, our AMA recommends that state medical societies work with appropriate state and local agencies to promote the following:

- (1) The development of standards for preparticipation athletic examinations that are consistent with consensus recommendations of the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine.
- (2) Only licensed MDs, DOs, and licensed physician extenders practicing under the supervision of licensed MDs and DOs perform preparticipation examinations.
- (3) The decision of whether or not an adolescent is healthy and physically mature enough to participate in a particular sport is made by a qualified physician.
- (4) The decision of when an injured athlete resumes participation is made by a qualified physician.
- (5) The most current guidelines established by the American Academy of Pediatrics, American College of Cardiology, American College of Sports Medicine, and other appropriate medical specialty societies are used to determine eligibility for sports participation.

BOT Rep. R, A-90; Amended: CSA Rep. 5, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: BOT Rep. 9, A-14; Reaffirmed: CSAPH Rep. 3, A-15

Reduction of Sports-Related Injury and Concussion H-470.954

1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.
2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations.
3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries.
4. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval

between head impacts and concussions; (c) develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and (d) develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients.

5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum from subconcussive head impacts to conditions such as chronic traumatic encephalopathy (CTE). ‘

CSAPH Rep. 3, A-15; Appended: Res. 905, I-16

Reducing Risk of Concussion and Other Injuries in Youth Sports H470.959

1. Our American Medical Association promotes the adoption of requirements that athletes participating in school or other organized youth sports and who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion be removed immediately from the activity in which they are engaged and not return to competitive play, practice, or other sports-related activity without the written approval of a physician (MD or DO) or a designated member of the physician-led care team who has been properly trained in the evaluation and management of concussion. When evaluating individuals for return-to-play, physicians (MD or DO) or the designated member of the physician-led care team should be mindful of the potential for other occult injuries.

2. Our AMA encourages physicians to: (a) assess the developmental readiness and medical suitability of children and adolescents to participate in organized sports and assist in matching a child's physical, social, and cognitive maturity with appropriate sports activities; (b) counsel young patients and their parents or caregivers about the risks and potential consequences of sports-related injuries, including concussion and recurrent concussions; (c) assist in state and local efforts to evaluate, implement, and promote measures to prevent or reduce the consequences of concussions, repetitive head impacts, and other injuries in youth sports; and (d) support preseason testing to collect baseline data for each individual.

3. Our AMA will work with interested agencies and organizations to: (a) identify harmful practices in the sports training of children and adolescents; (b) support the establishment of appropriate health standards for sports training of children and adolescents; (c) promote evidenced-based educational efforts to improve knowledge and understanding of concussion and other sport injuries among youth athletes, their parents, coaches, sports officials, school personnel, health professionals, and athletic trainers; and (d) encourage further research to determine the most effective educational tools for the prevention and management of pediatric/adolescent concussions.

4. Our AMA supports (a) requiring states to develop and revise as necessary, evidenced-based concussion information sheets that include the following information: (1) current best practices in the prevention of concussions, (2) the signs and symptoms of concussions, (3) the short-and long-term impact of mild, moderate, and severe head injuries, and (4) the procedures for allowing a student athlete to return to athletic activity; and (b) requiring parents/guardians and students to sign concussion information sheets on an annual basis as a condition of their participation in sports.

Res. 910, I-10; Reaffirmed: BOT Rep. 9, A-14; Modified: CSAPH Rep. 3, A-15; Modified: BOT Action in response to referred for decision: Res. 409, A-17

Physician Exercise of Conscience 1.1.7

1. Physicians should: (a) thoughtfully consider whether and how significantly an action (or declining to act) will undermine the physician's personal integrity, create emotional or moral distress for the physician, or compromise the physician's ability to provide care for the individual and other patients; (b) Take care that their actions do not discriminate against or unduly burden

individual patients or populations of patients and do not adversely affect patient or public trust;
(c) Be mindful of the burden their actions may place on fellow professionals.

AMA Principles of Medical Ethics: I,II,IV,VI,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

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 065
(I-22)

Introduced by: Sara Kazyak, Paige Awtrey, Chayton Fivecoat, Trisha Gupte, Abhijay Kumar, Nadeen Sukhon, Maria Tjilos, Wayne State University School of Medicine; Christine Saleeb, University of the Incarnate Word School of Osteopathic Medicine

Subject: Expanding Medical Nutrition Therapy Coverage in Medicare and Medicaid Plans

Sponsored by: Region 2, Region 4, Region 5

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Medical Nutrition Therapy (MNT) is a set of individualized nutrition and lifestyle recommendations provided by a registered dietitian following thorough evaluation and assessment of a patient's medical condition(s), nutrition habits, and lifestyle¹; and

Whereas, Registered Dietitian Nutritionists (RDNs) are food and nutrition experts who have earned a Bachelor's degree in a course program approved by the Academy of Nutrition and Dietetics (AND), completed 1200 hours of supervised practice, passed a national dietetics licensing exam, completed necessary state licensing, and meet continuing education requirements²; and

Whereas, Medicare Part B coverage of MNT is limited to those with diabetes, kidney disease, or patients having undergone kidney transplant in the past 36 months³; and

Whereas, Following physician referral, only 3 hours of MNT in the first year and 2 hours of MNT in each additional year are covered by Medicare Part B, though further coverage can be requested with a second referral and corresponding change in a patient's diagnosis, condition, or treatment⁴; and

Whereas, Medicaid coverage of MNT varies by state, though the Affordable Care Act only covers of MNT for obesity screening in all patients and adult patients deemed to be at high risk for chronic disease^{5,6}; and

Whereas, Chronic disease is defined as a health condition lasting for greater than one year that requires ongoing medical attention⁷; and

Whereas, It is currently estimated 69% of adults over 65 are managing 2 or more chronic health conditions⁸; and

Whereas, Chronic diseases such as heart disease, stroke, diabetes, and arthritis have contributed to approximately \$333.9 billion lost productivity and lost earnings⁹⁻¹¹; and

Whereas, Considering the aging population of the United States (US) and current upward trends in healthcare spending, the US is projected to spend \$42 trillion due to chronic diseases

1 between the years of 2016 and 2030 and the country could save an estimated \$6 trillion if
2 efforts for health and behavior change are utilized to prevent the onset of chronic disease^{12,13};
3 and

4
5 Whereas, Non-Hispanic Black adults experience higher rates of chronic diseases such as
6 diabetes, obesity, heart disease, asthma and hypertension, while Hispanic adults experience
7 higher rates of obesity, diabetes, and hypertension than their white counterparts^{14,15}; and

8
9 Whereas, Over 30% of those enrolled in a Medicare Advantage plan and over 60% of patients
10 enrolled in Medicaid are non-white^{16,17}; and

11
12 Whereas, Black and Hispanic Medicare Advantage enrollees are less likely to have controlled
13 blood pressure, cholesterol, and glycated hemoglobin than their white counterparts,
14 emphasizing a potential area of benefit if there was greater MNT coverage under Medicare
15 plans¹⁸; and

16
17 Whereas, Communities of color experience higher rates of chronic diseases and food insecurity,
18 indicating these patients are more likely to face barriers to accessing health care services
19 including MNT provided by a registered dietitian nutritionist and more likely to benefit from MNT
20 intervention⁸; and

21
22 Whereas, Both inpatient and outpatient MNT have been shown to result in cost savings for both
23 patient and physician, with MNT intervention reducing the costs for a variety of medical
24 conditions¹⁹⁻²²; and

25
26 Whereas, Medical nutrition therapy has been found to be effective for a variety of uses outside
27 obesity assessment and chronic kidney disease management, including gestational diabetes
28 management, diabetes mellitus management, maintaining nutritional status in pancreatic
29 cancer, lowering cholesterol measures in patients with dyslipidemia, reducing HbA1C, and
30 decreasing blood pressure^{20,23-26}; and

31
32 Whereas, Medical nutrition therapy effectively improves nutrition and physical activity status in
33 patients with HIV and nutrition screening in HIV patients is deemed “imperative” by The
34 Academy of Nutrition and Dietetics^{27,28}; and

35
36 Whereas, In conditions such as PCOS, MNT can have additional health benefits, such as
37 fertility protection, in addition to chronic disease management²⁹; and

38
39 Whereas, H.R.3108 bill, known as the Medical Nutrition Therapy Act of 2021, has proposed
40 extension of Medicare part B MNT coverage to to individuals with other diseases and
41 conditions, including obesity, eating disorders, cancer, GI disorders, and HIV/AIDS, though this
42 bill has yet to be passed by Congress³⁰; and

43
44 Whereas, AMA policy H-150.931 recognizes the value of nutrition support services and payment
45 for such services, though current policy fails to recognize the wide variety of benefits patients
46 may receive from MNT or expand insurance coverage accordingly; therefore, be it

47
48 RESOLVED, Our AMA advocates for expansion of Medicare and Medicaid plans to include all
49 medical nutrition therapy services deemed necessary by a physician referral in the treatment of
50 chronic disease.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Academy of Nutrition and Dietetics. RDNs and Medical Nutrition Therapy Services. eatrightpro.org. Accessed August 25, 2022. <https://www.eatright.org/food/resources/learn-more-about-rdns/rdns-and-medical-nutrition-therapy-services>.
2. Academy of Nutrition and Dietetics. Qualifications of a Registered Dietitian Nutritionist. eatrightpro.gov. Accessed August 25, 2022. <https://www.eatright.org/food/resources/learn-more-about-rdns/qualifications-of-a-registered-dietitian-nutritionist>.
3. U.S. Centers for Medicare and Medicaid Services. Your Medicare Coverage: Nutrition therapy services. medicare.gov. Accessed August 23, 2022. <https://www.medicare.gov/coverage/nutrition-therapy-services>.
4. Academy of Nutrition and Dietetics. Medicare MNT. eatrightpro.org. Accessed August 23, 2022. <https://www.eatrightpro.org/payment/medicare/mnt>.
5. Academy of Nutrition and Dietetics. Medicaid and RDNs. eatrightpro.org. Accessed August 25, 2022. <https://www.eatrightpro.org/payment/nutrition-services/medicaid/medicaid-and-rdns#1>.
6. Patient Protection and Affordable Care Act, HR 3590, 111th Cong (2010).
7. Centers for Disease Control and Prevention. About Chronic Disease. cdc.gov. Reviewed July 21, 2022. Accessed September 22, 2022. <https://www.cdc.gov/chronicdisease/about/index.htm>
8. Martin H, Kushner S, Iles K, Montgomery H. Advocating for Expanded Access to Medical Nutrition Therapy in Medicare. *J Acad Nutr Diet*. 2022;122(1):175-181. doi:10.1016/j.jand.2021.02.024
9. Benjamin EJ, Virani SS, Callaway CW, et al. Heart Disease and Stroke Statistics-2018 Update: A Report From the American Heart Association [published correction appears in *Circulation*. 2018 Mar 20;137(12):e493]. *Circulation*. 2018;137(12):e67-e492. doi:10.1161/CIR.0000000000000558.
10. American Diabetes Association. Economic Costs of Diabetes in the U.S. in 2017. *Diabetes Care*. 2018;41(5):917-928. doi:10.2337/dci18-0007.
11. Murphy LB, Cisternas MG, Pasta DJ, Helmick CG, Yelin EH. Medical Expenditures and Earnings Losses Among US Adults With Arthritis in 2013. *Arthritis Care Res (Hoboken)*. 2018;70(6):869-876. doi:10.1002/acr.23425.
12. Partnership to Fight Chronic Disease. What is the Impact of Chronic Disease in America? fightchronicdisease.org. Accessed August 24, 2022. https://www.fightchronicdisease.org/sites/default/files/pfcd_blocks/PFCD_US.FactSheet_FINAL1%20%282%29.pdf.
13. Waters H, Graf M. The Milken Institute. The Costs of Chronic Disease in the U.S. milkeninstitute.org. Published August 2018. Accessed August, 24, 2022. <https://milkeninstitute.org/sites/default/files/reports-pdf/ChronicDiseases-HighRes-FINAL.pdf>.
14. Odlum M, Moise N, Kronish IM, et al. Trends in Poor Health Indicators Among Black and Hispanic Middle-aged and Older Adults in the United States, 1999-2018. *JAMA Netw Open*. 2020;3(11):e2025134. Published 2020 Nov 2. doi:10.1001/jamanetworkopen.2020.25134
15. Stierman B, Afful J, Carrol M, et al. National Health and Nutrition Examination Survey 2017–March 2020 Prepandemic Data Files Development of Files and Prevalence

- Estimates for Selected Health Outcomes. Natl. Health Stat. Rep. 2021; 158: 1-21.
<http://dx.doi.org/10.15620 /cdc:106273>
16. MACPAC. Racial and Ethnic Disparities in Medicaid: An Annotated Bibliography. Published April 2021. [macpac.gov](https://www.macpac.gov) Accessed September 22, 2022.
<https://www.macpac.gov/wp-content/uploads/2021/04/Racial-and-Ethnic-Disparities-in-Medicaid-An-Annotated-Bibliography.pdf>
 17. CMS Office of Minority Health. Racial, Ethnic, & Gender Disparities in Health Care and Medicare Advantage. [cms.gov](https://www.cms.gov). Published April 2021. Accessed September 22, 2022.
<https://www.cms.gov/files/document/racial-ethnic-gender-disparities-health-care-medicare-advantage.pdf>
 18. Ayanian JZ, Landon BE, Newhouse JP, Zaslavsky AM. Racial and ethnic disparities among enrollees in Medicare Advantage plans. *N Engl J Med*. 2014;371(24):2288-2297. doi:10.1056/NEJMsa1407273
 19. Academy of Nutrition and Dietetics. MNT: Cost Effectiveness, Cost-Benefit, or Economic Savings of MNT (2009). Accessed August 23, 2022. https://www.andeal.org/topic.cfm?cat=4085&conclusion_statement_id=251001%26highlight=MNT%20for%20weight%20management%20diabetes%26home=1.
 20. Sikand G, Cole RE, Handu D, et al. Clinical and cost benefits of medical nutrition therapy by registered dietitian nutritionists for management of dyslipidemia: A systematic review and meta-analysis. *J Clin Lipidol*. 2018;12(5):1113-1122. doi:10.1016/j.jacl.2018.06.016.
 21. Briggs Early K, Stanley K. Position of the Academy of Nutrition and Dietetics: The Role of Medical Nutrition Therapy and Registered Dietitian Nutritionists in the Prevention and Treatment of Prediabetes and Type 2 Diabetes. *J Acad Nutr Diet*. 2018;118(2):343-353. doi:10.1016/j.jand.2017.11.021.
Siopis G, Wang L, Colagiuri S, Allman-Farinelli M. Cost effectiveness of dietitian-led nutrition therapy for people with type 2 diabetes mellitus: a scoping review. *J Hum Nutr Diet*. 2021;34(1):81-93. doi:10.1111/jhn.12821.
 22. Hernandez TL, Mande A, Barbour LA. Nutrition therapy within and beyond gestational diabetes. *Diabetes Res Clin Pract*. 2018 Nov;145:39-50. doi: 10.1016/j.diabres.2018.04.004.
Pastors JG, Warshaw H, Daly A, Franz M, Kulkarni K. The Evidence for the Effectiveness of Medical Nutrition Therapy in Diabetes Management. *Diabetes Care*. 2002; 25 (3): 608–613. <https://doi.org/10.2337/diacare.25.3.608>.
 23. Vashi P, Popiel B, Lammersfeld C, Gupta D. Outcomes of Systematic Nutritional Assessment and Medical Nutrition Therapy in Pancreatic Cancer. *Pancreas*. 2015; 44(5): 750-755 doi: 10.1097/MPA.0000000000000336.
 24. Mark D. Agee, Zane Gates, Patrick M. Irwin; Effect of Medical Nutrition Therapy for Patients With Type 2 Diabetes in a Low-/No-Cost Clinic: A Propensity Score–Matched Cohort Study. *Diabetes Spectr* 1 February 2018; 31 (1): 83–89.
<https://doi.org/10.2337/ds16-0077>.
 25. Singhato A, Khongkhon S, Rueangsri N, Booranasuksakul U. Effectiveness of Medical Nutrition Therapy to Improve Dietary Habits for Promoting Bone Health in People Living with Chronic HIV. *Ann Nutr Metab*. 2020;76(5):313-321. doi:10.1159/000510367
 26. Academy of Nutrition and Dietetics Evidence Analysis Library. H/A Executive Summary of Recommendations (2010). [andeal.org](https://www.andeal.org). Accessed September 22, 2022.
<https://www.andeal.org/topic.cfm?menu=5312&cat=4458>
 27. Calcaterra V, Verduci E, Cena H, et al. Polycystic Ovary Syndrome in Insulin-Resistant Adolescents with Obesity: The Role of Nutrition Therapy and Food Supplements as a Strategy to Protect Fertility. *Nutrients*. 2021;13(6):1848. Published 2021 May 28. doi:10.3390/nu13061848
 28. Medical Nutrition Therapy Act of 2021, HR 3108, 117th Cong, 2021.

RELEVANT AMA AND AMA-MSS POLICY

Nutrition Counseling for Pregnant and Recent Post-Partum Patients H-420.955

Our AMA: 1) supports physician referrals of pregnant and post-partum patients for nutrition counseling, and 2) will advocate for the extension of health insurance coverage for nutrition counseling for all pregnant and recent post-partum patients.

Res. 409, A-11; Reaffirmed: CSAPH Rep. 1, A-21

Payment for Nutrition Support Services H-150.931

Our AMA recognizes the value of nutrition support teams services and their role in positive patient outcomes and supports payment for the provision of their services.

Res. 705, A-14

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.

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-1

Healthy Lifestyles H-425.972

1. Our AMA: (A) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the *Journal of the American Medical Association* in 2010; (B) will urge physicians to acquire and

apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (C) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.

2. Our AMA supports policies and mechanisms that incentivize and/or provide funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate, graduate and continuing medical education.

Res. 423, A-12; Appended: Res. 959, I-17

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.

Reducing Racial and Ethnic Disparities in Health Care D-350.995

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:

- (1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
- (2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
- (3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

BOT Rep. 4, A-03; Reaffirmation A-11; Reaffirmation: A-16; Reaffirmed: CMS Rep. 10, A-19

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 066
(I-22)

Introduced by: Dhruv Puri, Jessica Kim, University of California San Diego School of Medicine; Matinder Dhillon, Rajvarun Grewal, California Health Sciences University-College of Medicine; Vish Vijayakumar, Carle Illinois College of Medicine

Subject: Increased regulation of commercial electric scooter use

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Commercial and for-rent electric scooter usage has increased over the past few years as an accessible means of transportation, particularly in urban communities, which has led to a significant rise in the number of falls and collision-related injuries¹; and

Whereas, According to the U.S. Consumer Product Safety Commission report, there has been a more than 3-fold increase in emergency room visits due to electric-scooters from 7,700 in 2017 to 25,400 in 2020²; and

Whereas, Electric scooter injuries commonly occur in the head and neck area (including traumatic brain injury), upper limbs, and lower limbs^{2,3,4,5}; and

Whereas, Patients who sustain orthopedic, facial, and cranial injuries have an average billing of \$95,710 to insurance⁶; and

Whereas, In one study, out of 28,702 electric scooter injuries, 8% were linked with alcohol use (of which 60% were associated with head trauma), 1% was linked with drug use, and 28% of non-alcohol-associated injuries led to head trauma^{7,8}; and

Whereas, In many states like Texas, Oklahoma, and Nebraska, driving under the influence or “DUI” laws do not apply to electric-scooters and are reserved for motor vehicles⁹⁻¹¹; and

Whereas, Riding an electric scooter under the influence of alcohol or drugs increases the likelihood of severe injury requiring hospital admission¹²; and

Whereas, In a study by Hamzani et al in 2022, in retrospective cohort study analyzing scooter injury patients who presented to level 1 trauma centers in an urban area, 0% were wearing protective gear and 33% admitted to alcohol consumption prior to riding, and of the injured

patients, more than 60% required direct medical interventional procedures including laceration repairs (26%), fracture reductions (17%), and operative fixation of fractures (7%)¹²; and

Whereas, Helmet safety requirements are standard practice in many states across the country for motorcyclists, bicyclists and snowboarders, and it is vital to translate this awareness to electric scooter users by regulating electric scooter safety and helmet requirements¹³; and

Whereas, The AMA has policy advocating for the safe use of scooters and motorized bicycles (H-10.964), supports helmet requirements for riders of scooters in all age groups (H-15.960), and has listed recommendations on legislation and education on driving “motor vehicles” while impaired (H-30.936); and therefore be it

RESOLVED, Our AMA collaborate with state and local medical societies to advocate for regulations against the use of commercial electric scooters while under the influence and without proper protective gear to reduce commercial electric scooter-related injury and death.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Coelho A, Feito P, Corominas L, Sánchez-Soler JF, Pérez-Prieto D, Martínez-Díaz S, Alier A, Monllau JC. Electric Scooter-Related Injuries: A New Epidemic in Orthopedics. *J Clin Med*. 2021 Jul 25;10(15):3283. doi: 10.3390/jcm10153283. PMID: 34362067; PMCID: PMC8348701.
2. Injuries Using E-Scooters, E-Bikes and Hoverboards Jump 70% During the Past Four Years. U.S. Consumer Product Safety Commission. <https://www.cpsc.gov/Newsroom/News-Releases/2021/Injuries-Using-E-Scooters-E-Bikes-and-Hoverboards-Jump-70-During-the-Past-Four-Years#:~:text=Much%20of%20the%20increase%20between,the%20head%20and%20the%20neck.> Published 2022. Accessed August 31, 2022.
3. Rizzo MG, Allegra PR, Yakkanti R, Luxenburg D, Dodds SD. Electric scooters as a source of orthopedic injuries at a Level-I trauma center. *J Orthop*. 2022;31:86-91. Published 2022 Apr 15. doi:10.1016/j.jor.2022.04.005
4. Tuckel P. Injuries from nonmotorized scooters treated in emergency departments in the United States, 2005-2020. *Am J Emerg Med*. 2022;54:30-35. doi:10.1016/j.ajem.2022.01.042
5. Azab M, Gamboa N, Nadel J, et al. Case Series and Systematic Review of Electronic Scooter Crashes and Severe Traumatic Brain Injury [published online ahead of print, 2022 Aug 6]. *World Neurosurg*. 2022;S1878-8750(22)01076-2. doi:10.1016/j.wneu.2022.07.126
6. Lavoie-Gagne O, Siow M, Harkin WE, Flores AR, Politzer CS, Mitchell BC, Girard PJ, Schwartz AK, Kent WT. Financial impact of electric scooters: a review of injuries over 27 months at an urban level 1 trauma center (cost of e-scooter injuries at an urban level 1 trauma center). *Trauma Surg Acute Care Open*. 2021 Jan 22;6(1):e000634. doi: 10.1136/tsaco-2020-000634. PMID: 33532597; PMCID: PMC7831709.
7. Texas State Legislature, Title 10 Chapter 49 Intoxication and Alcoholic Beverage Offenses (rev. 2003). <https://statutes.capitol.texas.gov/Docs/PE/htm/PE.49.htm>

8. 47 OS 11-902 Article 2 Vehicle Operation and Rules of the Road.
https://library.municode.com/ok/muldrow/codes/code_of_ordinances?nodeId=COOR_C H42TRVE_ARTIIVEOPRURO
9. NRS 60-6,196.Driving under influence of alcoholic liquor or drug; penalties.
<https://nebraskalegislature.gov/laws/statutes.php?statute=60-6,196>
10. Namiri NK, Lee AW, Amend GM, Vargo J, Breyer BN. Impact of alcohol and drug use on bicycle and electric scooter injuries and hospital admissions in the United States. Trauma. September 2021. doi:10.1177/14604086211044353
11. Hamzani Y, Demtriou H, Zelnik A, et al. Impact of Drug and Alcohol Use on Hospitalization for Injuries in Riders of Electric Bikes or Powered Scooters: A Retrospective Cross-Sectional Study. Healthcare (Basel). 2022;10(6):1026. Published 2022 Jun 1. doi:10.3390/healthcare10061026
12. Thaddeus J. Puzio, Patrick B. Murphy, Josh Gazzetta, Hannah A. Dineen, Stephanie A. Savage, Erik W. Streib & Ben L. Zarzaur (2020) The electric scooter: A surging new mode of transportation that comes with risk to riders, Traffic Injury Prevention, 21:2, 175-178, DOI: [10.1080/15389588.2019.1709176](https://doi.org/10.1080/15389588.2019.1709176)
13. Choron RL, Sakran JV. The Integration of Electric Scooters: Useful Technology or Public Health Problem? Am J Public Health. 2019 Apr;109(4):555-556. doi: 10.2105/AJPH.2019.304955. PMID: 30865508; PMCID: PMC6417591.

RELEVANT AMA AND AMA-MSS POLICY

Automobile-Related Injuries H-15.990

Our AMA: (1) Encourages physicians to increase their awareness of the still largely overlooked problem of motor vehicle-related injuries and to discuss with their patients how they can avoid or prevent such injuries. (2) Calls for the establishment of a reduction in motor vehicle injuries as a national goal. (3) Reaffirms its support for the development of effective passive crash protection systems for occupants of motor vehicles. (4) Strongly endorses and encourages the use of active restraints, such as lapbelts, lapbelt-shoulder harnesses, and those that are approved for children. (5) Encourages motor vehicle manufacturers to develop automobiles with stronger passenger compartments that would more effectively protect occupants, and with interiors having fewer protuberant objects and hard surfaces that could cause injuries in crashes. (6) Continues to support state and federal legislative efforts to strengthen drunk driving laws and their enforcement. (7) Encourages national and federal organizations, such as the National Institutes of Health, the National Highway Transportation Safety Agency, and the National Science Foundation, and appropriate private groups, to devote more of their resources to research concerning vehicle-related injuries and their prevention. (8) Urges states to review their standards for the construction and maintenance of roads and highways. The standards should be based on current engineering knowledge and good practice, particularly as related to use of skid-resistant surfaces; shoulder grading; drivers' lines of vision; removal of obstructions; and separation of opposing traffic streams. (9) Encourages state and local officials to monitor streets, roads, and highways to identify sites with disproportionate risks of crashes, in order to take appropriate remedial actions. (10) Encourages continued study of the effect of increasing the legal age at which young persons may drink alcoholic beverages and supports increased study of behavioral factors in crashes, such as those relating to education, training and driving experience; school, family and work problems; aggression; depression and personality disorders; use of drugs; and criminal behavior. (11) Believes that, before the adoption of passive crash protection systems and devices to reduce motor vehicle injuries, industry and government demonstrate through field studies that such systems and devices are effective, safe, cost-effective and acceptable to drivers. (12) Supports the use of legal and constitutional sobriety checkpoints to deter driving following alcohol consumption. (13) Will work with interested state

medical societies to pursue legislation to overturn bans on the use of sobriety checkpoints. (14) Our AMA will encourage the National Highway Traffic Safety Administration to undertake the necessary rulemaking to integrate automated high-beam to low-beam headlight switching lamps into the Federal Motor Vehicle Safety Standards. (15) Our AMA will support more comprehensive Graduated Driver Licensing programs including but not limited to more stringent permit and licensing age requirements, mandatory minimum training hours, and nighttime and teenage passenger restrictions.

CSA Rep. I, I-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-12; Appended: Res. 202, I-14; Reaffirmation A-15; Appended: Res. 401, A-18; Appended: Res. 426, A-18

Motor Vehicle and Bicycle Safety H-15.960

The AMA supports legislation that would make safety belt non-use by any occupants in automobiles and other enclosed motor vehicles a "primary offense" in all states; supports extension of motorcycle helmet laws to include motorized vehicles such as mopeds, scooters and all-terrain vehicles, and to cover all age groups; and supports legislation that would require helmet usage for riders of bicycles, including passengers.

Res. 226, A-95; Reaffirmed: BOT Rep. 12, A-05; Reaffirmed: CSAPH Rep. 1, A-15

Motor Vehicle Accidents H-15.992

Our AMA (1) recognizes motor vehicle-related trauma as a major public health problem, the resolution of which requires a leadership role by physicians in concert with safety experts; and (2) strongly encourages other medical and health care organizations, as well as departments of health and transportation, to endorse the concept of motor vehicle related trauma as a public health problem, thereby lending its treatment to traditional public health measures.

BOT Rep. LL, I-81; Reaffirmed: CLRPD Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21

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.

Helmets for Riders of Motorized and Non-motorized Cycles H-10.964

General Helmet Use: Our AMA: (1) encourages physicians to counsel their patients who ride motorized and non-motorized cycles to use approved helmets and appropriate protective clothing while cycling; (2) encourages patients and families to inform and train children about safe cycle-riding procedures, especially on roads and at intersections, the need to obey traffic laws, and the need for responsible behavior; (3) encourages community agencies, such as those involving law enforcement, schools, and parent-teacher organizations, to promote training programs for the responsible use of cycles; (4) urges manufacturers to improve the safety and reliability of the vehicles they produce and to support measures to improve cycling safety; (5) advocates further research on the effectiveness of helmets and on the health outcomes of community programs that mandate their use; (6) encourages efforts to investigate the impact of helmet use by riders of motorcycles and all bicycles, in order to establish the risk of major medical trauma from not wearing helmets, the costs added to the health care system by such behavior, and the payers of these added costs (i.e., private insurance, uncompensated care, Medicare, Medicaid, etc.); (7) supports the exploration of ways to ensure the wearing of helmets through the use of disincentives or incentives such as licensing fees, insurance premium adjustments and other payment possibilities.

Bicycles: Our AMA: (1) actively supports bicycle helmet use and encourages physicians to educate their patients about the importance of bicycle helmet use; (2) encourages the manufacture, distribution, and utilization of safe, effective, and reasonably priced bicycle helmets; and (3) encourages the availability of helmets at the point of bicycle purchase.

Scooters: Our AMA: (1) recommends the use of protective gear (certified helmets, elbow and knee pads, closed-toe shoes) for riders of scooters, especially children and adolescents; (2) encourages physicians to counsel patients, and their parents when appropriate, that full protective equipment should be worn and appropriate safety measures should be taken to prevent scooter injuries (e.g., riding away from traffic, and close supervision of riders under the age of eight); and (3) urges companies that manufacture or sell scooters to include appropriate information about the safe use of scooters on the scooters themselves, on or inside scooter packaging, on their web sites, and at the point of sale.

Motorcycles: Our AMA: (1) encourages physicians to be aware of motorcycle risks and safety measures and to counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs; (2) endorses the concept of legislative measures to require the use of helmets when riding or driving a motorcycle; (3) supports federal regulatory rules to make the receipt of federal highway funds by a state dependent on passage of mandatory motorcycle helmet laws by that state; (4) urges constituent societies to support the enactment or preservation of state motorcycle helmet laws; and (5) supports rider education legislation, which is more easily implemented and more effective than legislation requiring manufacturers to emphasize the dangers of operating motorcycles.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 067
(I-22)

Introduced by: Ursulina Tomczak, Rimzhim Kashikar, Maya Mathews, Samantha Thomas,
Bahareh Jabbari; Creighton University School of Medicine

Subject: Introduction of Pre-discharge Individualized Fall Risk Assessments for Older
Adults

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Falls are the leading cause of injury and death due to injury in adults 65 years and older¹; and

Whereas, One out of four adults age 65 years and older will fall each year¹; and

Whereas, Up to 40% of geriatric patients fall within 6 months of hospital discharge²; and

Whereas, Fall related injuries are leading diagnoses for hospital readmissions and increase Medicare hospital penalties³; and

Whereas, There has been some federal funding to prevent in home falls for adults above age 65⁵; and

Whereas, Title III-D of the Older Americans Act is a federal initiative that funds the Home Hazard Removal Program which targets behavioral interventions including home repair, adaptive equipment, and task modification⁵; and

Whereas, Not all providers are screening patients at risk for falls at the same rate⁶, and

Whereas, Nurse practitioners (NP) are more likely than primary care providers (PCP) to screen for fall risk at wellness visits⁶, and

Whereas, There are differences in the types of clinical resources used by NPs and other PCPs to assess fall risks and safety profile of medications⁶, and

Whereas, CDC's fall prevention initiative, Stopping Elderly Accidents Deaths and Injury (STEADI) is a free resource available to providers to assist them in their older adult fall prevention and safe medication prescribing efforts⁶, and

Whereas, The STEADI initiative has been implemented at the Rees-Jones Trauma Center at Parkland Memorial Hospital in Dallas, Texas⁷; and

Whereas, After the implementation of STEADI protocol, the average length of stay was decreased from 7.9 days to 6.5 days⁷; and

Whereas, After the implementation of STEADI, the number of older adults returning with second falls was reduced from 1.5% to 0.6%⁷; and

Whereas, Inpatient units must cater fall prevention assessment to the individual patient needs to maximize benefits, such as geriatric-psychiatry focus on gait, strength, and balance and neurology focus on interventions for patients with cognitive deficits⁸; and

Whereas, Avoiding even one hospital readmission can result in reimbursement gains of \$10,000 to \$58,000 for Medicare discharges⁴; and

Whereas, Every year an estimated \$50 billion is spent on the direct medical costs related to fall injuries, with 78% being paid for by Medicaid and Medicare⁹; and

Whereas, This total cost to the American Healthcare System is projected to increase to over \$101 billion by 2030¹⁰; therefore be it

RESOLVED, Our AMA encourages interprofessional, individualized fall assessment protocols, such as STEADI, in inpatient settings when preparing patients for discharge to reduce injury and financial burden.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. CDC. Keep on Your Feet. Centers for Disease Control and Prevention. Published December 16, 2020. Accessed August 29, 2022. <https://www.cdc.gov/injury/features/older-adult-falls/index.html>
2. Hill AM, McPhail SM, Haines TP, et al. Falls After Hospital Discharge: A Randomized Clinical Trial of Individualized Multimodal Falls Prevention Education. *J Gerontol A Biol Sci Med Sci*. 2019;74(9):1511-1517. doi:10.1093/gerona/glz026
3. Posthospital Fall Injuries and 30-Day Readmissions in Adults 65 Years and Older | Geriatrics | JAMA Network Open | JAMA Network. Accessed August 29, 2022. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2734065>
4. Yakusheva O, Hoffman GJ. Does a Reduction in Readmissions Result in Net Savings for Most Hospitals? An Examination of Medicare's Hospital Readmissions Reduction Program. *Med Care Res Rev*. 2020;77(4):334-344. doi:10.1177/1077558718795745
5. Introducing the Home Hazard Removal Program (HARP). @NCOAging. Accessed August 29, 2022. <https://www.ncoa.org/article/home-hazard-removal-program-harp-an-evidence-based-program-created-from-the-older-americans-act>
6. Mark JA, Haddad YK, Burns ER. Differences in Evaluating Fall Risk by Primary Care Provider Type. *J Nurse Pract*. 2020;16(7):528-532. doi:10.1016/j.nurpra.2020.04.014
7. Keep Them STEADI: Preventing Older Adult Falls in Hospital-Based Settings | STEADI - Older Adult Fall Prevention | CDC Injury Center. Published January 28, 2019. Accessed September 22, 2022. <https://www.cdc.gov/steady/stories/hospital.html>
8. 3. Which fall prevention practices do you want to use? Accessed August 29, 2022. <https://www.ahrq.gov/patient-safety/settings/hospital/fall-prevention/toolkit/practices.htm>
9. Falls Prevention Programs: Saving Lives, Saving Money Infographic. @NCOAging. Accessed August 29, 2022. <https://www.ncoa.org/article/falls-prevention-programs-saving-lives-saving-money-infographic>

10. Houry D, Florence C, Baldwin G, Stevens J, McClure R. The CDC Injury Center's Response to the Growing Public Health Problem of Falls Among Older Adults. Am J Lifestyle Med. 2015;10(1):74-77. doi:10.1177/1559827615600137

RELEVANT AMA AND AMA-MSS POLICY

Community Based Falls Prevention Programs H-25.988

Our American Medical Association will work with relevant organizations to support community-based falls prevention programs.

Res. 408, A-15

Hospital Falls and “Never Events”- A Need for a More in Depth Study D-450.952

Our AMA will work with interested state medical associations and national medical specialty societies to support research regarding the feasibility and impact of removing patient falls with injury from Medicare's list of “never events.”

Res. 706, A-19

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 068
(I-22)

Introduced by: Tanvi Karmarkar, University of Missouri - Kansas City School of Medicine; Catriona Hong, Sarah K Zemlock, University of Connecticut School of Medicine; Itisha Jefferson, Loyola University Stritch School of Medicine; Kaye Dandrea, University of New England College of Osteopathic Medicine; Samantha Pavlock, Florida State University College of Medicine; Fariya Fatima, University of North Texas Health and Science Center - Texas College of Osteopathic Medicine; Jhillika Patel, Rutgers Robert Wood Johnson Medical School; Dilpreet Kaeley, University of Toledo College of Medicine and Life Sciences; Raji Nagalla, University of California Irvine School of Medicine

Subject: Increasing regulation and labeling of fragrances in personal care products, cosmetics, and drugs.

Sponsored by: Region 2, Region 4, Region 5, Region 7

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, "Fragrance" may be defined as any established and suspected contact allergen or irritant or cross-reactor, not limited to, synthetic fragrances, essential oils, fragrant plant extracts, waxes, or oils ^{1,2}; and

Whereas, "Fragrances" are found in personal care products, cosmetics, household products, and drugs ^{1,2}; and

Whereas, Fragrances contain chemicals associated with contact dermatitis, eczema, photosensitivity, and other contact reactions, and are the most frequent causes of contact allergy due to widespread use, significantly impacting occupational accessibility, healthcare costs, and quality of life in adults, children, and infants ^{3,4,5,6,7,8,9}; and

Whereas, A "fragrance sensitivity" is any adverse health effect resulting from fragrance exposure, including adverse dermatologic, allergic, neurologic, and immunologic reactions ^{3,10,28}; and

Whereas, "Personal care products" (PCP) refer to skin moisturizers, perfumes, lipsticks, fingernail polishes, eye and facial makeup preparations, shampoos, permanent waves, hair colors, toothpaste, deodorants, and other products applied to one's body, but are not legally defined by the Food and Drug Administration (FDA) ¹¹; and

Whereas, Currently, the FDA and the U.S. Consumer Product Safety Commission (CPSC) do not govern the disclosure, regulation, or labeling of fragranced components added to PCPs, cosmetics, and drugs applied to one's body ^{3,12,13}; and

Whereas, FDA regulatory authority over cosmetics and PCPs items is limited to “adulteration”, defined as free of “poisonous or deleterious substances, decomposed or putrid substances, contamination or filth, and color additives” and “misbranding”, defined as “false or misleading labeling”, allowing “unscented” and “fragrance-free” products to contain masking fragrances, and the FDA has no regulatory authority over proprietary fragrance formulations due to “trade secret” protections, and has no authority to recall hazardous cosmetics ^{11,14,15, 16, 17}; and

Whereas, The CPSC specifies that cosmetics list discrete ingredients by their chemical or common name with the exception of fragrance or flavor, which may be listed as “fragrance or flavor” instead of the actual ingredients¹⁸; and

Whereas, The Federal Food, Drug, and Cosmetic Act (FD&C) is a federal law that establishes a legal framework within which the FDA develops its regulations ¹⁹; and

Whereas, the FD&C does not require cosmetic firms to register their establishments or list their product formulations with the FDA therefore, limiting the FDA to only require voluntary cosmetic registration through the voluntary cosmetic registration (VCRP) ^{19, 20}; and

Whereas, The manufacturer or distributor of a cosmetic product or ingredient is legally responsible for ensuring that a marketed product is safe when used as directed, however, this law is loosely instated with “safety” being poorly defined ¹⁴; and

Whereas, In 2019, the FDA issued a proposed rule on sunscreens which set new requirements for sunscreen active ingredients, maximum sun protection factor levels (SPF), broad-spectrum requirements against UVA & UVB, dosage forms, and sunscreen labeling provisions for consumers; setting precedent for FDA regulation of labeling in cosmetics and PCPs ^{21,27}; and

Whereas, The synthetic fragrance 2-(4-tert-butylbenzyl)propionaldehyde, widely used in PCPs, can be harmful to fertility and potentially endocrine disrupting, prompting European labeling regulations when its concentration exceeds certain levels in various products such as creams, lotions, deodorants, soaps, and shampoo; however, the U.S. has no such regulations²²; and

Whereas, The European Union has already banned nearly 1,400 chemicals from cosmetics and has required premarket safety assessments, mandatory registration and government authorization for the use of materials; in comparison, the U.S. has banned only 30 chemicals from PCPs, proving that the U.S. needs more regulation and assessment of these additives ^{19,23,24,25}; and

Whereas, Comprehensive labeling of fragrances is key in the diagnosis, prevention, and prognosis of patients with fragrance sensitivities who may experience: contact dermatitis, non-eczematous contact reactions, photosensitivity, photo-allergy, immediate contact reactions, eczema, asthma, and migraines ^{3,26}; and

Whereas, While AMA MSS policy 270.021MSS and 525.009MSS provide the infrastructure for this resolution by calling for increased transparency and labeling of cosmetics, it does not encompass the unique categorization of fragrances due to their “trade-secret designation” and presence in drugs and household items; and

Whereas, Pending transmittal 189, H-440.855 addresses the need for a fragrance free environments and acknowledges fragrance sensitivity as a disability, it poses no request for increased regulation or labeling of fragrances themselves; therefore be it

1 RESOLVED, That our AMA work with relevant stakeholders such as the Food and Drug
 2 Administration and the U.S Consumer Product Safety Commission to support the appropriate
 3 labeling of fragrance-containing personal care products and drugs with warnings about possible
 4 allergic reactions or adverse events due to the fragrance, and advocates for increased
 5 categorization on the use of a “fragrance free” designation; and be it further
 6

7 RESOLVED, That our AMA advocate for relevant stakeholders to regulate personal care
 8 products containing any known fragrance compounds regardless of its disclosure on label, and
 9 give the appropriate agencies the ability to recall items containing harmful fragrances; and be it
 10 further
 11

12 RESOLVED, That our AMA supports increased identification of hazardous chemicals in
 13 fragrance compounds, as well as research focused on fragrance sensitivity in order to remove
 14 these allergens from products applied to one’s body.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. OPINION on fragrance allergens in cosmetic products - european commission.
Directorate General for Health and Consumers, Scientific Committee on Consumer Safety.
2. Steinemann A. International prevalence of fragrance sensitivity. *Air Quality, Atmosphere & Health*. 2019;12(8):891-897. <https://doi.org/10.1007/s11869-019-00699-4>. doi: 10.1007/s11869-019-00699-4.
3. Pastor-Nieto MA, Gatica-Ortega ME. Ubiquity, hazardous effects, and risk assessment of fragrances in consumer products. *Curr Treat Options Allergy*. 2021;8(1):21-41. doi: 10.1007/s40521-020-00275-7 [doi].
4. Nematollahi N, Doronila A, Mornane PJ, Duan A, Kolev SD, Steinemann A. Volatile chemical emissions from fragranced baby products. *Air Qual Atmos Health*. 2018;11(7):785-790. doi: 10.1007/s11869-018-0593-1 [doi].
5. Tam I, Yu J. Allergic contact dermatitis in children: Recommendations for patch testing. *Current Allergy and Asthma Reports*. 2020;20(9):41. <https://doi.org/10.1007/s11882-020-00939-z>. doi: 10.1007/s11882-020-00939-z.
6. Warshaw EM, Schlarbaum JP, Silverberg JI, et al. Contact dermatitis to personal care products is increasing (but different!) in males and females: North american contact dermatitis group data, 1996-2016. *Journal of the American Academy of Dermatology*. 2021;85(6):1446-1455. <https://www.sciencedirect.com/science/article/pii/S0190962220327547>. doi: <https://doi.org/10.1016/j.jaad.2020.10.003>.
7. de Groot AC. Fragrances: Contact allergy and other adverse effects. *Dermatitis®*. 2020;31(1). [https://journals.lww.com/dermatitis/Fulltext/2020/01000/Fragrances and Other Adverse.3.aspx](https://journals.lww.com/dermatitis/Fulltext/2020/01000/Fragrances_and_Other_Adverse.3.aspx).
8. Johansen JD, Werfel T. Highlights in allergic contact dermatitis 2018/2019. *Current Opinion in Allergy and Clinical Immunology*. 2019;19(4). https://journals.lww.com/co-allergy/Fulltext/2019/08000/Highlights_in_allergic_contact_dermatitis.11.aspx.
9. Zhou J, Tierney NK, McCarthy TJ, Black KG, Hernandez M, Weisel CP. Estimating infants' and toddlers' inhalation exposure to fragrance ingredients in baby personal care products. *Int J Occup Environ Health*. 2017;23(4):291-298. doi:

- 10.1080/10773525.2018.1475446 [doi].
10. Herz RS, Larsson M, Trujillo R, et al. A three-factor benefits framework for understanding consumer preference for scented household products: Psychological interactions and implications for future development. *Cognitive Research: Principles and Implications*. 2022;7(1):28. <https://doi.org/10.1186/s41235-022-00378-6>. doi: 10.1186/s41235-022-00378-6.
 11. FDA regulation of cosmetics and personal care products. *Congressional Research Service*. 2022:1-33.
 12. Nutrition, Center for Food Safety and Applied. Is it a cosmetic, a drug, or both? (or is it soap?). FDA. 2022. <https://www.fda.gov/cosmetics/cosmetics-laws-regulations/it-cosmetic-drug-or-both-or-it-soap>. Accessed Aug 31, 2022.
 13. Affairs OoR. Are all "personal care products" regulated as cosmetics? FDA. 2022. <https://www.fda.gov/industry/fda-basics-industry/are-all-personal-care-products-regulated-cosmetics>. Accessed Aug 31, 2022.
 14. Nutrition, Center for Food Safety and Applied. Cosmetics guidance & regulation. FDA Web site. <https://www.fda.gov/cosmetics/cosmetics-guidance-regulation>. Updated 2022. Accessed Aug 31, 2022.
 15. Nutrition, Center for Food Safety and Applied. FDA authority over cosmetics: How cosmetics are not FDA-approved, but are FDA-regulated. FDA Web site. <https://www.fda.gov/cosmetics/cosmetics-laws-regulations/fda-authority-over-cosmetics-how-cosmetics-are-not-fda-approved-are-fda-regulated>. Updated 2013. Accessed Aug 31, 2022.
 16. Boozalis E, Patel S. Clinical utility of marketing terms used for over-the-counter dermatologic products. *J Dermatol Treat*. 2018;29(8):841-845. <https://doi.org/10.1080/09546634.2018.1467540>. doi: 10.1080/09546634.2018.1467540.
 17. Research, Center for Drug Evaluation and. Edgewell personal care issues voluntary nationwide recall of banana boat hair & scalp sunscreen due to the presence of benzene. U.S. Food and Drug Administration Web site. <https://www.fda.gov/safety/recalls-market-withdrawals-safety-alerts/edgewell-personal-care-issues-voluntary-nationwide-recall-banana-boat-hair-scalp-sunscreen-due>. Updated 2022. Accessed Aug 31, 2022.
 18. National Archives Code of Federal Regulations, US Consumer Product Safety Commission "701.3 Designation of ingredients." <https://www.ecfr.gov/current/title-21/chapter-I/subchapter-G/part-701/subpart-A/section-701.3>
 19. Commissioner, Office of The Law Revision Counsel. Federal food, drug, and cosmetic act (FD&C act). FDA Web site. <https://www.fda.gov/regulatory-information/laws-enforced-fda/federal-food-drug-and-cosmetic-act-fdc-act>. Updated 2018. Accessed Aug 31, 2022.
 20. Commissioner, O. of the. (n.d.). *FD&C Act, FDA regulations, and FDA guidance: What's the difference?* U.S. Food and Drug Administration. Retrieved September 22, 2022, from <https://www.fda.gov/about-fda/fda-basics/what-difference-between-federal-food-drug-and-cosmetic-act-fdc-act-fda-regulations-and-fda-guidance>
 21. Food & Drug Administration. "Questions and Answers: FDA announces new requirements for over-the-counter (OTC) sunscreen products marketed in the US. <https://www.fda.gov/drugs/understanding-over-counter-medicines/questions-and-answers-fda-announces-new-requirements-over-counter-otc-sunscreen-products-marketed-us#:~:text=Passing%20the%20broad%20spectrum%20test,both%20UVA%20and%20UVB%20rays>.
 22. Murawski A, Fiedler N, Schmied-Tobies MIH, et al. Metabolites of the fragrance 2-(4-tert-butylbenzyl)propionaldehyde (Iysmeral) in urine of children and adolescents in germany

- human biomonitoring results of the german environmental survey 2014–2017 (GerES V). *Int J Hyg Environ Health*. 2020;229:113594. <https://www.sciencedirect.com/science/article/pii/S143846392030540X>. doi: <https://doi.org/10.1016/j.ijheh.2020.113594>.
23. Steinemann A. Volatile emissions from common consumer products. *Air Quality, Atmosphere & Health*. 2015;8(3):273-281. <https://doi.org/10.1007/s11869-015-0327-6>. doi: 10.1007/s11869-015-0327-6.
24. Official Journal of the European Union. Regulation (EC) no 1223/2009 of the european parliament and of the council of 30 november 2009 on cosmetic products (text with EEA relevance) (recast). *EUR-Lex Access to European Union Law*. 2022. <https://eur-lex.europa.eu/eli/reg/2009/1223/oj>. Accessed Aug 31, 2022.
25. *Scientific Committee on consumer safety (SCCS)*. Public Health. (n.d.). Retrieved August 31, 2022, from https://health.ec.europa.eu/scientific-committees/scientific-committee-consumer-safety-sccs_en. Doi:10.2875/579644
26. Fyhrquist N, Lehto E, Lauerma A. New findings in allergic contact dermatitis. *Current Opinion in Allergy and Clinical Immunology*. 2014;14(5). [https://journals.lww.com/co-allergy/Fulltext/2014/10000/New findings in allergic contact dermatitis.10.aspx](https://journals.lww.com/co-allergy/Fulltext/2014/10000/New_findings_in_allergic_contact_dermatitis.10.aspx)
27. Center for Drug Evaluation and Research. (n.d.). *An update on sunscreen requirements*. U.S. Food and Drug Administration. Retrieved September 22, 2022, from <https://www.fda.gov/drugs/news-events-human-drugs/update-sunscreen-requirements-deemed-final-order-and-proposed-order>
28. Nassau S, Fonacier L. Allergic contact dermatitis. *Med Clin North Am*. 2020;104(1):61-76. <https://www.sciencedirect.com/science/article/pii/S0025712519300884>. doi: <https://doi.org/10.1016/j.mcna.2019.08.012>.

RELEVANT AMA AND AMA-MSS POLICY

Per- and Polyfluoroalkyl Substances (PFAS) and Human Health H-135.916

Our AMA: (1) supports continued research on the impact of perfluoroalkyl and polyfluoroalkyl chemicals on human health; (2) supports legislation and regulation seeking to address contamination, exposure, classification, and clean-up of PFAS substances; and (3) will advocate for states, at minimum, to follow guidelines presented in the Environmental Protection Agency's Drinking Water Health Advisories for perfluorooctanoic acid (PFOA) and perfluorooctane sulfonic acid (PFOS), with consideration of the appropriate use of Minimal Risk Levels (MRLs) presented in the CDC/ATSDR Toxicological Profile for PFAS.

Res. 901, I-19

Medical Sterilant Safety H-135.917

Our American Medical Association: (1) supports minimizing emissions of and exposure to toxic medical sterilants, such as ethylene oxide; (2) supports the substitution of toxic medical sterilants, such as ethylene oxide, with less toxic medical sterilization alternatives when appropriate; (3) supports prioritization of the modes of sterilization for the highest degree of worker and environmental safety, in addition to effectiveness of the device for best patient outcomes, when health care facilities are evaluating surgical and medical devices that require sterilization; and (4) urges research to advance innovative ways to sterilize medical devices with lower levels of currently used agents, and employ less toxic agents or alternatives, while maintaining device safety and effectiveness.

BOT Action in response to referred for decision Res. 507, A-19

Regulation of Endocrine Disrupting Chemicals H-135.920

Our American Medical Association will work with the federal government to pursue the following tenets: (1) Regulatory oversight of endocrine disrupting chemicals should be centralized such that regulations pass through a single office to ensure coordination among agencies, with the exception of pharmaceutical agents that are regulated by the Food and Drug Administration and are used for medical purposes (2) Policy should be based on comprehensive data covering both low-level and high-level exposures (3) Policy should be developed and revised under the direction of a collaborative group comprising endocrinologists, toxicologists, occupational/environmental medicine specialists, epidemiologists, and policymakers.

CSAPH Rep. 01, A-19

OSHA Standards for Lead H-135.935

Our AMA will advocate with the 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

Encouraging Alternatives to PVC/DEHP Products in Health H-135.945

Our AMA: (1) encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) medical device products, especially those containing Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-effective, alternative products where available; and (2) urges expanded manufacturer development of safe, cost-effective alternative products to PVC medical device products, especially those containing DEHP.

BOT Action in response to referred for decision Res. 502, A-06; Reaffirmed: CSAPH Rep. 01, A-16

Encouraging Alternatives to PVC/DEHP Products in Health H-135.945

Our AMA: (1) encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) medical device products, especially those containing Di(2-ethylhexyl)phthalate (DEHP), and urge adoption of safe, cost-effective, alternative products where available; and (2) urges expanded manufacturer development of safe, cost-effective alternative products to PVC medical device products, especially those containing DEHP.

BOT Action in response to referred for decision Res. 502, A-06 Reaffirmed: CSAPH Rep. 01, A-16

Manganese in Gasoline H-135.952

Our AMA: (1) urges the appropriate federal agencies and industries to support further research into health effects of manganese exposure from the use of methylcyclopentadienyl manganese tricarbonyl (MMT) in gasoline before it is introduced widely in the US gasoline supply. Research is especially needed to determine health effects of long-term low-dose exposures to MMT and its combustion products, particularly effects on vulnerable populations; (2) urges the appropriate government agencies to monitor the use of MMT by gasoline refiners and sellers and to make their findings available to the public; (3) urges appropriate federal agencies to fully inform physicians, other health care providers, and the public of any potential health effects of MMT; and (4) continues to monitor research and developments regarding potential health effects of MMT and its combustion products and that this report be updated as appropriate.

CSA Rep. 7, A-98 Reaffirmed: CSAPH Rep. 2, A-08 Reaffirmed: CSAPH Rep. 01, A-18

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

Modernization of the Federal Toxic Substances Control Act (TSCA) of 1976 D-135.976

Our AMA will: (1) collaborate with relevant stakeholders to advocate for modernizing the Toxic Substances Control Act ((TSCA)) to require chemical manufacturers to provide adequate safety information on all chemicals and give federal regulatory agencies reasonable authority to regulate hazardous chemicals in order to protect the health of all individuals, especially vulnerable populations; (2) support the public disclosure of chemical use, exposure and hazard data in forms that are appropriate for use by medical practitioners, workers, and the public; and (3) work with members of the Federation to promote a reformed (TSCA) that is consistent with goals of Registration, Evaluation, Authorisation, and Restriction of Chemicals (REACH).

Res. 515, A-12; Modified: Res. 907, I-13; Reaffirmation I-13; Reaffirmation I-16

Modern Chemicals Policies D-135.987

Our AMA: (1) will call upon the United States government to implement a national modern, comprehensive chemicals policy that is in line with current scientific knowledge on human and environmental health, and that requires a full evaluation of the health impacts of both newly developed and industrial chemicals now in use; and (2) encourages the training of medical students, physicians, and other health professionals about the human health effects of toxic chemical exposures.

Sub. Res. 404, A-08; Reaffirmation A-10; Reaffirmation I-16

AMA Position on Air Pollution H-135.998

Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties. (2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community. (3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends. (4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control.

BOT Rep. L, A-65; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-14; Reaffirmation A-16; Reaffirmed: BOT Rep. 29, A-19

Allergen Labeling on Food Packaging H-150.924

Our AMA encourages food manufacturers to pursue more obvious packaging distinctions between products that contain the most common food allergens identified in the Food Allergen Labeling and Consumer Protection Act and products that do not contain these allergens.

Res. 918, I-18

Effects of Work on Pregnancy H-420.960

Our AMA: (1) supports the right of employees to work in safe workplaces that do not endanger their reproductive health or that of their unborn children; (2) supports workplace policies that minimize the risk of excessive exposure to toxins with known reproductive hazards irrespective of gender or age; (3) encourages physicians to consider the potential benefits and risks of occupational activities and exposures on an individual basis and work with patients and employers to define a healthy working environment for pregnant women; (4) encourages employers to accommodate women's increased physical requirements during pregnancy; recommended accommodations include varied work positions, adequate rest and meal breaks, access to regular hydration, and minimizing heavy lifting; and (5) acknowledges that future research done by interdisciplinary study groups composed of obstetricians/gynecologists, occupational medicine specialists, pediatricians, and representatives from industry can best identify adverse reproductive exposures and appropriate accommodations.

CSA Rep. 9, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-12

National Cosmetics Registry and Regulation H-440.855

1. Our AMA: (a) supports the creation of a publicly available registry of all cosmetics and their ingredients in a manner which does not substantially affect the manufacturers' proprietary interests and (b) supports providing the Food and Drug Administration with sufficient authority to recall cosmetic products that it deems to be harmful.

2. Our AMA will monitor the progress of HR 759 (Food and Drug Administration Globalization Act of 2009) and respond as appropriate.

BOT Action in response to referred for decision Res. 907, I-09; Reaffirmed in lieu of: Res. 502, A-17

Latex Allergy Warning H-480.970

The AMA supports the appropriate labeling of latex-containing medical devices with warnings about possible allergic reactions. The AMA strongly encourages health care facilities to provide non-latex alternatives of at least comparable efficacy alongside their latex counterparts in all areas of patient care.

Sub. Res. 503, A-96; Appended Res. 504, I-97; Reaffirmed: CSAPH Rep. 3, A-07 Reaffirmed: CSAPH Rep. 01, A-17

Environmental Contributors to Disease and Advocating for Environmental Justice 135.021MSS

AMA-MSS will ask the AMA to amend Policy D-135.997, Research into the Environmental Contributors to Disease, by addition and deletion to read as follows: Research into the Environmental Contributors to Disease and Advocating for Environmental Justice Our AMA will (1) advocate for the greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as a priority public health issues; (3) encourage federal, state, and local agencies to address a remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies. (MSS Res. 019, A-21)

Promoting a Fragrance-Free Health Care Environment 160.045MSS

AMA-MSS will ask (1) that our AMA recognizes fragrance sensitivity as disability where the presence of fragranced products can limit accessibility of healthcare settings, (2) that our AMA

encourages all hospitals, outpatient clinics, urgent cares, and other patient care areas inclusive of medical schools to adopt a fragrance-free policy that pertains to employees, patients, and visitors of any kind, and (3) that our AMA will work with relevant stakeholders to advocate for governmental regulatory bodies, including but not limited to the Occupational Safety and Health Administration (OSHA), the Centers for Disease Control and Prevention (CDC), and the National Institute for Occupational Safety and Health (NIOSH) to recommend fragrance-free policies in all medical offices, buildings, and places of patient care. (MSS Res. 026, A-22)

National Cosmetics Registry and Regulation 270.021MSS

AMA-MSS will ask the AMA to (1) support legislation for the creation of a publicly available national registry of all cosmetics and their ingredients; and (2) support legislation for the FDA to be given strengthened authority to recall cosmetic products determined to be harmful based on the FDA's product recall classifications. (MSS Amended Res 11, A-09) (Reaffirmed: MSS GC Rep A, I-14)

Improving Transparency in Ingredient Lists for Cosmetic and Feminine Hygiene Products 525.009MSS

That our AMA-MSS support improved consumer reporting of ingredients that may be harmful in cosmetic and feminine hygiene products; (2) That our AMA-MSS support health professionals in counseling patients about the known risks of toxic ingredients in beauty and personal care products, including feminine hygiene products. (MSS Res 27-I-17)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 069
(I-22)

Introduced by: Nina Singh, New York University Grossman School of Medicine; Paul Suhwan Lee, University of Rochester School of Medicine; Andrew Alexander, Texas A&M College of Medicine; Matthew J. Swanson, Frank H. Netter MD School of Medicine at Quinnipiac University

Subject: Enabling Transmission of Third Party Data and Metadata to Electronic Health Records

Sponsored by: Region 7

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Patient-generated health data (PGHD) such as self-monitored blood pressure and blood glucose can lead to improved health outcomes when the data is received and responded to by healthcare providers¹⁻³; and

Whereas, Specialty societies such as the American Heart Association and the AMA advocate for increased use of PGHD such as self-monitored blood pressure⁴; and

Whereas, Efficient use of PGHD at scale requires transmission of data into the electronic health record (EHR)^{5,6}; and

Whereas, Read capability is the ability to pull data out of EHRs into other software⁷; and

Whereas, Write capability is the ability to send data to EHRs that can then be received and stored (e.g. a home blood pressure cuff sending blood pressure measurements to the EHR)⁷; and

Whereas, Write capability is required for third parties to transmit data into EHRs so that it is part of a patient's medical record^{5,8}; and

Whereas, Write capability is solely a software capability and does not preclude extensive security requirements for third parties to satisfy before they are granted permission to write data⁵; and

Whereas, The Office of the National Coordinator for Health Information Technology in the United States Department of Health & Human Services has defined criteria for certification of an EHR⁹; and

Whereas, The EHR certification process is used to verify a baseline level of quality and capacity to support meaningful use criteria^{9,10}; and

Whereas, Becoming a certified EHR currently only requires read capability and not write capability¹¹; and

Whereas, There are widespread challenges in writing not only data but also metadata to EHRs^{5,12}; and

Whereas, The AMA uses the term “data” in existing policies H-478.981, D-478.972, D-478.973, D-478.976, H-480.953, H-95.928, D-460.968, H-510.983, D-478.994, D-478.995, and D-478.981, but this is distinct from metadata, which refers to elements such as the source of the data¹³; and

Whereas, Metadata such as the company and type of device that generated the data is integral to informed data interpretation, such as determining whether the data comes from a clinically validated device¹⁴; and

Whereas, Using ambiguous terminology such as data liquidity and interoperability, as used throughout existing AMA policy such as H-478.981, leads to the lack of recognition and advocacy for overlooked but integral elements such as metadata and write capability^{5,8}; therefore be it

RESOLVED, That AMA policy H-478.981 be amended by addition and deletion as follows:

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 and metadata (i.e. information about the source of the data) liquidity;
7. Include write capability;
8. Facilitate digital and mobile patient engagement; and
9. Expedite user input into product design and post-implementation feedback.

Our AMA will ~~AMA~~-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;

- 1 5. Educate physicians about these priorities so they can lead in the development
- 2 and use of future EHRs that can improve patient care; ~~and~~
- 3 6. Promote the elimination of “Information Blocking”;
and
- 4 7. Promote the inclusion of write capability in all EHRs”

5
6 Our AMA policy is that the cost of installing, maintaining, and upgrading
7 information technology should be specifically acknowledged and addressed in
8 reimbursement schedules.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Green BB, Cook AJ, Ralston JD, et al. Effectiveness of home blood pressure monitoring, web communication, and pharmacist care on hypertension control: A randomized controlled trial. *JAMA - J Am Med Assoc*. 2008;299(24):2857-2867. doi:10.1001/jama.299.24.2857
2. Kirkland EB, Marsden J, Zhang J, et al. Remote patient monitoring sustains reductions of hemoglobin A1c in underserved patients to 12 months. *Prim Care Diabetes*. 2021;15(3):459-463. doi:10.1016/j.pcd.2021.01.005
3. Koehler F, Koehler K, Deckwart O, et al. Efficacy of telemedical interventional management in patients with heart failure (TIM-HF2): a randomised, controlled, parallel-group, unmasked trial. *Lancet*. 2018;392(10152):1047-1057. doi:10.1016/S0140-6736(18)31880-4
4. Shimbo D, Artinian NT, Basile JN, et al. Self-measured blood pressure monitoring at home: A joint policy statement from the american heart association and american medical association. *Circulation*. 2020;142(4):e42-e63. doi:10.1161/CIR.0000000000000803
5. Public Health Informatics Institute. *Self-Measured Blood Pressure Monitoring: Key Findings from a National Health Information Technology Landscape Analysis*.; 2021.
6. Adler-Milstein J, Nong P. Early experiences with patient generated health data: Health system and patient perspectives. *J Am Med Informatics Assoc*. 2019;26(10):952-959. doi:10.1093/jamia/ocz045
7. Anton L-D. *Application Programming Interface (API) Primer*. Technics Publications; 2020.
8. Savage M, Neinstein AB, Adler-Milstein J. Measure The Impact Of The Interoperability Rules Now. *Heal Aff Blog*. Published online 2020. doi:10.1377/hblog20200701.58142
9. Office of the National Coordinator for Health Information. About the ONC Health IT Certification Program. HealthIT.gov. Published 2021. <https://www.healthit.gov/topic/certification-ehrs/about-onc-health-it-certification-program>
10. Holmgren AJ, Adler-Milstein J, McCullough J. Are all certified EHRs created equal? Assessing the relationship between EHR vendor and hospital meaningful use performance. *J Am Med Informatics Assoc*. 2018;25(6):654-660.
11. United States Department of Health and Human Services. 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program. Published online 2020:25642-25961.
12. Tiase VL, Hull W, McFarland MM, et al. Patient-generated health data and electronic health record integration: A scoping review. *JAMIA Open*. 2020;3(4):619-627.

- doi:10.1093/jamiaopen/ooaa052
13. Vaidyam A, Halamka J, Torous J. Enabling Research and Clinical Use of Patient-Generated Health Data (the mindLAMP Platform): Digital Phenotyping Study. *JMIR mHealth uHealth*. 2022;10(1):e30557.
 14. Wall HK, Wright JS, Jackson SL, et al. How Do We Jump-Start Self-measured Blood Pressure Monitoring in the United States? Addressing Barriers Beyond the Published Literature. *Am J Hypertens*. 2022;35(3):244-255. doi:10.1093/ajh/hpab170

RELEVANT AMA AND AMA-MSS POLICY

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

EHR Interoperability D-478.972

Our AMA:

- (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System;
- (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;
- (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges;
- (4) will continue efforts to promote interoperability of EHRs and clinical registries;
- (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;
- (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;

(7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;

(8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and

(9) will review and advocate for the implementation of appropriate recommendations from the “Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care,” a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services.

Sub. Res. 212, I-15; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: Res. 221, I-16; Reaffirmed in lieu of: Res. 243, A-17; Reaffirmed: CMS Rep. 10, A-17; Appended: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Appended: Res. 202, A-18; Appended: Res. 226, I-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 7, I-20; Reaffirmed: CMS Rep. 2, A-22

Principles for Hospital Sponsored Electronic Health Records D-478.973

1. Our AMA will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).
2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.
3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.
4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.

BOT Rep. 1, I-15; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18

Innovation to Improve Usability and Decrease Costs of Electronic Health Record Systems for Physicians D-478.976

- 1) Our AMA will: (A) advocate for CMS and the Office of the National Coordinator (ONC) to support collaboration between and among proprietary and open-source EHR developers to help drive innovation in the marketplace; (B) continue to advocate for research and physician education on EHR adoption and design best practices specifically concerning key features that can improve the quality, safety, and efficiency of health care regardless of proprietary or open-source status; and (C) through its partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and support more informed decision making in the selection of EHRs.
- 2) Our AMA will, through partnership with AmericanEHR Partners, continue to survey physician use and issues with various EHRs--open source and proprietary--to create more transparency and formulate more formal decision making in the selection of EHRs.
- 3) Our AMA will work with AmericanEHR Partners to modify the current survey to better address the economics of EHR use by physicians including the impact of scribes.
- 4) Our AMA will make available the findings of the AmericanEHR Partners' survey and report back to the House of Delegates.

BOT Rep. 23, A-13; BOT Rep. 24, A-13; Reaffirmed: BOT Rep. 17, A-15; Appended: Res. 603, I-16; Modified: BOT Rep. 20, A-17

Interoperability of Medical Devices H-480.953

Our AMA believes that intercommunication and interoperability of electronic medical devices could lead to important advances in patient safety and patient care, and that the standards and protocols to allow such seamless intercommunication should be developed fully with these advances in mind. Our AMA also recognizes that, as in all technological advances, interoperability poses safety and medico-legal challenges as well. The development of standards and production of interoperable equipment protocols should strike the proper balance to achieve optimum patient safety, efficiency, and outcome benefit while preserving incentives to ensure continuing innovation.

Res. 519, A-09Reaffirmation I-15Reaffirmed: BOT Rep. 05, I-16

Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing H-95.928

1. Our AMA supports the ability of prescription drug monitoring programs (PDMPs) to have the capability for physicians to know when their patients have received a prescription for controlled substances from multiple prescribers or multiple pharmacies within a short time frame.
 2. Our AMA will advocate to key stakeholders, including the National Association of State Controlled Substances Authorities, the National Association of Boards of Pharmacy, and the National Governors Association, to ensure that efforts to reduce Multiple Provider Events (MPEs) are done in a manner that supports continuity of care.
 3. Our AMA will work with the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA) and other relevant federal agencies, to better understand the factors that lead to MPEs and develop medically and ethically appropriate strategies for reducing them.
 4. Our AMA will advocate for the interoperability of state PDMPs with electronic health records (EHRs).
 5. Our AMA will advocate for the Centers for Medicaid and Medicare Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) to better incorporate feedback from physicians to focus on outcomes and focusing ONC certification on testing for product safety, security, usability, and interoperability.
- BOT Rep. 03, I-16

The Precision Medicine Initiative D-460.968

1. Our AMA will work with the Precision Medicine Initiative (PMI) to gather input from physicians to assist in the planning stages of the initiative and to improve awareness and willingness to recruit patients as participants.
2. Our AMA encourages the PMI to develop resources that will assist physicians in understanding the goals of the PMI, how to recruit and enroll patients, and how to best use the research results generated by it.
3. Our AMA continues to advocate for improvements to electronic health record systems that will enable interoperability and access while not creating additional burdens and usability challenges for physicians.

CSAPH Rep. 03, A-16Reaffirmed: BOT Rep. 45, A-18

Expansion of US Veterans' Health Care Choices H-510.983

1. Our AMA will continue to work with the Veterans Administration (VA) to provide quality care to veterans.
2. Our AMA will continue to support efforts to improve the Veterans Choice Program (VCP) and make it a permanent program.
3. Our AMA encourages the VA to continue enhancing and developing alternative pathways for veterans to seek care outside of the established VA system if the VA system cannot provide

adequate or timely care, and that the VA develop criteria by which individual veterans may request alternative pathways.

4. Our AMA will support consolidation of all the VA community care programs.
5. Our AMA encourages the VA to use external assessments as necessary to identify and address systemic barriers to care.
6. Our AMA will support interventions to mitigate barriers to the VA from being able to achieve its mission.
7. Our AMA will advocate that clean claims submitted electronically to the VA should be paid within 14 days and that clean paper claims should be paid within 30 days.
8. Our AMA encourages the acceleration of interoperability of electronic personal and medical health records in order to ensure seamless, timely, secure and accurate exchange of information between VA and non-VA providers and encourage both the VA and physicians caring for veterans outside of the VA to exchange medical records in a timely manner to ensure efficient care.
9. Our AMA encourages the VA to engage with physicians providing care in the VA system to explore and develop solutions on improving the health care choices of veterans.
10. Our AMA will advocate for new funding to support expansion of the Veterans Choice Program.

CMS Rep. 06, A-17Reaffirmation: A-22

Health Information Technology D-478.994

Our AMA will:

- (1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT);
- (2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT;
- (3) support initiatives to ensure interoperability among all HIT systems; and
- (4) support the indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of Electronic Health Record (EHR) products and services, and will advocate for federal regulatory reform that will allow for indefinite extension of the Stark Law exception and the Anti-Kickback Statute safe harbor for the donation of EHR products and services.

Res. 723, A-05Reaffirmation A-07Reaffirmed in lieu of Res. 818, I-07Reaffirmed: Res. 726, A-08Reaffirmation I-08Reaffirmation I-09Reaffirmation A-10Reaffirmation I-10Reaffirmed: Res. 205, A-11Appended: Res. 220, A-12Reaffirmed in lieu of Res. 218, I-12Reaffirmed in lieu of Res. 219, I-12Reaffirmed in lieu of Res. 226, I-12Reaffirmed in lieu of Res. 228, I-12Reaffirmed in lieu of Res. 228, I-13Reaffirmation A-14Reaffirmed: BOT Rep. 03, I-16Reaffirmed: BOT Rep. 05, I-16Reaffirmed: BOT Rep. 45, A-18Reaffirmed: BOT Rep. 19, A-18

National Health Information Technology D-478.995

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE

and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

Res. 730, I-04Reaffirmed in lieu of Res. 818, I-07Reaffirmed in lieu of Res. 726, A-08Reaffirmation A-10Reaffirmed: BOT Rep. 16, A-11Modified: BOT Rep. 16, A-11Modified: BOT Rep. 17, A-12Reaffirmed in lieu of Res. 714, A-12Reaffirmed in lieu of Res. 715, A-12Reaffirmed: BOT Rep. 24, A-13Reaffirmed in lieu of Res. 724, A-13Appended: Res. 720, A-13Appended: Sub. Res. 721, A-13Reaffirmed: CMS Rep. 4, I-13Reaffirmation I-13Appended: BOT Rep. 18, A-14Appended: BOT Rep. 20, A-14Reaffirmation A-14Reaffirmed: BOT Rep. 17, A-15Reaffirmed in lieu of Res. 208, A-15Reaffirmed in lieu of Res. 223, A-15Reaffirmation I-15Reaffirmed: CMS Rep. 07, I-16Reaffirmed: BOT Rep. 05, I-16Appended: Res. 227, A-17

Exchange of Electronic Data Among Clinicians, Public Health Entities and Research Entities D-478.981

Our AMA will proactively work with the Department of Health and Human Services and appropriate public health and research entities to develop ways to facilitate, as much as possible, seamless, properly regulated, electronic exchange of data generated in the health care setting, including the development of open standards for such data exchange, provided that such technology has intrinsic systems that include the protection of individually identifiable health information that is acceptable to patients, to the extent that law permits.

Res. 827, I-10Reaffirmation I-13

Creating National Standards for Electronic Health Records Systems

The MSS formally establishes support for the following HOD policies:

D-478.996 Information Technology Standards and Costs

Our AMA will: (1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems;

(2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices;

(3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems;

(4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and

(5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

Health Information Technology D-478.994

Our AMA will:

(1) support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information technology (HIT);

(2) pursue legislative and regulatory changes to obtain an exception to any and all laws that would otherwise prohibit financial assistance to physicians purchasing HIT; and

(3) support initiatives to ensure interoperability among all HIT systems

(MSS Res 23, I-10)

Economic Sustainability and Improved Usage of Health Information Exchanges.

The MSS formally establishes support for the following HOD policies:

Exchange of Electronic Data Among Clinicians, Public Health Entities, and Research Entities D-478.981

Our AMA will proactively work with the Department of Health and Human Services and appropriate public health and research entities to develop ways to facilitate, as much as possible, seamless, properly regulated, electronic exchange of data generated in the health care setting, including the development of open standards for such data exchange, provided that such technology has intrinsic systems that include the protection of individually identifiable health information that is acceptable to patients, to the extent that law permits. (Res 827, I-10; Reaffirmed: 1-13)

National Health Information Technology D-478-995

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for more research on EHR, CPOE, and

clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

Health Information Technology H-478.994

Our AMA will support the principles that when financial assistance for Health IT originates from an inpatient facility:

(1) it not unreasonably constrain the physician's choice of which ambulatory HIT system to purchase; and

(2) it promote voluntary rather than mandatory sharing of Protected Health Information (HIPAA-PHI) with the facility consistent with the patient's wishes as well as applicable legal and ethical considerations.

D-478.996 Information Technology Standards and Costs

Our AMA will:

(1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems;

(2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices;

(3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems;

(4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and

(5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

(MSS Res 25, A-17)

Expand AMA Electronic Health Records (EHRS) Focus Towards EHR Open Application Marketplaces Standard Application Programming Interfaces (APIs) and Emergent EHR Technology Communication:

The MSS formally establishes support for the following HOD policies:

National Health Information Technology D-478.995

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

(Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: Bot Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15;

Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18)

EHR Interoperability D-478.972

Our AMA:

- (1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System;
 - (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;
 - (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges;
 - (4) will continue efforts to promote interoperability of EHRs and clinical registries;
 - (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;
 - (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;
 - (7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;
 - (8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and
 - (9) will review and advocate for the implementation of appropriate recommendations from the "Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care," a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services.
- (Sub. Res. 212, I-15; Reaffirmed: BOT Rep. 03, I-16; Reaffirmed: Res. 221, I-16; Reaffirmed in lieu of: Res. 243, A-17; Reaffirmed: CMS Rep. 10, A-17; Appended: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Appended: Res. 202, A-18; Appended: Res. 226, I-18)

(MSS Committee on Health Information Technology Report A, I-18)

315.003MSS Enabling a Contiguous, National Electronic Health Record Network:

AMA-MSS (1) supports collaboration with appropriate federal government agencies and industry partners to develop and promote legislative and policy initiatives that require the interoperability of independent healthcare systems such that electronic health records data be entirely transferable; and (2) will ask the AMA to study private and public sector initiatives regarding efforts to establish a nationwide health information network and other relevant interoperability initiatives. (MSS Res 12, A-13) (Reaffirmed: MSS GC Rep A, I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 070
(I-22)

Introduced by: Sairandri Sathyanarayanan, McGovern Medical School at UTHealth;
Anudeeta Gautam, Lewis Katz School of Medicine at Temple University;
Katie McLaughlin, University of Minnesota Medical School - Duluth Campus.

Subject: School Based Mental Health Programs for Children Exposed to Gun
Violence

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Gun violence is a public health epidemic in the United States, with the CDC reporting a record number of firearm-related deaths in 2020 (45,222)¹; and

Whereas, The Gun Violence Archive, an independent data research group that tracks gun-related incidents, reports 692 mass shootings in 2021 and 610 in 2020²⁻³; and

Whereas, The Gun Violence Archive reported that 246 mass shootings took place in the first five months of 2022³; and

Whereas, The United States saw a record 38% in firearm-related murders among children and young adults from 2019 to 2020 and a 43% increase in overall gun deaths since 2010^{4,5}; and

Whereas, A 2022 study found that Black and Latinx youth in large US cities were 3-7 times more likely, depending on exposure radius, to experience a firearm-related homicide in the past year than white youth⁶; and

Whereas, In 2020, guns were the leading cause of death among children and adolescents⁷; and

Whereas, Approximately 3 million children are exposed to gun violence every year⁸; and

Whereas, Exposure to gun violence and school shootings directly impair childrens' impulse control, cognitive function and ability to pay attention, decrease student enrollment, and lower performance on standardized tests⁹⁻¹⁰; and

Whereas, Children living in communities with lower rates of gun violence engage in 49 more minutes of physical activity per week compared to those living in areas with higher rates¹¹; and

Whereas, Youth exposure to firearm violence may engender a greater sense of danger compared to other types of violence¹²; and

Whereas, Adolescents engaging in self-injury using firearms are 35% more likely to die from suicide within a year compared to other forms of self harm¹³; and

Whereas, Frequent exposure to gun shootings and other forms of community violence can lead to feelings of hopelessness, disorganized social networks and altered social norms that can further promote violence¹⁴; and

Whereas, A 2021 study revealed that children residing within one-eighth of a mile of a shooting were 1.86 times more likely to present to the emergency department in the subsequent 14 days with mental-health related concerns such as adolescent depression, post traumatic stress disorder and recurrent injury¹⁵; and

Whereas, A 2021 study found that 25.7% of children with non-fatal firearm injury were diagnosed with a new mental condition, most commonly trauma disorders, substance abuse, and disruptive disorders, within 12 months post-injury¹⁶; and

Whereas, Reactive school safety strategies, such as active shooter drills, can worsen student mental health, increasing depression by 39%, stress and anxiety by 42% and physiological health problems by 23%, impacting children from the age of 5 up to high schoolers¹⁷; and

Whereas, The US Department of Health and Human Services Office of Adolescent Health states that students feel most comfortable accessing health care services in school-based clinics, where they spend a majority of their time¹⁸; and

Whereas, Conducting mental health intervention programs in schools provides several advantages including but not limited to large scale preventative outreach, allowing for community collaboration with healthcare professionals, and early, easy access to students¹⁹⁻²⁰; and

Whereas, Specific school based interventions, such as Bounce Back, for children exposed to traumatic events have shown short term benefits such as reduction of anxiety, post traumatic stress, and to a lesser extent, depression²¹; therefore be it

RESOLVED, that our AMA amend “Improving Pediatric Mental Health Screening”, H-345.977 by the addition as follows:

Improving Pediatric Mental Health Screening, H-345.977

Our AMA:

(1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals;

(2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and

(3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents (including those exposed to and affected by gun violence) access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.

RESOLVED, That our AMA endorses research into the impact of school-based mental health interventions on long-term health and behavioral outcomes in children.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Fast Facts: Firearm Violence Prevention. cdc.gov. Updated May 4, 2022. Accessed August 3, 2022. <https://www.cdc.gov/violenceprevention/firearms/fastfact.html>.
2. General Methodology. Gun Violence Archive. Updated June 23, 2021. Accessed June 6, 2022. <https://www.gunviolencearchive.org/methodology>.
3. Gun violence archive. Gun Violence Archive. <https://www.gunviolencearchive.org/>. Published September 21, 2022. Accessed September 21, 2022.
4. The Johns Hopkins Center for Gun Violence Solutions. A Year in Review: 2020 Gun Deaths in the U.S. <https://publichealth.jhu.edu/sites/default/files/2022-05/2020-gun-deaths-in-the-us-4-28-2022-b.pdf>. Published April 28, 2022. Accessed September 20, 2022.
5. Gramlich J. What the data says about gun deaths in the U.S. Pew Research Center. <https://www.pewresearch.org/fact-tank/2022/02/03/what-the-data-says-about-gun-deaths-in-the-u-s>. Published May 16, 2022. Accessed June 5, 2022.
6. Kravitz-Wirtz N, Bruns A, Aubel AJ, Zhang X, Buggs SA. Inequities in Community Exposure to Deadly Gun Violence by Race/Ethnicity, Poverty, and Neighborhood Disadvantage among Youth in Large US Cities. *J Urban Health*. 2022;99(4):610-625. doi:10.1007/s11524-022-00656-0
7. Cunningham RM, Walton MA, Carter PM. The major causes of death in children and adolescents in the United States. *N Engl J Med* 2018;379:2468-2475.
8. Finkelhor D, Turner HA, Shattuck A, Hamby SL. Prevalence of Childhood Exposure to Violence, Crime, and Abuse: Results From the National Survey of Children's Exposure to Violence. *JAMA Pediatr*. 2015;169(8):746–754. doi:10.1001/jamapediatrics.2015.0676
9. Sharkey PT, Tirado-Strayer N, Papachristos AV, Raver CC. The effect of local violence on children's attention and impulse control. *Am J Public Health*. 2012;102(12):2287-2293. doi:10.2105/AJPH.2012.300789
10. Beland L-P, Kim D. The Effect of High School Shootings on Schools and Student Performance. *Educational Evaluation and Policy Analysis*. 2016;38(1):113-126. doi:10.3102/0162373715590683
11. Molnar BE, Gortmaker SL, Bull FC, Buka SL. Unsafe to play? Neighborhood disorder and lack of safety predict reduced physical activity among urban children and adolescents. *Am J Health Promot*. 2004;18(5):378-386. doi:10.4278/0890-1171-18.5.378
12. Netburn D. Q&A: The role of PTSD in mass shootings: Let's separate myth from reality. *Los Angeles Times*. <https://www.latimes.com/science/sciencenow/la-sci-sn-ptsd-mass-shootings-20181110-story.html>. Published November 10, 2018. Accessed September 21, 2022.
13. Olsson M, Wall M, Wang S, et al. Suicide After Deliberate Self-Harm in Adolescents and Young Adults. *Pediatrics*. 2018;141(4):e20173517. doi:10.1542/peds.2017-3517
14. Opara I, Lardier DT Jr, Metzger I, et al. "Bullets Have no Names": A Qualitative Exploration of Community Trauma Among Black and Latinx Youth. *J Child Fam Stud*. 2020;29(8):2117-2129. doi:10.1007/s10826-020-01764-8
15. Vasan A, Mitchell HK, Fein JA, Buckler DG, Wiebe DJ, South EC. Association of Neighborhood Gun Violence With Mental Health-Related Pediatric Emergency Department Utilization. *JAMA Pediatr*. 2021;175(12):1244-1251. doi:10.1001/jamapediatrics.2021.3512

16. Oddo ER, Maldonado L, Hink AB, Simpson AN, Andrews AL. Increase in Mental Health Diagnoses Among Youth With Nonfatal Firearm Injuries. *Acad Pediatr*. 2021;21(7):1203-1208. doi:10.1016/j.acap.2021.06.003
17. ElSherief, M., Saha, K., Gupta, P. et al. Impacts of school shooter drills on the psychological well-being of American K-12 school communities: a social media study. *Humanit Soc Sci Commun* 8, 315 (2021). <https://doi.org/10.1057/s41599-021-00993-6>.
18. School based mental health. School Based Mental Health | Youth.gov. https://youth.gov/youth-topics/youth-mental-health/school-based#_ftn. Accessed August 31, 2022.
19. Castillo EG, Ijadi-Maghsoodi R, Shadravan S, et al. Community Interventions to Promote Mental Health and Social Equity. *Curr Psychiatry Rep*. 2019;21(5):35. Published 2019 Mar 29. doi:10.1007/s11920-019-1017-0
20. Durlak JA, Weissberg RP, Dymnicki AB, Taylor RD, Schellinger KB. The impact of enhancing students' social and emotional learning: a meta-analysis of school-based universal interventions. *Child Dev*. 2011;82:405–32
21. Langlely AK, Gonzalez A, Sugar CA, Solis D, Jaycox L. Bounce back: Effectiveness of an elementary school-based intervention for multicultural children exposed to traumatic events. *J Consult Clin Psychol*. 2015;83(5):853-865. doi:10.1037/ccp0000051

RELEVANT AMA AND AMA-MSS POLICY

Addressing Adverse Effects of Active-Shooter and Live-Crisis Drills on Children's Health D-145.993

1. Our AMA supports that any school system conducting active-shooter or live-crisis drills does so in an evidence-based and trauma-informed manner that (a) is cognizant of children's physical and mental wellness, (b) considers prior experiences that might affect children's response to a simulation, (c) avoids creating additional traumatic experiences for children, and (d) provides support for students who may be adversely affected.
 2. Our AMA will work with relevant stakeholders to raise awareness of ways to conduct active-shooter or live-crisis drills that are safe for children and developmentally appropriate.
 3. Our AMA will advocate for research into the impact of live-crisis exercises and drills on the physical and mental health and well-being of children including the goals, efficacy, and potential unintended consequences of crisis-preparedness activities involving children.
- Res. 441, A-22

National Child Traumatic Stress Network H-60.929

Our AMA: (1) recognizes the importance of and support the widespread integration of evidence-based pediatric trauma services with appropriate post-traumatic mental and physical care, such as those developed and implemented by the National Child Traumatic Stress Initiative; and (2) will work with mental health organizations and relevant health care organizations to support full funding of the National Child Traumatic Stress Initiative.

Res. 419, A-11; Modified: CSAPH Rep. 1, A-21

Guns in School Settings H-60.947

Our AMA recommends: (1) all children who take guns or other weapons to school should receive an evaluation by a psychiatrist or an appropriately trained mental health professional; and (2) that children who are determined by such evaluation to have a mental illness should receive appropriate treatment.

Res. 402, I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: CSAPH Rep. 01, A-18

Providing Medical Services through School-Based Health Programs H-60.991

(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12; Reaffirmed: CSAPH Rep. 1, A-22

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.

Res. 212, I-18; Modified: Res. 934, I-19

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.

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

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

1. Our AMA: (a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

3. Our AMA will support the development of reimbursement structures that incentivize physicians to counsel patients on firearm-related injury risk and prevention.

4. Our AMA supports the inclusion of firearm-related violence and suicide epidemiology, as well as evidence-based firearm-related injury prevention education in undergraduate and graduate medical education training programs, where appropriate.

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

School Violence H-145.983

Our AMA: (1) encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property; (2) advocates for schools to remain gun-free zones except for school-sanctioned activities and professional law enforcement officers; and (3) opposes requirements or incentives of teachers to carry weapons.

Sub. Res. 402, I-95; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Appended: Res. 402, A-18

Data on Firearm Deaths and Injuries H-145.984

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

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

Prevention of Firearm Accidents in Children H-145.990

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms;(2) encourages state medical societies to work with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.

Res. 165, I-89; Reaffirmed: Sunset Report and Appended: Sub. Res. 401, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Modified: BOT Rep. 11, I-18

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.

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

Improving Pediatric Mental Health Screening H-345.977

Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure

at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.

Res. 414, A-11; Appended: BOT Rep. 12, A-14; Reaffirmed: Res. 403, A-18

Adverse Childhood Experiences and Trauma-Informed Care H-515.952

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

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

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

Res. 504, A-19; Appended: CSAPH Rep. 3, A-21

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 071
(I-22)

Introduced by: Andrew Alexander, Texas A&M College of Medicine; Sarah Holzmann, California Health Sciences University; Matthew Swanson, Frank H. Netter MD School of Medicine; Siam Muquit, John Hopkins School of Medicine

Subject: Addressing Medical Misinformation Online

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Medical misinformation is information contrary to the consensus of the scientific community that may or may not be intended to mislead, while medical disinformation is misinformation that is deliberately spread with intent to mislead^{1,2,3}; and

Whereas, Medical misinformation is spread by many different sources online, such as online forums, advertisements, user comments on news and retail sites, social media, search engines, digital magazines, and products sold by online retailers^{1,3,4,5}; and

Whereas, Medical misinformation has a large impact on a wide variety of healthcare topics including smoking, statin use, use of unproven treatments, harassment of health workers, and vaccine hesitancy^{5,6}; and

Whereas, It was found that misinformation propagated significantly farther and faster online than did accurate information^{5,7,8}; and

Whereas, Misinformation about the Zika virus was three times more likely to be shared than were verified stories as seen on multiple social media sites, with half of the top-10 news stories regarding Zika thought to be misinformation^{7,8}; and

Whereas, More than half of the United States population used the internet as their primary source for health information in 2018, indicating a reliance on websites for health information⁹; and

Whereas, Research has shown that exposure to just five online misinformation posts about the COVID-19 vaccine were sufficient to make respondents less likely to want a COVID-19 vaccine^{5,10}; and

Whereas, Search engine algorithms provide results based on the user's search history and usage of suggested sites or videos, meaning that if one clicks on a site or video promoting medical misinformation, they will have more misinformation sites or videos promoted to them over accurate information^{5,11}; and

Whereas, The likelihood that a person will view a particular website and the trust in that website are influenced by its order of appearance on major search engines^{12,13}; and

Whereas, Search engines often fail to ensure that the search results provided are credible or trustworthy¹³; and

Whereas, Search engine algorithms can lead a single (potentially unintentional) click on a medical misinformation link to result in an echo chamber effect where personalized results are heavily in favor of medical misinformation¹³; and

Whereas, Sites or product owners can pay to be promoted on the front page of a search engine and therefore increase their influence, creating a potential source of misinformation if not moderated properly¹²; and

Whereas, Search engines for online retailer sites such as Amazon are biased in favor of misinformative products such as anti-vaccination books, ranking them higher in search results¹³; and

Whereas, Inadequate moderation and verification of user testimonials on both WebMD and online retailers like Amazon have promoted the idea of using apricot seeds as a cancer treatment, leading to a 4.60 out of 5 rating for effectiveness on WebMD despite the site's own description of apricot seeds as 'likely unsafe'¹; and

Whereas, Three measures for quality of information showed that the websites from the first 10 pages of Google searches on COVID-19 were lacking in quality, with only 52.7% of prevention-focused websites mentioning physical distancing, and the number of sites suggesting treatment via oxygen, ventilation and fluids was equal to the number of sites suggesting hydroxychloroquine¹⁴; and

Whereas, Our AMA endorses policy D-440.915, but this policy is currently limited to online medical misinformation from social media, without any regard for any other potential online vectors such as search engines, online retailers, or any other type of website online; therefore be it

RESOLVED, That AMA policy D-440.915 be amended by addition and deletion as follows:

Medical and Public Health Misinformation in the ~~Age of Social Media~~ Online D-440.915

Our AMA:

(1) encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information;

(2) encourages social media companies and organizations, search engine companies, online retail companies, online healthcare companies, and other entities owning websites to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this

problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms;
(3) will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and
(4) will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Swire-Thompson B, Lazer D. Public Health and Online Misinformation: Challenges and Recommendations. *ARPH*. 2020. <https://doi.org/10.1146/annurev-publhealth-040119-094127>
2. Jaiswal J, LoSchiavo C, Perlman DC. Disinformation, misinformation and inequality-driven mistrust in the time of COVID-19: lessons unlearned from AIDS denialism. *AIDS Behav*. 2020. <https://doi.org/10.1007/s10461-020-02925-y>.
3. Bin Naeem, S.; Kamel Boulos, M.N. COVID-19 Misinformation Online and Health Literacy: A Brief Overview. *Int. J. Environ. Res. Public Health* **2021**, *18*, 8091.
4. Lavorgna, A., & Myles, H. (2021). Science denial and medical misinformation in pandemic times: A psycho-criminological analysis. *European Journal of Criminology*, 0(0). <https://doi.org/10.1177/1477370820988832>
5. Office of the Surgeon General. (2021). Confronting health misinformation: The U.S. Surgeon General's advisory on building a healthy information environment. US Department of Health and Human Services. <https://www.hhs.gov/sites/default/files/surgeon-general-misinformation-advisory.pdf>.
6. Navar AM. Fear-Based Medical Misinformation and Disease Prevention: From Vaccines to Statins. *JAMA Cardiol*. 2019;4(8):723–724. doi:10.1001/jamacardio.2019.1972
7. Sommariva S, Vamos C, Mantzaris A, Đào LUL, Martinez Tyson D. 2018. Spreading the (fake) news: exploring health messages on social media and the implications for health professionals using a case study. *Am. J. Health Educ*. 49(4):246–55
8. Sharma M, Yadav K, Yadav N, Ferdinand KC. 2017. Zika virus pandemic—analysis of Facebook as a social media health information platform. *Am. J. Infect. Control* 45(3):301–2
9. Wang X, Shi J, Kong H. Online Health Information Seeking: A Review and Meta-Analysis. *Health Communication*. 2020 Apr 16:1–3.
10. Loomba, S., de Figueiredo, A., Piatek, S.J., et al. (2021). Measuring the impact of COVID-19 vaccine misinformation on vaccination intent in the UK and USA. *Nature Human Behavior*, 5, 337–348. <http://doi.org/10.1038/s41562-021-01056-1>
11. Hussein E, Juneja P, Mitra T. Measuring Misinformation in Video Search Platforms: An Audit Study on YouTube. *Proc. ACM Hum. -Comput. Interact*. 2020;48:1-27. doi:10.1145/3392854
12. Cuan-Baltazar JY, Muñoz-Perez MJ, Robledo-Vega C, Pérez-Zepeda MF, Soto-Vega E Misinformation of COVID-19 on the Internet: Infodemiology Study *JMIR Public Health Surveill* 2020;6(2):e18444 doi: 10.2196/18444
13. Juneja P, Mitra T. Auditing E-Commerce Platforms for Algorithmically Curated Vaccine Misinformation. *Proceedings of the 2021 CHI Conference on Human Factors in Computing Systems*. 2021;186:1-27. doi:10.1145/3411764.3445250

14. Fan KS, Ghani SA, Machairas N, Lenti L, Fan KH, Richardson D, et al. COVID-19 prevention and treatment information on the internet: a systematic analysis and quality assessment. *BMJ Open* 2020 Sep 10;10(9):e040487

RELEVANT AMA AND AMA-MSS POLICY

Medical and Public Health Misinformation in the Age of Social Media D-440.915

Our AMA:

- (1) encourages social media companies and organizations to further strengthen their content moderation policies related to medical and public health misinformation, including, but not limited to enhanced content monitoring, augmentation of recommendation engines focused on false information, and stronger integration of verified health information;
- (2) encourages social media companies and organizations to recognize the spread of medical and public health misinformation over dissemination networks and collaborate with relevant stakeholders to address this problem as appropriate, including but not limited to altering underlying network dynamics or redesigning platform algorithms;
- (3) will continue to support the dissemination of accurate medical and public health information by public health organizations and health policy experts; and
- (4) will work with public health agencies in an effort to establish relationships with journalists and news agencies to enhance the public reach in disseminating accurate medical and public health information.

Res. 421, A-21 Reaffirmed: BOT Rep. 15, A-22

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 072
(I-22)

Introduced by: Madisen Faulkner, Sahil Garg, University of South Carolina School of
Medicine Greenville

Subject: Sleep Deprivation as a Public Health Crisis

Sponsored by: Region 4

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Sleep deprivation is a public health crisis¹; and

Whereas, Research demonstrates that sleep deprivation can lead to deterioration in
cardiovascular, neurological, psychological, endocrine, and immunological health²⁻⁴; and

Whereas, Despite the obvious and detrimental health outcomes associated with sleep
deprivation, sleep among adults continues to decline since 1960 with more than 70 million US
adults who slept less than 6 hours a night on average in 2012 and in 2014, more than 1/3 of the
nation's population had short sleep duration, defined by less than 7 hours^{4,5}; and

Whereas, In 2016, the Centers for Disease Control and Prevention (CDC) announced sleep
deprivation as an epidemic in the US stating less than 7 hours of sleep duration prevailed
across all 50 states (median = 35.1%), with the prevalence of less than 5 and 6 hours of sleep
being 11.8% and 23.0%, respectively²; and

Whereas, Several studies outline the benefits of sleep hygiene for improving sleep quality and
reducing consequences of sleep deprivation in children and adults⁶⁻⁸; and

Whereas, In the adult and geriatric populations, sleep deprivation has been identified as a
potentially modifiable risk factor associated with falls, the leading cause of injury and injury
related death in the 65+ population, as well as work related injuries⁹⁻¹¹; and

Whereas, The Sleep Education for Elders Program (SLEEP), a virtual sleep education program,
illustrated the efficacy of such programs to improve sleep quality, reduce maladaptive sleep
hygiene behaviors, and decrease daytime sleepiness, which are key indicators of increased
falls^{12,13}; and

Whereas, Although AMA policy H-60.930 identifies sleep as a public health issue for
adolescents and supports education regarding sleep health as standard care for adolescent
patients, recognizing sleep deprivation as a public health crisis for all age groups is a gap in
policy; and

Whereas, For ideal sleep health, the American Academy of Sleep Medicine (AASM) and the Sleep Research Society (SRS) recommends 7+ hours of sleep at night on average for ages 18 to 60⁷; and

Whereas, The National Sleep Foundation (NSF) consensus reports states that 7-9 hours of sleep and 7-8 hours of sleep is recommended for ages 18-64 years and 65+, respectively⁷; and

Whereas, The AMA has previously supported the importance of sleep health in policies H-310.907, H-15.958, H-170.986, and H-295.894; therefore be it

RESOLVED, That our AMA partner with stakeholder organizations, such as but not limited to the Centers for Disease Control and Prevention, the American Academy of Sleep Medicine, and the National Sleep Foundation, to promote sleep deprivation as a public health crisis for all age groups.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Liu, Y. et al. Prevalence of Healthy Sleep Duration among Adults - United States, 2014. MMWR Morb Mortal Wkly Rep. 2016 Feb.; 65(6):137–141.
2. Gradner, M. et al. Sleep, Health, and Society. Sleep Med Clin. 2017 Mar.; 12(1):1-22.
3. Gaine, M. et al. Sleep Deprivation and the Epigenome. Front Neural Circuits. 2018 Feb.; 12:14.
4. Liew, D. et al. Sleep Deprivation and its Association with Diseases - a Review. Sleep Medicine. 2021 Jan.; 77:192-204.
5. Kim, B. et al. Neighborhoods and Sleep Health among Adults: a Systematic Review. Sleep Health. 2022 Jun.; 8:322-333.
6. Huessler, H. et al. Sleep in children with neurodevelopmental difficulties. Journal of Pediatrics and Child Health. 2018 Oct.; 54(10):1142-1147.
7. Herscher, M. et al. A Sleep Hygiene Intervention to Improve Sleep Quality for Hospitalized Patients. Jt Comm J Qual Patient Saf. 2021 Jun; 47(6):343-346.
8. Phipp, P. et al. Sleep Restriction, Sleep Hygiene, and Driving Safety: The Importance of Situational Sleepiness. Sleep Med Clin. 2019 Dec; 14(4):407-412.
9. Essien, SK. et al. Sleep duration and sleep disturbances in association with falls among the middle-aged and older adults in China: a population-based nationwide study. BMC Geriatr. 2018; 18(1):196.
10. Chattu, VK. et al. The Global Problem of Insufficient Sleep and Its Serious Public Health Implications. Healthcare. 2019; 7(1):1.
11. Centers for Disease Control and Prevention. Keep on your feet-preventing older Adult Falls. <https://www.cdc.gov/injury/features/older-adult-falls/index.html>. Accessed August 26, 2022.
12. Tucker, RM. et al. Sleep Education for Elders Program (SLEEP): Promising Pilot Results of a Virtual, Health Educator-Led, Community-Delivered Sleep Behavior Change Intervention. Nat Sci Sleep. 2021; 13:625-633.
13. Min, Y. et al. Poor sleep and risk of falls in community-dwelling older adults: A systematic review. Journal of Applied Gerontology. 2016; 37(9):1059-1084.

RELEVANT AMA AND AMA-MSS POLICY

Insufficient Sleep in Adolescents H-60.930

1. Our AMA identifies adolescent insufficient sleep and sleepiness as a public health issue and supports education about sleep health as a standard component of care for adolescent patients.

2. Our AMA: (a) encourages school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep; (b) encourages physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the biologic sleep needs of adolescents; and (c) encourages continued research on the impact of sleep on adolescent health and academic performance.

Res. 503, A-10; Appended: CSAPH Rep. 06, 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.

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

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.

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

Health Information and Education H-170.986

(1) Individuals should seek out and act upon information that promotes appropriate use of the health care system and that promotes a healthy lifestyle for themselves, their families and others for whom they are responsible. Individuals should seek informed opinions from health care professionals regarding health information delivered by the mass media self-help and mutual aid groups are important components of health promotion/disease and injury prevention, and their development and maintenance should be promoted.

(2) Employers should provide and employees should participate in programs on health awareness, safety and the use of health care benefit packages.

(3) Employers should provide a safe workplace and should contribute to a safe community environment. Further, they should promptly inform employees and the community when they know that hazardous substances are being used or produced at the worksite.

(4) Government, business and industry should cooperatively develop effective worksite programs for health promotion and disease and injury prevention, with special emphasis on substance abuse.

(5) Federal and state governments should provide funds and allocate resources for health promotion and disease and injury prevention activities.

(6) Public and private agencies should increase their efforts to identify and curtail false and misleading information on health and health care.

(7) Health care professionals and providers should provide information on disease processes, healthy lifestyles and the use of the health care delivery system to their patients and to the local community.

(8) Information on health and health care should be presented in an accurate and objective manner.

(9) Educational programs for health professionals at all levels should incorporate an appropriate emphasis on health promotion/disease and injury prevention and patient education in their curricula.

(10) Third party payers should provide options in benefit plans that enable employers and individuals to select plans that encourage healthy lifestyles and are most appropriate for their particular needs. They should also continue to develop and disseminate information on the appropriate utilization of health care services for the plans they market.

(11) State and local educational agencies should incorporate comprehensive health education programs into their curricula, with minimum standards for sex education, sexual responsibility, and substance abuse education. Teachers should be qualified and competent to instruct in health education programs.

(12) Private organizations should continue to support health promotion/disease and injury prevention activities by coordinating these activities, adequately funding them, and increasing public awareness of such services.

(13) Basic information is needed about those channels of communication used by the public to gather health information. Studies should be conducted on how well research news is disseminated by the media to the public. Evaluation should be undertaken to determine the effectiveness of health information and education efforts. When available, the results of evaluation studies should guide the selection of health education programs.

BOT Rep. NN, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-07; Reaffirmation A-15; Reaffirmed: BOT Rep. 15, A-19

Medical Education on Sleep and Sleep Disorders H-295.894

Our AMA supports diagnosis and management of sleep and sleep disorders as an essential and integral component of medical education.

Res. 310 , I-98; Reaffirmed: CME Rep. 2, A-08; Reaffirmed: CME Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 073
(I-22)

Introduced by: Maddy Mash, Carine Tabak, University of Kansas School of Medicine; Avery Gulino, Cooper School of Medicine at Rowan University; Shreya Mandava, University of Virginia School of Medicine

Subject: Decreasing the Burden of Out-of-Pocket Costs for Biologic Therapies

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, 38-40% of pharmaceutical expenditure in the United States can be attributed to biologic drugs, which are medications commonly used to treat diseases with underlying immune pathogenesis^{2,18}; and

Whereas, Currently 3.2 million Americans or 2% of the population are being treated with biologics²; and

Whereas, Biologic medications incur costs averaging \$10,000-\$40,000 per year per patient, with the most expensive incurring upwards of \$500,000^{1,6}; and

Whereas, Biologic drugs were responsible for 93% of the rise in net drug spending in the U.S. between 2014 and 2017, with high costs largely due to stringent regulations on patents and approvals under the Biologics Price Competition and Innovation Act⁵; and

Whereas, Biologics are considered first line therapy for many autoimmune diseases and have been shown to be efficacious for disease control and advancement toward remission^{4,19,20,21,22}; and

Whereas, In the U.S., self-reported low-income patients have medication non-adherence rates of up to 25% due to healthcare cost-related barriers. Increased costs are a leading cause of patients switching to alternate biologic therapies^{6,16,17}; and

Whereas, Switching biologic therapies is associated with higher healthcare costs compared to persisting on the same biologic therapy; for a patient with rheumatoid arthritis, treatment costs averaged \$44,244 for patients who switched therapies, as opposed to \$41,901 for patients who persisted on the same therapy^{13,14,15}; and

Whereas, Due to stringent restrictions from Medicare or commercial insurance policies, patients are unable to receive self-administered drugs, including biologics, at an outpatient or hospital facility, precluding them from being covered through Medicare Part B or major medical insurance plans. These treatments then fall under Medicare Part D or a pharmaceutical/prescription drug insurance^{3,9}; and

Whereas, Self-administered biologics that are run through Medicare Part D or pharmaceutical/prescription drug insurance still leave patients with a substantial, upfront, out-of-pocket cost burden, with newer biologics costing upwards of \$20,000 per treatment^{3,8,10}; and

Whereas, The Inflation Reduction Act (IRA) of 2022 introduced out-of-pocket cost price capping of \$2,000 per year for Medicare Part D, but did not address price capping for commercial pharmaceutical/prescription drug insurance^{25,28}; and

Whereas, The IRA addressed the limited numbers of biosimilars available by allowing the Center for Medicare & Medicaid Services to negotiate the prices of biologics for which no biosimilars are available^{25,26}; and

Whereas, The IRA encourages an increased number of biosimilars on the market and limits biologic price increases to the price of inflation, yet because patients may respond differently to biosimilars than the original biologic, there is a need for more interchangeable biosimilars, which are generic alternatives identical to existing biologics^{27,28}; and

Whereas, Patient assistance programs have been demonstrated to increase costs for patients only when suitable alternatives are available, such as biosimilars or interchangeable biosimilars. Patient assistance programs, however, are still options for patients who are on biologics without aforementioned alternative options^{7,8,11,12,23}; and

Whereas, There are over 300 biologics that are currently approved in the U.S. market. Only 33 biosimilar alternatives exist and only 21 of those are marketed in the U.S. Further, there are only two approved interchangeable biosimilars, so there is still a discrepancy between the number of biologics that exist and their available alternatives^{28,29}; and

Whereas, There has been a severe underutilization of biosimilars, or generic versions of biosimilars. This is in part because of the limited number of biosimilars on the U.S. market which has been addressed by the IRA, but also because of limited education and sparse encouragement to use the few alternatives that do exist¹; and

Whereas, Physicians in self-reported surveys attributed limited use of biosimilars to an incomplete knowledge of what biosimilars were, how they were evaluated and tested against existing biologics, their safety profile, and general awareness of their availability²⁴; and

Whereas, Patients also experience some hurdles switching complex medications, so patient education programs have been successful in deterring fears about switching from biologics to biosimilars and improving medication compliance^{30, 31}; and

Whereas, While several AMA policies have addressed rising pharmaceutical costs and access to patient assistance programs, existing policies do not address gaps in care specific to exorbitant costs of biologic drugs (H-110.988, H-110.992); and therefore be it

RESOLVED, Our AMA advocates for policy on price capping for pharmaceutical/prescription drug insurance plans alongside Medicare Part D.

RESOLVED, Our AMA encourages expansion of both patient and physician education programs to increase awareness and understanding of biosimilars that exist in the U.S. and advocate for the development of patient assistance programs for biologics that do not have biosimilar or interchangeable biosimilar alternatives.

RESOLVED, Our AMA encourages expansion of research for interchangeable biosimilar, generic alternatives identical to current biologics on the market, and biosimilars.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Chen BK, Yang YT, Bennett CL. Why Biologics and Biosimilars Remain So Expensive: Despite Two Wins for Biosimilars, the Supreme Court's Recent Rulings do not Solve Fundamental Barriers to Competition. *Drugs*. 2018;78(17):1777-1781. doi:10.1007/s40265-018-1009-0
2. Zhai M, Sarpatwari A, Kesselheim, AS. Why Are Biosimilars Not Living Up to Their Promise in the US? *AMA J Ethics*. 2019;21(8):E668-678. doi: 10.1001/amajethics.2019.668
3. Center for Medicaid and Medicare Services. How Medicare Covers Self-Administered Drugs Given in Outpatient Hospital Settings. *Medicare*, <https://www.medicare.gov/Pubs/pdf/11333-Outpatient-Self-Administered-Drugs.pdf>, Revised June 2020, Accessed August 28, 2022.
4. Makurvet FD. Biologics vs. Small Molecules: Drug costs and patient access. *Medicine in Drug Discovery*. 2019; 9: 100075. doi.org/10.1016/j.medidd.2020.100075
5. Roy, A. Biologic Medicines: The Biggest Driver of Rising Drug Prices. *Forbes*, <https://www.forbes.com/sites/theapothecary/2019/03/08/biologic-medicines-the-biggest-driver-of-rising-drug-prices/?sh=72e153a118b0>. March 8, 2019, Accessed August 28, 2022.
6. Morgan SG, Lee A. Cost-related non-adherence to prescribed medicines among older adults: a cross-sectional analysis of a survey in 11 developed countries. *BMJ Open*. 2017;7(1):e014287. doi:10.1136/bmjopen-2016-014287
7. Stelara Savings Program. <https://www.stelarawithme.com/sites/www.stelarawithme.com/files/stelara-savings-program-overview.pdf>. Published May 2022..
8. Janssen Biotech. Stelara® (USTEKINUMAB) cost support. STELARA® (ustekinumab). <https://www.stelarahcp.com/plaque-psoriasis/cost-support>. Published August 3, 2021. Accessed August 31, 2022.

9. Centers for Medicare and Medicaid Services: Self-Administered Drug Exclusion List. <https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=53127>. Published October 1, 2015. Revised September 19, 2022. Accessed August 31, 2022.
10. Yazdany J, Dudley RA, Chen R, Lin GA, Tseng CW. Coverage for high-cost specialty drugs for rheumatoid arthritis in Medicare Part D. *Arthritis Rheumatol*. 2015;67(6):1474-1480. doi:10.1002/art.39079
11. Paying for remicade® - Cost Support. Janssen CarePath. <https://www.janssencarepath.com/patient/remicade/cost-support>. Published August 19, 2022. Accessed August 31, 2022.
12. Find out if you may be eligible. Find Out If You May Be Eligible | Johnson & Johnson Patient Assistance Foundation, Inc. <https://www.jjpaf.org/eligibility/>. Accessed August 31, 2022.
13. Gu T, Mutebi A, Stolshek BS, Tan H. Cost of biologic treatment persistence or switching in rheumatoid arthritis. *Am J Manag Care*. 2018;24(8 Spec No.):SP338-SP345.
14. Hur P, Kim N, Dai D, Piao OW, Zheng JZ, Yi E. Healthcare Cost and Utilization Associated with Biologic Treatment Patterns Among Patients with Psoriatic Arthritis: Analyses from a Large US Claims Database. *Drugs Real World Outcomes*. 2021;8(1):29-38. doi:10.1007/s40801-020-00217-4
15. Tian H, Gilloteau I, Mollon P, McDwyer P, Lotya J. Biologics Switching Patterns and Associated Costs in Psoriasis Patients in a Large Commercially Insured Population in the United States. *Value in Health*. 2016;19(3):125. doi:10.1016/j.jval.2016.03.1852
16. Strand V, Miller P, Williams SA, Saunders K, Grant S, Kremer J. Discontinuation of Biologic Therapy in Rheumatoid Arthritis: Analysis from the Corrona RA Registry. *Rheumatol Ther*. 2017;4(2):489-502. doi:10.1007/s40744-017-0078-y
17. Silver J, Bogart M, Molfino NA, et al. Factors leading to discontinuation of biologic therapy in patients with severe asthma. *J Asthma*. 2022;59(9):1839-1849. doi:10.1080/02770903.2021.1971700
18. Johnston SL. Biologic therapies: what and when? [published correction appears in *J Clin Pathol*. 2007 Mar;60(3):336]. *J Clin Pathol*. 2007;60(1):8-17. doi:10.1136/jcp.2005.032300
19. Hernández Cruz B. [Biologics as first line therapy in the treatment of rheumatoid arthritis. A posture a favor]. *Reumatol Clin*. 2009;5 Suppl 1:22-27. doi:10.1016/j.reuma.2009.01.004
20. Anisdahl K, Svatun Lirhus S, Medhus AW, Moum B, Melberg HO, Høivik ML. First-line biologic treatment of inflammatory bowel disease during the first 12 months after diagnosis from 2010 to 2016: a Norwegian nationwide registry study. *Scand J Gastroenterol*. 2021;56(10):1163-1168. doi:10.1080/00365521.2021.1955147
21. Amin M, No DJ, Egeberg A, Wu JJ. Choosing First-Line Biologic Treatment for Moderate-to-Severe Psoriasis: What Does the Evidence Say?. *Am J Clin Dermatol*. 2018;19(1):1-13. doi:10.1007/s40257-017-0328-3
22. Murray K, Turk M, Alammari Y, et al. Long-term remission and biologic persistence rates: 12-year real-world data. *Arthritis Res Ther*. 2021;23(1):25. Published 2021 Jan 13. doi:10.1186/s13075-020-02380-z
23. Dafny L, Ody C, Schmitt, M. Eliminating Prescription Drug Copay Coupons - 1% Steps for Health Care Reform. <https://onepercentsteps.com/policy-briefs/eliminating-prescription-drug-copay-coupons/>. Published February 8, 2021. Accessed September 22, 2022.
24. Cohen H, Beydoun D, Chien D, et al. Awareness, Knowledge, and Perceptions of Biosimilars Among Specialty Physicians. *Adv Ther*. 2017;33(12):2160-2172. doi:10.1007/s12325-016-0431-5

25. Cubanski J, Neuman T, Freed M, Damico A. How Will the Prescription Drug Provisions in the Inflation Reduction Act Affect Medicare Beneficiaries? *Kaiser Family Foundation*. <https://www.kff.org/medicare/issue-brief/how-will-the-prescription-drug-provisions-in-the-inflation-reduction-act-affect-medicare-beneficiaries/>. Published August 18, 2022. Accessed September 22, 2022.
26. Hagan T. How the Inflation Reduction Act May Affect Biosimilars. *Managed Healthcare Executive*. <https://www.managedhealthcareexecutive.com/view/how-the-inflation-reduction-act-may-affect-biosimilars>. Published September 13, 2022. Accessed September 22, 2022.
27. Interchangeable Biological Products. *U.S. FDA*. <https://www.fda.gov/media/151094/download>. Accessed September 22, 2022.
28. Baumann J. Drug Negotiations Will Drive Biosimilars as Patent Tactics Shift. *Bloomberg Law*. <https://news.bloomberglaw.com/ip-law/drug-negotiations-will-drive-biosimilars-as-patent-tactics-shift>. Published August 25, 2022. Accessed September 22, 2022.
29. Oskoue S, Feinberg B, Lam G, Holekamp N, Rariy, C, Baldetti J, Hunter H. 2022 Biosimilars Report: The U.S. Journey and Path Ahead. *Cardinal Health*. <https://www.cardinalhealth.com/content/dam/corp/web/documents/Report/cardinal-health-2022-biosimilars-report.pdf>. Published January 2022. Accessed September 22, 2022.
30. Fendrick AM, Brixner D, Rubin DT, et al. Sustained long-term benefits of patient support program participation in immune-mediated diseases: improved medication-taking behavior and lower risk of a hospital visit. *J Manag Care Spec Pharm*. 2021;27(8):1086-1095. doi:10.18553/jmcp.2021.20560
31. Feagan BG, Marabani M, Wu JJ, Faccin F, Spronk C, Castañeda-Hernández G. The Challenges of Switching Therapies in an Evolving Multiple Biosimilars Landscape: A Narrative Review of Current Evidence. *Adv Ther*. 2020;37(11):4491-4518. doi:10.1007/s12325-020-01472-1

RELEVANT AMA AND AMA-MSS POLICY

Cost of Prescription Drugs H-110.997

(1) Our AMA supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs; 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

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.

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

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. 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

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.

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.

Res. 112, I-89; Reaffirmed: Res. 520, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 229, I-14

Maximum Allowable Cost of Prescription Medications H-155.962

Our AMA opposes the use of price controls in any segment of the health care industry, and continues to promote market-based strategies to achieve access to and affordability of health care goods and services.

CMS Rep. 2, A-07; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed: CMS Res. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Reaffirmation: A-17

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.

CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Modified: CMS Rep. 4, A-22

Drug Issues in Health System Reform H-100.964

Our AMA:

- (1) Consistent with AMA Policy H-165.925, supports coverage of prescription drugs, including insulin, in the AMA standard benefits package.
 - (2) Supports consumer choice of at least two options for their pharmaceutical benefits program. This must include a fee-for-service option where restrictions on patient access and physician autonomy to prescribe any FDA-approved medication are prohibited.
 - (3) Reaffirms AMA Policy H-110.997, supporting the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourage physicians to supplement medical judgments with cost considerations in making these choices.
 - (4) Supports a managed pharmaceutical benefits option with market-driven mechanisms to control costs, provided cost control strategies satisfy AMA criteria defined in AMA Policy H-110.997 and that drug formulary systems employed are consistent with standards defined in AMA Policy H-125.991.
 - (5) Supports prospective and retrospective drug utilization review (DUR) as a quality assurance component of pharmaceutical benefits programs, provided the DUR program is consistent with Principles of Drug Use Review defined in AMA Policy H-120.978.
- BOT Rep. 53, A-94; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed by CSA Rep. 3, A-97; Amended: CSA Rep. 2, I-98; Renumbered: CMS Rep. 7, I-05; Reaffirmation A-10; Reaffirmed in lieu of Res. 201, I-11; Modified: CMS Rep. 1, A-21

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

Certifying Indigent Patients for Pharmaceutical Manufacturers' Free Drug Programs H-120.975

Our AMA: (1) supports Pharmaceutical Research and Manufacturers of America (PhRMA) programs for indigent patients and the development of a universal application process, eligibility criteria and form for all prescription drug patient-assistance programs to facilitate enrollment of patients and physicians; (2) encourages PhRMA to provide information to physicians and hospital medical staffs about member programs that provide pharmaceuticals to indigent patients; (3) urges drug companies to develop user-friendly and culturally sensitive uniform centralized policies and procedures for certifying indigent patients for free or discounted

medications; and (4) opposes the practice of charging patients to apply for or gain access to pharmaceutical assistance programs.

Sub. Res. 105, I-92; Sub. Res. 507, A-96; Appended: Sub. Res. 513, I-97; Reaffirmation I-98; Reaffirmation I-00; Reaffirmation A-01; Amended: Res. 513, A-02; Reaffirmed and Appended: Sub. Res. 705, I-03; Reaffirmed and Modified: BOT Rep. 13, A-04; Reaffirmation I-04; Modified: CSAPH Rep. 1, A-14

Caps on Insulin Co-Payments for Patients with Insurance 100.026MSS

Our AMA-MSS will ask the AMA to amend existing AMA policy H-110.984, Insulin Affordability, by addition and deletion to read: INSULIN AFFORDABILITY, H-110.984.

Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing market competition and take enforcement actions as appropriate; and (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.; and (3) support state and national efforts to limit the copayments insured patients pay per month for prescribed insulin. (MSS Res. 011, Nov. 2020) (AMA Res. 118, Adopt as Amended [], A-22)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 074
(I-22)

Introduced by: Chayton Fivecoat, Johan Harris, Wayne State University School of Medicine;
Kristofer Jackson, University of Toledo College of Medicine and Life
Sciences

Subject: Encouraging the Transition from Artificial Turf to Natural Grass Surfaces for
Athletic Use

Sponsored by: Region 5

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Synthetic turf is a ground surfacing material designed to imitate both the appearance
and function of natural grass¹; and

Whereas, There are more than 11,000 artificial turf fields in the United States¹; and

Whereas, Artificial turf was first used in the Houston Astrodome for the Houston Astros (Major
League Baseball) because their domed stadium could not sustain natural grass because
sunlight could not reach the field²; and

Whereas, Natural grass strains, agriculture techniques, and lighting technology have since been
developed that can grow under stadium lights, thereby eliminating the need for artificial turf³;
and

Whereas, Of the 306 known components of crumb rubber (the major component of artificial turf
pellets) 52 are known, presumed, or suspected carcinogens⁴; and

Whereas, Equipment, supplies, and labor costs for artificial turf range from \$600,000-
\$1,000,000 and natural grass costs \$50,000-\$600,000 to install⁴; and

Whereas, Artificial turf requires \$5,000-\$22,000 and 375 hours of labor and natural
grass requires \$4,000 and 250 hours of labor, to maintain per year⁴; and

Whereas, Artificial turf has a maximal lifespan of 10 years and must be completely replaced at
the end of its lifetime costing at least \$500,000⁴; and

Whereas, In both the short and long term, natural grass can be cheaper to maintain and install
than its artificial turf counterparts, if both fields are kept to the same standard of playability⁴; and

Whereas, Approximately 56.1% of children and adolescents aged 6-17 “participated in a sport
team” or “took lessons after school or on weekends” with the United States Department of
Health and Human Services (HHS) hoping to increase that number to 63.3% by 2030⁵; and

Whereas, Approximately 276,365 National Collegiate Athletic Association (NCAA) athletes participated in sports that could practice or play on artificial turf surfaces during the 2018-2019 athletic seasons based on their institution and competitors⁶; and

Whereas, There are 1696 players on National Football League (NFL) active rosters⁷, 811 Major League Soccer (MLS) players⁸, and 906 MLB players⁹ that play and practice on turf surfaces each year; and

Whereas, Artificial turf is found to have lower shock absorption, higher friction coefficients, creation of a higher magnitude of torque, which directly correlate to higher incidence of injury in the average athlete¹⁰; and

Whereas, It has been shown that amongst MLS players, the rate of Achilles injury was twice as high on turf as it was grass and the rate of ankle fracture was 6 times as high on turf compared to grass¹¹; and

Whereas, Total cost of operative management of Achilles tendon rupture costs on average of \$13,936¹²; and

Whereas, It has been shown that over 10 years the rate of PCL tears in all three divisions of NCAA football was almost 3 times greater on turf than on grass and ACL tears occurred 1.6 times as often on artificial turf than on grass¹³; and

Whereas, The median total health care utilization cost per ACL tear and reconstruction is \$13,403.38¹⁴; and

Whereas, Concussions resulting from contact with the ground in both collegiate and high school football were disproportionately associated with playing on artificial turf and these concussions were also associated with greater severity on turf¹⁵; and

Whereas, It has been shown that high school athletes were 58% more likely to sustain a lower extremity, upper extremity, or torso injury while on turf compared to natural grass surfaces¹⁶; and

Whereas, It has been shown that overall men and women are sidelined due to “non-season ending” injury longer on artificial turf than the same injuries sustained on natural grass surfaces¹⁷; and

Whereas, Playing on artificial turf in NFL games results in a 16% increase in lower extremity injury per play compared to playing on natural grass surfaces¹⁸; and

Whereas, According to a 2020 letter from the National Football League’s Player Association (NFLPA) President JC Tretter, “The NFLPA is advocating for teams to convert artificial practice and game fields to natural grass fields” due to the increased risk of both contact and non-contact joint injuries¹⁹; therefore be it

RESOLVED, that our AMA supports the use of natural grass over artificial turf in all youth, high school, college, and professional athletic facilities and encourages the use of artificial turf in their facilities to transition to natural grass fields; and be it further

1 RESOLVED, that our AMA encourage injury prevention training while utilizing artificial turf in
 2 areas where transition to natural grass fields is not possible.

3 Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Perkins AN, Inayat-Hussain SH, Deziel NC, et al. Evaluation of potential carcinogenicity of organic chemicals in synthetic turf crumb rubber. Environmental Research. https://www.sciencedirect.com/science/article/abs/pii/S0013935118305528?casa_token=yNk_mYcV65cAAAAA%3ARY0NYslcFq5DUS4OclW6JG6kkmG4LVEEqdA7kq19pqaY_Y9Gs7y2sjP0qqqsQLvW81uy7A2RGbl4 Published October 24, 2018. Accessed August 26, 2022.
2. Jordan A. Artificial pitches and football: A history. Bleacher Report. <https://bleacherreport.com/articles/449490-artificial-pitches-and-football-a-history> Published October 1, 2017. Accessed August 31, 2022.
3. Editors BD. Astros to unveil new turf, club renovations: Ballpark Digest. Ballpark Digest - Chronicling the Business and Culture of Baseball Ballparks--MLB, MiLB, College. <https://ballparkdigest.com/2015/04/06/astros-to-unveil-new-turf-club-renovations/>. Published April 6, 2015. Accessed August 31, 2022.
4. Rossi F, Schimenti C. Sports Field Management: Maintaining safe sports fields. Sports field management. <https://safesportsfields.cals.cornell.edu/synthetic-turf/>. Accessed August 31, 2022.
5. National Survey of Children's Health (NSCH). National Survey of Children's Health (NSCH) - Healthy People 2030. <https://health.gov/healthypeople/objectives-and-data/data-sources-and-methods/data-sources/national-survey-childrens-health-nsch> Accessed August 22, 2022.
6. NCAA. "Estimated probability of competing in college athletics." NCAA.org, 8 April 2020, <https://www.ncaa.org/sports/2015/3/2/estimated-probability-of-competing-in-college-athletics.aspx>. Accessed 22 August 2022.
7. Putnik, Gary. "NFL players by college on 2021 rosters." NCAA.com, 12 September 2021, <https://www.ncaa.com/news/football/article/2021-09-06/nfl-players-college-2021-rosters>. Accessed 22 August 2022.
8. Transfermarkt.us. "Major League Soccer 2022." Transfermarkt, <https://www.transfermarkt.us/major-league-soccer/startseite/wettbewerb/MLS1>. Accessed 22 August 2022.
9. Anderson, Ashley. "MLB stadiums by grass type." The TwinSpires Edge, 24 February 2022, <https://edge.twinspires.com/mlb/mlb-stadiums-by-grass-type/>. Accessed 22 August 2022.
10. Ataabadi YA, Sadeghi H, Alizadeh MH. The effects of artificial turf on the performance of soccer players and evaluating the risk factors compared to natural grass. Journal Of Neurological Research And Therapy. 2017;2(2):1-16. doi:10.14302/issn.2470-5020.jnrt-17-1487
11. Calloway SP, Hardin DM, Crawford MD, Hardin JM, Lemak LJ, Giza E, Forsythe B, Lu Y, Patel BH, Osbahr DC, Gerhardt MB, Mandelbaum BR, Baldwin WW. Injury Surveillance in Major League Soccer: A 4-Year Comparison of Injury on Natural Grass Versus Artificial Turf Field. Am J Sports Med. 2019 Aug;47(10):2279-2286. doi: 10.1177/0363546519860522. Epub 2019 Jul 15. PMID: 31306590.

12. Koltsov JC, Gribbin C, Ellis SJ, Nwachukwu BU. Cost-effectiveness of operative versus non-operative management of Acute Achilles tendon ruptures. *HSS Journal* ®. 2019;16(1):39-45. doi:10.1007/s11420-019-09684-0
13. Loughran GJ, Vulpis CT, Murphy JP, Weiner DA, Svoboda SJ, Hinton RY, Milzman DP. Incidence of Knee Injuries on Artificial Turf Versus Natural Grass in National Collegiate Athletic Association American Football: 2004-2005 Through 2013-2014 Seasons. *Am J Sports Med*. 2019 May;47(6):1294-1301. doi: 10.1177/0363546519833925. Epub 2019 Apr 17. PMID: 30995074.
14. Herzog MM, Marshall SW, Lund JL, Pate V, Spang JT. Cost of outpatient arthroscopic anterior cruciate ligament reconstruction among commercially insured patients in the United States, 2005-2013. *Orthopaedic Journal of Sports Medicine*. 2017;5(1):232596711668477. doi:10.1177/2325967116684776
15. Guskiewicz KM, Weaver NL, Padua DA, Garrett WE. Epidemiology of Concussion in Collegiate and High School Football Players. *The American Journal of Sports Medicine*. 2000;28(5):643-650. doi:10.1177/03635465000280050401
16. Voos, MD, J., 2022. Artificial Turf versus Natural Grass. UH Hospitals. <https://www.uhhospitals.org/for-clinicians/articles-and-news/articles/2019/08/artificial-turf-versus-natural-grass> [Accessed 26 August 2022].
17. Fuller CW, Dick RW, Corlette J, Schmalz R. Comparison of the incidence, nature and cause of injuries sustained on grass and new generation artificial turf by male and female football players. Part 2: training injuries. *Br J Sports Med*. 2007;41 Suppl 1(Suppl 1):i27-i32. doi:10.1136/bjsm.2007.037275
18. Mack CD, Hershman EB, Anderson RB, et al. Higher Rates of Lower Extremity Injury on Synthetic Turf Compared With Natural Turf Among National Football League Athletes: Epidemiologic Confirmation of a Biomechanical Hypothesis. *Am J Sports Med*. 2019;47(1):189-196. doi:10.1177/0363546518808499
19. Tretter JC. Only natural grass can level the NFL's playing field. NFL Players Association. <https://nflpa.com/posts/only-natural-grass-can-level-the-nfls-playing-field#:~:text=Specifically%2C%20players%20have%20a%2028,on%20turf%20compared%20to%20grass> Accessed August 22, 2022

RELEVANT AMA AND AMA-MSS POLICY

Reduction of Sports-Related Injury and Concussion H-470.954

1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.
2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations.
3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries.
4. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions; (c) develop and evaluate effective risk reduction

measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and (d) develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients.

5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum from subconcussive head impacts to conditions such as chronic traumatic encephalopathy (CTE).

CSAPH Rep. 3, A-15; Appended: Res. 905, I-16

Reducing the Risk of Concussion and Other Injuries in Youth Sports H-470.959

1. Our American Medical Association promotes the adoption of requirements that athletes participating in school or other organized youth sports and who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion be removed immediately from the activity in which they are engaged and not return to competitive play, practice, or other sports-related activity without the written approval of a physician (MD or DO) or a designated member of the physician-led care team who has been properly trained in the evaluation and management of concussion. When evaluating individuals for return-to-play, physicians (MD or DO) or the designated member of the physician-led care team should be mindful of the potential for other occult injuries.

2. Our AMA encourages physicians to: (a) assess the developmental readiness and medical suitability of children and adolescents to participate in organized sports and assist in matching a child's physical, social, and cognitive maturity with appropriate sports activities; (b) counsel young patients and their parents or caregivers about the risks and potential consequences of sports-related injuries, including concussion and recurrent concussions; (c) assist in state and local efforts to evaluate, implement, and promote measures to prevent or reduce the consequences of concussions, repetitive head impacts, and other injuries in youth sports; and (d) support preseason testing to collect baseline data for each individual.

3. Our AMA will work with interested agencies and organizations to: (a) identify harmful practices in the sports training of children and adolescents; (b) support the establishment of appropriate health standards for sports training of children and adolescents; (c) promote evidenced-based educational efforts to improve knowledge and understanding of concussion and other sport injuries among youth athletes, their parents, coaches, sports officials, school personnel, health professionals, and athletic trainers; and (d) encourage further research to determine the most effective educational tools for the prevention and management of pediatric/adolescent concussions.

4. Our AMA supports (a) requiring states to develop and revise as necessary, evidenced-based concussion information sheets that include the following information: (1) current best practices in the prevention of concussions, (2) the signs and symptoms of concussions, (3) the short-and long-term impact of mild, moderate, and severe head injuries, and (4) the procedures for allowing a student athlete to return to athletic activity; and (b) requiring parents/guardians and students to sign concussion information sheets on an annual basis as a condition of their participation in sports.

Res. 910, I-10; Reaffirmed: BOT Rep. 9, A-14; Modified: CSAPH Rep. 3, A-15, Modified: BOT Action in response to referred for decision: Res. 409, A-17

Soccer Injuries H-470.960

Our AMA recognizes the problem of injuries in soccer and encourages additional studies into the incidence of soccer-related injuries and methods to reduce those injuries.

Sub. Res. 404, A-09; Reaffirmed: CSAPH Rep. 3, A-15

Injuries in Cheerleading H-470.956

Our AMA: (1) supports the designation of cheerleading as a sport; and (2) recognizes the potential dangers of cheerleading, including the potential for concussion and catastrophic injury, and supports the implementation of recommendations designed to improve its safety equivalent to those that apply to other athletic activities formally recognized as 'sports' by appropriate accrediting bodies. These include proper training of coaches, avoidance of inappropriate surfaces when performing stunts and adherence to rules for the proper execution of stunts. BOT Rep. 9, A-14; Reaffirmed: CSAPH Rep. 3, A-15

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 075
(I-22)

Introduced by: Rafay Nasir, Elhaam Jawadi, Penn State College of Medicine

Subject: Mitigating Barriers Faced by Muslim Healthcare Workers

Sponsored by: Asian Pacific American Medical Student Association

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, The AMA opposes any discrimination based on an individual's religion according to H-65.965; and

Whereas, Muslim healthcare workers face unique barriers and discrimination that impact their physical and mental health¹; and

Whereas, Nearly 20% of Muslim healthcare workers report experiencing Islamophobia within the workplace²; and

Whereas, Muslim healthcare workers who report facing discrimination have a 6.6 times higher risk of moderate or severe psychological distress²; and

Whereas, Some healthcare institutions may not provide proper accommodations for religious obligations, including prayer and fasting³; and

Whereas, Women who observe the hijab find it challenging to abide by their religious beliefs while also maintaining sterile policy in the hospital and operating room⁴; and

Whereas, Hijab-wearing women prefer to specialize in non-surgical specialties due to dress code issues⁴; and

Whereas, Majority of hijab-wearing women agree that wearing the hijab was important for them and their religious beliefs, yet many felt embarrassed (23.4%), anxious (37.1%) and bullied (36.5%) when attempting to wear the hijab in the operating room⁴; and

Whereas, According to Title VII of Equal Employment Opportunity Commission, religious harassment occurs when an employee is required to alter a religious practice as a condition of employment or is subjected to unwelcome statements or conduct and thus finds the work environment to be hostile or offensive⁵; and

Whereas, Title VII of Equal Employment Opportunity Commission requires an employer, to reasonably accommodate an employee whose religious belief, such as prayer or wearing hijab, conflicts with a work requirement⁵; and

Whereas, Common religious accommodations include modifications to workplace policies or practices and flexible scheduling⁵; therefore be it

1 RESOLVED, That our AMA support:

- 2 1. Work and school accommodations made for religious obligations, including prayer and
- 3 fasting
- 4 2. Inclusion of Islamophobia awareness and prevention in diversity and inclusion
- 5 programming
- 6 3. Systematic solutions to mitigate instances of discrimination faced in receiving career-
- 7 advancing opportunities, or by patients and colleagues in the healthcare setting
- 8 4. Methods to mitigate instances of violence and hate crimes directed towards Muslim
- 9 healthcare workers

Fiscal Note: TBD

Date Received: 9/22/22

References:

1. Ali, Hira. "The Discrimination Faced by UK's Muslim Healthcare Workers." <https://English.Alaraby.Co.Uk/>, The New Arab, 3 Dec. 2021, <https://english.alaraby.co.uk/features/discrimination-faced-uks-muslim-healthcare-workers>.
2. Awaad, Rania, et al. Mental Health of Muslim Healthcare Workers | ISPU. <https://www.ispu.org/mental-health-muslim-healthcare-workers/>. Accessed 1 Sept. 2022.
3. Shahid, Hina, and Hira Ali. Excluded on the Frontline: Discrimination, Racism and Islamophobia in the NHS. Muslim Doctors Association, <https://muslimdoctors.org/wp-content/uploads/2021/12/Exclusion-On-The-Front-line.pdf>. Accessed 1 Sept. 2022.
4. Malik A, Qureshi H, Abdul-Razakq H, et al. "I decided not to go into surgery due to dress code": A cross-sectional study within the UK investigating experiences of female Muslim medical health professionals on bare below the elbows (BBE) policy and wearing headscarves (hijabs) in theatre. *BMJ Open*. 2019;9(3). doi:10.1136/bmjopen-2017-019954
5. Religious discrimination. US EEOC. <https://www.eeoc.gov/religious-discrimination>. Accessed July 21, 2022.

RELEVANT AMA AND AMA-MSS 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.

Eliminating Religious and Cultural Discrimination from Residency and Fellowship Programs and Medical Schools H-310.923

Our AMA encourages residency programs, fellowship programs, and medical schools to: (1) allow trainees to take leave and attend religious and cultural holidays and observances, provided that patient care and the rights of other trainees are not compromised; and (2) explicitly inform applicants and entrants about their policies and procedures related to accommodation for religious and cultural holidays and observances.

CME Rep. 10, A-06; Reaffirmed: CME Rep. 01, A-16; Modified: Res. 323, A-22

Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism H-65.949

Our AMA: (1) recognizes that discrimination against natural hair/hairstyles and cultural headwear is a form of racial, ethnic and/or religious discrimination; (2) opposes discrimination against individuals based on their hair or cultural headwear in health care settings; (3) acknowledges the acceptance of natural hair/hairstyles and cultural headwear as crucial to professionalism in the standards for the health care workplace; (4) encourages medical schools, residency and fellowship programs, and medical employers to create policies to oppose discrimination based on hairstyle and cultural headwear in the interview process, medical education, and the workplace; and (5) encourages healthcare institutions to provide adequate protective equipment in accordance with appropriate patient safety for healthcare workers with natural hair/hairstyles or cultural headwear.

Res. 006, A-22

Code of Medical Ethics 1.1.2 Prospective Patients

As professionals dedicated to protecting the well-being of patients, physicians have an ethical obligation to provide care in cases of medical emergency. Physicians must also uphold ethical responsibilities not to discriminate against a prospective patient on the basis of race, gender, sexual orientation or gender identity, or other personal or social characteristics that are not clinically relevant to the individual's care. Nor may physicians decline a patient based solely on the individual's infectious disease status. Physicians should not decline patients for whom they have accepted a contractual obligation to provide care.

However, physicians are not ethically required to accept all prospective patients. Physicians should be thoughtful in exercising their right to choose whom to serve.

A physician may decline to establish a patient-physician relationship with a prospective patient, or provide specific care to an existing patient, in certain limited circumstances:

- (a) The patient requests care that is beyond the physician's competence or scope of practice; is known to be scientifically invalid, has no medical indication, or cannot reasonably be expected to achieve the intended clinical benefit; or is incompatible with the physician's deeply held personal, religious, or moral beliefs in keeping with ethics guidance on exercise of conscience.
- (b) The physician lacks the resources needed to provide safe, competent, respectful care for the individual. Physicians may not decline to accept a patient for reasons that would constitute discrimination against a class or category of patients
- (c) Meeting the medical needs of the prospective patient could seriously compromise the physician's ability to provide the care needed by his or her other patients. The greater the prospective patient's medical need, however, the stronger is the physician's obligation to provide care, in keeping with the professional obligation to promote access to care.
- (d) The individual is abusive or threatens the physician, staff, or other patients, unless the physician is legally required to provide emergency medical care. Physicians should be aware of the possibility that an underlying medical condition may contribute to this behavior.

AMA Principles of Medical Ethics: I,VI,VIII,X

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 MEDICAL STUDENT SECTION ASSEMBLY

Resolution 076
(I-22)

Introduced by: Camilla Cascardo, Sara Diltz, Mallory Evans, Dana Rector, Lauren Troppens, Oakland University William Beaumont School of Medicine

Subject: Emphasizing and Expanding Sun Protection Lessons in K-12 Children

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Skin cancer is the most common cancer in the United States, and millions of new cases are diagnosed each year¹; and

Whereas, Non-melanoma skin cancers are found most frequently on parts of the body that are commonly exposed to the sun implying that long-term, repeated UV radiation exposure is a major causal factor²,

Whereas, Brief exposure to intense UV radiation, most of which occurs in the first two decades of life, is also related to the development of melanoma³; and

Whereas, Greater than five lifetime sunburns doubles a person's risk for developing melanoma, and just one blistering sunburn in childhood or adolescence carries the same risk⁴; and

Whereas, Less than one-third of youths aged 11-18 years old routinely use sun protection⁵; and

Whereas, Stage I melanoma patients treated more than 119 days after biopsy have 41% higher mortality compared to those treated within 30 days of biopsy⁶; and

Whereas, When people of color develop skin cancer it is often diagnosed at a later stage, worsening the prognosis⁷; and

Whereas, Non-Hispanic Black children are less likely than non-Hispanic White children to use sunscreen; and⁸

Whereas, The American Academy of Pediatrics (AAP) and American Academy of Dermatology (AAD) recommend incorporation of sun protection into annual well-child care, but 25% of physicians offer no counseling; and⁸

Whereas, Several states have legislation regarding sunscreen use in school, though no standardized curriculum exists that equips children with the knowledge to protect their skin from the sun⁹; and

Whereas, Health education is most impactful for children when it is reinforced consistently and sequentially, and is supplemented by policies, teachers, and families¹⁰; and

Whereas, The Center for Disease Control (CDC) outline the importance of effective professional development for teachers, school nurses, and coaches regarding sun safety and skin cancer prevention¹¹; and

Whereas, Our American Medical Association (AMA) already encourages students to possess and use sunscreen at school without physician authorization (AMA Policy H-440.841); and

Whereas, Our AMA already encourages physicians to counsel their patients on sun-protective behavior and partners with organizations that promote education on the importance of skin cancer screenings and self-examinations (AMA Policy H-55.972 and H-440.839); therefore be it

RESOLVED, that our American Medical Association to amend policy MSS 60.011 "Sun Protection Programs and Education in K-12 Schools," by addition to read as follows:

"AMA-MSS will support working with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, American Academy of Pediatrics, American Academy of Dermatology and other appropriate entities to encourage schools, after-school programs, community centers, and fitness facilities to incorporate sun protection policies and annual sun safety education, including the disparity of skin cancer prognosis in people with skin of color"

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. *Cancer Facts and Figures 2022*. American Cancer Society. <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2022/2022-cancer-facts-and-figures.pdf> Accessed July, 12, 2022.
2. Radiation: Ultraviolet (UV) radiation and skin cancer. World Health Organization. [https://www.who.int/news-room/questions-and-answers/item/radiation-ultraviolet-\(uv\)-radiation-and-skin-cancer](https://www.who.int/news-room/questions-and-answers/item/radiation-ultraviolet-(uv)-radiation-and-skin-cancer). Published October 16, 2017. Accessed September 21, 2022.
3. Watts CG, Drummond M, Goumas C, et al. Sunscreen Use and Melanoma Risk Among Young Australian Adults. *JAMA Dermatol*. Published online July 18, 2018. doi:10.1001/jamadermatol.2018.1774.
4. Sunburn. The Skin Cancer Foundation. <https://www.skincancer.org/risk-factors/sunburn/>. Published May 1, 2021. Accessed September 21, 2022.
5. Strome A, Herbert K, Walsh K, Lamberg O, Waselewski ME, Chang T. Assessment of Sun Protection Knowledge and Behaviors of US Youth. *JAMA Netw Open*. 2021;4(11):e2134550. Published 2021 Nov 1. doi:10.1001/jamanetworkopen.2021.34550
6. Conic RZ, Cabrera CI, Khorana AA, Gastman BR. Determination of the impact of melanoma surgical timing on survival using the National Cancer Database. *J Am Acad Dermatol* 2018; 78(1):40-46.e7. doi:10.1016/j.jaad.2017.08.039.
7. Skin cancer in people of color. American Academy of Dermatology Association. <https://www.aad.org/public/diseases/skin-cancer/types/common/melanoma/skin-color>. Published 2022. Accessed September 21, 2022.
8. Correnti CM, Klein DJ, Elliott MN, et al. Racial disparities in fifth-grade sun protection: Evidence from the Healthy Passages study. *Pediatr Dermatol*. 2018;35(5):588-596. doi:10.1111/pde.13550

9. House Energy and Commerce; Education and the Workforce Committees (2017), "H.Res.282 - 115th Congress (2017-2018): Supporting State, local, and community initiatives to encourage parents, teachers, camp counselors, and childcare professionals to take measures to prevent sunburns in the minors they care for, and expressing the sense of the House of Representatives that State, local, and community entities should continue to support efforts to curb the incidences of skin cancer beginning with childhood skin protection.," *Congress.gov | Library of Congress*, www.congress.gov, (accessed July 12, 2022).
10. Glanz, K., Saraiya, M., & Wechsler, H. (2002). *Guidelines for School Programs To Prevent Skin Cancer. Morbidity and Mortality Weekly Report: Recommendations and Reports*, 51(RR-4), 1–18. <http://www.jstor.org/stable/42000889>
11. Guidelines for school programs to prevent skin cancer. Centers for Disease Control and Prevention. Published April 18, 2022. Accessed August 4, 2022. https://www.cdc.gov/cancer/skin/what_cdc_is_doing/guidelines.htm

RELEVANT AMA AND AMA-MSS POLICY

Sun Protection Programs and Education in K-12 Schools 60.011MSS

AMA-MSS will support working with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, and other appropriate entities to encourage schools to incorporate sun protection policies and sun safety education curricula.

(MSS Res 16,A-04) (Reaffirmed: MSS Res 16, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Appended: MSS Res. 072, Nov. 2020) (Reaffirmed: MSS GC Rep B, A-21)

Permitting Sunscreen in Schools H-440.841

Our AMA: (1) supports the exemption of sunscreen from over-the-counter medication possession bans in schools and encourages all schools to allow students to bring and possess sunscreen at school without restriction and without requiring physician authorization; (2) will work with state and specialty medical societies and patient advocacy groups to provide advocacy resources and model legislation for use in state advocacy campaigns seeking the removal of sunscreen-related bans at schools and summer camp programs.

Res. 403, A-13; Appended: Res. 422, A-16

Early Detection and Prevention of Skin Cancer H-55.972

Our AMA: (1) encourages all physicians to (a) perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday; (b) examine their patients' skins for the early detection of melanoma and nonmelanoma skin cancer; (c) urge their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; and (d) educate their patients concerning the correct way to perform skin self-examination; (2) supports mechanisms for the education of lay professionals, such as hairdressers and barbers, on skin self-examination to encourage early skin cancer referrals to qualified health care professionals; and (3) supports and encourages prevention efforts to increase awareness of skin cancer risks and sun-protective behavior in communities of color. Our AMA will continue to work with the American Academy of Dermatology, National Medical Association and National Hispanic Medical Association and public health organizations to promote education on the importance of skin cancer screening and skin cancer screening in patients of color.

Protecting the Public from Dangers of Ultraviolet Radiation H-440.839

1. Our AMA encourages physicians to counsel their patients on sun-protective behavior.

TANNING PARLORS: Our AMA supports: (a) educational campaigns on the hazards of tanning parlors, as well as the development of local tanning parlor ordinances to protect our patients and the general public from improper and dangerous exposure to ultraviolet radiation; (b) legislation to strengthen state laws to make the consumer as informed and safe as possible; (c) dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; (d) collaboration between medical societies and schools to achieve the inclusion of information in the health curricula on the hazards of exposure to tanning rays; (e) the enactment of federal legislation to: (i) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR 1040.20 [a][9]) by anyone under the age of 18; and (ii) require a United States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; (f) warning the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units, particularly the FDA's findings warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (g) working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including posted warnings in commercial tanning salons and spas; (h) an educational campaign in conjunction with various concerned national specialty societies to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to reduce improper and dangerous exposure to ultraviolet light by patients and general public consumers; and (i) intensified efforts to enforce current regulations.

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

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

3. Our AMA, as part of a successful skin cancer prevention strategy, supports free public sunscreen programs that: (a) provide sunscreen that is SPF 15 or higher and broad spectrum; (b) supply the sunscreen in public spaces where the population would have a high risk of sun exposure; and (c) protect the product from excessive heat and direct sun.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 077
(I-22)

Introduced by: Rohini Vyas, Liberty University College of Osteopathic Medicine

Subject: Amending Existing Preventative Policy to Decrease Comorbidities in Patients with Developmental Disabilities

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, After immunizations, access to healthcare is the second most prevalent factor that affects preventable diseases¹; and

Whereas, Adults with developmental disabilities experience healthcare disparities due to inadequate access to care, communication barriers with healthcare workers, and various levels of independence^{2,3}; and

Whereas, In 2017, one out of every six children was diagnosed with a developmental disability, and the number of adults >60 years with developmental disabilities is expected to double from the 640,000 in 2000 to 1.2 million in 2030^{2,4}; and

Whereas, Adults with developmental disabilities have increased risk of comorbidities including cardiovascular diseases, muscle hypotonia, osteoporosis, arthritis, osteoarthritis, and diabetes due to higher rates of obesity, sedentary lifestyle, and poor dietary habits which qualify them as a “disparity” population^{5,2,6,17}; and

Whereas, Adults with developmental disabilities have population-level differences in health outcomes due to preventable diseases that are not caused by their genetic syndromes^{5,2,6}; and

Whereas, Patients with developmental disabilities are traditionally high users of healthcare, but receive suboptimal care compared to typically-developing patients; this can be due to under-utilization of screening tools, and/or underdiagnosis³; and

Whereas, Down syndrome continues to be the most common chromosomal disorder in the United States with 1 in every 700 babies being born with the disorder, typically due to an extra chromosome 21^{7,8}; and

Whereas, Down syndrome is the leading genetic cause of Alzheimer’s disease (AD), likely due to high gene dosage of amyloid precursor protein, which is also found on chromosome 21, and individuals with Down syndrome are more likely to experience early-onset Alzheimer’s disease, representing the majority of AD patients under 65 years old^{5,7}; and

Whereas, It has been shown that physical activity 30-60 min several times a week lowers the risk for AD by 45% and dementia by 28%, in addition to improving cognition, independent functioning, and mental health^{9,10,12}; and

Whereas, Research data from patients with existing neurodegeneration showed that exercise improved their cognitive function by increasing neuronal survival, plasticity, neurogenesis, angiogenesis, autophagy, as well as the amount of brain-derived neurotrophic factor (BDNF) while mitigating endocrine responses to stress^{10,12}; and

Whereas, Encouraging physical activity has become a vital non-pharmacologic method of preventing neurological, metabolic, psychiatric, and cardiovascular disease in addition to increasing quality of life, attention, working memory, and psychomotor speed while decreasing depressive symptoms¹⁰; and

Whereas, The Adult Disability Medical Healthcare (ADMH), established in Atlanta, Georgia, is a multidisciplinary team-based model that coordinates primary care for individuals with developmental disabilities by increasing healthcare staff training, decreasing wait times for intake and rooming of patients, using topical anesthetics for blood draws, and/or playing soft music to create a more calm environment²; and

Whereas, ADMH have partnered with numerous healthcare entities in the Atlanta community, and have found that there is a need to increase quality of communication between patients with developmental disabilities and physicians due to the complexities of their comorbidities, the importance of preventing progression and furthering understanding of measures such as lifestyle modifications²; and

Whereas, The Division of Human Development and Disability (DHDD) collaborates with Research Triangle Institute International, The CDC Foundation, and Georgia Tech's Center for Inclusive Design to create accessible and inclusive health resources for those with disabilities, their caregivers and healthcare providers⁶; and

Whereas, The DHDD created Covid-19 information materials in many formats including easy-to-read documents for those with developmental disabilities⁶; and

Whereas, Healthcare workers are required to complete training in addressing cultural differences, but are not required to have neurodivergent training⁴; and

Whereas, 75% of the US healthcare expenditure is targeted at treating chronic diseases such as cardiovascular disease, AD, and diabetes, and 77% of the increased spending is due to unhealthy lifestyle habits^{15,16}; and

Whereas, The US healthcare system prioritizes reimbursements for treating chronic disease rather than preventative care, with the total cost of chronic diseases surpassing \$3.7 trillion, and more than 80 million inhabitants in the US will have at least 3 chronic diseases by 2030^{15,16}; and

Whereas, For children with developmental disabilities, choice, fun, friends, achievement, and aspiration are essential motivating factors to participate in preventative measures such as physical activity programs; and successful trainers have adapted their teaching styles in order to achieve success with these patients^{5,11,13,14,16}; and

Whereas, While there are policies in place for following care of children with developmental disabilities, there is a lack of concrete policy for adults with developmental disabilities, as well as a lack of physician education on evidence-based practice for this population²; and

Whereas, Physical activity programs improve the health status of individuals with Down syndrome and other developmental disabilities through improving cardiometabolic risk, strength, proprioception, postural stability, and by meeting all levels of the International Classification of Functioning, Disability, and Health approved by the World Health Organization^{5,11}; therefore be it

RESOLVED, That our AMA amend H-425.987, "Preventive Medicine Services", by addition as follows:

Preventive Medicine Services, H-425.987

1. Our AMA supports (A) continuing to work with the appropriate national medical specialty societies in evaluating and coordinating the development of practice parameters, including those for preventive services; (B) working with relevant stakeholders to promote communication and practice styles that apply to patients with developmental delays; (BC) continuing to actively encourage the insurance industry to offer products that include coverage for general preventive services; and (GD) appropriate reimbursement and coding for established preventive services.

2. Our AMA will seek legislation or regulation so that evidence-based screenings are paid for separately when provided as part of a comprehensive well-patient examination/review.

RESOLVED, That our AMA amend H-460.894, "Value of Preventive Services", by addition as follows:

Value of Preventive Services, H-460.894

Our AMA: (1) encourages committees that make preventive services recommendations to: (a) follow processes that promote transparency and clarity among their methods; (b) develop evidence reviews and recommendations with enough specificity to inform cost-effectiveness analyses; (c) rely on the very best evidence available, with consideration of expert consensus only when other evidence is not available; (d) work together to identify preventive services that are not supported by evidence or are not cost-effective, with the goal of prioritizing preventive services; ~~and~~ (e) consider the development of recommendations on both primary and secondary prevention, and (f) advocate the position that preventive services are inclusive to all patient populations in order to decrease avoidable healthcare disparities; (2) encourages relevant national medical specialty societies to provide input during the preventive services recommendation development process; (3) encourages comparative-effectiveness research on secondary prevention to provide data that could support evidence-based decision making; and (4) encourages public and private payers to cover preventive services for which consensus has emerged in the recommendations of multiple guidelines-making groups.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Batareseh FA, Ghassib I, Chong DS, Su P-H. Preventive Healthcare policies in the US: Solutions for disease management using Big Data Analytics. *Journal of big data*. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7309216/>. Published June 23, 2020. Accessed September 18, 2022.
2. Videlefsky AS, Reznik JM, Nodvin JT, Heiman HJ. Addressing Health Disparities in Adults with Developmental Disabilities. *Ethn Dis*. 2019;29(Suppl 2):355-358. Published 2019 Jun 13. doi:10.18865/ed.29.S2.355
3. Cuypers M, Tobi H, Huijsmans CA, et al. Disparities in cancer-related healthcare among people with intellectual disabilities: A population-based cohort study with health insurance claims data. *Cancer Medicine*. 2020;9(18):6888-6895. doi:10.1002/cam4.3333.
4. Patel, Tulsi, "Health Disparities in Adults with Developmental and Intellectual Disabilities" (2022). Nursing | Senior Theses. 47. <https://doi.org/10.33015/dominican.edu/2022.NURS.ST.03>
5. Gomez W, Morales R, Maracaja-Coutinho V, Parra V, Nassif M. Down syndrome and Alzheimer's disease: common molecular traits beyond the amyloid precursor protein. *Aging (Albany NY)*. 2020;12(1):1011-1033. doi:10.18632/aging.102677
6. Health equity for people with disabilities. Centers for Disease Control and Prevention. <https://www.cdc.gov/ncbddd/humandevelopment/health-equity.html>. Published January 25, 2022. Accessed September 17, 2022.
7. Data and Statistics on Down Syndrome. Centers for Disease Control and Prevention. <https://www.cdc.gov/ncbddd/birthdefects/downsyndrome/data.html#:~:text=Down%20syndrome%20continues%20to%20be,in%20every%20700%20babies%20born.&text=Between%201979%20and%202003%2C%20the,syndrome%20increased%20by%20about%2030%25>. Published October 23, 2020. Accessed August 20, 2022.
8. Cuckle, H, Morris, J. Maternal age in the epidemiology of common autosomal trisomies. *Prenatal Diagnosis*. 2021; 41: 573– 583. <https://doi.org/10.1002/pd.5840>
9. Alzheimer's disease: Can exercise prevent memory loss? Mayo Clinic. <https://www.mayoclinic.org/diseases-conditions/alzheimers-disease/expert-answers/alzheimers-disease/faq-20057881>. Published May 12, 2021. Accessed August 20, 2022.
10. Mahalakshmi B, Maurya N, Lee SD, Bharath Kumar V. Possible Neuroprotective Mechanisms of Physical Exercise in Neurodegeneration. *Int J Mol Sci*. 2020;21(16):5895. Published 2020 Aug 16. doi:10.3390/ijms21165895
11. Willis CE, Reid S, Elliott C, et al. A realist evaluation of a physical activity participation intervention for children and youth with disabilities: what works, for whom, in what circumstances, and how?. *BMC Pediatr*. 2018;18(1):113. Published 2018 Mar 15. doi:10.1186/s12887-018-1089-8
12. Nuzum H, Stickel A, Corona M, Zeller M, Melrose RJ, Wilkins SS. Potential Benefits of Physical Activity in MCI and Dementia. *Behav Neurol*. 2020;2020:7807856. Published 2020 Feb 12. doi:10.1155/2020/7807856
13. Woods A. How to Design Fitness Programs for Clients with Down Syndrome. American Council on Exercise. <https://www.acefitness.org/continuing-education/certified/july-2020/7591/how-to-design-fitness-programs-for-clients-with-down-syndrome/>. Published July 2022. Accessed August 25, 2022.
14. Woods A. How to Design Fitness Programs for Clients with Down Syndrome. American Council on Exercise. <https://www.acefitness.org/continuing-education/certified/july-2020/7591/how-to-design-fitness-programs-for-clients-with-down-syndrome/>. Published July 2022. Accessed August 25, 2022.

15. Waldman SA, Terzic A. Health Care Evolves From Reactive to Proactive. *Clin Pharmacol Ther.* 2019;105(1):10-13. doi:10.1002/cpt.1295
16. Levine S, Malone E, Lekachvili A, Briss P. Health Care Industry Insights: Why the use of Preventive Services is still low. Centers for Disease Control and Prevention. https://www.cdc.gov/pcd/issues/2019/18_0625.htm. Published March 14, 2019. Accessed August 30, 2022.
17. Paul Y, Ellapen TJ, Barnard M, Hammill HV, Swanepoel M. The health benefits of exercise therapy for patients with Down syndrome: A systematic review. *Afr J Disabil.* 2019;8:576. Published 2019 Oct 23. doi:10.4102/ajod.v8i0.576

RELEVANT AMA AND AMA-MSS POLICY

Alzheimer's Disease H-25.991

Our AMA:(1) encourages physicians to make appropriate use of guidelines for clinical decision making in the diagnosis and treatment of Alzheimer's disease and other dementias; (2) encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services; (3) encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders; (4) encourages studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders; (5) supports the use of evidence-based cost-effective technologies with prior consent of patients or designated healthcare power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer's disease and other related dementias with the help of appropriate allied specialty organizations; (6) supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer's disease and related dementias; and (7) encourages increased enrollment in clinical trials of appropriate patients with Alzheimer's disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer's disease and related dementias.

CSA Rep. 6, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Appended: Res. 503, A-16; Appended: Res. 915, I-16

Exercise and Physical Fitness H-470.997

The AMA encourages all physicians to utilize the health potentialities of exercise for their patients as a most important part of health promotion and rehabilitation, and urges state and local medical societies to emphasize through all available channels the need for physical activity for all age groups and both sexes. The AMA encourages other organizations and agencies to join with the Association in promoting physical fitness through all appropriate means.

BOT Rep. K, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmed: BOT Rep. 10, A-14

Mandatory Physical Education H-470.975

The AMA continues its commitment to support state and local efforts to implement quality physical education programs for all students, including those with physical, developmental, or intellectual challenges or other special needs in grades kindergarten through twelve, including ungraded classes.

Sub. Res. 1, I-88; Reaffirmation and Sunset Report, I-98; Reaffirmation A-07; Modified: BOT Rep. 21, A-12; Reaffirmed: CSAPH Rep. 1, A-22

Promotion of Exercise Within Medicine and Society H-470.990

Our AMA supports (1) education of the profession on exercise, including instruction on the role of exercise prescription in medical practice in its continuing education courses and conferences, whenever feasible and appropriate; (2) medical student instruction on the prescription of exercise; (3) physical education instruction in the school system; and (4) education of the public on the benefits of exercise, through its public relations program. Res. 56, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation I-98; Reaffirmation A-07; Reaffirmed: BOT Rep. 21, A-12; Reaffirmed: CSAPH Rep. 1, A-22

Promoting Health Awareness and Preventive Screenings in Individuals with Disabilities H-425.970

Our AMA will work closely with relevant stakeholders to advocate for equitable access to health promotion and preventive screenings for individuals with disabilities.

Res. 911, I-13

Coverage of Preventive Medical Services by Medicare H-425.992

The AMA advocates revision of current Medicare guidelines to include coverage of appropriate preventive medical services.

Res. 85, A-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmation A-99; Reaffirmed in lieu of Res. 104, A-06; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 123, A-17

Aligning Clinical and Financial Incentives for High-Value Care D-185.979

1. Our AMA supports Value-Based Insurance Design (VBID) plans designed in accordance with the tenets of “clinical nuance,” recognizing that (a) medical services may differ in the amount of health produced, and (b) the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided.

2. Our AMA supports initiatives that align provider-facing financial incentives created through payment reform and patient-facing financial incentives created through benefit design reform, to ensure that patient, provider, and payer incentives all promote the same quality care. Such initiatives may include reducing patient cost-sharing for the items and services that are tied to provider quality metrics.

3. Our AMA will develop coding guidance tools to help providers appropriately bill for zero-dollar preventive interventions and promote common understanding among health care providers, payers, patients, and health care information technology vendors regarding what will be covered at given cost-sharing levels.

4. Our AMA will develop physician educational tools that prepare physicians for conversations with their patients about the scope of preventive services provided without cost-sharing and instances where and when preventive services may result in financial obligations for the patient.

5. Our AMA will continue to support requiring private health plans to provide coverage for evidence-based preventive services without imposing cost-sharing (such as co-payments, deductibles, or coinsurance) on patients.

6. Our AMA will continue to support implementing innovative VBID programs in Medicare Advantage plans.

7. Our AMA supports legislative and regulatory flexibility to accommodate VBID that (a) preserves health plan coverage without patient cost-sharing for evidence-based preventive

services; and (b) allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services.

8. Our AMA encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services.

Joint CMS CSAPH Rep. 01, I-18; Reaffirmed: CMS Rep. 06, A-19; Reaffirmed in lieu of: Res. 101, A-19; Reaffirmed: CMS Rep. 2, I-20; Reaffirmation: A-22

Coverage of Preventive Medical Services by Medicare H-425.992

The AMA advocates revision of current Medicare guidelines to include coverage of appropriate preventive medical services.

Res. 85, A-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmation A-99; Reaffirmed in lieu of Res. 104, A-06; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 123, A-17

Medicare Payment for Preventive Examinations D-330.967

Our AMA shall: (1) continue to disseminate evidence-based recommendations regarding the appropriate use of clinical preventive services to physicians, the general public and policy makers; (2) continue to collaborate with national medical specialty societies and interest groups to facilitate implementation of these recommendations by practicing physicians; and (3) advocate especially for the provision of these services to populations at high risk for a given condition under guidelines available on the AMA website.

BOT Rep. 26, A-02; Modified: CCB/CLRPD Rep. 4, A-12; Reaffirmed: CMS/CSAPH Joint Rep. 01, A-18

Physician Payment Reform H-390.849

1. Our AMA will advocate for the development and adoption of physician payment reforms that adhere to the following principles:

- a) promote improved patient access to high-quality, cost-effective care;
- b) be designed with input from the physician community;
- c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions;
- d) not require budget neutrality within Medicare Part B;
- e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice;
- f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process;
- g) make participation options available for varying practice sizes, patient mixes, specialties, and locales;
- h) use adequate risk adjustment methodologies;
- i) incorporate incentives large enough to merit additional investments by physicians;
- j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols;
- k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization;
- l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and

m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data.

4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment.

CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17; Reaffirmation: A-19; Reaffirmed: BOT Action in response to referred for decision Res. 111, A-19; Reaffirmed: BOT Action in response to referred for decision Res. 132, A-19; Reaffirmed: Res. 212, I-21; Reaffirmed: Res. 240, A-22; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 078
(I-22)

Introduced by: Samir Cayenne, Ayush Singh, John Sealy School of Medicine

Subject: Mental Health Protocols for Surgery

Sponsored by: PsychSIGN

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Mental illness is found to have been a notable risk factor in patient recovery from surgery, with those diagnosed with a mental illness being 3 times more likely to have a prolonged hospital stay, are more likely to require ICU admission, and have up to a 270% increased likelihood postoperative surgical complications ¹; and

Whereas, The mental health impairments that are most commonly found for individuals suffering from post-intensive care syndrome (PICS) include depression for approximately 30% of survivors, anxiety for up to 70% of survivors, and PTSD for 10-50% of survivors ²; and

Whereas, In 2018, 56,800 cases out of approximately 3.8 million adult hospital readmissions classified as depressive disorders, incurring a \$15,200 cost per readmission and categorized as “self-pay” ³; and

Whereas, acute postoperative pain is known to cause depression and clinically diagnosed depression is a strong predictor for chronic post-surgical pain and has been identified as a risk factor for postoperative delirium ⁴; and

Whereas, Postoperative pain is not adequately managed in greater than 80% of patients in the United States, causing functional and quality-of-life impairment, higher health-care costs, and prolonged duration of opioid use ⁵; and

Whereas, Total duration of opioid use is noted as the strongest predictor for misuse, with each additional week of use associated with a 44.0% increase in the rate of misuse, contributing further to the prevalent opioid crisis in the United States ⁶; and

Whereas, The cost of opioid use and health care for patients experiencing comorbidity with psychiatric disorders is estimated to be \$62.3 million healthcare cost annually ⁷; and

Whereas, Research of patients following bariatric treatment has revealed an increased risk of suicide post-operation, indicating a role for preoperative psychiatric evaluation as well as postoperative surveillance ⁸; and

Whereas, Due to misinformation about psychiatric illness and the assumption that liberal psychiatric benefits result in excessive use, there is a lack of insurance coverage for those suffering from mental illness, substance use disorders, and psychiatric referrals from surgical clinics or intensive care units ³; and

Whereas, Surgeons less frequently inquire about their patient's mental health and are more likely to overlook comorbid psychiatric disorders ⁹; and

Whereas, Existing mental health screening models such as the Kessler Psychological Distress Scale (K10) and Somatic and Psychological Health Report-12 (Sphere-12) that have been shown to indicate statistically significant validity in patient mental health screens are not integrated into routine surgical practice ¹⁰; therefore be it

RESOLVED, That our AMA encourages the use of an existing mental health screening prior to and following all non-emergent surgeries as a preventative measure to provide both the physician and patient insight into the mental fortitude of the patient prior to surgery as well as their ability to cope with the gravity of their situation following the procedure.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Afford, Rebecca, et al. "Improving Surgical Quality for Patients with Mental Illnesses: A Narrative Review." *Annals of Surgery*, U.S. National Library of Medicine, 1 Mar. 2022, <https://pubmed.ncbi.nlm.nih.gov/34417360/>.
2. Canavera, Kristin, and Andrew Elliott. "Mental Health Care during and after the ICU: A Call to Action." *Chest*, American College of Chest Physicians. Published by Elsevier Inc., 27 June 2020, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7319916/>.
3. Weiss, Audrey, and Joanna Jiang. "User Support." *Overview of Clinical Conditions With Frequent and Costly Hospital Readmissions by Payer*, 2018 #278, July 2021, <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb278-Conditions-Frequent-Readmissions-By-Payer-2018.jsp>.
4. Ghoneim, Mohamed M., and Michael W. Hara. "Depression and Postoperative Complications: An Overview - BMC Surgery." *BioMed Central*, BMS Surgery, 2 Feb. 2016, <https://bmcsurg.biomedcentral.com/articles/10.1186/s12893-016-0120-y>.
5. Gan, Tong J. "Poorly Controlled Postoperative Pain: Prevalence, Consequences, and Prevention." *Journal of Pain Research*, Dove Medical Press, 25 Sept. 2017, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5626380/>.
6. Brat, Gabriel A, et al. "Postsurgical Prescriptions for Opioid Naive Patients and Association with Overdose and Misuse: Retrospective Cohort Study." *BMJ (Clinical Research Ed.)*, BMJ Publishing Group Ltd., 17 Jan. 2018, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5769574/>.
7. Cronin, K. J. (2020, June 1). Increased Healthcare Costs and Opioid Use in Patients with Anxiety and Depression Undergoing Rotator Cuff Repair. NCBI. Retrieved September 20, 2022, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7554073/>
8. Kaupilla, Joonas, et al. "Risk Factors for Suicide after Bariatric Surgery in a Population-Based Nationwide Study in Five Nordic Countries." *Annals of Surgery*, U.S. National Library of Medicine, Feb. 2022, <https://pubmed.ncbi.nlm.nih.gov/32657942/>.
9. Surgical experience for patients with serious mental illness: a qualitative study - *BMC Psychiatry*. (2021, January 20). *BMC Psychiatry*. Retrieved August 31, 2022, from <https://bmcp psychiatry.biomedcentral.com/articles/10.1186/s12888-021-03056-x>
10. Acceptability and face validity of two mental health screening tools for use in the routine surgical setting. (2021, October 30). NCBI. Retrieved September 23, 2022, from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8556895/>

RELEVANT AMA AND AMA-MSS POLICY

Increasing Detection of Mental Illness and Encouraging Education D-345.994

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

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

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

Counseling - Serious Medical Problems H-385.977

The AMA (1) affirms that physician counseling of patients and their families with respect to serious medical problems is a vital medical service; (2) believes that insurance companies, third party carriers, and governmental agencies involved in medical care should regard and treat counseling by physicians as an important medical service; and (3) urges all physicians not only to counsel their patients with respect to serious medical problems, but also to use the CSN/CPT codes for counseling when billing patients or third parties for medical services.

Res. 56, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 079
(I-22)

Introduced by: Devin M. Kellis, Adam C. Stafford, University of South Carolina School of
Medicine Columbia

Subject: Support and Advocacy for Permanent Standard Time

Sponsored by: PsychSIGN

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Daylight Saving Time (DST) was first adopted in the early 1900s following World War I and made permanent in the 1970s¹; and

Whereas, Permanent DST (pDST) in the 1970s was met with dissatisfaction among Americans, leading to the current trade-off of DST only from March to November^{2,3}; and

Whereas, Biannual time changes disrupt people's circadian rhythm and are associated with increased risk of heart attack, stroke, motor vehicle accidents, severe workplace injuries, and medical errors that compromise patient safety⁴⁻⁷; and

Whereas, In March 2022, the U.S. Senate passed the S.623 Sunshine Protection Act of 2021, which could eliminate biannual time changes and make DST permanent year-round^{8,9}; and

Whereas, The S.623 Sunshine Protection Act of 2021 has been held in the U.S. House of Representatives since March 16, 2022 with uncertainty regarding whether pDST or permanent Standard Time (pST) should be adopted^{10,11}; and

Whereas, Over the past four years, at least eighteen U.S. states have passed measures in favor of switching to pDST like the federal Sunshine Protection Act¹²; and

Whereas, AMA MSS recently adopted 440.109MSS after MSS CSI Report B, A-21, which supported ending of biannual time changes and adoption of pDST (pending transmittal); and

Whereas, MSS CSI Report B, A-21 highlights "...little evidence that the standard time was explicitly detrimental when compared to daylight time..." but did not adequately discuss health risks of pDST or health benefits of permanent Standard Time (pST); and

Whereas, A reason for adopting pDST put forward in MSS CSI Report B, A-21 was increased "...physical exercise in youth," but the study cited indicated that this effect was small, limited to Europe and Australia, and (most importantly) not present in American samples¹³; and

Whereas, Another study not cited by MSS CSI Report B, A-21 shows that the shift to DST does not alter moderate-to-vigorous physical activity among Americans in the southwest¹⁴; and

Whereas, MSS CSI Report B, A-21 cites reduced crime rates as a reason to adopt pDST, but this decrease in crime following transition to DST may not generalize to pDST as some crime rates return back to pre-DST levels shortly after the shift to DST and potential root causes, including poor public street lighting, remain unaddressed¹⁵; and

Whereas, MSS CSI Report B, A-21 highlighted that evening daylight is associated with lower pedestrian fatalities, but a systematic review examining overall traffic-related risk found conflicting evidence across studies¹⁶; and

Whereas, Adopting pDST is contrary to evidence-based recommendations from leading medical and scientific organizations including the American Academy of Sleep Medicine and Society for Research on Biological Rhythms, who agree that pST should instead be adopted as pDST would cause circadian rhythm misalignment that negatively affects health^{4,17}; and

Whereas, Circadian misalignment is associated with lower life expectancy and increased risk or morbidity for depression, cardiovascular disease, metabolic syndrome, and obesity^{4,18-21}; and

Whereas, Extra evening sunlight on western aspects of current time zones, which would worsen under pDST, has been associated with reduced sleep duration, self-reported insufficient sleep, and additional adverse health outcomes including increased breast cancer risk^{17,22,23}; and

Whereas, The earlier sunrise with pST promotes religious freedoms by providing time for spiritual practices tied to sunrise (e.g., prayer) prior to work and engagement in spiritual practices is associated with better physical and mental health outcomes²⁴⁻²⁶; and

Whereas, A natural experiment in Indiana suggested that pDST would increase pollution, which might slow the fight against climate change²⁷; and

Whereas, Permanent DST would be especially detrimental to child and adolescent health in winter by delaying sunrises, which would essentially “undo” prior public health policies supported by the American Academy of Pediatrics that delayed high school start times^{4,28}; and

Whereas, Negative health effects of pDST would most strongly affect historically marginalized groups, including Black and Latino Americans, and those with lower socioeconomic status as they make up a greater proportion of the workforce with early work start times²⁹; therefore be it

RESOLVED, That our AMA-MSS amend Policy 440.109MSS, “Supporting Daylight Savings Time as the New, Permanent Standard Time” to read as follows:

Supporting and Advocacy for Daylight Savings Time as the New, Permanent Standard Time 440.109MSS AMA-MSS will ask the AMA to: (1) recognize the adverse health effects of biannual time changes and support the elimination of biannual time changing, and (2) recognize the positive health effects of daylight savings permanent standard time and support the adoption of permanent standard time (apt to longitude), (3) recognize the detrimental health effects of permanent daylight savings time, and (4) advocate at the US federal level for the adoption of permanent standard time (apt to longitude) alongside relevant advocacy, state medical, and specialty medical societies support daylight savings time as the permanent standard time.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Osborne-Christenson EJ. Saving light, losing lives: How daylight saving time impacts deaths from suicide and substance abuse. *Health Economics*. 2022. doi: <https://doi.org/10.1002/hec.4581>.
2. Waxman OB. The u.S. Tried permanent daylight saving time before. Here's what happened. [Webpage]. 2022; <https://time.com/6157915/daylight-saving-time-history/>.
3. Gray TR, Jenkins JA. Congress and the political economy of daylight saving time, 1918–1985. *Social Science Quarterly*. 2019;100(5):1664-1684. doi: <https://doi.org/10.1111/ssqu.12656>.
4. Rishi MA, Ahmed O, Barrantes Perez JH, et al. Daylight saving time: An american academy of sleep medicine position statement. *Journal of clinical sleep medicine*. 2020;16(10):1781-1784. doi: <https://doi.org/10.5664/jcsm.8780>.
5. Barnes CM, Wagner DT. Changing to daylight saving time cuts into sleep and increases workplace injuries. *Journal of applied psychology*. 2009;94(5):1305. doi: <https://doi.org/10.1037/a0015320>.
6. Kolla BP, Coombes BJ, Morgenthaler TI, Mansukhani MP. Increased patient safety-related incidents following the transition into daylight savings time. *Journal of general internal medicine*. 2021;36(1):51-54. doi: <https://doi.org/10.1007/s11606-020-06090-9>.
7. Rishi MA, Chaudhry S. Patient safety–related incidents and daylight saving time transitions. *Journal of General Internal Medicine*. 2021;36(4):1120-1120. doi: <https://doi.org/10.1007/s11606-021-06599-7>.
8. Voght K. The senate just voted for you to get less sleep, expert says. [Webpage]. 2022; <https://www.rollingstone.com/politics/politics-news/daylight-savings-times-senate-sleep-science-1322200/>.
9. NBC Chicago. Why do we have daylight saving time and how did it start?
1. . [Webpage]. 2022; <https://www.nbcchicago.com/news/local/why-do-we-have-daylight-saving-time-and-how-did-it-start/2784487/>.
10. BillTrack50. Us s623 summary. [Webpage]. 2022; <https://www.billtrack50.com/BillDetail/1341805>.
11. Schnell M. Permanent daylight saving time hits brick wall in house. *The Hill* [Webpage]. 2022; <https://thehill.com/homenews/house/3571007-permanent-daylight-saving-time-hits-brick-wall-in-house/>.
12. Hernandez J. The senate approves a bill to make daylight saving time permanent. *National* [Webpage]. 2022; <https://www.npr.org/2022/03/15/1086773840/daylight-saving-time-permanent-senate#:~:text=Over%20the%20last%20four%20years,be%20changed%20to%20allow%20it>.
13. Goodman A, Page AS, Cooper AR. Daylight saving time as a potential public health intervention: An observational study of evening daylight and objectively-measured physical activity among 23,000 children from 9 countries. *International Journal of Behavioral Nutrition and Physical Activity*. 2014;11(1):1-9. doi: <https://doi.org/10.1186/1479-5868-11-84>.
14. Zick CD. Does daylight savings time encourage physical activity? *Journal of physical activity and health*. 2014;11(5):1057-1060. doi: <https://doi.org/10.1123/jpah.2012-0300>.
15. Tealde E. The unequal impact of natural light on crime. *Journal of Population Economics*. 2022;35(3):893-934. doi: <https://doi.org/10.1007/s00148-021-00831-8>.
16. Carey RN, Sarma KM. Impact of daylight saving time on road traffic collision risk: A systematic review. *BMJ open*. 2017;7(6):e014319. doi: <http://dx.doi.org/10.1136/bmjopen-2016-014319>.

17. Roenneberg T, Wirz-Justice A, Skene DJ, et al. Why should we abolish daylight saving time? *Journal of biological rhythms*. 2019;34(3):227-230. doi: <https://doi.org/10.1177/0748730419854197>.
18. Borisenkov MF. Latitude of residence and position in time zone are predictors of cancer incidence, cancer mortality, and life expectancy at birth. *Chronobiology international*. 2011;28(2):155-162. doi: <https://doi.org/10.3109/07420528.2010.541312>.
19. Levandovski R, Dantas G, Fernandes LC, et al. Depression scores associate with chronotype and social jetlag in a rural population. *Chronobiology international*. 2011;28(9):771-778. doi: <https://doi.org/10.3109/07420528.2011.602445>.
20. Roenneberg T, Allebrandt KV, Merrow M, Vetter C. Social jetlag and obesity. *Current Biology*. 2012;22(10):939-943. doi: <https://doi.org/10.1016/j.cub.2012.03.038>.
21. Koopman AD, Rauh SP, van 't Riet E, et al. The association between social jetlag, the metabolic syndrome, and type 2 diabetes mellitus in the general population: The new hoorn study. *Journal of biological rhythms*. 2017;32(4):359-368. doi: <https://doi.org/10.1177/0748730417713572>.
22. Giuntella O, Mazzonna F. Sunset time and the economic effects of social jetlag: Evidence from us time zone borders. *Journal of health economics*. 2019;65:210-226. doi: <https://doi.org/10.1016/j.jhealeco.2019.03.007>.
23. Gu F, Xu S, Devesa SS, et al. Longitude position in a time zone and cancer risk in the united states. *Cancer Epidemiology, Biomarkers & Prevention*. 2017;26(8):1306-1311. doi: <https://doi.org/10.1158/1055-9965.EPI-16-1029>.
24. Kornbluh J. Orthodox groups launch uphill battle against daylight saving time bill. *Forward* [Webpage]. 2022; <https://forward.com/news/484265/orthodox-union-jewish-sunshine-protection-act-daylight-saving-time-bill/>.
25. Lucchetti G, Koenig HG, Lucchetti ALG. Spirituality, religiousness, and mental health: A review of the current scientific evidence. *World Journal of Clinical Cases*. 2021;9(26):7620. doi: <http://dx.doi.org/10.12998/wjcc.v9.i26.7620>.
26. Gonçalves JPdB, Lucchetti G, Menezes PR, Vallada H. Complementary religious and spiritual interventions in physical health and quality of life: A systematic review of randomized controlled clinical trials. *PloS one*. 2017;12(10):e0186539. doi: <https://doi.org/10.1371/journal.pone.0186539>.
27. Kotchen MJ, Grant LE. Does daylight saving time save energy? Evidence from a natural experiment in indiana. *Review of Economics and Statistics*. 2011;93(4):1172-1185. doi: https://doi.org/10.1162/REST_a_00131.
28. Au R, Carskadon M, Millman R, et al. School start times for adolescents. *Pediatrics*. 2014;134(3):642-649.
29. Population Reference Bureau. A demographic profile of u.S. Workers around the clock. [Webpage]. 2008; <https://www.prb.org/resources/a-demographic-profile-of-u-s-workers-around-the-clock/>.

RELEVANT AMA AND AMA-MSS 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. 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

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.

CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22

Supporting Daylight Savings Time as the New, Permanent Standard Time 440.109MSS

AMA-MSS will ask the AMA to: (1) recognize the adverse health effects of biannual time changes and support the elimination of biannual time changing and (2) recognize the positive health effects of daylight savings time and support daylight savings time as the permanent standard time. (MSS CSI Report B, A-21)

Insufficient Sleep in Adolescents H-60.930

1. Our AMA identifies adolescent insufficient sleep and sleepiness as a public health issue and supports education about sleep health as a standard component of care for adolescent patients.
2. Our AMA: (a) encourages school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep; (b) encourages physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the biologic sleep needs of adolescents; and (c) encourages continued research on the impact of sleep on adolescent health and academic performance.

Res 503, A-10; Appended: CSAPH Rep. 06, A-16

Altering School Days to Alleviate Adolescent Sleep Deprivation 60.022MSS

That our AMA support appropriate entities in establishing clear evidence-based recommendations from existing research on adolescent sleep needs and school start times and that the AMA support legislation congruent with those guidelines. (MSS Res 31, A-14) (AMA Res 404, A-15 Referred) (Reaffirmed: MSS GC Rep A, I-19)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 080
(I-22)

Introduced by: Nivan Wadhawan, Shilpa Rajagopal, Joshua Fernandez de la Vega,
University of Texas Medical Branch John Sealy School of Medicine

Subject: Amend AMA-MSS 65.017 to Expand LGBTQ+ Health Training

Sponsored by: PsychSIGN

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, “Healthcare providers” are defined as individuals who provide health services, such as doctors of medicine or osteopathic medicine¹; and

Whereas, All clinical and non-clinical staff, including healthcare providers, play an integral role in patients’ experiences^{2,3}; and

Whereas, Biases among healthcare providers as well as within healthcare settings and systems have been found to negatively affect LGBTQ+ patient experiences due to discrimination and denial of care^{4,5}; and

Whereas, Current AMA-MSS policy only mentions LGBTQ+ training for healthcare providers, even though education of all clinical and non-clinical staff through LGBTQ+ health training is essential to increasing LGBTQ+ patients’ quality of care and their experience^{6,7}; and

Whereas, LGBTQ+ patient-specific training programs increase knowledge of LGBTQ+ healthcare issues and promote more tolerant attitudes towards LGBTQ+ patients^{8,9}; and

Whereas, The biopsychosocial model of health, which expands the traditional biomedical model to include the impact of psychological and social factors on health, more comprehensively covers the unique health needs of the LGBTQ+ community^{10,11}; therefore be it

RESOLVED, Our AMA-MSS advocate for the AMA to broaden the scope of LGBTQ+ health training programs to include education on LGBTQ+ biopsychosocial health needs for all patient-facing roles by amending Policy 65.017MSS, “LGBTQ+ Patient Specific Training Programs for Healthcare Providers, as follows:”

LGBTQ+ Patient Specific Training Programs for Healthcare Providers, 65.017MSS
AMA-MSS will ask the AMA to support the training of healthcare providers and all other patient-facing roles in cultural competency as well as in physical biopsychosocial health needs for LGBTQ+ patient populations.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Legal Information Institute. Cornell Law School. 29 CFR § 825.125 - Definition of health care provider. Available at: <https://www.law.cornell.edu/cfr/text/29/825.125>. Accessed August 30, 2022.
2. Butler R, Monsalve M, Thomas GW, et al. Estimating time physicians and other health care workers spend with patients in an intensive care unit using a sensor network. *Am J Med*. 2018;131(8):972.e9-972.e15. doi:10.1016/j.amjmed.2018.03.015
3. Agency for Healthcare Research and Quality. What is patient experience? Available at: <https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html>. Accessed August 30, 2022.
4. Casanova-Perez R, Apodaca C, Bascom E, et al. Broken down by bias: Healthcare biases experienced by BIPOC and LGBTQ+ patients. *AMIA Annu Symp Proc*. 2022;2021:275-284. PMID: 35308990; PMCID: PMC8861755.
5. Mirza SA, Rooney C. Discrimination prevents LGBTQ people from accessing health care. Center for American Progress. <https://www.americanprogress.org/article/discrimination-prevents-lgbtq-people-accessing-health-care/>. Published January 18, 2018. Accessed September 21, 2022.
6. Bass B, Nagy H. Cultural Competence in the Care of LGBTQ Patients. [Updated 2021 Oct 9]. In: StatPearls [Internet]. Treasure Island, FL: StatPearls Publishing; 2022. Available at: <https://www.ncbi.nlm.nih.gov/books/NBK563176/>.
7. Medina-Martínez J, Saus-Ortega C, Sánchez-Lorente MM, Sosa-Palanca EM, García-Martínez P, Mármol-López MI. Health inequities in LGBT people and nursing interventions to reduce them: A systematic review. *Int J Environ Res Public Health*. 2021;18(22):11801. doi:10.3390/ijerph182211801
8. Morris M, Cooper RL, Ramesh A, et al. Training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers: A systematic review. *BMC Med Educ*. 2019;19(1):325. doi:10.1186/s12909-019-1727-3
9. Lee M, Tasa-Vinyals E, Gahagan J. Improving the LGBTQ2S+ cultural competency of healthcare trainees: Advancing health professional education. *Can Med Educ J*. 2021;12(1):e7-e20. doi:10.36834/cmej.67870
10. Lehman BJ, David, DM, Gruber, JA. Rethinking the biopsychosocial model of health: Understanding health as a dynamic system. *Soc Personal Psychol Compass*. 2017; 11(8): e12328. doi:10.1111/spc3.12328
11. Christian LM, Cole SW, McDade T, et al. A biopsychosocial framework for understanding sexual and gender minority health: A call for action. *Neurosci Biobehav Rev*. 2021;129:107-116. doi:10.1016/j.neubiorev.2021.06.004

RELEVANT AMA AND AMA-MSS 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.

CSA Rep. C, I-81Reaffirmed: CLRPD Rep. F, I-91CSA Rep. 8 - I-94Appended: Res. 506, A-00Modified and Reaffirmed: Res. 501, A-07Modified: CSAPH Rep. 9, A-08Reaffirmation A-12Modified: Res. 08, A-16Modified: Res. 903, I-17Modified: Res. 904, I-17Res. 16, A-18Reaffirmed: CSAPH Rep. 01, I-18

Promoting Awareness and Education of LGBTQ+ Health Issues on Medical School Campuses 65.010MSS

AMA-MSS (1) supports medical student interest groups to organize and congregate under the auspices of furthering their medical education or enhancing patient care by improving their knowledge and understanding of various communities – without regard to their gender, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students who wish to conduct on-campus educational seminars and workshops on health issues in LGBTQ+ communities; (3) encourages the LCME to require all medical schools to incorporate LGBTQ+ health issues in their curricula; and (4) reaffirms its opposition to discrimination against any medical student on the basis of sexual orientation and/or gender identity or expression. (MSS Amended Res 28, A-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Amended: LGBTQ+ Affairs Report A, A-21)

LGBTQ+ Patient Specific Training Programs for Healthcare Providers 65.017MSS

AMA-MSS will ask the AMA to support the training of healthcare providers in cultural competency as well as in physical health needs for LGBTQ+ patient populations. (MSS Res 13, I-11) (Reaffirmed Existing Policy in Lieu of AMA Res 304, A-12) (Reaffirmed: MSS GC Rep A, I-16) (Reaffirmed, MSS Res 40, A-19) (Amended: LGBTQ+ Affairs Report A, A-21)

Cultural Competency Training for Medical School Faculty, Staff, and Students concerning Individuals Who Are LGBTQ+ 295.19MSS

Our AMA-MSS (1) supports the development and implementation of cultural competency programs by medical schools that train and guide medical school faculty, staff, and students in effective and compassionate communication with individuals of different backgrounds, including but not limited to gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age; and (2) support the development and implementation of supportive programs and confidential counseling services by medical schools to individuals within their institutions who have faced challenges due to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin, or age. (MSS Res 03, A-16) (Amended: LGBTQ+ Affairs Report A, A-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 081
(I-22)

Introduced by: Jenna Gage, Nivan Wadhawan, UTMB John Sealy School of Medicine;
Region 5 Rommel Morales, Northeast Ohio Medical University

Subject: Establishment of a Climate Change Standing Committee

Sponsored by: Region 1 and Region 5

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Climate change is expected to cause approximately 250,000 deaths per year between 2030 and 2050 due to extreme weather events, respiratory and heat-related illnesses, vector and water-borne diseases, zoonoses, malnutrition, mental health decline, and more¹⁻⁴; and

Whereas, Climate change affects the health of every individual on the planet, but disproportionately impacts marginalized communities⁵⁻⁶; and

Whereas, Approximately 84% of children and young adults ages 16 to 25 are at least moderately worried about climate change, and 59% are very or extremely worried⁷; and

Whereas, A well-regarded method to reduce climate anxiety is to take action through activities such as activism, conscious consumerism, connecting with those with similar concerns, etc...⁸⁻¹⁰; and

Whereas, AMA policy D-135.966, Declaring Climate Change a Public Health Crisis, has recognized the detrimental impact of climate change on global health and well-being; and

Whereas, A standing committee would be able to focus on utilizing climate experts to combat misinformation and use culturally-aligned messages that are often used by climate leaders due to their efficacy in messaging¹¹⁻¹³; and

Whereas, There has been the recent creation of MSS standing committees even when they could have been defined under the scope and purview of pre-existing committees, but the importance of focused advocacy was recognized and it was seen that the creation of a new standing committee would be able to significantly change the MSS's advocacy; and

Whereas, The scope of the Committee on Global and Public Health and Committee on Legislation and Advocacy are often too broad to dedicate significant resources on climate change, there are currently no longitudinal medical student climate change initiatives, and none of the current standing committee descriptions even mention climate change¹⁴; and

Whereas, The AMA has recently passed policy H-65.947 Support for Democracy, in support for democracy, and as such, there should be democratic selection of large priority items such as a climate change standing committee; and

Whereas, The AMA-MSS is passionate about climate change, but it is often difficult to create novel policy, exemplified by multiple unsuccessful attempts to adopt previous resolutions on climate advocacy¹⁵⁻¹⁶; and

Whereas, A climate change standing committee would provide policy briefs on national, state, and local policy, create and spread awareness of opportunities for environmental health research and advocacy, recognize environmental project accomplishments, host art competitions and Op-ed workshops, collaborate with other organizations such as Medical Students for a Sustainable future (MS4SF), and review climate change related resolutions, etc.; therefore be it

RESOLVED, That our AMA-MSS create a climate change standing committee.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Climate change and health. World Health Organization. <https://www.who.int/news-room/fact-sheets/detail/climate-change-and-health>. Accessed August 30, 2022.
2. Ziegler C, Morelli V, Fawibe O. Climate Change and Underserved Communities. *Prim Care*. 2017;44(1):171-184. doi:10.1016/j.pop.2016.09.017
3. Patz JA, Epstein PR, Burke TA, Balbus JM. Global climate change and emerging infectious diseases. *JAMA*. 1996;275(3):217-223.
4. Kuehn L, McCormick S. Heat Exposure and Maternal Health in the Face of Climate Change. *Int J Environ Res Public Health*. 2017;14(8):853. Published 2017 Jul 29. doi:10.3390/ijerph14080853
5. PA. 2021. Climate Change and Social Vulnerability in the United States: A Focus on Six Impacts. U.S. Environmental Protection Agency, EPA 430-R-21-003.
6. Shi, L., Chu, E., Anguelovski, I. et al. Roadmap towards justice in urban climate adaptation research. *Nature Clim Change* 6, 131–137 (2016). <https://doi.org/10.1038/nclimate2841>
7. Hickman C, Marks E, Pihkala P, et al. Climate anxiety in children and young people and their beliefs about government responses to climate change: a global survey. *Lancet Planet Health*. 2021;5(12):e863-e873. doi:10.1016/S2542-5196(21)00278-3
8. Stephanie Collier MD. If climate change keeps you up at night, here's how to Cope. *Harvard Health*. <https://www.health.harvard.edu/blog/is-climate-change-keeping-you-up-at-night-you-may-have-climate-anxiety-202206132761>. Published June 13, 2022. Accessed August 30, 2022.
9. Peterson M. How to calm your climate anxiety. *The New York Times*. <https://www.nytimes.com/2021/07/23/well/mind/mental-health-climate-anxiety.html>. Published July 23, 2021. Accessed August 31, 2022.
10. Stollberg J, Jonas E. Existential threat as a challenge for individual and collective engagement: Climate change and the motivation to act. *Curr Opin Psychol*. 2021;42:145-150. doi:10.1016/j.copsyc.2021.10.004
11. Lewandowsky S. Climate Change Disinformation and How to Combat It. *Annu Rev Public Health*. 2021;42:1-21. doi:10.1146/annurev-publhealth-090419-102409
12. Readout of the First National Climate Task Force Meeting. The White House. <https://www.whitehouse.gov/briefing-room/statements-releases/2021/02/11/readout-of-the-first-national-climate-task-force-meeting/>. Published February 11, 2021. Accessed August 31, 2022.

13. United States will halve carbon emissions over next decade, says Biden. ShareAmerica. <https://share.america.gov/biden-us-will-halve-carbon-emissions-over-next-decade/>. Published April 23, 2021. Accessed August 31, 2022.
14. Medical student section (MSS) standing committees. American Medical Association. <https://www.ama-assn.org/member-groups-sections/medical-students/medical-student-section-mss-standing-committees>. Accessed September 19, 2022.

RELEVANT AMA AND AMA-MSS POLICY

Declaring Climate Change a Public Health Crisis D-135.966

1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals.
2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens.
3. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting.

Res. 420, A-22

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.

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.

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.

Res. 924, I-16; Reaffirmation: I-19

Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Health Care Leadership D-135.968

Our AMA will continue to explore environmentally sustainable practices for JAMA distribution. BOT Rep. 8, I-19

AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies D-135.969

Our AMA, AMA Foundation, and any affiliated corporations will work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, 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. BOT Rep. 34, A-18

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.

BOT Rep. 34, A-18; Appended: Res. 607, A-22

Stewardship of the Environment H-135.973

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation; (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

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

Climate Change Education Across the Medical Education Continuum H-135.919

Our AMA: (1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education.

Res. 302, A-19

Support the Health Based Provisions of the Clean Air Act H-135.950

Our AMA opposes legislation to weaken the existing provisions of the Clean Air Act.

Res. 417, A-03; Reaffirmation A-05; Reaffirmation I-11; Modified: CSAPH Rep. 1, A-21

Environmental Protection and Safety in Federal Facilities H-135.985

The AMA urges physicians to contribute to the solution of environmental problems by serving as knowledgeable and concerned consultants to environmental, radiation, and public health protection agencies of state and local governments.

BOT Rep. T, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07;

Reaffirmed: CSAPH Rep. 01, A-17

Clean Air H-135.991

(1) The AMA supports setting the national primary and secondary ambient air quality standards at the level necessary to protect the public health. Establishing such standards at the level necessary to protect the public health. Establishing such standards at a level "allowing an adequate margin of safety," as provided in current law, should be maintained, but more scientific research should be conducted on the health effects of the standards currently set by the EPA.

(2) The AMA supports continued protection of certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources.

(3) The AMA endorses a more effective hazardous pollutant program to allow for efficient control of serious health hazards posed by airborne toxic pollutants.

(4) The AMA believes that more research is needed on the causes and effects of acid rain, and that the procedures to control pollution from another state need to be improved.

(5) The AMA believes that attaining the national ambient air quality standards for nitrogen oxides and carbon monoxide is necessary for the long-term benefit of the public health.

Emission limitations for motor vehicles should be supported as a long-term goal until appropriate peer-reviewed scientific data demonstrate that the limitations are not required to protect the public health.

BOT Rep. R, A-82; Reaffirmed: CLRPD Rep. A, I-92; Amended: CSA Rep. 8, A-03;

Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation I-09; Reaffirmation A-14

Reducing Sources of Diesel Exhaust D-135.996

Our AMA will: (1) encourage the US Environmental Protection Agency (EPA) to set and enforce the most stringent feasible standards to control pollutant emissions from both large and small non-road engines including construction equipment, farm equipment, boats and trains; (2) encourage all states to continue to pursue opportunities to reduce diesel exhaust pollution, including reducing harmful emissions from glider trucks and existing diesel engines; (3) call for all trucks traveling within the United States, regardless of country of origin, to be in compliance with the most stringent and current diesel emissions standards promulgated by US EPA; and (4) send a letter to US EPA Administrator opposing the EPA's proposal to roll back the "glider Kit Rule" which would effectively allow the unlimited sale of re-conditioned diesel truck engines that do not meet current EPA new diesel engine emission standards.

Res. 428, A-04; Reaffirmed in lieu of Res. 507, A-09; Reaffirmation A-11; Reaffirmation A-14;

Modified: Res. 521, A-18

Human and Environmental Health Impacts of Chlorinated Chemicals H-135.956

The AMA: (1) encourages the Environmental Protection Agency to base its evaluations of the potential public health and environmental risks posed by exposure to an individual chlorinated organic compound, other industrial compound, or manufacturing process on reliable data specific to that compound or process; (2) encourages the chemical industry to increase knowledge of the environmental behavior, bioaccumulation potential, and toxicology of their products and by-products; and (3) supports the implementation of risk reduction practices by the chemical and manufacturing industries.

Sub. Res. 503, A-94; Reaffirmation I-98; Reaffirmed: CSAPH Rep. 2, A-08; Reaffirmation I-16

Assurance and Accountability for EPA's State Level Agencies H-135.924

Our AMA supports requiring that the United States Environmental Protection Agency (EPA) conduct regular quality assurance reviews of state agencies that are delegated to enforce EPA regulations.

Res. 221, A-16

Environmental Preservation H-135.972

It is the policy of the AMA to support state society environmental activities by:

- (1) identifying areas of concern and encouraging productive research designed to provide authoritative data regarding health risks of environmental pollutants;
- (2) encouraging continued efforts by the CSAPH to prepare focused environmental studies, where these studies can be decisive in the public consideration of such problems;
- (3) maintaining a global perspective on environmental problems;
- (4) considering preparation of public service announcements or other materials appropriate for public/patient education; and
- (5) encouraging state and component societies that have not already done so to create environmental committees.

Res. 52, A-90; Reaffirmed: Sunset Report, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Green Initiatives and the Health Care Community H-135.939

Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of: Res. 504, A-16; Modified: Res. 516, A-18; Modified: Res. 923, I-19

Synthetic Gasification H-135.914

Our AMA supports the study of the health effects of clean coal technologies including synthetic gasification plants.

CSAPH Rep. 1, A-22

Air Pollution and Public Health D-135.985

Our AMA: (1) promotes education among its members and the general public and will support efforts that lead to significant reduction in fuel emissions in all states; and (2) will declare the need for authorities in all states to expeditiously adopt, and implement effective air pollution control strategies to reduce emissions, and this position will be disseminated to state and specialty societies.

Res. 408, A-08; Reaffirmation A-14

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. 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

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.

Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of: Res. 505, A-19

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.

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

AMA Position on Air Pollution H-135.998

Our AMA urges that: (1) Maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants, should be sought by all responsible parties.

(2) Community control programs should be implemented wherever air pollution produces widespread environmental effects or physiological responses, particularly if these are accompanied by a significant incidence of chronic respiratory diseases in the affected community.

(3) Prevention programs should be implemented in areas where the above conditions can be predicted from population and industrial trends.

(4) Governmental control programs should be implemented primarily at those local, regional, or state levels which have jurisdiction over the respective sources of air pollution and the population and areas immediately affected, and which possess the resources to bring about equitable and effective control.

BOT Rep. L, A-65; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmation I-06; Reaffirmed in lieu of Res. 509, A-09; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-14; Reaffirmation A-16; Reaffirmed: BOT Rep. 29, A-19

Protecting Public Health from Natural Gas Infrastructure H-135.930

Our AMA recognizes the potential impact on human health associated with natural gas infrastructure and supports legislation that would require a comprehensive Health Impact Assessment regarding the health risks that may be associated with natural gas pipelines.

Res. 519, A-15

Support Reduction of Carbon Dioxide Emissions D-135.972

Our AMA will (1) inform the President of the United States, the Administrator of the Environmental Protection Agency (EPA), and Congress that our American Medical Association supports the Administration's efforts to limit carbon dioxide emissions from power plants to protect public health; and (2) working with state medical societies, encourage state governors to support and comply with EPA regulations designed to limit carbon dioxide emissions from coal fired power plants.

Res. 421, A-14; Modified: Res. 506, A-15

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.

Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Appended: Res. 523, A-17

Clean Air H-135.979

Our AMA supports cooperative efforts with the Administration, Congress, national, state and local medical societies, and other organizations to achieve a comprehensive national policy and program to address the adverse health effects from environmental pollution factors, including air and water pollution, toxic substances, the "greenhouse effect," stratospheric ozone depletion and other contaminants.

Sub. Res. 43, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed in lieu of Res. 507, A-09; Reaffirmed in lieu of Res. 509, A-09; Reaffirmed: CSAPH Rep. 01, A-19

135.012MSS Toward Environmental Responsibility

AMA-MSS will ask the AMA to recognize the negative impact of climate change on global human health, particularly in the areas of infectious disease, the direct effects of heat, severe storms, food and water availability, and biodiversity. (MSS Amended Rep A, I-07) (AMA Res 607, A-08 Referred) (Modified: MSS GC Report A, I-16) (Reaffirmed: MSS GC Report A, I-21)

135.013MSS Statement of Sustainability Principles

AMA-MSS will (1) develop a model sustainability statement that medical schools can use as a template for creating institution-specific sustainability mission statements; and (2) encourage all medical schools to adopt mission statements which promote institutional sustainability initiatives such as consumption awareness, waste reduction, energy and water conservation, and the utilization of reusable/recyclable goods. (MSS Res 2, A-10) (Reaffirmed: MSS Res 10, I-11) (Reaffirmed, MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

135.014MSS Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability

AMA-MSS will ask that our AMA (1) amend policy H-135.949 by addition and deletion to read as follows:

Support of Clean Air and Reduction in Power Plant Emissions H-135.949

Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide;

and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants, ~~substitution of natural gas in lieu of other carbon-based fossil fuels, and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.~~

(2) support the implementation of buffer zones between oil and gas development sites and residences, schools, hospitals, and religious institutions. (MSS Res 23, A-17)

135.015MSS AMA Policy on Investing in the Fossil Fuel Industry

AMA-MSS supports (1) the American Medical Association, Foundation, and any affiliated corporations, to work in a timely and fiscally responsible manner to end all financial investments or relationships with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; (2) the AMA, when fiscally responsible, to choose for its commercial relationships vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and (3) efforts of physicians and of other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators and government policy makers. (MSS Res 33, A-17)

135.017MSS Health Impact of Per- and Polyfluoroalkyl Substances (PFAS) Contamination in Drinking Water

AMA-MSS will ask the AMA to support legislation and regulation seeking to address contamination, exposure, classification, and clean-up of Per- and Polyfluoroalkyl substances. (MSS Res 02, A-19) (AMA Res. 901, Adopt Alternate Resolution in Lieu of Res. 901 and Res. 922 [H- 135.916], I-19)

135.018MSS Be the Change: Implementing AMA Climate Change Principles Through JAMA Paper Consumption Reduction and Green Healthcare Leadership

AMA-MSS will ask the AMA to shift existing all-inclusive paper JAMA to opt-in paper JAMA subscriptions by the year 2020, still giving students an option to receive paper JAMA, while reducing AMA paper waste, supporting a green initiative, and saving cost. (MSS Res 45, I-18) (AMA Res 615, A-19, Referred) (BOT Report 8, Adopted, I-19)

135.019MSS Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room

AMA-MSS will ask the AMA to advocate for research into and development of intended multi-use operating room equipment and attire over devices, equipment and attire labeled for "single-use" wither verified similar safety and efficacy profiles. (MSS Res. 42, I-19)

135.021MSS Environmental Contributors to Disease and Advocating for Environmental Justice

AMA-MSS will ask the AMA to amend Policy D-135.997, Research into the Environmental Contributors to Disease, by addition and deletion to read as follows:

Research into the Environmental Contributors to Disease and Advocating for Environmental Justice

Our AMA will (1) advocate for the greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease and environmental racism as a priority public health issues; (3) encourage federal, state, and local agencies to address a remediate environmental injustice, environmental racism, and all

other environmental conditions that are adversely impacting health, especially in marginalized communities; and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies. (MSS Res. 019, A-21)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 082
(I-22)

Introduced by: Paul Suhwan Lee, University of Rochester School of Medicine and Dentistry;
Nina Singh, New York University Grossman School of Medicine; Victoria
Mityul, Washington University in St. Louis School of Medicine; Matthew J.
Swanson, Frank H. Netter MD School of Medicine at Quinnipiac University;
Andrew Alexander, Texas A&M College of Medicine

Subject: Amendment to AMA Policy Sharing of Medical Disciplinary Data Among
Nations D-275.975

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Various barriers to international health data sharing exist, including but not limited to
lack of clear policies, compliance issues, and lack of incentives or support¹; and

Whereas, One of the critical and notable advancements during the COVID-19 pandemic was
international intersectoral sharing of COVID-19 preclinical and clinical data, which led to benefits
such as fast-track COVID-19 vaccine development^{2,3,4}; and

Whereas, Rapid response to the COVID-19 pandemic was made possible by temporary
initiatives by national health institutions, which pushed for rapid sharing of COVID-19 research
results upon research funding⁵; and

Whereas, The Research Data Alliance provided recommendations and guidelines for sharing of
COVID-19 data divided into four research areas with four cross cutting themes⁶; and

Whereas, Outside of the COVID-19 pandemic, health data sharing agreements such as The
Global Alliance for Genomics and Health and The Collaborating Consortium of Cohorts
Producing NIDA Opportunities stimulated high impact science^{7,8}; and

Whereas, There is no existing AMA policy that covers the sharing of preclinical data; therefore
be it

RESOLVED, That AMA policy D-275.975, "Sharing of Medical Disciplinary Data Among
Nations" be amended by addition and deletion as follows:

Sharing of ~~Medical Disciplinary~~ Health Data Among Nations D-275.975

1. Our AMA will, in conjunction with the Federation of State Medical Boards, support

the efforts of the International Association of Medical Regulatory Authorities in its current efforts toward the exchange of health information among medical regulatory authorities worldwide.

2. Our AMA support further initiatives and funding into developing guidelines for international and intersectoral sharing of preclinical and clinical health data that advance scientific and medical research to improve patient care.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. van Panhuis WG, et. al. A systematic review of barriers to data sharing in public health. BMC Public Health. 2014 Nov 5;14:1144.
2. Duan Y. et. al. Reporting and data sharing level for COVID-19 vaccine trials: A cross-sectional study. EBioMedicine. 2022 Apr;78:103962.
3. Foraker, R. et. al. Transmission dynamics: Data sharing in the COVID-19 era. Learn Health Syst. 2020 Jun 28;5(1):e10235.
4. Rios, R. et. al. Data sharing during COVID-19 pandemic: what to take away. Expert Review of Gastroenterology & Hepatology. 2020 Dec;14(12):1125-1130.
5. NIAID Now. Reflections on a Year of COVID-19 Data Sharing. NIAID Now Blog. October 28, 2021.
6. RDA COVID-19 Working Group. Recommendations and Guidelines on data sharing. Research Data Alliance; June 30, 2020.
7. Rehm, HL, et. al. GA4GH: International policies and standards for data sharing across genomic research and healthcare. Cell Genom. 2021 Nov 10;1(2):100029.
8. Siminski S, et. al. C3PNO Cohort Investigators. A Virtual Data Repository Stimulates Data Sharing in a Consortium. Online J Public Health Inform. 2021 Dec 24;13(3):e19.

RELEVANT AMA AND AMA-MSS POLICY

Sharing of Medical Disciplinary Data Among Nations D-275.975

Our AMA will, in conjunction with the Federation of State Medical Boards, support the efforts of the International Association of Medical Regulatory Authorities in its current efforts toward the exchange of information among medical regulatory authorities worldwide. (Res. 318, A-05) (Reaffirmed: CME Rep. 1, A-15)

7.2.1 Principles for Disseminating Research Results

Physicians have an ethical responsibility to learn from and contribute to the total store of scientific knowledge. When they engage in biomedical or health research, physicians have obligations as scientists, which include disseminating research findings. Prompt presentation to scientific peers and publication of research findings are foundational to good medical care and promote enhanced patient care, early evaluation of clinical innovations, and rapid dissemination of improved techniques. To fulfill their ethical responsibilities with respect to sharing research findings for the ultimate benefit of patients, physicians should: (a) Advocate for timely and transparent dissemination of research data and findings. Physicians should not intentionally withhold information for reasons of personal gain; (b) Report the results of research accurately, including subsequent negative findings. This is particularly important where the findings do not support the research hypothesis; (c) Maintain a commitment to peer review; (d) Disclose

sponsorship and conflicts of interest relating to the research, in keeping with ethics guidance; (e) Be responsible in their release of research results to the media, ensuring that any information the researcher provides is prompt and accurate and that informed consent to the release of information has been obtained from research participants (or participants' legally authorized representative when the participant lacks decision-making capacity) prior to releasing any identifiable information. In rare circumstances, the potential for misuse of research results could affect the decision about when and whether to disseminate research findings. Physician-researchers should assess foreseeable ramifications of their research in an effort to balance the promise of benefit against potential harms from corrupt application. Only under rare circumstances should findings be withheld, and then only to the extent required to reasonably protect against misuse. (AMA Principles of Medical Ethics: I,II,III,V,VII, I-16)

7.3.3 International Research

Biomedical and health research in international settings often raises special ethical questions, particularly when research is carried out in resource-poor settings by sponsors or researchers from resource-rich countries. Physicians engaged in international research may encounter differing cultural traditions, economic conditions, health care systems, and ethical or regulatory standards and traditions than in the US. While fundamental requirements to ensure scientifically sound research and to protect the welfare, safety, and comfort of human participants apply in any research setting, physicians who are involved in international research may need to address special concerns about selection of research topic and study design, informed consent, and the impact of the research on the participating community. In addition to following general ethical guidelines for biomedical and health research, physicians who are involved in international research have obligations to: *Study design*: (a) Ensure that the research responds to a medical need in the region in which it is undertaken; (b) Ensure that the research does not exploit the populations and communities from which participants will be drawn; (c) Be sensitive to special considerations in assessing the risks and benefits of the research in the particular setting and employ a research design that minimizes risks to the participant population by: (i) ascertaining that there is genuine uncertainty within the clinical community about the comparative merits of the experimental intervention and the intervention that will be offered as a control for the population to be enrolled; (ii) obtaining relevant input from representatives of the host community and from the research population; (iii) considering the harm that is likely to result for the host community or research population if the research is not carried out; (d) In some instances, a three-pronged protocol that offers the standard of care in the US, an intervention that meets a level of care that can be attained in and sustained by the host community, and a placebo may offer the most ethically desirable means for evaluating the safety and efficacy of an intervention in a given population. *Informed consent*: (e) Ensure that a suitable process for informed consent is in place. If consent is to be meaningful, physicians (or other health professionals) who obtain consent must communicate with sensitivity to local customs. Notwithstanding, they should always ensure that individual participants are informed and that their voluntary consent is sought. *Impact on the host community*: (f) Foster research with the potential for lasting benefits to the host community, especially when the research is carried out among populations that are severely deficient in health care resources. This can be achieved by: (i) facilitating development of a health care infrastructure that will be of use during and after the research period itself; (ii) encouraging sponsors to provide interventions that have been demonstrated to be beneficial to all study participants after the study concludes. (AMA Principles of Medical Ethics: I,IV,VII,VIII,IX, I-16)

Promoting Electronic Data Interchange H-190.978

Our AMA: (1) adopts the following policy principles to encourage greater use of electronic data interchange (EDI) by physicians and improve the efficiency of electronic claims processing: (a)

public and private payers who do not currently do so should cover the processing costs of physician electronic claims and remittance advice; (b) vendors, claims clearinghouses, and payers should offer physicians a full complement of EDI transactions (e.g., claims submission; remittance advice; and eligibility, coverage and benefit inquiry); (c) vendors, clearinghouses, and payers should adopt American National Standards Institute (ANSI) Accredited Standard's Committee (ASC) Insurance Subcommittee (X12N) standards for electronic health care transactions and recommendations of the National Uniform Claim Committee (NUCC) on a uniform data set for a physician claim; (d) all clearinghouses should act as all-payer clearinghouses (i.e., accept claims intended for all public and private payers); (e) practice management systems developers should incorporate EDI capabilities, including electronic claims submission; remittance advice; and eligibility, coverage and benefit inquiry into all of their physician office-based products; (f) states should be encouraged to adopt AMA model legislation concerning turnaround time for "clean" paper and electronic claims; and (g) federal legislation should call for the acceptance of the Medicare National Standard Format (NSF) and ANSI ASC X12N standards for electronic transactions and NUCC recommendations on a uniform data set for a physician claim. This legislation should also require that (i) any resulting conversions, including maintenance and technical updates, be fully clarified to physicians and their office staffs by vendors, billing agencies or health insurers through educational demonstrations and (ii) that all costs for such services based on the NSF and ANSI formats, including educational efforts be fully explained to physicians and/or their office staffs during negotiations for such contracted services; (2) continues to encourage physicians to develop electronic data interchange (EDI) capabilities and to contract with vendors and payers who accept American National Standards Institute (ANSI) standards and who provide electronic remittance advice as well as claims processing; (3) continues to explore EDI-related business opportunities; (4) continues to facilitate the rapid development of uniform, industry-wide, easy-to-use, low cost means for physicians to exchange electronically claims and eligibility information and remittance advice with payers and others in a manner that protects confidentiality of medical information and to assist physicians in the transition to electronic data interchange; (5) continues its leadership roles in the NUCC and WEDI; and. (6) through its participation in the National Uniform Claim Committee, will work with third party payers to determine the reasons for claims rejection and advocate methods to improve the efficiency of electronic claims approval. (BOT Rep. 9, A-96) (Amended: CMS Rep. 11, I-96) (Appended: Sub. Res. 702, A-00) (Modified: CMS Rep. 6, A-10) (Reaffirmation I-13) (Reaffirmation: A-22)

Guiding Principles for the Collection, Use and Warehousing of Electronic Medical Records and Claims Data H-315.973

1. It is AMA policy that any payer, clearinghouse, vendor, or other entity that collects and uses electronic medical records and claims data adhere to the following principles: (a) Electronic medical records and claims data transmitted for any given purpose to a third party must be the minimum necessary needed to accomplish the intended purpose; (b) All covered entities involved in the collection and use of electronic medical records and claims data must comply with the HIPAA Privacy and Security Rules; (c) The physician must be informed and provide permission for any analysis undertaken with his/her electronic medical records and claims data, including the data being studied and how the results will be used; (d) Any additional work required by the physician practice to collect data beyond the average data collection for the submission of transactions (e.g., claims, eligibility) must be compensated by the entity requesting the data; (e) Criteria developed for the analysis of physician claims or medical record data must be open for review and input by relevant outside entities; (f) Methods and criteria for analyzing the electronic medical records and claims data must be provided to the physician or an independent third party so re-analysis of the data can be performed; (g) An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived

from an analysis of his/her electronic medical records and claims data; (h) Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care operations. 2. It is AMA policy that any physician, payer, clearinghouse, vendor, or other entity that warehouses electronic medical records and claims data adhere to the following principles: (a) The warehouse vendor must take the necessary steps to ensure the confidentiality, integrity, and availability of electronic medical records and claims data while protecting against threats to the security or integrity and unauthorized uses or disclosure of the information; (b) Electronic medical records data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research; (c) Physician and patient permission must be obtained for any person or entity other than the physician or patient to access and use individually identifiable clinical data, when the physician is specifically identified; (d) Following the request from a physician to transfer his/her data to another data warehouse, the current vendor must transfer the electronic medical records and claims data and must delete/destroy the data from its data warehouse once the transfer has been completed and confirmed. (CMS Rep. 6, I-06) (Reaffirmed: BOT Rep. 17, A-13)

Clinical Data Registries H-450.933

1. Our AMA encourages multi-stakeholder efforts to develop and fund clinical data registries for the purpose of facilitating quality improvements and research that result in better health care, improved population health, and lower costs; 2. Our AMA encourages national medical specialty societies, state medical associations, and other physician groups to join the National Quality Registry Network and to participate in efforts to advance the development and use of clinical data registries; 3. Our AMA supports flexibility in the development and implementation of clinical data registries. The following guidelines can help maximize opportunities for clinical data registries to enhance the quality of care provided to patients: (a) Practicing physicians must be actively involved in decisions related to the development, maintenance and use of clinical data registries and registry data; (b) Data elements, risk-adjustment models and measures used in the registry should be fully transparent; (c) Registries should provide timely, actionable feedback reports to individual physicians or entities reporting at the organizational level; (d) Registries and electronic health records should be interoperable, and should be capable of sharing and integrating information across registries and with other data sources in a HIPAA-compliant and confidential manner; (e) Registry stewards should establish a formal process to facilitate the modification, expansion, or dissolution of the registry in order to accommodate advances in technology and changing clinical data needs to ensure continued utility of their registry; 4. Our AMA encourages physicians to participate in clinical data registries, and will encourage efforts that help physicians identify existing registries suitable for and of benefit to their patient populations and their practices; 5. Our AMA will continue to advocate for and support initiatives that minimize the costs and maximize the benefits of physician practice participation in clinical data registries; 6. Our AMA supports that, with the consent of the participating physician, physician-specific clinical registry data may be used to meet third-party quality reporting requirements, in accordance with the following principles: (a) Data should be used to improve the quality of patient care and the efficient use of resources in the delivery of health care services; (b) Data related to resource use and cost of care must be evaluated and reported in conjunction with quality of care information; (c) Effective safeguards must be established to protect against the dissemination of inconsistent, incomplete, invalid or inaccurate physician-specific medical practice data; (d) Case-matched, risk-adjusted quality measure and resource use data are provided to physicians to assist them in determining their relative utilization of resources in providing care to their patients; (e) When data are collected and analyzed for the purpose of meeting quality reporting requirements, the methodologies used to create the profiles and report the results are

developed in conjunction with relevant physician organizations and practicing physicians, and are disclosed in sufficient detail to allow each physician or medical group to re-analyze the validity of the reported results prior to more general disclosure. (CMS Rep. 8, A-14) (Reaffirmed: CMS Rep. 05, I-16) (Reaffirmed: CMS Rep. 10, A-17) (Reaffirmed: CMS Rep. 06, A-18) (Reaffirmed: CSAPH Rep. 2, I-19)

Data Ownership and Access to Clinical Data in Health Information Exchanges H-478.988

1. Our AMA: (A) will continue its efforts to educate physicians on health information exchange (HIE) issues, with particular emphasis placed on alerting physicians to the importance of thoroughly reviewing HIE business associate contracts and clarifying any and all secondary uses of HIE data prior to agreeing to participate in a particular HIE; (B) will advocate for HIEs to provide an overview of their business models and offered services to physicians who are considering joining the organization; (C) will advocate for HIE contracts to clearly identify details of participation, including transparency regarding any secondary uses of patient data; (D) will advocate that HIEs comply with all provisions of HIPAA in handling clinical data; and (E) encourages physicians who experience problems accessing and using HIE data to inform the AMA about these issues. 2. Our AMA supports the inclusion of actively practicing physicians and patients in health information exchange governing structures. 3. Our AMA will advocate that physician participation in health information exchanges should be voluntary, to support and protect physician freedom of practice. 4. Our AMA will advocate that the direct and indirect costs of participating in health information exchanges should not discourage physician participation or undermine the economic viability of physician practices. (BOT Rep. 17, A-13) (CMS Rep. 6, A-13) (Reaffirmed: CMS Rep. 4, I-13)

Maximizing Patient Outcomes through Public Access to all Past, Present and Future Clinical Trials 460.017MSS

AMA-MSS will ask the AMA to (1) support the timely dissemination of clinical trial data for public accessibility; (2) sign the petition titled "All Trials Registered; All Results Reported" at Alltrials.net that supports the registration of all past, present and future clinical trials and the release of their summary reports; (3) support the promotion of improved data sharing, the reaffirmation and enforcement of deadlines for submitting results from clinical research studies, and the creation of a global organization to oversee policies regarding the timely sharing of clinical trial data; and (4) encourage the expansion of clinical trial registrants to clinicaltrials.gov. (MSS Res 23, A-15) (First, third, and fourth Resolves of Res 907, I-15 Adopted as Amended, H-460.912 and D-460.970 Reaffirmed)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 083
(I-22)

Introduced by: Aparna Kanjhlia and Shefali Jain, Medical College of Georgia

Subject: Establishing and Maintaining Patient Libraries in Hospitals

Sponsored by: Region 4, PsychSIGN

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Bibliotherapy is defined as the utility of reading books within a therapeutic context¹; and

Whereas, Bibliotherapy is arising as a unique adjunct to pharmacologic treatment to improve outcomes for people with cancer, autism, and various mental health disorders^{1, 2}; and

Whereas, The average length of stay (LOS) for a hospitalization in the United States is 5.5 days as reported in 2018, however unnecessary delays secondary to poor discharge planning, placement challenges and delayed decision making may lead to longer hospitalizations³; and

Whereas, A 2018 retrospective study analyzing nearly 17,000 patients with chronic medical illnesses showed that patients with comorbid mental illness had significantly prolonged LOS compared to patients without comorbid mental illness, and a 2017 systematic literature review comprising of 1347 subjects demonstrated that bibliotherapy was effective in the treatment of depression, which may suggest the utility of bibliotherapy and patient libraries for hospitalized patients with comorbid mental illness and/or in the setting of extended LOS^{4, 5}; and

Whereas, Hospital librarians play a pivotal role in bridging the gap between data and clinical practice by guiding caregivers and patients to relevant, accurate and evidence based materials, especially those with lower health literacy and hence improving the overall patient experience⁶; and

Whereas, In a 2019 study conducted in Chicago evaluating the role of hospital libraries in clinical scenarios, nearly two thirds of physicians responded highly valued quality of information they received and its impact on patient care and management⁷; and

Whereas, The Vital Pathways Project highlighted the alarming number of hospital libraries closures, from 44% in 1989 to 30% in 2006, which was further reiterated by the The Library and Book Trade Almanac showing a 30% decrease in hospital libraries from 2007 to 2017, but there is a scarcity of research about alternative library services, as well as the effect of these closures on physicians' clinical knowledge and patient care^{8, 9}; and

Whereas, A 2020 study assessing 60 academic health science libraries found that cost was the most frequently cited challenge in maintaining the library, due to cost of resources and difficulty

obtaining funding; however, clinical librarians have shown a positive impact on cost savings in hospitals by avoiding unnecessary tests, preventing readmissions, and reducing LOS^{10, 11}; and

Whereas, While multiple older studies have shown promise of benefit from patient libraries, such as promoting healing through recreational reading and providing educational materials and programs for patient health education, there is a lack of recent research exploring their use in a post-pandemic, fiscally-constrained hospital environment^{12, 13}; and

Whereas, Existing policy H-160.931 focuses on improving health literacy and promote the development of patient education materials for the same purpose, and the establishment and maintenance of patient libraries in the hospital setting aligns with these policies; therefore be it

RESOLVED, That our AMA support research into the utility of patient libraries in the hospital setting and their impact on patients' health and hospital experience.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Bibliotherapy: Improving Patient's Health Through Reading | Alternative and Complementary Therapies. Alternative and Complementary Therapies. <https://www.liebertpub.com/doi/full/10.1089/act.2021.29351.pro>. Published 2022. Accessed September 1, 2022.
2. Malibiran R, Tariman JD, Amer K. Bibliotherapy: Appraisal of Evidence for Patients Diagnosed With Cancer. *Clin J Oncol Nurs*. 2018;22(4):377-380. doi:10.1188/18.CJON.377-380
3. Tipton K, Leas B, Mull N et al. Introduction. Ncbi.nlm.nih.gov. <https://www.ncbi.nlm.nih.gov/books/NBK574438/>. Published 2022. Accessed September 1, 2022.
4. Siddiqui N, Dwyer M, Stankovich J, et al. Hospital length of stay variation and comorbidity of mental illness: a retrospective study of five common chronic medical conditions. *BMC Health Serv Res*. 2018;18(1):498. Published 2018 Jun 27. doi:10.1186/s12913-018-3316-2
5. Gualano MR, Bert F, Martorana M, et al. The long-term effects of bibliotherapy in depression treatment: Systematic review of randomized clinical trials. *Clin Psychol Rev*. 2017;58:49-58. doi:10.1016/j.cpr.2017.09.006
6. Holst R, Funk CJ, Adams HS, et al. Vital pathways for hospital librarians: present and future roles. *J Med Libr Assoc*. 2009;97(4):285-292. doi:10.3163/1536-5050.97.4.013
7. King DN. The contribution of hospital library information services to clinical care: a study in eight hospitals. *Bull Med Libr Assoc*. 75(4); October 1987. *J Med Libr Assoc*. 2012;100(4 Suppl):H.
8. Schwartz DG, Elkin PL. Health Sciences Library Closings; A Context Sensitive Pilot Study. *Stud Health Technol Inform*. 2017;241:21-27.
9. Harrow A, Marks LA, Schneider D, et al. Hospital library closures and consolidations: a case series. *J Med Libr Assoc*. 2019;107(2):129-136. doi:10.5195/jmla.2019.520
10. Allison AE, Bryan B, Franklin SG, Schick LC. Academic health sciences libraries and affiliated hospitals: a conversation about licensing electronic resources. *J Med Libr Assoc*. 2020;108(2):242-252. doi:10.5195/jmla.2020.625
11. Brettelle A, Maden M, Payne C. The impact of clinical librarian services on patients and health care organisations. *Health Info Libr J*. 2016;33(2):100-120. doi:10.1111/hir.12136

12. McDowell DJ. Bibliotherapy in a patients' library. *Bull Med Libr Assoc.* 1971;59(3):450-457.
13. Roth BG. Health information for patients: The hospital library's role. *Bull Med Libr Assoc.* 1978;66(1):14-18.

RELEVANT AMA AND AMA-MSS POLICY

Health Literacy H-160.931

Our AMA:

- (1) recognizes that limited patient literacy is a barrier to effective medical diagnosis and treatment;
 - (2) encourages the development of literacy appropriate, culturally diverse health-related patient education materials for distribution in the outpatient and inpatient setting;
 - (3) will work with members of the Federation and other relevant medical and nonmedical organizations to make the health care community aware that approximately one fourth of the adult population has limited literacy and difficulty understanding both oral and written health care information;
 - (4) encourages the development of undergraduate, graduate, and continuing medical education programs that train physicians to communicate with patients who have limited literacy skills;
 - (5) encourages all third party payers to compensate physicians for formal patient education programs directed at individuals with limited literacy skills;
 - (6) encourages the US Department of Education to include questions regarding health status, health behaviors, and difficulties communicating with health care professionals in all future National Assessment of Adult Literacy studies;
 - (7) encourages the allocation of federal and private funds for research on health literacy;
 - (8) recommends all healthcare institutions adopt a health literacy policy with the primary goal of enhancing provider communication and educational approaches to the patient visit;
 - (9) recommends all healthcare and pharmaceutical institutions adopt the USP prescription standards and provide prescription instructions in the patient's preferred language when available and appropriate; and
 - (10) encourages the development of low-cost community- and health system resources, support state legislation and consider annual initiatives focused on improving health literacy.
- CSA Rep. 1, A-98; Appended: Res. 415, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Appended: Res. 718, A-13

160.006MSS Development Of Low-Literacy Patient Education Materials

AMA-MSS supports the development of literacy appropriate health related patient education materials for distribution in the outpatient and inpatient setting when appropriate. (MSS Sub Res 4, I-99) (Reaffirmed: MSS Rep A, I-04) (Reaffirmed: MSS GC Report B, I-09) (Reaffirmed: MSS GC Report A, I-16)

160.027MSS Readability of Patient Materials

AMA-MSS supports health literacy such that patient materials be written at a level understandable by the patient population. (MSS Res 16, A-13)

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 084
(I-22)

Introduced by: Camilla Cascardo, Sara Diltz, Mallory Evans, Dana Rector, Lauren Troppens, Oakland University William Beaumont School of Medicine

Subject: Combating Antimicrobial Resistance through Ethnopharmacology

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, The development of multidrug resistant microorganisms poses a serious threat to public health management and the treatment of infectious diseases¹; and

Whereas, The World Health Organization (WHO) has declared antimicrobial resistance one of the top ten global public health threats facing humanity²; and

Whereas, Antimicrobial resistance killed at least 1.27 million people worldwide and was associated with nearly five million deaths in 2019³; and

Whereas, More than 2.8 million antimicrobial-resistant infections occur each year in the United States³; and

Whereas, The increasing ineffectiveness of antibiotics is leading to longer hospital admissions, higher medical costs and increased mortality⁴; and

Whereas, Ethnopharmacology, the exploration of agents with potential biological activity, typically sourced from plants, that are commonly and historically used in traditional and alternative medical systems for the purpose of healing is a potential supply for novel therapeutics⁵; and

Whereas, The complex defense mechanisms used by plants against microbes provides a unique set of secondary metabolites that may be beneficial in medications for humans⁶; and

Whereas, Synergistic effects exist between ethnopharmacologic agents and current antibiotics, which has been shown to increase efficacy and decrease resistance^{7,8}; and

Whereas, Specific compounds, such as castaneroxy from the leaves of chestnuts (*Castanea sativa*), have been found to inhibit quorum sensing, thus decreasing the virulence of Methicillin-resistant *Staphylococcus aureus*⁷; and

Whereas, Clerodane diterpene, extracted from the American beautyberry (*Callicarpa americana*) has been found to resensitize Methicillin-resistant *Staphylococcus aureus* to β -Lactam antibiotics⁹; and

Whereas, Triterpenoid acids isolated from Christmas berries (*Schinus terebinthifolia*) have been found to reduce *Staphylococcus aureus* virulence and decrease dermal necrosis¹⁰; and

Whereas, There are approximately 374,000 plant species in the world, yet only 28,187 of them are estimated to be used by humans for medicine at this time, and although not all of these may hold medicinal properties, it highlights a significant opportunity to expand our understanding of plants for this purpose⁶; and

Whereas, Our American Medical Association (AMA) has existing policy H-100.973, “Combating Antimicrobial Resistance through Education”, (a) encouraging national organizations to provide more effective education on appropriate antibiotic use (b) strongly urging physicians to counsel patients about the issue of antimicrobial resistance, and (c) encouraging scientific research on antibiotic resistance; and

Whereas, AMA policy H-440.827, “Surveillance of Antibiotic Use and Resistance” recommends adequate funding to organizations achieving the goals and objectives outlined in the National Action Plan for Combating Antibiotic Resistant Bacteria; therefore be it

RESOLVED, that our American Medical Association to amend policy H-100.973, “Combating Antimicrobial Resistance through Education,” by addition to read as follows:

Combating Antimicrobial Resistance through Education H-100.973

Our AMA: (1) encourages the federal government, the World Health Organization, the World Medical Association, and the International Federation of Pharmacists to promote more effective education concerning the appropriate use of antibiotics;

(2) strongly urges physicians to educate their patients about their antimicrobial therapy, the importance of compliance with the prescribed regimen, and the problem of antimicrobial resistance;

(3) will continue to educate physicians and physicians-in-training about the appropriate prescribing of antimicrobial agents;

(4) encourages the use of antibiotic resistance management programs; these education-based programs should be multidisciplinary and cooperative (i.e., including infectious disease physicians, infection-control specialists, microbiology laboratory personnel, and clinical pharmacists);

(5) encourages continued scientific research on the issue of antibiotic resistance;

including the efficacy and safety of ethnopharmacologic agents that work independently from and synergistically with current antibiotics

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. van Duin D, Paterson DL. Multidrug-Resistant Bacteria in the Community: Trends and Lessons Learned. *Infect Dis Clin North Am*. 2016 Jun;30(2):377-390. doi: 10.1016/j.idc.2016.02.004. PMID: 27208764; PMCID: PMC5314345.
2. Antimicrobial Resistance. World Health Organization. Published November 17, 2021. Accessed August 27, 2022. <https://www.who.int/news-room/fact-sheets/detail/antimicrobial-resistance>.

3. Antimicrobial Resistance. Centers for Disease Control and Prevention. Updated December 13, 2021. Accessed August 27, 2022. <https://www.cdc.gov/drugresistance/about.html>
4. Antibiotic Resistance. World Health Organization. Published July 31, 2021. Accessed August 27, 2022. <https://www.who.int/news-room/fact-sheets/detail/antibiotic-resistance>
5. Anand U, Jacobo-Herrera N, Altemimi A, Lakhssassi N. A Comprehensive Review on Medicinal Plants as Antimicrobial Therapeutics: Potential Avenues of Biocompatible Drug Discovery. *Metabolites*. 2019 Nov 1;9(11):258. doi: 10.3390/metabo9110258. PMID: 31683833; PMCID: PMC6918160.
6. Porras G, Chassagne F, Lyles JT, Marquez L, Dettweiler M, Salam AM, Samarakoon T, Shabih S, Farrokhi DR, Quave CL. Ethnobotany and the Role of Plant Natural Products in Antibiotic Drug Discovery. *Chem Rev*. 2021 Mar 24;121(6):3495-3560. doi: 10.1021/acs.chemrev.0c00922. Epub 2020 Nov 9. PMID: 33164487; PMCID: PMC8183567.
7. Salam AM, Porras G, Cho YK, et al. Castaneroxy A From the Leaves of *Castanea sativa* Inhibits Virulence in *Staphylococcus aureus*. *Front Pharmacol*. 2021;12:640179. Published 2021 Jun 28. doi:10.3389/fphar.2021.640179
8. Salam AM, Quave CL. Opportunities for plant natural products in infection control. *Curr Opin Microbiol*. 2018 Oct;45:189-194. doi: 10.1016/j.mib.2018.08.004. Epub 2018 Sep 13. PMID: 30218951; PMCID: PMC6295356.
9. Dettweiler M, Melander RJ, Porras G, et al. A Clerodane Diterpene from *Callicarpa americana* Resensitizes Methicillin-Resistant *Staphylococcus aureus* to β -Lactam Antibiotics. *ACS Infect Dis*. 2020;6(7):1667-1673. doi:10.1021/acsinfectdis.0c00307
10. Tang H, Porras G, Brown MM, et al. Triterpenoid acids isolated from *Schinus terebinthifolia* fruits reduce *Staphylococcus aureus* virulence and abate dermonecrosis. *Sci Rep*. 2020;10(1):8046. Published 2020 May 15. doi:10.1038/s41598-020-65080-3

RELEVANT AMA AND AMA-MSS POLICY

Surveillance of Antibiotic Use and Resistance H-440.827

Our AMA: (1) recognizes the importance of public health and veterinary health surveillance for antimicrobial resistance and antibiotic use; and (2) recommends that public health and veterinary health agencies be adequately funded, as outlined in the President's Council of Advisors on Science and Technology Report, to achieve the surveillance goals and objectives outlined in the National Action Plan for Combating Antibiotic Resistant Bacteria. CSAPH Rep. 3, I-15

Combating Antimicrobial Resistance through Education H-100.973

Our AMA: (1) encourages the federal government, the World Health Organization, the World Medical Association, and the International Federation of Pharmacists to promote more effective education concerning the appropriate use of antibiotics; (2) strongly urges physicians to educate their patients about their antimicrobial therapy, the importance of compliance with the prescribed regimen, and the problem of antimicrobial resistance; (3) will continue to educate physicians and physicians-in-training about the appropriate prescribing of antimicrobial agents; (4) encourages the use of antibiotic resistance management programs; these education-based programs should be multidisciplinary and cooperative (i.e., including infectious disease physicians, infection-control specialists, microbiology laboratory personnel, and clinical pharmacists); and (5) encourages continued scientific research on the issue of antibiotic resistance.

Sub. Res. 521, A-94; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation I-98; Modified: CSA Rep. 3, A-00; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 3, I-15

Combating Antibiotic Resistance Via Physician Action and Education: AMA Activities D-100.998

Our AMA will continue to collaborate with the appropriate federal agencies, other medical specialty societies, and other appropriate public health organizations to address the urgent problem of increasing antimicrobial resistance and its impact on public health.

CMS Rep. 3, A-00; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 3, I-15

The 10 x '20 Initiative (10 New Antibiotics by 2020) H-100.960

Our AMA: (1) supports efforts to educate physicians, the Administration, Congress, and the public about the problem of antimicrobial resistance and the lack of new antibiotics in the drug development pipeline; and (2) endorses the 10 x '20 Initiative (10 new antibiotics by 2020) and supports efforts to bring together experts from the industrial, medical, scientific, policy, regulatory, and financial communities to determine and adopt the right combination of incentives needed to create a sustainable antibiotic research and development enterprise.

Res. 505, A-10; Reaffirmed: CSAPH Rep. 3, I-15

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Resolution 085
(I-22)

Introduced by: Christoph Baker, Senila Yasmin, Nishanth Ganeshbabu, Tufts University
School of Medicine

Subject: Against Legacy Preferences as a Factor in Medical School Admissions

Sponsored by: Association of Native American Medical Students

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, Legacy admissions but are defined as a preference given by an institution to children of alumni and sometimes to applicants of varying relation to alumni^{1,2}; and

Whereas, Legacy admissions date back to the 1920s when they were established to protect universities' white, wealthy and Protestant applicants from competing with recent European and Jewish immigrants¹; and

Whereas, Legacy admissions continue today to significantly favor the admission of white, wealthy, applicants, with nearly 70% of legacy applicants to Harvard identifying as white³; and

Whereas, 75% of the nation's major research universities and elite liberal arts college - including their medical schools - factor legacy status into the decision to admit or reject an applicant⁴; and

Whereas, 42% of private institutions - including most of the nation's elite institutions - use legacy admissions^{5,6}; and

Whereas, Admissions data are tightly kept university secrets and ascertaining information on how legacy admissions factor into the admissions process is extremely difficult⁵; and

Whereas, The advantage awarded by legacy status can be stark, with one study estimating that legacy status provides an undergraduate applicant with the equivalent of 160 extra points on the SAT and another indicating that legacy applicants are admitted at the rate of more than five times non-legacy applicants^{7,8}; and

Whereas, In 2014, Johns Hopkins University removed legacy as a factor in admissions, in efforts to increase its student diversity, and subsequently from 2009 to 2019, Pell Grant eligible students increased by 10%, students on financial aid increased by more than 20% and minority students increased by 10%⁹; and

Whereas, Johns Hopkins University attributes ending legacy admissions with building a more diverse student body¹⁰; and

Whereas, Johns Hopkins University in 2014 and Amherst College in 2021 recently ended their legacy policies^{11,12}; and

Whereas, the State of Colorado State banned the use of legacy admissions based on the conviction that providing preferential treatment to students with familial relationships to alumni is discriminatory¹³; and

Whereas, US Congressional Democrats have introduced legislation that ends federal funding for universities that employ legacy admissions due to their ability to exacerbate racial and economic inequalities¹⁴; and

Whereas, The ACLU has called for an end to legacy admissions in order to help address long-standing disparities and inequality in higher education while increasing access for underrepresented students¹⁵; and

Whereas, A bill was introduced by state lawmakers in New York and Connecticut in 2022 to bar public and private colleges from using legacy admissions due to the impact on low income students and underrepresented communities¹⁶; and

Whereas, Experts on racial and ethnic inequality in education, such as Natasha Warikoo Professor of Sociology at Tufts University, believe that legacy admissions are an indefensible policy of special access serving the most privileged, which should cease to exist¹⁷; and

Whereas, Experts on race, ethnicity, inequality, and social policy, such as Helen Marrow, Professor of Sociology at Tufts University, believe that legacy admissions limit access for medium and low-income students as well as African American, Latino, and Native American students¹⁸; and

Whereas, Physicians' children are 24x more likely to become physicians than their peers making it the most inherited career requiring higher education¹⁹; and

Whereas, The most common occupation for a wealthy person, i.e. the nation's 1% of top earners, is medical doctor²⁰; and

Whereas, Applicants, especially those not from medical or privileged backgrounds, face numerous barriers to entry in medical school; and

Whereas, Legacy admissions have been shown to limit social mobility making it harder for disadvantaged students such as those without resources or knowledge to gain admission¹⁵; and

Whereas, The University of Arizona College of Medicine, guarantees an interview for legacy applicants – those who have a sibling, parent or grandparent who graduated from the University of Arizona College of Medicine - a privilege it offers to only 6.6% of non-legacy applicants^{21,22}; and

Whereas, Most medical schools “have some sort of legacy process in place,” per the University of Arizona College of Medicine’s executive director of admissions²¹; and

Whereas, Tufts University School of Medicine in April of 2021 eliminated its use of legacy admissions in response to its anti-racism initiative²³; and

Whereas, The AAMC recognizes the impact of racism on all aspects of medicine, including “inequitable admissions practices”²⁴; and

Whereas, The AMA released a strategic plan in 2021 to dismantle structural racism, address the historical inequities that marginalized populations have faced, and “pivot from ambivalence to urgent action [...] and from lack of accountability to an active embrace of equity as a core mission and strategy”^{25,26}; and

Whereas, The AMA recognizes that much of medical education is built on racist ideas that no longer hold merit such as the notion that there are biological differences between racial groups²⁶; and

Whereas, Policy H-65.952 states that AMA recognizes racism as a serious threat to public health and supports the development of policies that combat racism and its effects, but does not oppose the use of legacy admissions²⁷; and

Whereas, Policy H-200.951 states that the AMA encourages medical school policies that promote diversity and include underrepresented in medicine individuals, but does not oppose the use of legacy admissions, which have been shown to limit racial and socioeconomic diversity²⁸; and

Whereas, Policy H-350.970 states that the AMA will work with stakeholders to promote programs that are aimed at increasing minority medical student admissions, but does not recognize that the lack of a stance against legacy admissions contradicts this policy²⁹; and

Whereas, Policy H-295.888 states that the AMA encourages medical schools to give weight to personal qualities (such as empathy, integrity, commitment to service) during the admissions process, but does not have a policy stating legacy admissions are not one of the personal qualities that should be considered³⁰; and

Whereas, Policy H-295.998 reaffirms the Liaison Committee on Medical Education’s policy about establishing effective policies and procedures in regards to medical school admissions, but does not recognize that preferential legacy admissions policies fail to guarantee an equitable admissions process and therefore current policies and procedures are not effective³¹; and

Whereas, Policy 295.169MSS asks the AMA to oppose the use of legacy status in medical school admissions and support more inclusive policies, but the House of Delegates did not adopt this policy in 2012³²; and

Whereas, Legacy admissions are incompatible with the AMA’s current plan to dismantle structural racism by perpetuating socioeconomic and racial disparities across medical institutions; therefore be it

RESOLVED, our AMA-MSS amend policy 295.169MSS as follows:

Eliminating Legacy Admissions, 295.169MSS

Our AMA oppose ~~Our AMA oppose~~ ~~AMA-MSS will ask the AMA to oppose the use~~ consideration of legacy status in medical school admissions and to support mechanisms to eliminate its inclusion from the application process such as by encouraging medical schools, the AAMC, AACOM, LCME, ~~and the AACOM~~, and other relevant stakeholders to remove any questions on ~~secondary~~ applications pertaining to legacy status.

Fiscal Note: TBD

Date Received: 09/22/2022

References:

1. Coe DL, Davidson JD. The Origins of Legacy Admissions: A Sociological Explanation. *Review of Religious Research*. 2011;52(3):233-247. https://www.jstor.org/stable/23055549?seq=1#metadata_info_tab_contents
2. How ending legacy admissions can help achieve greater education equity: News & commentary. American Civil Liberties Union. <https://www.aclu.org/news/racial-justice/how-ending-legacy-admissions-can-help-achieve-greater-education-equity>. Published April 12, 2022. Accessed September 14, 2022.
3. Arcidiacono P, Kinsler J, Ransom T. Legacy and athlete preferences at Harvard. *Journal of Labor Economics*. 2022;40(1):133-156. doi:10.1086/713744
4. Ornstein A. Wealth, legacy and college admission. *Society*. 2019;56(4):335-339. doi:10.1007/s12115-019-00377-2
5. Saul S. Elite Colleges' quiet fight to favor alumni children. *The New York Times*. <https://www.nytimes.com/2022/07/13/us/legacy-admissions-colleges-universities.html#:~:text=The%20exact%20number%20of%20schools,public%20schools%20used%20the%20strategy>. Published July 13, 2022. Accessed September 14, 2022.
6. The 2018 surveys of admissions leaders: The pressure grows. *Inside Higher Ed*. <https://www.insidehighered.com/news/survey/2018-surveys-admissions-leaders-pressure-grows>. Accessed September 14, 2022.
7. Epenshade TA, Chung CY, Walling JL. Admission Preferences for Minority Students, Athletes, and Legacies at Elite Universities. *Social Science Quarterly*. 2004;85(5). https://scholar.princeton.edu/sites/default/files/tje/files/admission_preferences_espenshade_chung_walling_dec_2004_full.pdf
8. Larkin M, Aina M. Legacy admissions offer an advantage - and not just at schools like Harvard. *NPR*. <https://www.npr.org/2018/11/04/663629750/legacy-admissions-offer-an-advantage-and-not-just-at-schools-like-harvard#:~:text=An%20analysis%20commissioned%20by%20Students,year%20period%3A%20just%205.9%20percent>. Published November 4, 2018. Accessed August 28, 2022.
9. Weissman S. Johns Hopkins ditched legacy admissions to boost diversity – and it worked. *Diverse Issues in Higher Education*. <https://www.diverseeducation.com/home/article/15106230/johns-hopkins-ditched-legacy-admissions-to-boost-diversity-and-it-worked>. Published February 6, 2020. Accessed August 28, 2022.
10. Anderson N. Hopkins says scrapping 'legacy' preference has boosted campus diversity. *The Washington Post*. https://www.washingtonpost.com/local/education/hopkins-scraps-legacy-preference-for-children-of-alumni-who-seek-admission/2020/01/13/d559314a-3624-11ea-bb7b-265f4554af6d_story.html. Published January 14, 2020. Accessed September 14, 2022.
11. Daniels RJ. Why we ended legacy admissions at Johns Hopkins. *The Atlantic*. <https://www.theatlantic.com/ideas/archive/2020/01/why-we-ended-legacy-admissions-johns-hopkins/605131/>. Published January 24, 2020. Accessed August 28, 2022.
12. Reilly K. Why Amherst dropped legacy admissions. *Time*. <https://time.com/6109673/amherst-legacy-admissions/>. Published October 22, 2021. Accessed August 28, 2022.
13. Jaschik S. Inside higher ed. Colorado bars public colleges from using legacy admissions. <https://www.insidehighered.com/admissions/article/2021/06/01/colorado->

- bars-public-colleges-using-legacy-admissions. Published June 1, 2021. Accessed August 28, 2022.
14. Marcos C. Democrats unveil bill to ban legacy admissions at universities. The Hill. <https://thehill.com/homenews/house/592486-democrats-unveil-bill-to-ban-legacy-admissions-at-universities/>. Published February 2, 2022. Accessed August 28, 2022.
 15. Moreno C. How ending legacy admissions can help achieve greater education equity: News & commentary. American Civil Liberties Union. <https://www.aclu.org/news/racial-justice/how-ending-legacy-admissions-can-help-achieve-greater-education-equity>. Published April 12, 2022. Accessed August 28, 2022.
 16. Jaschik S. Attacking Legacy and Early-Decision Admissions. Inside Higher Ed. <https://www.insidehighered.com/admissions/article/2022/03/14/new-york-bill-would-ban-legacy-admissions-and-early-decision>. Accessed September 14, 2022.
 17. Warikoo N. The easiest reform for college admissions. The Atlantic. <https://www.theatlantic.com/ideas/archive/2020/01/least-difficult-reform-college-admissions/605689/>. Published January 29, 2020. Accessed September 19, 2022.
 18. King O. Legacy admissions at Tufts from a sociological perspective. The Tufts Daily. <https://tuftsdaily.com/features/2020/03/11/legacy-admissions-tufts-sociological-perspective/>. Published March 11, 2020. Accessed September 19, 2022.
 19. Friedman, S., & Laurison, D. The class ceiling: Why it pays to be privileged. Bristol University Press, 2019. <https://doi.org/10.2307/j.ctv5zftbj>
 20. Bui Q. The most common jobs for the rich, middle class and poor. NPR. <https://www.npr.org/sections/money/2014/10/16/356176018/the-most-popular-jobs-for-the-rich-middle-class-and-poor>. Published October 16, 2014. Accessed September 15, 2022.
 21. Eriksen J. For 'Legacy' Applicants, a First Interview is Guaranteed. College of Medicine - Tucson. <https://medicine.arizona.edu/alumni/alumni-slide/legacy-applicants-first-interview-guaranteed>. Published October 1, 2015. Accessed September 14, 2022.
 22. MD program - applicant profile. University of Arizona College of Medicine. <https://phoenixmed.arizona.edu/applicant-snapshot>. Accessed September 18, 2022.
 23. Update for TUSM Community: April 2021. <https://tufts.app.box.com/s/4jgvvqo356isskkp85t8spmva6nznf6s>. April 2021. Accessed August 30, 2022.
 24. Redford G, Editor M. AAMC releases framework to address and eliminate racism. AAMC. <https://www.aamc.org/news-insights/aamc-releases-framework-address-and-eliminate-racism>. Published October 6, 2020. Accessed August 30, 2022.
 25. AMA releases plan dedicated to embedding racial justice and Advancing Health Equity. American Medical Association. <https://www.ama-assn.org/press-center/press-releases/ama-releases-plan-dedicated-embedding-racial-justice-and-advancing>. Published May 11, 2021. Accessed August 28, 2022.
 26. Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity. <https://www.ama-assn.org/system/files/2021-05/ama-equity-strategic-plan.pdf>. Published 2021. Accessed August 28, 2022.
 27. Policy finder. AMA. <https://policysearch.ama-assn.org/policyfinder/detail/H-65.952?uri=%2FAMADoc%2FHOD.xml-H-65.952.xml>. Accessed September 19, 2022.
 28. Policy finder. AMA. <https://policysearch.ama-assn.org/policyfinder/detail/H-200.951?uri=%2FAMADoc%2FHOD.xml-0-1341.xml>. Accessed September 19, 2022.
 29. Policy finder. AMA. <https://policysearch.ama-assn.org/policyfinder/detail/350.970?uri=%2FAMADoc%2FHOD.xml-0-3020.xml>. Accessed September 19, 2022.

30. Policy finder. AMA. <https://policysearch.ama-assn.org/policyfinder/detail/295.888?uri=%2FAMADoc%2FHOD.xml-0-2187.xml>. Accessed September 19, 2022.
31. Policy finder. AMA. <https://policysearch.ama-assn.org/policyfinder/detail/295.998?uri=%2FAMADoc%2FHOD.xml-0-2297.xml>. Accessed September 19, 2022.
32. APPENDIX - REPORTS OF REFERENCE COMMITTEES. 2012 INTERIM MEETING OF THE HOUSE OF DELEGATES. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/hod/i12-reference-committee-reports_0.pdf. Published 2012. Accessed August 30, 2022.

RELEVANT AMA AND AMA-MSS 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.

Racism as a Public Health Threat H-65.952

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

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

Diversity in Medical Education H-350.970

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

BOT Rep. 15, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 311, A-15

Progress in Medical Education: the Medical School Admission Process H-295.888

1. Our AMA encourages: (A) research on ways to reliably evaluate the personal qualities (such as empathy, integrity, commitment to service) of applicants to medical school and support broad dissemination of the results. Medical schools should be encouraged to give significant weight to these qualities in the admissions process; (B) premedical coursework in the humanities, behavioral sciences, and social sciences, as a way to ensure a broadly-educated applicant pool; and (C) dissemination of models that allow medical schools to meet their goals related to diversity in the context of existing legal requirements, for example through outreach to elementary schools, high schools, and colleges.

2. Our AMA: (A) will continue to work with the Association of American Medical Colleges (AAMC) and other relevant organizations to encourage improved assessment of personal qualities in the recruitment process for medical school applicants including types of information to be solicited in applications to medical school; (B) will work with the AAMC and other relevant organizations to explore the range of measures used to assess personal qualities among applicants, including those used by related fields; (C) encourages the development of innovative methodologies to assess personal qualities among medical school applicants; (D) will work with medical schools and other relevant stakeholder groups to review the ways in which medical schools communicate the importance of personal qualities among applicants, including how and when specified personal qualities will be assessed in the admissions process; (E) encourages continued research on the personal qualities most pertinent to success as a medical student and as a physician to assist admissions committees to adequately assess applicants; and (F) encourages continued research on the factors that impact negatively on humanistic and empathetic traits of medical students during medical school.

CME Rep. 8, I-99; Reaffirmed: CME Rep. 2, A-09; Appended: CME Rep. 3, A-11; Reaffirmed: CME Rep. 1, A-21

Due Process H-295.998

(1) Our AMA reaffirms its 1974 approval of the policy adopted by the Liaison Committee on Medical Education, which states: "The faculty of a medical school establish criteria for student selection and develop and implement effective policies and procedures regarding, and make decisions about, medical student application, selection, admission, assessment, promotion, graduation, and any disciplinary action. The medical school makes available to all interested parties its criteria, standards, policies, and procedures regarding these matters."

(2) In addition, to clarify and protect the rights of medical students, the AMA recommends that: (a) Each school develop and publish in its catalog, student handbook or similar publication the institutional policies and procedures both for evaluation of academic performance (promotion, graduation, dismissal, probation, remedial work, and the like) and for nonacademic disciplinary decisions. (b) These policies and procedures should define the responsible bodies and their function and membership, provide for timely progressive verbal and written notification to the

student that his/her academic/nonacademic performance is in question, and provide an opportunity for the student to learn why it has been questioned. (c) These policies and procedures should also ensure that when a student has been notified of recommendations by the responsible committee for nonadvancement or dismissal, he/she has adequate notice and the opportunity to appear before the decision-making body to respond to the data submitted and introduce his/her own data. (d) The student should be allowed to be accompanied by a student or faculty advisor. (e) The policies and procedures should include an appeal mechanism within the medical school. (f) The student should be allowed to continue in the academic program during the proceedings unless extraordinary circumstances exist, such as physical threat to others.

CME Rep. D, A-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CME Rep. 2, A-10; Modified: CEJA Rep. 01, A-20

Eliminating Legacy Admissions 295.169MSS

AMA-MSS will ask the AMA to oppose the use of legacy status in medical school admissions and to support mechanisms to eliminate its inclusion from the application process such as by encouraging the AAMC, AACOM, LCME, and the AACOM to remove any questions on secondary applications pertaining to legacy status. MSS Res 8, A-12. Reaffirmed: MSS GC Report A, I-17.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

Late Resolution 001
(I-22)

Introduced by: MSS Governing Council

Subject: Sunset Report Update

Sponsored by:

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

Whereas, transitions in leadership of the Governing Council and staff resulted in an oversight regarding the creation and development of the 2022 AMA-MSS Sunset Report.

Whereas, the MSS Sunset Mechanism allows the MSS Governing Council to make recommendations to MSS Assembly regarding the retention of MSS policy on the five or five and one-half year anniversary of the policy's adoption and is an important process for ensuring MSS policy is streamlined and remains actionable.

Whereas, to appropriately fulfill the requirements for review of policies set to be rescinded, as indicated by the recently amended Sunset Mechanism for AMA-MSS Policy - 630.044MSS, the Governing Council would like to delay this report until the Annual 2023 MSS Assembly Meeting.

RESOLVED, That our AMA-MSS retain all MSS policies due to be rescinded at the Interim 2022 MSS Assembly; and be it further

RESOLVED, That the AMA-MSS Governing Council review all policies retained by the Interim 2022 MSS Assembly and prepare a sunset report for the Annual 2023 MSS Assembly, in accordance with the sunset mechanism outlined in 630.044MSS.

Fiscal Note: Minimal

Date Received: 10/25/2022

RELEVANT AMA AND AMA-MSS POLICY

Sunset Mechanism for AMA-MSS Policy - 630.044MSS

AMA-MSS will establish and use a sunset mechanism for AMA-MSS policy with a five year time horizon whereby a policy will remain viable for five years unless action is taken by the Assembly to reestablish or refer it. The implementation of a sunset mechanism for AMA-MSS policy shall follow the following procedures: (1) review of policies will be the ultimate responsibility of the Governing Council, whereby the report is authored by the Chair of the Governing Council with initial policy recommendations being solicited from relevant Standing Committees as appropriate; (2) The Governing Council will provide Standing Committees clear guidance regarding criteria for recommendations of retention, retention with amendments, or sunset; (3) policy recommendations will be reported to the AMA-MSS Assembly at each Interim Meeting on the five or five and one-half year anniversary of a policy's adoption, with a brief rationale

accompanying each recommendation; (4) a consent calendar format will be used by the Assembly in considering the policies encompassed within the report; and (5) a vote will not be necessary on policies recommended for rescission as they will automatically expire under the auspices of the sunset mechanism unless referred back to the Governing Council. (COLRP Rep B, I-95) (MSS Amended Rep C, A-00) (Reaffirmed: MSS Rep E, I-05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21) (MSS Amended GC Report A, A-22).

REPORT OF THE MEDICAL STUDENT SECTION

MSS Delegate Report A
(I-22)

Introduced by: Ryan Englander, Section Delegate, and Brittany Ikwuagwu, Alternate
Section Delegate

Subject: Delegate Report A: Status of Pending MSS-Authored Resolutions to the
House of Delegates

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

INTRODUCTION

The AMA Medical Student Section serves to provide “meaningful input into the decision and policy-making process of the AMA,” (IOP 2.1) “promote membership and activity within organized medicine on the local, state, and national levels,” (IOP 2.7) and “work cooperatively with other student groups and AMA Sections to meet [stated] objectives.” (IOP 2.8) One of the ways in which the MSS achieves this purpose is by participating in the AMA House of Delegates (HOD) through the submission of MSS-authored resolutions. To be considered by the HOD, MSS-authored resolutions must first be submitted to the MSS Assembly by MSS member(s) and adopted at a national meeting of the MSS Assembly.

In accordance with IOP 10.4.5, the purpose of the MSS Assembly is “to adopt resolutions for MSS Policy and for submission to the House of Delegates of the AMA.” If a resolution secures a simple majority vote for adoption by the Assembly, it can be incorporated into the MSS Digest of Policy Actions (“internal resolution”) and/or forwarded for consideration by the AMA HOD as an MSS-authored resolution (“external resolution”). Notably, IOP 10.8.8 decrees that external resolutions “shall be submitted to the AMA House of Delegates at the next appropriate meeting.” Resolutions to be transmitted to the HOD shall be referred to as “transmittals” for the duration of this report.

AMA SPECIAL MEETINGS AND THE MSS TRANSMITTAL SELECTION PROCESS

First Special Meeting, without policy considerations: June 2020

Due to the COVID-19 pandemic, the AMA Annual 2020 Meeting was canceled. In its place, the AMA convened a Special Meeting, in which no policy deliberation had taken place. At the time of that announcement, our MSS had 41 transmittals in our queue—predominantly resolutions adopted at the Interim 2019 MSS Assembly—none of which could be submitted for consideration.

Second and third Special Meetings, including limited policy considerations: November 2020 and June 2021

Given the ongoing pandemic, our AMA also convened a Special November 2020 Meeting of the HOD and a Special June 2021 Meeting of the HOD. Both Special HOD Meetings incorporated limited policy-making processes, with new meeting procedures released by our AMA Speakers, including specific requests asking all delegations to limit the number of items for House

consideration and the use of a special resolutions committee.

With this in mind and the volume of transmittals in queue (including any potential resolutions requesting immediate forwarding), the 2020-2021 Section Delegates (Pauline Huynh, MD, and Justin Magrath) executed a prioritization process for the November 2020 and June 2021 Special Meetings in accordance with MSS Policy 945.023 – Medical Student Section Policy Making Procedures:

“(2) When deemed necessary by the MSS Delegate and Alternate Delegate, AMA-MSS will employ a ranking/prioritization process for MSS resolutions intended to be forwarded to the AMA House of Delegates”.

This process took place from August 14th through October 1st, 2020 for the November 2020 Special HOD and again from February 21st through April 25th, 2021 for the June 2021 Special HOD. It involved our MSS Caucus, which is comprised of the AMA Delegate and Alternate Delegate, the Regional Delegates and Alternate Regional Delegates, and any MSS member serving on any HOD delegation (IOP 9.1.1.), as well as our House Coordination Committee. The prioritization process involved 4 major stages:

1. Determination of our Section’s focus priorities
2. An open comment period for Caucus members, authors, and Section members
3. Evaluation (scoring) of all transmittals
4. Caucus discussion of a resultant transmittal consent calendar

At the conclusion of the November 2020 prioritization process, our MSS transmitted 9 resolutions to the HOD, of which 5 were accepted by the House as business. The remaining transmittals, along with the external resolutions adopted by our November 2020 MSS Assembly, led to a total of 101 transmittals in queue at the start of the June 2021 policy cycle. Throughout the June 2021 transmittal prioritization process, our MSS Caucus re-evaluated the issue of our Section’s growing transmittal backlog. After numerous extensive discussions and engagement with other stakeholders, the Caucus ultimately voted to transmit 40 resolutions at the June 2021 Special HOD, which was at the time the largest volume in our Section’s history.

Last Special Meeting, including limited policy considerations: November 2021

Following the precedent of actions taken at the previous two special meetings and recognizing that the November 2021 meeting would have special procedures regarding prioritization, the current (2021–2022) Section Delegates anticipated a need to decide which resolutions to transmit at the 2021 November Meeting and began working with the Caucus on this process on August 10, 2021. The Speakers named the November 2021 Meeting a Special Meeting on August 27, 2021. Following this announcement, they also informed the House that there would be a prioritization process involving a resolutions committee, similar to the ones which had been used at the prior two meetings. Given this, your section delegates found merit in developing a transmittal process for the upcoming meeting that was based on previous transmittal plans and the wants of our MSS Caucus. On August 26, 2021, your previous section delegates held a town hall regarding the section’s transmittal process where we heard the following concerns and desires for a transmittal process:

1. Regional Delegates asked for increased guidance from Section Delegates. Specifically, it was requested that the Section Delegates offer more direct recommendations and guidance regarding how to handle individual transmittals.
2. There is an inherent amount of subjectivity that can be introduced through a scoring system when not everyone scores every resolution. This can lead to a less valid

measure of what is actually a top priority item for our section.

3. The volume of work associated with previous transmittal processes has been significant and often cumbersome at times for our regional delegates.
4. The criteria for prioritizing transmittals must consider urgency, both in terms of timeliness (or what is going to happen if we do/don't have this policy in place in the next 6-12 months) and in terms of MSS priorities (or what are the things we are jumping to have passed, today if possible), and considerations of things specific to medical students. Additionally, there were requests to better account for the amount of time that a resolution had been in the transmittal queue.
5. Involvement from our caucus and section members must remain a priority for any transmittal process but should focus on gathering valuable input about transmittals. Specific suggestions on how to accomplish this including allowing for individuals to provide comments on items that related to each of the considerations listed in point 4.
6. Equity must remain a focus of any transmittal process and should be priority in not only the theme of the resolutions we decide to transmit, but also within the process itself. Specifically, requests were made to solicit input from equity-focused NMSOs and similar groups within our Section, and that this input be heavily weighed.
7. The resolutions committee and its processes have been concerning for our Section members and caucus, which raised various questions about the number of items we should transmit. There were suggestions that we should transmit our entire queue, while others felt the need to only transmit a select number of items in order to maintain political capital within the House. Ultimately, the majority of voices heard felt that we should increase the number of transmittals that we send to the House as compared to previous meetings.

With these concerns in mind, your 2021-2022 Section Delegates developed a transmittal plan with the following stages (the full details are available [here](#)):

1. Step 1: Spreadsheets for comments on each resolution were made available to Caucus members, resolution authors, and the Section. Comments were solicited in terms of a) the urgency and timeliness of the issue, b) particular relevance to medical students, and c) MSS priority.
2. Step 2: The Section Delegates assigned different overarching "themes" (for example, gender equity, public assistance, disability rights, etc) to each resolution. A list of 28 themes was extracted from the 105 transmittals in this way. Caucus members were then asked to vote on the order in which these themes should be considered priority.
3. Step 3: Once the themes were ranked, the Section Delegates ordered the transmittals by their highest ranking themes. The Delegates then rearranged this ordering using the comments on the comment spreadsheets from Step 1 and released this preliminary transmittal ranking to the Caucus. The comment spreadsheets remained open, and comments on further rearrangement were encouraged.
4. Step 4: The Caucus held a meeting in which to decide upon the final transmittal list. Any member was able to extract an item and suggest its movement up or down in the

transmittal list. At the end of this meeting, 50 resolutions were ordered for preparation to be transmitted to the House of Delegates.

Your 2021–2022 executed this transmittal plan according to the November 2021 Transmittal Calendar (Appendix 1). On September 30, 2021, your 2021-2022 section delegates submitted 50 resolutions and priority statements for consideration to the House. This represented the largest volume of resolutions that our section had transmitted to the House at that time.

First in Person Meeting Since the COVID-19 Pandemic: 2022 Annual Meeting

The 2022 Annual Meeting was an in-person regular meeting that took place in Chicago from June 10-15, 2022. This meeting was announced as a regular meeting that will be governed by any AMA bylaws and precedent pertaining to these meetings. Therefore, it was determined that the prior prioritization process involving a resolutions committee, similar to the ones which had been used at the prior three meetings, would not be utilized at this meeting.

Regardless, the Speakers of the AMA House of Delegates did encourage all constituent societies and sections to be mindful of the volume of business that would be transmitted to the House, especially considering the large backlog that existed due to the virtual nature of the prior three meetings. Given these considerations, your 2021-2022 section delegates found merit in continuing to utilize a similar transmittal process in order to decide which resolutions should be transmitted to the House.

On March 8, 2022, your 2021-2022 Section Delegates held a caucus meeting regarding the Section's transmittal process, in which they described previous processes and solicited feedback, comments, and concerns. Caucus members and liaisons and other leadership present expressed the importance of a) balancing the workload for current delegates; b) balancing the number of controversial and noncontroversial resolutions sent for this meeting, and responsibility to the burden future caucuses will have to send; c) fairness to the many transmittals remaining in our queue and ensuring each one is heard and excellently defended in a timely manner; and d) continuing to have greater guidance from the Section Delegates while maintaining crucial spaces for delegate input and feedback into processes and decision. With this in mind, your 2021-2022 Section Delegates developed a transmittal plan with the following stages (the full details are available [here](#)):

1. Step 1: Spreadsheets for comments on each resolution were made available to Caucus members, resolution authors, and the Section. Comments were solicited in terms of a) urgency, b) timeliness, c) medical student specificity, d) support from other groups, e) degree of controversiality, f) whether transmittals could be combined with others, g) whether the ask of any transmittal's aims has already been accomplished by other means, and h) any other comments members believed may be helpful.

2. Step 2: The Section Delegates assigned different "themes" (for example, gender equity, public assistance, disability rights, etc) to each resolution, with each resolution having more than one theme. The 28 themes extracted from transmittals from November 2021 were found to completely cover the 113 transmittals in the queue at this time. Caucus members were again asked to vote on the order in which these themes should be considered priority.

3. Step 3: The SDs then arranged the resolutions by highest-ranking themes and, along with considering comments from the comment sheet and the amount of time we've held

each transmittal, the SDs chose ~30-35 transmittals for a Preliminary Transmittal Calendar. This list was then sent to the caucus and released to the section. The comment spreadsheets remained open, and comments on further rearrangement were encouraged.

4. Step 4: The Caucus held a meeting in which to decide upon the final transmittal list. Any member was able to extract an item and suggest its addition or removal from the final transmittal list. At the end of this meeting, 37 resolutions were ordered for preparation to be transmitted to the House of Delegates.

5. Step 5: The remaining 13 transmittals were selected via a randomized lottery that was conducted by your section delegates, who still took into account the comments/controversiality/etc. of any resolution selected by lottery. These transmittals were then added to the final transmittal list and all 50 resolutions were approved for transmittal to the House via a majority vote of the MSS Caucus.

Your 2021–2022 Section Delegates executed this transmittal plan according to the Annual 2022 Transmittal Calendar (Appendix 1). On April 8, 2022, your 2021-2022 section delegates submitted 23 previously submitted resolutions for consideration to the House. Your section delegates submitted the remaining 27 “on-time” resolutions to the House before the deadline of May 11, 2022. This represents the largest volume of resolutions that our section transmitted to the House at a regular, in-person meeting.

Current Meeting: Interim 2022

The Interim 2022 Meeting is scheduled as an in person meeting to take place in Honolulu, HI from November 10-15, 2022. In preparation for this meeting, your Section Delegates went through the pending transmittal list and discussed the best way to move forward in an effort to clear our section’s backlog. For this effort, on August 15, 2022 the first Caucus meeting was held to discuss the best way forward in choosing which transmittals should be sent to the House of Delegates for the I-22 Meeting. Following this initial Caucus meeting, the following was decided on how the process should process:

1. First, it was confirmed that we should continue with the theme prioritization process that was utilized at the A-22 meeting. Your Section Delegates assigned one of 28 themes to each resolution, after which Caucus members were asked to vote on the order in which these themes should be considered priority.
2. After consideration of the A-22 transmittal process, it was decided that your Section Delegations come up with an additional way to prioritize transmittal by considering the timeliness of each resolution. After deliberation, your Section Delegates proposed to score each resolution by three characteristics, each on a 1|2|3 point scale. The sum of these scores were added up and used to rank resolutions (minimum score of 3, maximum of 9). Those characteristics were as follows:
 - Impact (to be scored by the Caucus):
 - 3 - High impact
 - Substantial change to policy OR fills a massive gap
 - Impacts a large group or has a profound impact on a smaller group
 - 2 - Moderate impact
 - Changes policy or fills a gap that impacts a core issue

- Has a small impact on a large group or impacts a smaller group
- 1 - Low impact
 - Unlikely to substantially change AMA advocacy OR effect will be limited

Urgency (to be scored by Caucus):

- 3 - High urgency
 - Failure of AMA to act NOW may lead to irreparable harm to the ISSUE
 - Note that this does not consider the impact that acting on this issue may have, but only whether failure to act now will preclude future action!
- 2 - Moderate urgency
 - AMA engagement would materially assist the ISSUE in the short term but would not cause irreparable harm if there was no action
- 1 - Low urgency
 - AMA action can be delayed indefinitely without causing harm to advocacy on the issue

Length of time in queue:

- 3 - Passed in I-20 or before
- 2 - Passed in A-21 or I-21
- 1 - Passed in A-22

For the criteria listed as reviewed by the Caucus, we randomly assigned 10 transmittals per person to score for urgency and impact. Note that these were *just based on the resolved clauses*; it did NOT require a wholesale review of the entire transmittal. The sum of the scores were then used to rank each transmittal within the themes that the Caucus voted on. We felt that it was important that the Caucus be able to weigh in on both the impact and urgency of the proposed resolutions, and figured a simple scoring metric like this one would help identify the Caucus' perspective on each transmittal without being too time-consuming. We did recognize that this system is inherently biased against older transmittals, as those were likely retained in the queue because they have been judged in the past to have a lower impact and/or less urgency; therefore, we felt including a score that incorporates how long a resolution is left in the queue would help correct for that bias.

3. The SDs then created two options for the Preliminary Transmittal Calendar: Option A was to rank transmittals by their theme priority score, then their timeliness score and Option B was to rank transmittals by their timeliness score then their theme priority score. Both options were sent to the Caucus and an extraction form was sent to allow for more discussion on the rankings.
4. The Caucus held a meeting On September 15, 2022 which to decide upon the final transmittal list. It was decided to go with Option B for our Transmittal Calendar. Any member was able to extract an item and suggest its addition or removal from the final transmittal list. At the end of this meeting, 38 resolutions were ordered for preparation to be transmitted to the House of Delegates.

Your 2022–2023 Section Delegates executed this transmittal plan according to the Annual 2022 Transmittal Calendar (Appendix 1). On September 19, 2022, your 2022-2023 section delegates

submitted 10 resolutions from A-22 that had not previously been submitted for consideration to the House. Your section delegates submitted the remaining 28 “on-time” resolutions to the House before the deadline of October 13, 2022.

CONCERNS WITH A GROWING TRANSMITTAL QUEUE

The MSS Governing Council (GC) welcomes the increased interest in our MSS policy process and Assembly, and encourages students to submit resolutions advocating on issues which are important to them. However, several stakeholders have raised concerns about the growing transmittal queue. These concerns include:

- Insufficient time for adequate discussion of resolutions in the House of Delegates, including the bandwidth to garner external support for each resolution and potential dilution of MSS capital
- Timeliness of resolutions once they are transmitted, especially if left in queue beyond the standard 6-month period between national meetings
- Increasing impact on student leadership (including section and region delegates as well as the House Coordinating Committee) in regard to reviewing business items, preparing testimony, and defending MSS-authored resolutions, most of which cannot increase in size due to our bylaws
- Impact on AMA staff (including MSS staff, legal review, and advocacy review), who offer their feedback while concurrently preparing for the HOD and maintaining advocacy responsibilities

Table 1 shows the trend in MSS-authored resolutions discussed at each House of Delegates, and the ratio of MSS-authored to total number of HOD resolutions. *(Note that the idea of limiting the number or imposing additional thresholds for external resolutions has been considered by the 2018 MSS Resolutions Task Force, but was ultimately not recommended due to concerns on restricting the democratic process. Further, the MSS has tried restricting resolutions considered by a Resolutions Committee in the recent past and [found that the exercise did not ultimately reduce the amount of time or effort required for the resolutions process.](#)*

Meeting	Total No. of MSS Authored Resolutions	Total No. of HOD Resolutions	Ratio of MSS/HOD
A-06	13	-	-
I-06	4	-	-
A-07	12	254	4.72%
I-07	8	90	8.89%
A-08	13	239	5.44%
I-08	5	99	5.05%
A-09	10	224	4.46%
I-09	10	90	11.11%
A-10	14	198	7.07%

I-10	17	98	17.35%
A-11	23	189	12.17%
I-11	21	108	19.44%
A-12	29	216	13.43%
I-12	12	76	15.79%
A-13	17	179	9.50%
I-13	6	88	6.82%
A-14	13	200	6.50%
I-14	17	110	15.45%
A-15	16	199	8.04%
I-15	13	93	13.98%
A-16	17	185	9.19%
I-16	20	103	19.42%
A-17	19	197	9.64%
I-17	14	102	13.73%
A-18	31	200	15.5%
I-18	12	98	12.2%
A-19	23	232	9.9%
I-19	30	98	30.6%
A-20 **No policy discussion	(41 in queue)	N/A	-
I-20 **Special Meeting	9 transmitted, 5 considered	36 considered	13.9% of resolutions considered
A-21 **Special Meeting	(started with 101 in queue) 40 transmitted, 16 considered	66	24.2% of resolutions considered
I-21 **Special Meeting	(started with 105 in queue) 54 transmitted, 13 considered	39	33.3% of resolutions considered
A-22	(started with 113 in queue) 50 transmitted	232	21.6% of resolutions considered

I-22	(started with 74 in queue) 38 transmitted	TBD	TBD% of resolutions considered
MSS Average			13.28% (23.3% within the past 4 meetings)

TIMELINESS OF QUEUED TRANSMITTALS

Your Section Delegates and MSS Governing Council recognize the importance of finding a democratic solution that allows our Section to contribute meaningfully to the policy-making process of the AMA, and the capacity of our MSS Caucus to adequately defend each policy proposal brought forth to the HOD.

Appendix 2 of this report outlines the remaining transmittals along with a recommendation and supporting rationale where appropriate. Specifically, your Section Delegates sought to clarify whether the ask (1) remains timely and (2) has otherwise been carried out by the organization. If it was determined that a resolution's proposed policy has been accomplished elsewhere within the AMA, then your Section Delegates interpret transmission to the House of Delegates to be unnecessary as there would be no future "appropriate meeting" where such policy be considered timely, novel, or necessary to guide the AMA's operations or advocacy. In those resolutions, detailed justifications will be provided for the Assembly's consideration. **Appendix 3** of this report lists the resolutions to be transmitted to the House of Delegates at the Interim 2022 meeting. **Appendix 4** of this report gives the themes extracted from the current MSS pending transmittals with their rank and mean ranking.

Regardless of transmittal status, all policies shall be retained in the AMA-MSS Digest of Actions until sunset review. Individuals or organizations seeking support for a particular issue will have this available to reference.

RECOMMENDATIONS

Your Section Delegates recommend that the following resolutions be discharged from the transmittal queue:

1. 60 Anti-Harassment Training
2. 62 Mental Health First Aid Training
3. 93 Incorporating the Evidence-Based Concepts of the Choosing Wisely Program into Undergraduate and Graduate Medical Education
4. 76 Banning LGBTQ+ Panic Defenses

Your Section Delegates further recommend that the following resolutions be combined:

1. Addressing the Use of Mail-order Naloxone to Curb the Opioid Epidemic to Access to Naloxone for Vulnerable and Underserved Populations (New Title: Access to Naloxone for Vulnerable and Underserved Populations))

Your Section Delegates further recommend the following resolutions change its title:

1. 195 Comparative Effectiveness Research to 195 Study Integrating Comparative Effectiveness Research into the FDA Approval Process

Your Section Delegates further recommend that the following resolutions be held in the queue for the duration of the current meeting being due to other ongoing movement on related items:

1. 134 Movement Away from Employer-Sponsored Health Insurance
2. 160 Support of Vision Screenings and Visual Aids for Adults Covered by Medicaid
3. 107 Abolishment of the Resolution Committee
4. 127 Supporting Daylight Saving Time as the New, Permanent Standard Time
5. 143 Amending Policy on a Public Option to Maximize AMA Advocacy
6. 206 Indian Health Service Licensure Exemptions

Appendix 1: Transmittal Calendars

November 2020 Meeting

Dates	Event
Aug 14th (Fri)	Release I-2020 Transmittal Calendar to MSS Caucus.
Aug 19th (Wed)	I-2020 Transmittal Focus Priorities submission deadline @ 11:59pm CT.
Aug 21st (Fri)	Release summarized list of potential themes for Caucus to vote.
Aug 25th (Tue)	Deadline to vote for I-2020 Transmittal Focus Priorities @ 11:59pm CT.
Aug 26th (Wed)	I-2020 Transmittal Focus Priorities released to MSS Caucus.
Aug 28th (Fri)	Announce Transmittal Focus Priorities to I-2020 Transmittal Authors. Release Google Form for authors and MSS Caucus to submit comments in support of any transmittal candidates, and how that resolution aligns with Focus Priorities, timeliness, impact (300 characters max).
Sept 5th (Sat)	Deadline for transmittal authors and MSS Caucus to comment on resolutions @ 11:59pm CT.
Sept 6th (Sun)	Transmittal Scoring Assignments released to MSS Caucus. Submitted comments will be included for reviewers to consider while scoring/tiering.
Sept 18th (Fri)	Transmittal Scoring Deadline @ 11:59pm CT.
Sept 21st (Mon)	Release list of I-2020 Final Resolutions asking for immediate forwarding to Caucus for review.
Sept 24th (Thu)	MSS Caucus Town Hall to discuss the I-2020 Resolutions @ 8pm CT.
Sept 25th (Fri)	Release “consent calendar” of transmittals, after incorporating potential immediately forwarded resolutions, for Caucus review in preparation for town hall. Notify transmittal authors of decision.
Sept 30th (Wed)	MSS Caucus Town Hall to discuss transmittals list @ 7pm CT. If planning to extract, please complete this form 24hrs before the Town Hall.

Oct.1st (Thu)	Submit I-2020 Transmittals to the House of Delegates

June 2021 Meeting

Dates	Event
Feb 21 (Sun)	MSS Caucus meeting to brainstorm transmittal process, including any potential changes.
Mar 13th (Sat)	Transmittal Focus Priorities submission deadline @ 11:59pm CT.
Mar 14th (Sun)	Release summarized list of potential themes for Caucus to vote.
Mar 18th (Thu)	Deadline to vote for J-2021 Transmittal Focus Priorities @ 11:59pm CT.
Mar 19th (Fri)	Announce Transmittal Focus Priorities to J-2021 Transmittal Authors. Open Comment Period all MSS members to submit comments in support of any transmittal candidates, and how that resolution aligns with Focus Priorities, timeliness, impact (1000 characters max). Send resolutions for preliminary advocacy feedback.
Mar 28th (Sun)	Open Comment Period on MSS Transmittals closes @ 11:59pm CT.
Mar 29th (Mon)	Transmittal Scoring Assignments released to MSS Caucus. Submitted comments will be included for reviewers to consider while scoring/tiering.
Apr 10th (Sat)	Transmittal Scoring Deadline/Voting @ 11:59pm CT.
Apr 13th (Tue)	Release list of J-2021 Final Resolutions asking for immediate forwarding to Caucus for review.
Apr 23rd (Fri)	Release preliminary “consent calendar” of transmittals, after incorporating potential immediately forwarded resolutions, for Caucus review in preparation for town hall.
Apr 25th (Sun)	MSS Caucus Town Hall to discuss transmittals list (MANDATORY) @ 3pm CT. Transmittal Calendar finalized following MSS Caucus Town Hall.
May 12th (Wed)	Deadline to submit J-2021 Transmittals (batch #1) to the House of Delegates

November 2021 Transmittal Calendar

Dates	Event
Aug. 10 (Tues)	First email to Caucus regarding transmittal process for upcoming meeting.
Aug. 26th (Thurs)	Section Delegates solicit feedback on previous transmittal processes and input on proposed ideas from Caucus.
Aug. 29th (Sun)	Release N-2021 Transmittal Calendar and Process to MSS Caucus. The N-2021 Transmittal Comments sheet was released and would remain open for the entirety of this process.
Sept. 5th (Sun)	Section Delegates release N-2021 Transmittal Themes for voting by MSS Caucus.
Sept. 7th (Tues)	MSS Town Hall to discuss N-2021 Transmittal Process. The event was open to all MSS members, recorded, and posted online.
Sept. 10th (Fri)	Deadline for MSS Caucus to vote on prioritization of N-2021 Transmittal Themes .
Sept. 16th (Thurs)	Section Delegates release Transmittal List, which included the preliminary N-21 Delegate Report plan, to the Caucus.
Sept 20-26th (Mon-Thu)	Extractions for changing the Transmittal list are open to the Caucus and due by 12 pm CT the day of the meeting.
Sept 26th (Sun)	MSS Caucus meeting to discuss the N-2021 Transmittal Consent Calendar.
Sept 27th (Mon)	Section Delegates release approved N-2021 Transmittal Consent Calendar
Sept. 30th (Thurs)	Deadline to submit N-2021 Transmittals to the House of Delegates

Annual 2022 Transmittal Calendar

Dates	Event
Feb.26 (Sat)	First email to Caucus regarding transmittal process for upcoming meeting.
March 8 (Tues)	Section Delegates solicit feedback on proposed ideas and previous transmittal processes from Caucus.
March 9 (Wed)	Release A-22 Transmittal Calendar and Process to MSS Caucus. Additionally, the A-22 Transmittal Comments is released and will remain open for the entirety of this process.
March 14 (Mon)	Section Delegates release A-22 Transmittal Themes for voting by MSS Caucus.
March 24 (Thu)	Deadline to vote on prioritization of A-22 Transmittal Themes by 11:59 PM PST
March 26 (Sat)	Section Delegates release A-22 Preliminary Transmittal Calendar to MSS Caucus.
March 26 thru April 4	Extractions (for removal from the calendar or addition to the calendar) will be due at the beginning of the meeting with justification.
April 4-5 (Mon–Tues)	MSS Caucus Town Hall to discuss the A-22 Transmittal Consent Calendar and additions (MANDATORY)
April 7 (Thurs)	Section Delegates release approved A-2022 Transmittal Consent Calendar to MSS Caucus and send previously-submitted transmittals to staff to be sent to the House of Delegates
April 8 (Fri)	Deadline to submit A-22 resubmissions to the House of Delegates
April 29 (Fri)	Section Delegates send “on-time” (never previously submitted) transmittals to staff to be sent to the House of Delegates
May 11 (Wed)	Deadline to submit A-22 “on-time” transmittals to the House of Delegates

Interim 2022 Transmittal Calendar

Dates	Event
Aug.21 (Sun)	First email to Caucus regarding transmittal process for upcoming meeting.
Aug 30 (Tues)	Section Delegates have first feedback on proposed ideas and previous transmittal processes from Caucus.
Aug 31 (Wed)	Section Delegates release I-22 Transmittal Themes for voting by MSS Caucus.
Sept 6 (Tues)	Deadline to vote on prioritization of I-22 Transmittal Themes by 11:59 PM PST
Sept 6 (Tues)	Section Delegates release I-22 Transmittal Timeliness scoring by MSS Caucus.
Sept 12 (Mon)	Deadline to score I-22 transmittals on timeliness by 11:59 PM PST
Sept 13 (Tues)	Section Delegates release I-22 Preliminary Transmittal Calendar to MSS Caucus.
Sept 13 thru Sept 15	Extractions (for removal from the calendar or addition to the calendar) will be due at the beginning of the meeting with justification.
Sept 15 (Thurs)	MSS Caucus Town Hall to discuss the I-22 Transmittal Consent Calendar
Sept 19 (Mon)	Section Delegates release approved I-2022 Transmittal Consent Calendar to MSS Caucus and send A-22 transmittals that have not been previously submitted to staff to be sent to the House of Delegates
Oct 13 (Thurs)	Deadline to submit I-22 “on-time” transmittals to the House of Delegates

Appendix 2 – Recommendations for Pending MSS Transmittals to the House of Delegates

Transmittal	Recommendation
Reducing Disparities in HIV Incidence through PREP for HIV RESOLVED, That our AMA amend AMA Policy H-20.895 “Pre-Exposure Prophylaxis (PrEP) for HIV” by insertion to read as follows: H-20.895 – PRE-EXPOSURE PROPHYLAXIS (PREP) FOR HIV 1. Our AMA will educate physicians, <u>physicians-in-training</u>, and the public about the effective use of pre exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines. 2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances. 3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant. 4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use. 5. <u>Our AMA encourages the discussion of an education about PrEP during routine sexual health counseling, regardless of a patient’s current reported sexual behaviors.</u>	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Reducing Costs of CMS Limited Data Sets for Academic Use RESOLVED, That our AMA encourage the Centers for Medicare and Medicaid Services to adjust the pricing of limited data sets in order to increase access for academic use.	Retain in transmittal queue – No concrete evidence of significant & relevant activity from the AMA
Promoting Multi-Use Devices and Sustainable Practices in the OR RESOLVED, That our AMA advocate for research into and development of intended multi-use operating room equipment and attire over devices, equipment, and attire labeled for “single-use” with verified similar safety and efficacy profiles.	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Amending G-630.140, Lodging, Meeting Venues, and Social Functions RESOLVED, That our AMA amend AMA policy G-630.140 Lodging, Meeting Venues, and Social Functions	Retain in transmittal queue – There is evidence that a similar resolution will be brought forward at the I-22 meeting

be amended by addition as follows:

**LODGING, MEETING VENUES, AND SOCIAL
FUNCTIONS, G-630.140**

1. Our AMA supports choosing hotels for its meetings, conferences, and conventions based on size, service, location, cost, and similar factors.
2. Our AMA shall attempt, when allocating meeting space, to locate the Section Assembly Meetings in the House of Delegates Meeting hotel or in a hotel in close proximity.
3. All meetings and conferences organized and/or primarily sponsored by our AMA will be held in a town, city, county, or state that has enacted comprehensive legislation requiring smoke-free worksites and public places (including restaurants and bars), unless intended or existing contracts or special circumstances justify an exception to this policy, and our AMA encourages state and local medical societies, national medical specialty societies, and other health organizations to adopt a similar policy.
4. It is the policy of our AMA not to hold national 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.

**Medicaid and CHIP Coverage of Continuous Glucose
Monitoring Devices for Patients with Insulin Dependent
Diabetes**

RESOLVED, That our AMA advocate for broadening the classification criteria of Durable Medical Equipment to include all clinically effective and cost-saving diabetic glucose monitors; and be it further

RESOLVED, That our AMA amend policy H-330.885 by addition and deletion as follows:

**H-330.885 – ~~MEDICARE~~ PUBLIC INSURANCE
COVERAGE OF CONTINUOUS**

**This item will be transmitted by our section to
the 2022 Interim Meeting of the AMA House of
Delegates (please see Appendix 3).**

GLUCOSE MONITORING DEVICES FOR PATIENTS WITH INSULIN DEPENDENT DIABETES Our AMA supports efforts to achieve Medicare coverage of continuous <u>and flash</u> glucose monitoring systems for <u>all diabetic patients with diabetes with insulin-dependent diabetes by all public insurance programs.</u> RESOLVED, That our AMA amend Policy H-330.885, to include the following: ~~MEDICARE-PUBLIC INSURANCE~~ COVERAGE OF CONTINUOUS GLUCOSE MONITORING DEVICES FOR PATIENTS WITH INSULIN-DEPENDENT DIABETES, H-330.885 Our AMA supports efforts to achieve ~~Medicare, Medicaid, and Children's Health Insurance Program (CHIP)~~ coverage of continuous glucose monitoring systems for patients with insulin-dependent diabetes <u>by all public insurance programs.</u>	
Supporting the Use of Gender-Neutral Language RESOLVED, That our AMA (1) Recognize the importance of using gender-neutral language such as gender-neutral pronouns, terms, imagery, and symbols in respecting the spectrum of gender identity (2) Revise all relevant policies to utilize gender-neutral language in place of gendered language where such text inappropriately appears (3) Utilize gender-neutral language in future policies, internal communications, and external communications where gendered language does not specifically need to be used. (4) Encourage the use of gender-neutral language in public health and medical messaging (5) Encourage other professional societies to utilize gender-neutral language in their work (6) Support the use of gender-neutral language in clinical spaces that may serve both cisgender and gender-diverse individuals	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Support for Mental Health Courts RESOLVED, That AMA Policy H-100.955, Support for Drug Courts, be amended by addition and deletion as follows: SUPPORT FOR MENTAL HEALTH DRUG COURTS, H-100.955 Our AMA: (1) supports the establishment <u>and use of mental health drug courts, including drug courts and sobriety courts,</u> as an effective method of intervention for individuals with <u>mental illness involved in the justice</u>	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

<u>system within a comprehensive system of community-based services and supports</u>; (2) encourages legislators to establish <u>mental health drug</u> courts at the state and local level in the United States; and (3) encourages <u>mental health drug</u> courts to rely upon evidence-based models of care for those who the judge or court determine would benefit from intervention rather than incarceration.	
Decreasing Youth Access to E-Cigarettes RESOLVED, That AMA policy H-495.986 be amended by insertion as follows: Tobacco Product Sales and Distribution, H-495.986 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;	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

(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. <u>(11) supports measures that prevent retailers from opening new tobacco specialty stores in proximity to elementary schools, middle schools, and high schools;</u> <u>and</u> <u>(12) supports measures that decrease the overall density of tobacco specialty stores.</u>	
Non-Cervical HPV-Associated Cancer Prevention RESOLVED, That our AMA amend policy H-440.872, HPV Vaccine and Cervical Cancer Prevention Worldwide, by addition and deletion as follows: HPV VACCINE AND ~~CERVICAL~~-CANCER PREVENTION WORLDWIDE, H-440.872 1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine ~~cervical~~-cancer screening <u>for those at risk</u>; 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	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

and understanding about HPV and associated diseases, <u>in all individuals regardless of sex, such as, but not limited to cervical cancer, head and neck cancer, anal cancer, and penile cancer</u>, the availability and efficacy of HPV vaccinations, and 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. <u>4. Our AMA encourage appropriate stakeholders to investigate means to increase HPV vaccination rates by:</u> <u>(a) facilitating administration of HPV vaccinations in community-based settings including school settings, and</u> <u>(b) supporting state mandates for HPV vaccination for school attendance.</u> RESOLVED, That our AMA support legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV-associated cancers.	
Anti-Harassment Training RESOLVED, That our AMA require all members elected and appointed to national and regional AMA leadership positions to complete AMA Code of Conduct and anti-harassment training, with continuous evaluation of the training for effectiveness in reducing harassment within the AMA; and be it further RESOLVED, That our AMA work with the Women Physicians Section, American Medical Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer to leadership.	This item will be discharged from the transmittal queue. This resolution was adopted by the House of Delegates via Resolution 615 at A-22, such that Policy D-65.989, Advancing Gender Equity in Medicine, now reads in part: <i>"5. Our AMA will: (a) require all members elected and appointed to national and regional AMA leadership positions to complete AMA Code of Conduct and anti-harassment training, with continued evaluation of the training for effectiveness in reducing harassment within the AMA; and (b) work with the Women Physicians Section, American Medical Women's Association, GLMA: Health Professionals Advancing LGBTQ Equality, and other stakeholders to identify an appropriate, evidence-based anti-harassment and sexual harassment prevention training to administer to leadership."</i> It should therefore be discharged from the queue.
Mental Health First Aid Training RESOLVED, That our AMA encourage appropriate stakeholders including physicians, medical societies, physician specialty organizations, federation of state medical boards, and state medical boards to provide	This item will be discharged from the queue Nearly-identical language proffered by Michigan at A-22 in Resolution 426 was combined with Resolution 425 and adopted by the House of Delegates. The resultant policy D-345.972, Mental Health Crisis, reads in part:

access to evidence-based mental illness rescue training programs as accredited Continuing Medical Education (CME) commensurate with their responsibilities in emergent mental illness crises, both in the clinical setting and community.	<i>“2. Our AMA supports physician acquisition of emergency mental health response skills by promoting education courses for physicians, fellows, residents, and medical students including, but not limited to, mental health first aid training.”</i> This language encapsulates the intent of “Mental Health First Aid Training”. This resolution should therefore be discharged from the queue.
Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings RESOLVED, That our AMA commit to reaching net zero emissions for its business operations by 2030, and remain net zero or net negative, as defined by a carbon neutral certifying organization, and report annually on the AMA's progress towards implementation; and be it further RESOLVED, That our AMA work with appropriate stakeholders to encourage the United States healthcare system, including but not limited to hospitals, clinics, ambulatory care centers, and healthcare professionals, to decrease emissions to half of 2010 levels by 2030 and become net zero by 2050, and remain net zero or negative, as defined by a carbon neutral certifying organization, including by creating educational materials; and be it further RESOLVED, That our AMA evaluate the feasibility of purchasing carbon offsets for member travel to and from Annual and Interim meetings and report back to the House of Delegates; and be it further RESOLVED, That our AMA evaluate the feasibility of holding future Annual and Interim meetings at Leadership in Energy and Environmental Design- certified or sustainable conference centers and report back to the House of Delegates. RESOLVED, That our AMA amend Policy D-135.997, “Research into the Environmental Contributors to Disease,” by addition and deletion to read as follows: D-135.997 – ~~RESEARCH INTO THE ENVIRONMENTAL CONTRIBUTORS TO~~ <u>DISEASE AND ADVOCATING FOR ENVIRONMENTAL JUSTICE</u> Our AMA will (1) advocate for the greater public and private funding for research into the environment causes of disease, and urge the National committee of the Medicine and Public Health Initiative Coalition to	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

consider environmental contributors to disease <u>and environmental racism</u> as a-priority public health issues; (3) <u>encourage federal, state, and local agencies to address and remediate environmental injustice, environmental racism, and all other environmental conditions that are adversely impacting health, especially in marginalized communities;</u> and (4) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies. Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering	
Opposition to Alcoholic Industry Marketing Self-Regulation RESOLVED, That our AMA amend policy H-30.940, Labeling, Advertising, and Promotion of Alcoholic Beverages, by addition and deletion as follows: LABELING, ADVERTISING, AND PROMOTION OF ALCOHOLIC BEVERAGES, H-30.940 (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 underaged use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

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); and (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). (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 federal and/or state oversight for all forms of alcohol advertising in lieu of the alcohol industry's current practice of self-regulated advertising and marketing; ~~(a)~~(b) 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)~~(c) opposes the use of the radio and television any form of advertising which links alcoholic products to agents of socialization in order to promote drinking; ~~(c)~~(d) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; ~~(d)~~(e) 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)~~(f) 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 all advertising directed toward youth, including such as ~~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); (e) 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 (f) commends those automobile and alcoholic beverage companies that have

advertised against driving while under the influence of alcohol.	
Banning LGBTQ+ Panic Defenses RESOLVED, That our AMA advocate for legislation that would ban the use of LGBTQ+ “panic” defenses in court.	This item will be discharged from the transmittal queue. Resolution 203, introduced by multiple sections including the MSS, was adopted by the House of Delegates in A-22, resulting in Policy D-65.986, Ban the Gay/Trans (LGBTQ+) Panic Defense, which reads as follows (underline introduced to highlight similarities with this resolution): <i>“Our AMA will: (1) <u>support federal legislation banning the use of the so-called “gay/trans (LGBTQ+) panic” defense in homicide, manslaughter, physical or sexual assault cases</u>; and (2) <u>develop an issue brief and talking points on the topic of so called “gay/trans (LGBTQ+) panic” defense, that can be used by our AMA in support of federal legislation, and can be used and adapted by state and specialty medical societies, other allies, and stakeholders as model legislation when seeking state legislation to ban the use of so-called “gay/trans (LGBTQ+) panic” defense to mitigate personal responsibility for violent crimes such as assault, rape, manslaughter, or homicide.</u>”</i> The similarity of D-65.986 to this resolution is notable, and significantly expands on the original language to establish support for federal legislation and produce an infographic to guide state medical societies as they advocate for similar state-level legislation. As such, this resolution should be discharged from the queue.
Providing Reduced Parking Fees for Patients and Trainees RESOLVED, That our AMA works with relevant stakeholders to recognize parking fees as a barrier to patient care and encourage mechanisms for reducing parking costs for patients and trainees.	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA
Opposing Use of Vulnerable Incarcerated People in Response to Public Health Emergencies of Infectious Disease Origin RESOLVED, That our AMA opposes the use of forced or coercive labor practices for incarcerated populations; and be it further RESOLVED, That our AMA supports that any labor performed by incarcerated individuals or other captive	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

populations should include adequate workplace safety and fairness standards similar to those outside of carceral institutions and support their reintegration into the workforce after incarceration.	
Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers RESOLVED, That AMA policy H-430.983 be amended by addition and deletion as follows: ~~REDUCING~~ <u>OPPOSING THE USE OF RESTRICTIVE HOUSING IN FOR PRISONERS WITH MENTAL ILLNESS</u> Our AMA will: (1) ~~support limiting~~ <u>oppose</u> the use of solitary confinement of any length, ~~with rare exceptions~~, for incarcerated persons ~~with mental illness~~, in adult correctional facilities <u>and detention centers, except for medical isolation or to protect individuals who are actively being harmed or will be immediately harmed by a physically violent individual, in which cases</u> <u>confinement may be used for as short a time as possible;</u> ~~and~~ (2) <u>while solitary confinement practices are still in place</u>, 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) <u>encourage appropriate stakeholders to develop and implement safe, human, and ethical alternatives to solitary confinement for incarcerated persons in all correctional facilities;</u> ~~and~~ (3) ~~encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.~~	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
TV Broadcast and Online Streaming of LGBTQ+ Inclusive Sexual Encounters and Public Health Awareness on Social Media Platforms RESOLVED, That our AMA amend policy H-485.994, "Television Broadcast of Sexual Encounters and Public Health Awareness" by addition and deletion, to read as follows: TELEVISION BROADCAST <u>AND ONLINE STREAMING</u>	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA

OF SEXUAL ENCOUNTERS AND PUBLIC HEALTH AWARENESS <u>ON SOCIAL MEDIA PLATFORMS</u>, H-485.994 The AMA urges television broadcasters <u>and online streaming services</u>, producers, ~~and~~ sponsors, <u>and any associated social media outlets</u> to encourage education about <u>heterosexual and LGBTQ+ inclusive</u> safe sexual practices, including but not limited to condom use and abstinence, in television <u>or online</u> programming of sexual encounters, and to accurately represent the consequences of unsafe sex.	
Encouraging Collaboration between Physicians and Industry in AI Development RESOLVED, That our AMA augment the existing Physician Innovation Network (PIN) through the creation of advisors to specifically link physician members of AMA and its associated specialty societies with companies or individuals working on augmented intelligence (AI) research and development, focusing on: (1) Expanding recruitment among AMA physician members, (2) Advising AMA physician members who are interested in healthcare innovation/AI without knowledge of proper channels to pursue their ideas, (3) Increasing outreach from AMA to industry leaders and companies to both further promote the PIN and to understand the needs of specific companies, (4) Facilitating communication between companies and physicians with similar interests, (5) Matching physicians to projects early in their design and testing stages, (6) Decreasing the time and workload spent by individual physicians on finding projects themselves, (7) Above all, boosting physician-centered innovation in the field of AI research and development; and be it further RESOLVED, That our AMA support selection of PIN advisors through an application process where candidates are screened by PIN leadership for interpersonal skills, problem solving, networking abilities, objective decision making, and familiarity with industry.	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Incorporating the Evidence-Based Concepts of the Choosing Wisely Program into Undergraduate and Graduate Medical Education RESOLVED, That our American Medical Association amend D-155.988, Support for the concepts of the “Choosing Wisely” Program by insertion as follows:	At A-22, Report 6 from the Council on Medical Education amended D-155.988, Support for the Concepts of the Choosing Wisely Program, to include the following language: <i>“2. Our AMA will work with relevant stakeholders, including specialty societies in the Federation of Medicine, such as the American Society for Clinical</i>

SUPPORT FOR THE CONCEPTS OF THE “CHOOSING WISELY” PROGRAM, D-155.988 1. Our AMA supports the concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program. <u>2. Our AMA supports the inclusion of the evidence-based concepts of the American Board of Internal Medicine Foundation's Choosing Wisely program in undergraduate and graduate medical education.</u>	<i>Pathology and College of American Pathologists, to promote educational resources regarding appropriate test ordering and interpretation.”</i> The Choosing Wisely program/campaign encourages physicians and patients to avoid unnecessary tests and procedures through education. The language included in D-155.988 via the Council's report broadens this language to include promotion of all educational resources regarding appropriate test ordering and interpretation. Since the first clause of D-155.988 establishes AMA support for the Choosing Wisely program, this language thus accomplishes the intent of this resolution, which should therefore be discharged from the queue.
Hospital Bans on TOLAC RESOLVED, That our AMA encourage hospitals that can provide basic maternal care as defined by American College of Obstetrics and Gynecology not to prohibit trial of labor after cesarean (TOLAC); and be it further RESOLVED, That our AMA encourage hospitals that do not have resources to perform trial of labor after cesarean (TOLAC) to assist in the transfer of care of patients who desire TOLAC to a hospital that is equipped to perform TOLAC.	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Guidelines on Chaperones for Sensitive Exams RESOLVED, That our AMA ask the Council on Ethical & Judicial Affairs to consider amending E-1.2.4, “Use of Chaperones in Code of Medical Ethics,” to ensure that it is most in line with the current best practices and potentially considers the following topics: a) opt-out chaperones for breast, genital, and rectal exams; b) documentation surrounding the use or not-use of chaperones; c) use of chaperones for patients without capacity; d) asking patients' consent regarding the gender of the chaperone and attempting to accommodate that preference as able.	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Development and Implementation of Recommendations for Responsible Media Coverage of Drug Overdoses RESOLVED, That our AMA encourages the Centers for Disease Control and Prevention, in collaboration with other public and private organizations, to develop recommendations or best practices for media coverage and portrayal of Opioid Drug overdoses.	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Teaching and Assessing Osteopathic Manipulative	Retain in transmittal queue – no concrete

Treatment and Osteopathic Principles and Practice to Resident Physicians in the Context of ACGME Single System Accreditation RESOLVED, That our AMA collaborate with the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and any other relevant stakeholders to investigate the need for graduate medical education faculty development in the supervision of Osteopathic Manipulative Treatment across ACGME accredited residency programs.	evidence of significant & relevant activity from the AMA
Abolishment of the Resolution Committee RESOLVED, That our AMA abolish the Resolution Committee by amending the AMA Bylaws B-2.13.3, "Resolution Committee," as follows by deletion: ~~Resolution Committee, B-2.13.3~~ ~~The Resolution Committee is responsible for reviewing resolutions submitted for consideration at an Interim Meeting and determining compliance of the resolutions with the purpose of the Interim Meeting.~~ ~~2.13.3.1 Appointment. The Speaker shall appoint the members of the committee. Membership on this committee is restricted to delegates.~~ ~~2.13.3.2 Size. The committee shall consist of a maximum of 31 members.~~ ~~2.13.3.3 Term. The committee shall serve only during the meeting at which it is appointed, unless otherwise directed by the House of Delegates.~~ ~~2.13.3.4 Quorum. A majority of the members of the committee shall constitute a quorum.~~ ~~2.13.3.5 Meetings. The committee shall not be required to hold meetings.~~ ~~Action may be taken by written or electronic communications.~~ ~~2.13.3.6 Procedure. A resolution shall be accepted for consideration at an Interim meeting upon majority vote of committee members voting. The Speaker shall only vote in the case of a tie. If a resolution is not accepted, it may be submitted for consideration at the next Annual Meeting in accordance with the procedure in Bylaw 2.11.3.1.~~ ~~2.13.3.7 Report. The committee shall report to the Speaker. A report of the committee shall be presented to the House of Delegates at the call of~~	Retain in transmittal queue – There is a forthcoming BOT report at the I-22 meeting, and the MSS Caucus voted to wait and view the contents of this report before transmitting.

the Speaker.	
Increase Employment Services Funding to People with Disabilities RESOLVED, That our AMA support increased resources for employment services to reduce health disparities for people with disabilities.	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Promoting Oral Anticancer Drug Parity RESOLVED, That our AMA amend H-55.986, Home Chemotherapy and Antibiotic Infusions by addition and deletion as follows: H-55.986 – HOME CHEMOTHERAPY AND ANTIBIOTIC INFUSIONS Our AMA: (1) endorses the use of home <u>medications to include those orally-administered</u>, 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	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

events associated with drug infusion and disposal are not in place; this includes withholding of payment or prior authorization requirements for other settings-; and (7) advocates for patient cost-sharing parity between office- and home administered anticancer drugs.	
Formal Transitional Care Program for Children and Youth with Special Healthcare Needs RESOLVED, That our AMA amend policy H-60.974, Children and Youth with Disabilities, by addition and deletion as follows, to strengthen our AMA policy and to include population of patients that do not fall under “disability” but also need extra care, especially when transitioning to adult health care, that they are currently not receiving due to a gap: H-60.974 – CHILDREN AND YOUTH WITH DISABILITIES AND WITH SPECIAL HEALTH CARE NEEDS It is the policy of the AMA: (1) to inform physicians of the special health care needs of children and youth with disabilities <u>and children and youth with special health care needs (CYSHCN)</u>; (2) to encourage physicians to pay special attention during the preschool physical examination to identify physical, emotional, or developmental disabilities that have not been previously noted; (3) to encourage physicians to provide services to children and youth with disabilities and <u>CYSHCN</u> that are family-centered, community-based, and coordinated among the various individual providers and programs serving the child; (4) to encourage physicians to provide schools with medical information to ensure that children and youth with disabilities <u>and CYSHCN</u> receive appropriate school health services; (5) to encourage physicians to establish formal transition programs or activities that help adolescents with disabilities, <u>and CYSHCN</u>, and their families to plan and make the transition to the adult medical care system; (6) to inform physicians of available educational and other local resources, as well as various manuals that would help prepare them to provide family-centered health care; and (7) to encourage physicians to make their offices accessible to patients with disabilities <u>and CYSHCN</u>, especially when doing office construction and renovations.	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA
Exclusion of Race and Ethnicity in the First Sentence of	Retain in transmittal queue – no concrete

Case Reports RESOLVED, That our AMA encourages curriculum and clinical practice that omits race and/or ethnicity from the first sentence of case reports and other medical documentation; and be it further RESOLVED, That our AMA encourages the maintenance of race and ethnicity in other relevant sections of case reports and other medical documentation.	evidence of significant & relevant activity from the AMA
Regulation of Phthalates in Adult Personal Sexual Products RESOLVED, That AMA H-135.945 be amended by addition and deletion as follows: H-135.945 – ENCOURAGING ALTERNATIVES TO PVC/PHthalate ~~DEHP~~ PRODUCTS IN HEALTH Our AMA: (1) Encourages hospitals and physicians to reduce and phase out polyvinyl chloride (PVC) ~~medical device products~~, especially those containing <u>phthalates such as Di(2-ethylhexyl)phthalate (DEHP)</u>, and urge adoption of safe, cost-effective, alternative products where available; and (2) Urges expanded manufacturer development of safe, cost-effective alternative products to PVC ~~medical device products~~, especially those containing <u>phthalates such as DEHP;</u> and (3) <u>Encourages the U.S. Consumer Product Safety Commission to conduct a risk assessment of adult personal consumer products, including adult personal sexual products, as a source of phthalates;</u> and (4) <u>Supports consumer education about the potential for exposure to toxic substances in adult personal sexual products.</u>	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA
Supporting Daylight Saving Time as the New, Permanent Standard Time RESOLVED, That our AMA recognize the adverse health effects of biannual time changes and support the	Retain in transmittal queue – There is a similar resolution being brought forward at the I-22 Meeting by another delegation.

elimination of biannual time changing; and be it further RESOLVED, That our AMA recognize the positive health effects of daylight savings time and support daylight savings time as the permanent standard time.	
Establishing Comprehensive Dental Benefits Under State Medicaid Programs RESOLVED, That our AMA amend H-330.872, “Medicare Coverage for Dental Services” by addition and deletion as follows: H-330.872 - <u>MEDICARE, MEDICAID, AND OTHER PUBLIC HEALTH INSURANCE</u> COVERAGE FOR DENTAL SERVICES Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare, ~~and Medicaid, and other~~ <u>public health insurance program</u> beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease ~~among in both~~ <u>Medicare, and Medicaid, and other public health insurance program</u> ~~beneficiaries populations~~, the optimal dental benefit plan designs to cost effectively improve health and prevent disease ~~in both~~ <u>among Medicare, and Medicaid, and other public health insurance program beneficiaries</u> ~~populations~~, and the impact of expanded dental coverage on health care costs and utilization.	Retain in transmittal queue –
Updating AMA Bylaw 2.12.2, Special Meetings of the House of Delegates RESOLVED, That our AMA update its Special Meeting procedures by updating the Special Meetings Bylaws as follows: 1. Specification that the processes used to determine which items of business meet or do not meet the purpose for which the Special Meeting is called shall be published online and electronically sent to all members of the House of Delegates prior to the initiation of the Special Meeting. 2. Specification concerning the processes for how formal	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

feedback may be submitted and reviewed prior to, during, and after the conclusion of the Special Meeting. 3. Description of how a Special Meeting report, detailing the processes that were used in the meeting, along with a summary of the concerns and suggestions submitted by the formal feedback mechanism, shall be produced by the Speakers and Board of Trustees following each Special Meeting that occurs. 4. Description of how, after each Special Meeting, a committee that is representative of House membership shall be formed for the purpose of (a) reviewing the Special Meeting and (b) proposing any improvements to the processes for future Special Meetings.	
Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements RESOLVED, That our AMA encourages transplant centers to expand potential recipient evaluation criteria to include patients that may not satisfy center-specific alcohol sobriety requirements on a case by-case basis, using medically appropriate criteria supportable by peer-reviewed and published research.	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Movement Away from Employer-Sponsored Health Insurance RESOLVED, That our AMA recognize the inefficiencies and complexity of the employer-sponsored health insurance system and the existence of alternative models that better align incentives to facilitate access to high quality healthcare; and be it further RESOLVED, That our AMA support movement toward a healthcare system that does not rely on employer sponsored health insurance and enables universal access to high quality healthcare; and be it further RESOLVED, That our AMA amend Policy H-165.828, "Health Insurance Affordability," by addition and deletion to read as follows: H-165.828 – HEALTH INSURANCE AFFORDABILITY 1. ~~Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA). Our AMA advocates for the elimination of the employer sponsored insurance firewall such that no individual would be ineligible for premium tax credits and cost-sharing assistance for marketplace~~	Retain in transmittal queue – There is evidence of a similar resolution being brought forward for the I-22 meeting by another delegation

coverage solely on the basis of having access to employer-sponsored health insurance.

2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage.

3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.

4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.

5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost sharing responsibilities for common procedures and services.

6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.

7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.

RESOLVED, That our AMA amend Policy H-165.823, "Options to Maximize Coverage under the AMA Proposal for Reform," by addition and deletion to read as follows:

H-165.823 – OPTIONS TO MAXIMIZE COVERAGE UNDER THE AMA PROPOSAL FOR REFORM

1. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:

a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.

~~b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for~~

~~minimum value of benefits.~~

- ~~b~~e. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
 - ~~c~~d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
 - ~~d~~e. The public option is financially self-sustaining and has uniform solvency requirements.
 - ~~e~~f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
 - fg. The public option shall be made available to uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.
2. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
- a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
 - b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children’s Health Insurance Program (CHIP) or zero-premium marketplace coverage.
 - c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
 - d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto enrollment.
 - e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
 - f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.

g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans. h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost sharing reductions, and establishing a special enrollment period	
Addressing Longitudinal Health Care Needs of Children in Foster Care RESOLVED, That our AMA support the construction of health information systems to enhance information exchange between both tribal and nontribal child welfare agencies and healthcare professionals; and be it further RESOLVED, That our AMA advocate for the designation of medical teams, and/or committees to longitudinally follow children in foster care; and be it further RESOLVED, That our AMA advocate for pediatrician oversight of local, tribal, and state child welfare systems; and be it further RESOLVED, that our AMA recognize the historical and ongoing disproportionate removal and placement of American Indian and Alaska Native children in foster care.	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Re-Evaluating the FDA's Citizen Petition Process RESOLVED, That our AMA work with relevant stakeholders to advocate for further public transparency of citizen petitions to the Food and Drug Administration (FDA), including the relationship between citizen petitions and decisions to delay generic approval, conflicts of interest to be disclosed, and the time and resources expended on petition reviews.	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Drug Policy Reform RESOLVED, That our AMA advocate for federal and state reclassification of drug possession offenses as civil infractions and the corresponding reduction of sentences and penalties for individuals currently incarcerated, monitored, or penalized for previous drug related felonies; and be it further RESOLVED, That our AMA support federal and state efforts to expunge criminal records for drug possession upon completion of a sentence or penalty at no cost to the individuals; and be it further RESOLVED, That our AMA support federal and state	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

efforts to eliminate incarceration-based penalties for persons under parole, probation, pre-trial, or other criminal supervision for drug possession; and be it further RESOLVED, That our AMA-MSS forward this resolution to a future House of Delegates meeting taking place after the HOD considers its upcoming report pursuant to D-95.960 Public Health Impacts of Cannabis Legalization.	
Amending Policy on a Public Option to Maximize AMA Advocacy RESOLVED, That our AMA amend Policy H-165.823, “Options to Maximize Coverage under the AMA Proposal for Reform,” by addition and deletion as follows: H-165.823 – OPTIONS TO MAXIMIZE COVERAGE UNDER THE AMA PROPOSAL FOR REFORM 1. Our AMA will advocate ~~that any for a~~ public option to expand health insurance coverage ~~must that~~ <u>meets</u> the following standards: a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan market place competition. b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets 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	Retain in transmittal queue – There is evidence of a similar resolution being brought forward for the I-22 meeting by another delegation

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.	
Opposition to Debt Litigation Against Patients RESOLVED, That our AMA encourage health care organizations to: 1) Manage medical debt with patients directly and consider several options, including assistance applying for coverage, discounts, payment plans with flexibility and extensions as needed, or forgiveness of debt altogether, before using third-party debt collectors, while avoiding those that harass debtors; 2) Consider the relative financial benefit of collecting medical debt to their revenue, against the detrimental cost to patients' well-being; and 3) Make multiple attempts to reach and negotiate with patients before proceeding with litigation against patients or any other punitive actions and reserve litigation for patients who are able, but unwilling to pay.	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
The Importance of Keeping Health Information Technology (HIT) Advancements Age-Friendly RESOLVED, That our AMA support the development of a standardized definition of “age-friendliness” in health information technology (HIT) advancements; and be it further RESOLVED, That our AMA encourage the appropriate stakeholders to identify current best practices to set expectations of HIT developers to ensure that they create devices and technology applicable to and easily accessible by older adults.	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA
AMA Study of Chemical Castration in Incarceration RESOLVED, That our AMA study the use of chemical castration in the treatment of incarcerated individuals	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA

with paraphilic disorders and for other individuals who commit sexual offenses, including ethical concerns over coercion in its use as an alternative to incarceration and in probation and parole proceedings.	
Evaluating Clinical Outcomes of Mobile Health Technology RESOLVED, That our AMA amend D-480.972, “Guidelines for Mobile Medical Applications and Devices,” by addition as follows: D-480.972 – GUIDELINES FOR MOBILE MEDICAL APPLICATIONS AND DEVICES 1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement. 2. <u>Our AMA will monitor and report on how mHealth apps and devices impact patient outcomes, especially in patient populations at whom interventions may be targeted, such as those managing chronic diseases and consumers seeking healthier lifestyles.</u> ~~2-3.~~ Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful, and trustworthy mHealth market. ~~3-4.~~ Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence based. ~~4-5.~~ Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications. ~~5-6.~~ Our AMA encourages further research integrating mobile devices into clinical care, particularly to address challenges of reducing work burden while maintaining clinical autonomy for residents	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA

and fellows. ~~6-7.~~ Our AMA will collaborate with the Liaison Committee on Medical Education and Accreditation Council for Graduate Medical Education to develop germane policies, especially with consideration of potential financial burden and personal privacy of trainees, to ensure more uniform regulation for use of mobile devices in medical education and clinical training. ~~7-8.~~ Our AMA encourages medical schools and residency programs to educate all trainees on proper hygiene and professional guidelines for using personal mobile devices in clinical environments. ~~8-9.~~ Our AMA encourages the development of mobile health applications that employ linguistically appropriate and culturally informed health content tailored to linguistically and/or culturally diverse backgrounds, with emphasis on underserved and low-income populations.	
Amending H-160.903, Eradicating Homelessness to Include Support for Street Medicine Programs and Reduce Evictions “Amending H-160.903, Eradicating Homelessness to Include Support for Street Medicine Programs” by addition and deletion to read as follows: Eradicating Homelessness, H-160.903 Our AMA: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost-effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically homeless;	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

(3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;

(4) supports the use of street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;

(45) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;

(56) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;

(67) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;

(78) encourages the development of holistic, cost-effective, evidence based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;

(89) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;

(910) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that

would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and (4011) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods--; and (12) supports federal and state efforts to enact just cause eviction statutes and examine and restructure punitive eviction practices; instate inflation-based rent control; guarantee tenants' right to counsel in housing disputes and improve affordability of legal fees; and create national, state, and/or local rental registries.	
Government Manufacturing of Generic Drugs to Address Market Failures RESOLVED, That our AMA support the formation of a non-profit government pharmaceutical manufacturer to produce generic drugs to address market failures, including the existence of small markets for generics, the absence of generics in the market after expiration of patents and exclusivity, and shortages of necessary medications.	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive Populations RESOLVED, That our AMA oppose the practice of pharmaceutical marketing towards those who make decisions for captive populations, including, but not limited to, doctors working in a correctional capacity, judges, wardens, sheriffs, correctional officers, Immigration and Customs Enforcement, and other detention administrators; and be it further RESOLVED, That our AMA advocate for the inclusion of physicians in the selection of medications available to vulnerable populations such as incarcerated individuals; and be it further RESOLVED, That our AMA support and work with state medical societies to support measures to increase transparency in medication procurement, including but not limited to: (1) requiring those responsible for medical procurement to report gifts from pharmaceutical companies over a minimum amount; and (2) centralizing	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

formulary choices in a physician-led office, agency, or commission following the principles of a sound formulary.	
Support of Vision Screenings and Visual Aids for Adults Covered by Medicaid RESOLVED, That our AMA advocate that routine comprehensive vision exams and visual aids (including eyeglasses and contact lenses) be covered in all Medicaid and CHIP programs and any new public insurance programs.	Retain in transmittal queue – At the A-22 meeting, there was a similar resolution in the House of Delegates that is due for report back. The MSS Caucus voted to retain this in the queue until then.
Reporting of Residency Demographic Data RESOLVED, That our AMA work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, (a) demographic data, including but not limited to the composition of their program over the last 5 years by age, gender identity, URM status, and LGBTQIA+ status; (b) parental and family leave policies; and (c) the number and/or proportion of residents who have utilized parental or family leave in the past 5 years; and be it further RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on pregnancy, childbirth, and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Supporting and Funding Sobering Centers RESOLVED, That our AMA support local, state, and national funding for the development and maintenance of sobering centers to serve as an alternative to emergency departments, hospitalization, or incarceration.	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Studying Virtual and Hybrid Options for Medical School, Residency, and Fellowship Interviews RESOLVED, That our AMA work with relevant stakeholders to study the advantages and disadvantages of an online medical school interview option for future medical school applicants, including but not limited to financial implications and potential solutions, long term success, and well-being of students and residents; and be it further RESOLVED, That our AMA encourage appropriate stakeholders, such as the Association of American	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

Medical Colleges and the Accreditation Council for Graduate Medical Education, to study the feasibility and utility of videoconferencing for graduate medical education (GME) interviews and examine interviewee and program perspectives on incorporating videoconferencing as an adjunct to GME interviews, in order to guide the development of equitable protocols for expansion of hybrid GME interviews.	
Accessible Electronic Charting Software and Alternative Access to Health Information for Visually Impaired Patients RESOLVED, That our AMA work with relevant organizations to encourage the utilization of industry standards of web content accessibility to make electronic health record software accessible for patients with visual impairments without requiring them to use third-party programs.	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA
Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures RESOLVED, That our AMA recognizes the disparity in pain management in gynecological procedures compared to procedures of similarly reported pain and encourages discussion of pain control options, risks, and benefits with patients as a part of the shared decision making process; and be it further RESOLVED, That our AMA supports further research into evidence-based anesthetic and anxiolytic medication options for long-acting reversible contraception procedures and other gynecological procedures, including but not limited to colposcopy, endometrial biopsy, and LEEP procedures.	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA
Supporting Intimate Partner And Sexual Violence Safe Leave RESOLVED, That our AMA recognize the positive impact of paid safe leave on public health outcomes and support legislation that offers safe leave; and be it further RESOLVED, That our AMA amend the existing policy H-420.979 AMA Statement on Family and Medical Leave to promote inclusivity by addition as follows: AMA Statement on Family and Medical Leave, H-420.979 Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

in the event leave by an employee becomes necessary due to documented medical conditions <u>and/or concerns for safety</u>. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; (4) leave for adoption or for foster care leading to adoption; <u>and (5) safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking</u>. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.	
Interrupted Patient Sleep RESOLVED, Our AMA encourages physicians, trainees, inpatient care teams, and hospital administration to reduce the number of patient sleep interruptions as much as possible, including considering the impact of circadian and environmental factors on sleep, to only those interruptions which are necessary and cannot be	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA

performed at another time; and be it further RESOLVED, Our AMA support efforts to improve quality, duration, and timing of inpatient sleep.	
Increased Access to HIV Treatment and Supportive Services in the Unstably Housed and Homeless Population RESOLVED, That our AMA supports the development of regulations and incentives to encourage retention of homeless patients in HIV/AIDS treatment programs; and be it further RESOLVED, That our AMA recognizes that stable housing promotes adherence to HIV treatment; and be it further RESOLVED, That our AMA amend current policy HIV/AIDS as a Global Public Health Priority H-20.922 to state the following HIV/AIDS as a Global Public Health Priority H-20.922 In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA: (1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic; (2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, ~~and~~ patient care, <u>and access to stable housing</u> for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates; (3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease; (4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care; (5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts; (6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

the spread of HIV infection through the exchange of sex for money or goods; (7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions; (8) Supports increased availability of and financial assistance for antiretroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic; and be it further; and (9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.	
Access to Naloxone for Vulnerable and Underserved Populations RESOLVED, That our AMA amend Increasing Availability of Naloxone H-95.932 as follows: 1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery. 2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone. 3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients. 4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing. 5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law. 6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively. 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.	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

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. <u>10. That our AMA supports efforts to increase the availability, delivery, possession and use of mail-order Naloxone to help prevent opioid-related overdose, especially in underserved communities and American Indian reservations.</u> and be it further RESOLVED, That our AMA amend Policy H-420.950, “Substance Use Disorders During Pregnancy” by addition and deletion to read as follows: Our AMA will: (1) oppose any efforts to imply that the diagnosis of substance use disorder during pregnancy represents child abuse; (2) support legislative and other appropriate efforts for the expansion and improved access to evidence-based treatment for substance use disorders during pregnancy; (3) oppose the removal of infants from their mothers solely based on a single positive prenatal drug screen without appropriate evaluation; and (4) advocate for appropriate medical evaluation prior to the removal of a child, which takes into account (a) the desire to preserve the individual’s family structure, (b) the patient’s treatment status, and (c) current impairment status when substance use is suspected, and (5) <u>that our AMA support universal opioid use screenings at prenatal care visits with early intervention, comprehensive naloxone use education and distribution for those who screen positive and following overdose-related emergency department visits.</u>	
Inclusion of Disability in Medical Student Mistreatment Reporting RESOLVED, Our AMA will work with the Association of American Medical Colleges (AAMC) and other relevant bodies to encourage data collection of medical student mistreatment based on disability as a protected category in internal and external mistreatment surveys, including the AAMC Medical School Graduation Questionnaire.	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA
Expanding Employee Leave to Include Medical Students, Miscarriage, and Stillbirth	This item will be transmitted by our section to

RESOLVED, That our AMA amends Policy H-405.960, "Policies for Parental, Family, and Medical Necessity Leave":

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; and (j) leave policy for miscarriage or stillbirth.

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

the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

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) duration of leave allowed after miscarriage or stillbirth; ~~(e)~~(d) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); ~~(d)~~(e) whether leave is paid or unpaid; ~~(e)~~(f) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; ~~(f)~~(g) whether sick leave and vacation time may be accrued from year to year or used in advance; ~~(g)~~(h) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or

fetal life; ~~(h)~~(i) how time can be made up in order for a resident physician to be considered board eligible; ~~(j)~~(i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; ~~(j)~~(k) whether time spent in making up a leave will be paid; and ~~(k)~~(l) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements: (a) leave policy for birth, adoption, stillbirth, or miscarriage; (b) duration of leave allowed before and after delivery; (c) extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (d) how time can be made up in order for a medical student to be eligible for graduation without delays; (e) what period of leave would result in a medical student being required to complete an extra or delayed year of training; and (f) whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.

~~8~~9. Our AMA endorses the concept of equal parental leave for birth, stillbirth, miscarriage, and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

~~9~~10. 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.

101. 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.

142. 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.

123. Our AMA encourages flexibility in residency training programs, and medical schools incorporating parental leave and alternative schedules for pregnant ~~house staff~~ trainees.

134. 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.

145. These policies as above should be freely available online and in writing to all current trainees applicants to medical school, residency or fellowship. and be it further

RESOLVED, that due to the prevalence of miscarriage and stillbirth and the need for physical and psychological healing afterwards, our AMA amends H-420.979 “AMA Statement on Family and Medical Leave” as follows:

AMA Statement on Family and Medical Leave H-420.979

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions. Such policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the employee, including pregnancy; miscarriage, and stillbirth;

(2) maternity leave for the employee-mother;

(3) leave if medically appropriate to care for a member of the employee's immediate family, i.e., a spouse or children; and

(4) leave for adoption or for foster care leading to adoption. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without

financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers.	
Revision of H-185.921, Removal of AMA Support for Applied Behavior Analysis RESOLVED, That our AMA supports research towards the evaluation and the development of interventions and programs for autistic individuals; and be it further RESOLVED, That our AMA work with relevant stakeholders to advocate for a comprehensive spectrum of primary and specialty care that recognizes the diversity and personhood of individuals who are neurodivergent, including people with autism; and be it further RESOLVED, That our AMA amend Policy H-185.921 "Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder" as follows: ~~Standardizing Coverage of Applied Behavioral Analysis Therapy~~ for Persons with Autism Spectrum Disorder, H-185.921 Our AMA supports coverage and reimbursement for evidence-based ~~treatment of services~~ for Autism Spectrum Disorder ~~including, but not limited to, Applied Behavior Analysis Therapy.~~	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA
Amending Policy H-525.988, "Sex and Gender Differences in Medical Research" RESOLVED, Our AMA amend Policy H-525.988, "Sex and Gender Differences in Medical Research," as follows: Sex and Gender Differences in Medical Research, H-525.988 Our AMA: (1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies' impact on the health care of society at large; (2) affirms the need to include ~~both~~ <u>all</u> genders in studies that involve the health of society at large and publicize	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA

its policies; (3) supports increased funding into areas of women's health and <u>sexual and gender minority</u> health research; (4) supports increased research on women's health and <u>sexual and gender minority health</u> and <u>the</u> participation of women <u>and sexual and gender minorities</u> in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women <u>and sexual and gender minorities</u> from diverse cultural and ethnic groups, geographic locations, and socioeconomic status; and (5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based and gender-based analysis of data, even if such comparisons are negative-; <u>(6) recommends that medical and scientific journals diversify their review processes to better represent women and sexual and gender minorities</u> <u>(7) encourages the FDA to internally develop criteria for identifying medication and medical devices seeking FDA approval that were developed based on research that did not include adequate participation of women, and sexual and gender minorities.</u>	
Assessing The Humanitarian Impact Of Sanctions RESOLVED, That our AMA recognizes that economic sanctions can negatively impact health and exacerbate humanitarian crises; and be it further RESOLVED, That our AMA supports legislative and regulatory efforts to study the humanitarian impact of economic sanctions imposed by the United States.	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Promoting a Fragrance-Free Health Care Environment RESOLVED, Our AMA recognizes fragrance sensitivity as disability where the presence of fragranced products can limit accessibility of healthcare settings; and be it further RESOLVED, Our AMA encourages all hospitals, outpatient clinics, urgent cares, and other patient care areas inclusive of medical schools to adopt a fragrance-free policy that pertains to employees, patients, and visitors of any kind; and be it further RESOLVED, Our AMA will work with relevant stakeholders to advocate for governmental regulatory bodies, including but not limited to the Occupational Safety and Health Administration (OSHA), the Centers for Disease Control and Prevention (CDC), and the National Institute for Occupational Safety and Health	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA

(NIOSH) to recommend fragrance-free policies in all medical offices, buildings, and places of patient care.	
Recognizing The Burden Of Rare Disease RESOLVED, That our AMA recognize the under-treatment and under-diagnosis of orphan diseases, the burden of costs to health care systems and affected individuals, and the health disparities among patients with orphan diseases; and be it further RESOLVED, That our AMA support efforts to increase awareness of patient registries, to improve diagnostic and genetic tests, and to incentivize drug companies to develop novel therapeutics to better understand and treat orphan diseases.	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA
Increasing the Availability of Automated External Defibrillators RESOLVED, That our AMA amend Policy H-130.938, “Cardiopulmonary Resuscitation (CPR) and Defibrillators,” by addition to read as follows: Cardiopulmonary Resuscitation (CPR) and Defibrillators H-130.938 Our AMA: (1) supports publicizing the importance of teaching CPR, including the use of automated external defibrillation; (2) strongly recommends the incorporation of CPR classes as a voluntary part of secondary school programs; (3) encourages the American public to become trained in CPR and the use of automated external defibrillators; (4) advocates the widespread placement of automated external defibrillators, including on all grade K-12 school campuses and locations at which school events are held; (5) encourages all grade K-12 schools to develop an emergency action plan for sudden cardiac events; (6) supports increasing government and industry funding for the purchase of automated external defibrillator devices; (7) endorses increased funding for cardiopulmonary resuscitation and defibrillation training of community organization and school personnel; (8) supports the development and use of universal connectivity for all defibrillators; (9) supports legislation that would encourage high school students be trained in cardiopulmonary resuscitation and automated external defibrillator use; (10) will update its policy on cardiopulmonary resuscitation and automated external defibrillators	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA

(AEDs) by endorsing efforts to promote the importance of AED use and public awareness of AED locations, by using solutions such as integrating AED sites into widely accessible mobile maps and applications; (11) urges AED vendors to remove labeling from AED stations that stipulate that only trained medical professionals can use the defibrillators; and (12) supports consistent and uniform legislation across states for the legal protection of those who use AEDs in the course of attempting to aid a sudden cardiac arrest victim-; <u>and</u> <u>(13) encourages the distribution of Automated External Defibrillators in an equitable manner through the utilization of targeted placement strategies in order to increase availability and decrease disparities in areas where disproportionate rates of out-of-hospital cardiac arrest episodes exist.</u>	
SNAP Expansion for DACA Recipients RESOLVED, That our AMA will actively support expansion of SNAP to Deferred Action Childhood Arrivals (DACA) recipients who would otherwise qualify.	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Indigenous Data Sovereignty RESOLVED, Our AMA recognizes that American Indian and Alaska Native Tribes and Villages are sovereign governments that should be consulted before the conduct of research specific to their members, lands, and properties; and be it further RESOLVED, Our AMA supports that American Indian and Alaska Native (AI/AN) Tribes and Villages' Institutional Review Boards and research departments retain the right to oversee and regulate the collection, ownership, and management of research data generated by their members, and that individual members of AI/AN Tribes and Villages retain their autonomy and privacy regarding research data shared with researchers, AI/AN Tribes and Villages, and governments, consistent with existing protections under 45 CFR 46; RESOLVED, Our AMA encourages the use and regular review of data-sharing agreements for all studies between academic medical centers and American Indian and Alaska Native Tribes and Villages; and be it further RESOLVED, Our AMA encourages the National Institutes of Health and other stakeholders to provide flexible funding to American Indian and Alaska Native Tribes and Villages for research efforts, including the creation and maintenance of Institutional Review Boards	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

(IRBs).	
Reforming The Medicare Part B “Buy And Bill” Process To Encourage Biosimilar Use RESOLVED, That our AMA encourage the Centers for Medicare and Medicaid Services (CMS) to: (a) identify groups of Physician-Administered Drugs (PADs), each comprised of the reference biologic and its biosimilars (based on FDA approvals), to be reimbursed at the same rate to incentivize selection of less expensive PADs while preserving access for patients and reimbursement for physicians; and (b) determine the method rate by which a group of PADs will be reimbursed such that physicians are compensated appropriately for acquisition, inventory, carrying, and administration costs, including but not limited to creating fixed add-on fees to be used for all PADs in a group and indexing rate increases for a group of PADs to the rate of inflation.	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA
Study Integrating Comparative Effectiveness Research into the FDA Approval Process RESOLVED, That our AMA study the feasibility of including comparative effectiveness studies in various FDA drug regulatory processes, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter; and be it further RESOLVED, That our AMA ask the National Institutes of Health to support and fund comparative effectiveness research for approved drugs, including comparisons with existing standard of care, available generics and biosimilars, and drugs commonly used off-label and over-the-counter.	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA
Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants RESOLVED, Our AMA will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, the Association of American Medical Colleges, and other interested parties to eliminate questioning about or discrimination based on American Indian and Alaska Native blood quantum during the medical school, residency, and fellowship application process.	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
Protecting Workers During Catastrophes	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the

RESOLVED, That our AMA will advocate for legislation that creates federal standards of safety and protection of workers during natural or man-made catastrophes; and be it further RESOLVED, That our AMA will advocate that the United States Department of Labor, the Occupational Safety and Health Administration (OSHA), and other appropriate stakeholders to develop and enforce evidence-based policies, guidelines, and protections for workers at their place of employment and traveling to and from their place of employment during catastrophes.	AMA
Incorporating Holocaust Education in Medical Schools on International Remembrance Day RESOLVED, Our AMA host an annual event in support of International Holocaust Remembrance Day (January 27) to provide education to medical trainees about the role of physicians in the Holocaust.	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA
Supporting Further Study of Kratom RESOLVED, That policy H-95.934 be amended by addition and deletion as follows: Kratom and its Growing Use Within the United States H-95.934 Our AMA: ~~supports legislative or regulatory efforts to prohibit the sale or distribution of Kratom in the United States which do not inhibit proper scientific research.~~ <u>efforts to further study the clinical uses, benefits, and potential harms of Kratom, and oppose efforts that may restrict research.</u>	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).
National Fertility Coverage Mandate RESOLVED, That our AMA amend Policy H-185.990, “Infertility and Fertility Preservation Insurance Coverage” by addition and deletion to read as follows: 1. Our AMA ~~encourages third-party payer health insurance carriers to make available insurance benefits~~ <u>supports federal protections that ensure insurance coverage by all payers</u> 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	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA

medical treatments as determined by a licensed physician.	
Addressing Inequity in Onsite Wastewater Treatment RESOLVED, That our AMA supports that federal, state, and local governments abate individual financial and criminal penalties for insufficient wastewater management, especially those placed on underserved communities and American Indian reservations due to environmental racism and socioeconomic disparities; and be it further RESOLVED, That our AMA supports research by federal, state, and local governments to develop strategies to reduce insufficient wastewater management and eliminate detrimental health effects due to inadequate wastewater systems.	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA
Indian Health Service Licensure Exemptions RESOLVED, Our AMA will advocate that physicians at Indian Health Service, Tribal, and Urban Indian Health Programs be exempt from duplicative licensure requirements, such as requirements for state licensure when these physicians are already federally licensed; and be it further RESOLVED, Our AMA will advocate that future health reform proposals include corresponding licensure and eligibility exceptions for Indian Health Service, Tribal, and Urban Indian Health Program facilities and physicians to ensure that these physicians can fully participate.	Retain in transmittal queue – It was voted on by your MSS Caucus that this resolution not be transmitted for the I-22 meeting due to it not being as advocacy focused and timely. Instead, your MSS Caucus voted to elevate transmittal 196: Strengthening Interview Guidelines for American Indian and Alaska Native Medical School, Residency, and Fellowship Applicants
Support for Research on Plant-Based Meat RESOLVED, That our AMA works with appropriate stakeholders to support plant-based meat research funding.	Retain in transmittal queue – no concrete evidence of significant & relevant activity from the AMA
Reducing Burden of Incarceration on Public Health RESOLVED, That our AMA support efforts to reduce the negative health impacts of incarceration, such as 1) implementation and incentivization of adequate funding and resources towards indigent defense systems; 2) implementation of practices that promote access to stable employment and laws that ensure employment non-discrimination for workers with previous non-felony criminal records;	This item will be transmitted by our section to the 2022 Interim Meeting of the AMA House of Delegates (please see Appendix 3).

3) housing support for formerly incarcerated people, including programs that facilitate access to immediate housing after release from carceral settings; and be it further

RESOLVED, That our AMA partner with the American Public Health Association and other stakeholders to urge Congress, the Department of Justice, and the Department of Health & Human Services to minimize the negative health effects of incarceration by supporting programs that facilitate employment and housing opportunities for formerly incarcerated individuals as well as research into alternatives to incarceration.

Appendix 3 - Transmittals being sent to the 2022 Interim Meeting of the House of Delegates

1. Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings
2. Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers
3. Non-Cervical HPV-Associated Cancer Prevention
4. Opposing Use of Vulnerable Incarcerated People in Response to Public Health Emergencies of Infectious Disease Origin
5. Medicaid and CHIP Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin Dependent Diabetes
6. Hospital Bans on TOLAC
7. Decreasing Youth Access to E-Cigarettes
8. Support for Mental Health Courts
9. Reducing Disparities in HIV Incidence through PREP for HIV
10. Supporting the Use of Gender-Neutral Language
11. Drug Policy Reform
12. Government Manufacturing of Generic Drugs to Address Market Failures
13. Studying Virtual and Hybrid Options for Medical School; Residency; and Fellowship Interviews
14. Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements
15. Amending H-160.903; Eradicating Homelessness to Include Support for Street Medicine Programs and Reduce Evictions
16. Promoting Multi-Use Devices and Sustainable Practices in the OR
17. Addressing Longitudinal Health Care Needs of Children in Foster Care
18. Reporting of Residency Demographic Data
19. Assessing The Humanitarian Impact Of Sanctions
20. Supporting Intimate Partner And Sexual Violence Safe Leave
21. SNAP Expansion for DACA Recipients
22. Opposition to Debt Litigation Against Patients
23. Increase Employment Services Funding to People with Disabilities
24. Updating AMA Bylaw 2.12.2; Special Meetings of the House of Delegates
25. Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive Populations
26. Encouraging Collaboration between Physicians and Industry in AI Development
27. Guidelines on Chaperones for Sensitive Exams
28. Re-Evaluating the FDA's Citizen Petition Process
29. Supporting Further Study of Kratom
30. Opposition to Alcoholic Industry Marketing Self-Regulation
31. Development and Implementation of Recommendations for Responsible Media Coverage of Drug Overdoses
32. Indigenous Data Sovereignty
33. Reducing Burden of Incarceration on Public Health
34. Supporting and Funding Sobering Centers
35. Strengthening Interview Guidelines for American Indian and Alaska Native Medical School; Residency; and Fellowship Applicants
36. Expanding Employee Leave to Include Miscarriage and Stillbirth
37. Amendment to Policy H-405.960, Policies for Parental, Family, and Medical Necessity Leave
38. Promoting Oral Anticancer Drug Parity

Appendix 4 - Timeliness and Themes from MSS pending transmittals ranked, by the MSS Caucus, from highest to lowest priority

Transmittal	Theme_Rank	Impact	Urgency	Time_In_Queue	Timeliness
73_Mitigating Environmental Contributors to Disease and Sustainability of AMA National Meetings	4	2.71	2.57	3	2.76
201_Rights and Protections for Vulnerable Incarcerated People	16	2.50	2.17	3	2.56
58_Non-Cervical HPV-Associated Cancer Prevention	2	2.71	1.86	3	2.52
60_Anti-Harassment Training	25	2.14	2.14	3	2.43
51_Medicaid and CHIP Coverage of Continuous Glucose Monitoring Devices for Patients with Insulin Dependent Diabetes	19	2.33	1.89	3	2.41
94_Hospital Bans on TOLAC	1	2.40	1.80	3	2.40
56_Decreasing Youth Access to E-Cigarettes	10	2.17	2.00	3	2.39
54_Support for Mental Health Courts	11	2.17	2.00	3	2.39
62_Mental Health First Aid Training	6	2.17	1.83	3	2.33
3_Reducing Disparities in HIV Incidence through PREP for HIV	7	2.20	1.80	3	2.33
53_Supporting the Use of Gender-Neutral Language	12	2.40	1.60	3	2.33
139_Drug Policy Reform	18	3.00	2.00	2	2.33
153_Government Manufacturing of Generic Drugs to Address Market Failures	12	2.80	2.10	2	2.30
172_Studying Virtual and Hybrid Options for Medical School; Residency; and Fellowship Interviews	6	2.25	2.63	2	2.29
133_Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements	2	2.71	2.14	2	2.29
152_Amending H-160.903; Eradicating Homelessness to Include Support for Street Medicine Programs and Reduce Evictions	10	2.67	2.17	2	2.28

24_Promoting Multi-Use Devices and Sustainable Practices in the OR	23	2.20	1.60	3	2.27
136_Addressing Longitudinal Health Care Needs of Children in Foster Care	22	2.75	2.00	2	2.25
134_Movement Away from Employer-Sponsored Health Insurance	5	2.67	2.00	2	2.22
160_Support of Vision Screenings and Visual Aids for Adults Covered by Medicaid	5	2.60	2.00	2	2.20
130_Establishing Comprehensive Dental Benefits Under State Medicaid Programs	5	2.38	2.13	2	2.17
93_Incorporating the Evidence-Based Concepts of the Choosing Wisely Program into Undergraduate and Graduate Medical Education	6	2.00	1.50	3	2.17
163_Reporting of Residency Demographic Data	6	2.67	1.83	2	2.17
107_Abolishment of the Resolution Committee	24	2.50	2.00	2	2.17
185_ASSESSING THE HUMANITARIAN IMPACT OF SANCTIONS	10	2.75	2.63	1	2.13
176_SUPPORTING INTIMATE PARTNER AND SEXUAL VIOLENCE SAFE LEAVE	17	2.88	2.50	1	2.13
192_SNAP Expansion for DACA Recipients	19	2.75	2.50	1	2.08
146_Opposition to Debt Litigation Against Patients	5	2.33	1.83	2	2.06
111_Increase Employment Services Funding to People with Disabilities	9	2.33	1.83	2	2.06
132_Updating AMA Bylaw 2.12.2; Special Meetings of the House of Delegates	24	2.17	2.00	2	2.06
127_Supporting Daylight Saving Time as the New; Permanent Standard Time	10	2.25	1.88	2	2.04
159_Opposing the Marketing of Pharmaceuticals to Parties Responsible for Captive Populations	16	2.38	1.75	2	2.04
91_Encouraging Collaboration between	23	2.00	1.13	3	2.04

Physicians and Industry in AI Development					
95_Guidelines on Chaperones for Sensitive Exams	5	1.75	1.25	3	2.00
137_Re-Evaluating the FDA's Citizen Petition Process	12	2.29	1.71	2	2.00
80_Providing Reduced Parking Fees for Patients and Trainees	19	1.60	1.40	3	2.00
74_Opposition to Alcoholic Industry Marketing Self-Regulation	28	1.75	1.25	3	2.00
96_Development and Implementation of Recommendations for Responsible Media Coverage of Drug Overdoses	28	1.57	1.29	3	1.95
193_Indigenous Data Sovereignty	2	2.60	2.20	1	1.93
143_Amending Policy on a Public Option to Maximize AMA Advocacy	5	2.00	1.80	2	1.93
208_Reducing Burden of Incarceration on Public Health	16	2.80	2.00	1	1.93
164_Supporting and Funding Sobering Centers	18	2.20	1.60	2	1.93
206_Indian Health Service Licensure Exemptions	6	2.67	2.11	1	1.93
200_Expanding Employee Leave to Include Medical Students; Miscarriage; and Stillbirth	14	2.50	2.25	1	1.92
118_Promoting Oral Anticancer Drug Parity	12	2.29	1.43	2	1.90
12_Reducing Costs of CMS Limited Data Sets for Academic Use	27	1.50	1.17	3	1.89
85_TV Broadcast and Online Streaming of LGBTQ+ Inclusive Sexual Encounters and Public Health Awareness on Social Media Platforms	28	1.33	1.33	3	1.89
205_Addressing Inequity in Onsite Wastewater Treatment	2	2.33	2.17	1	1.83
99_Teaching and Assessing Osteopathic Manipulative Treatment and Osteopathic Principles and Practice to Resident Physicians in the	6	1.50	1.00	3	1.83

Context of ACGME Single System Accreditation					
197_PROTECTING WORKERS DURING CATASTROPHES	8	2.50	2.00	1	1.83
194_REFORMING THE MEDICARE PART B “BUY AND BILL” PROCESS TO ENCOURAGE BIOSIMILAR USE	12	2.50	2.00	1	1.83
184_Amending Policy H-525.988; “Sex and Gender Differences in Medical Research”	14	2.50	2.00	1	1.83
148_The Importance of Keeping Health Information Technology (HIT) Advancements Age-Friendly	23	1.86	1.57	2	1.81
120_Formal Transitional Care Program for Children and Youth with Special Healthcare Needs	22	1.80	1.60	2	1.80
37_Amending G-630.140; Lodging; Meeting Venues; and Social Functions	24	1.40	1.00	3	1.80
125_Exclusion of Race and Ethnicity in the First Sentence of Case Reports	2	1.75	1.63	2	1.79
195_Comparative Effectiveness Research	12	2.50	1.83	1	1.78
149_AMA Study of Chemical Castration in Incarceration	16	1.83	1.50	2	1.78
174_Accessible Electronic Charting Software and Alternative Access to Health Information for Visually Impaired Patients	23	2.60	1.60	1	1.73
190_RECOGNIZING THE BURDEN OF RARE DISEASE	2	2.50	1.50	1	1.67
181_Inclusion of Disability in Medical Student Mistreatment Reporting	6	2.43	1.57	1	1.67
202_Access to Naloxone for Vulnerable and Underserved Populations	18	2.00	2.00	1	1.67
151_Evaluating Clinical Outcomes of Mobile Health Technology	23	1.75	1.25	2	1.67
175_Pain Management for Long-Acting Reversible Contraception and other Gynecological Procedures	14	2.22	1.67	1	1.63
179_Increased Access to HIV	10	2.13	1.75	1	1.63

Treatment and Supportive Services in the Unstably Housed and Homeless Population					
191_Increasing the Availability of AUTOMATED EXTERNAL DEFIBRILLATORS	23	2.25	1.63	1	1.63
196_Strengthening Interview Guidelines for American Indian and Alaska Native Medical School; Residency; and Fellowship Applicants	4	2.00	1.67	1	1.56
126_Regulation of Phthalates in Adult Personal Sexual Products	23	1.67	1.00	2	1.56
178_Interrupted Patient Sleep	6	2.00	1.25	1	1.42
204_National Fertility Coverage Mandate	14	2.00	1.25	1	1.42
207_Support for Research on Plant-Based Meat	27	1.80	1.40	1	1.40
183_Revision of H-185.921; Removal of AMA Support for Applied Behavior Analysis	9	1.75	1.38	1	1.38
189_Promoting a Fragrance-Free Health Care Environment	23	1.60	1.40	1	1.33
198_Incorporating Holocaust Education in Medical Schools on International Remembrance Day	20	1.75	1.13	1	1.29
203_Supporting Further Study of Kratom	23	1.25	1.00	1	1.08

REPORT OF THE MEDICAL STUDENT SECTION
INTERNAL OPERATING PROCEDURES TASK FORCE

IOPTF Report
(I-22)

Introduced by: MSS Internal Operating Procedures Task Force

Subject: Internal Operating Procedures Task Force Report

Referred to: MSS Reference Committee
(TBD, Chair)

Table of Contents

MSS Internal Operating Procedures/Election Task Force Report

Section 1. Name	Page 2
Section 2. Purpose and Objectives	Page 2
Section 3. Membership	Page 3
Section 4. Officers	Page 3
Section 5. Medical Student Trustee	Page 10
Section 6. Elections	Page 10
Section 7. MSS Standing Committees	Page 22
Section 8. Regions	Page 22
Section 9. MSS Caucus to the HOD	Page 26
Section 10. MSS Assembly Meeting	Page 29
Section 11. Appointments	Page 42
Section 12. Miscellaneous	Page 44
Section 13. Dispute Resolution	Page 44
Section 14. Amendments to the Internal Operating Procedures	Page 44

American Medical Association Medical Student Section Internal Operating Procedures

1. Name.

The name of this organization shall be the Medical Student Section (MSS) of the American Medical Association (AMA). This is a special section for medical student members of the AMA ~~as set forth in~~ (AMA Bylaw 7.3).

2. Purpose and ~~Objectives~~Principles.¹

The purpose of the MSS shall be to provide medical student participation in the activities of the AMA ~~with the following objectives through adherence to the following principles:~~

2.1. ~~Have meaningful input into~~ Ensure representation in and advance the concerns of medical students in the decision and policy-making process of the AMA.

~~2.2. Serve as a forum for medical students to discuss and disseminate information regarding AMA activities.~~

~~2.3. Improve medical education and further professional excellence develop the next generation of physician leaders in national, state, local, and institutional policy.~~

~~2.4. Involve medical students in addressing and solving the problems of healthcare and health care delivery and provide a forum for the discussion and dissemination of information.~~

~~2.4. Develop medical leadership.~~

~~2.5. Initiate and effect necessary change. Exemplify values of social justice (such as racial, gender, disability, and economic justice), diversity, equity, inclusion, and accessibility in all activities of the MSS.~~

2.6. Promote high personal and professional ethics, and a humanistic approach to the delivery of quality patient care.

2.7. Promote membership and activity within organized medicine on the local, state, and national levels.

2.8. ~~Work cooperatively~~ Collaborate with other ~~student groups and AMA Sections~~ AMA bodies; other professional, specialty, and state medical societies; and other organizations representing medical students and healthcare professionals as appropriate to meet these objectives.

¹Discussion on Section 2 “Purpose and Principles” centered around accurately reflecting the mission-driven operations and practices of the MSS. Your Task Force felt that “input,” “leadership,” and “change” were vague and defined these more explicitly. Your Task Force also wanted to represent the defining values of our Section, particularly justice, diversity, equity, inclusion, and accessibility. We recognize that this is not an exhaustive list, but hope this summarizes and codifies our priorities well.

3. Membership.

Membership eligibility shall be limited to medical student members of the AMA (AMA Bylaw 1.1.1).—Eligibility for student membership is outlined in AMA Bylaw 1.1.1.²

4. Officers.

4.1 Designations. The officers of the MSS shall be the nine GC (GC) members: Chair, Vice Chair, Section Delegate, Section Alternate Delegate, At-Large Officer, Chair-elect/Immediate Past Chair, Speaker, Vice Speaker, and Diversity, Equity, & Inclusion Officer. The Chair-elect/Immediate Past Chair shall be non-voting members of the GC. The officers of the Assembly for the purpose of business meetings will be the Speaker and Vice Speaker.

4.2. Authority. The GC shall direct the programs and activities of the MSS. During the interval between meetings of the MSS Assembly, the GC shall act on behalf of the MSS in formulating decisions related to the development, administration, and implementation of student activities, programs, goals, and objectives. The MSS ~~shall~~should be notified on at least a monthly basis and at each National Meeting of actions taken by the GC on its behalf.

4.3. Qualifications. All members of the GC must be medical student members of the AMA at the time of their election and throughout the duration of their term. Any medical student member of the AMA is eligible for a position on the MSS GC, except as prohibited by these IOPs or by the AMA Bylaws.³

4.4. Duties and Privileges. The GC shall direct the programs and activities of the MSS, subject to the approval of such programs and activities by the Board of Trustees or House of Delegates (HOD) of the AMA.⁴

4.4.1. Chair. The Chair shall:

4.4.1.1. Preside at all meetings of the GC, and otherwise represent the MSS when appropriate.

4.4.1.2. Preside at Assembly meetings if both the Speaker and Vice Speaker positions are vacant, until such time that successors to the Speaker or Vice Speaker may be elected.

²Discussion on Section 3 “Membership” recognized that the IOPs refer to “medical student members of the AMA in good standing” several times for eligibility for certain positions, but do not define “good standing” in the context of AMA membership. AMA Bylaws appear to refer to medical student good standing only in the context of those returning from approved sabbatical from medical school. Our MSS staff confirmed that they consider conduct violations and membership dues when evaluating membership, so your Task Force reflected this in these amendments for clarity.

³Discussion on Section 4.3 “Qualifications” focused on lack of clarity over simply stating that all GC members must be medical student members. Your Task Force added a defined timeframe.

⁴Discussion of all items pertaining to the MSS GC in Section 4.4 “Duties and Privileges” were conducted by your Task Force in consideration of direct feedback from current and past GC members, as well as AMA-MSS Staff. Your Task Force opted to keep language broad to avoid prescriptiveness and to allow for flexibility in the execution of GC duties.

4.4.1.3. Be the primary spokesperson for the MSS both inside the AMA and to outside organizations.

4.4.2. **Vice Chair.** The Vice Chair shall:

4.4.2.1. Preside at meetings of the GC in the absence of the Chair or at the request of the Chair.

4.4.2.2. Assist the Chair in the performance of ~~his or her~~their duties.

4.4.2.3. Have the primary responsibility of coordinating the internal operations of the MSS, including but not limited to the MSS standing and ad-hoc committees.

4.4.2.4. Organize MSS Assembly educational programming within the structure of the assembly, as set forth by the MSS Speakers. This includes, but is not limited to, applications, selection, and speaker procurement.⁵

4.4.3. **MSS Section Delegate and Section Alternate Delegate.** ~~(the “Section Delegates”). The AMA-Section Delegates and Alternate Delegate~~ shall:

4.4.3.1. Represent the MSS in the AMA HOD.

4.4.3.2. Serve as Chair and Vice Chair, respectively, of the MSS Caucus.

4.4.3.3. Forward resolutions from the MSS in the AMA HOD and provide a summary of pertinent actions for the MSS on resolutions sent to the AMA HOD.

4.4.3.4. Administer the MSS resolution review process.

4.4.3.5. Lead, with delegation to other GC members where needed, the review of the MSS Digest of Actions for consistency with Assembly action and Summary of MSS Proceedings prior to its annual posting to the AMA website.⁶

4.4.4. **At-Large Officer.** The At-Large Officer shall:

4.4.4.1. Perform such functions as determined by the GC, and assist the other officers in the performance of their duties.

4.4.4.2. Coordinate the activities of the MSS Regions, including the organization

⁵ Your Task Force elicited feedback from MSS leadership. It was noted that the Vice Chair has a stronger relationship with Standing Committees, who usually submit programming proposals, and thus would be a better liaison between the Committees and MSS staff. However, this would not foreclose your Speakers from involvement, particularly as they are most closely associated with planning of Assembly.

⁶Your Task Force elicited feedback from MSS leadership; these amendments to the Section Delegate objectives aim to codify existing practice.

of region conferences.

4.4.5. Speaker and Vice Speaker ~~(the “Speakers”). The Speaker and Vice Speaker~~ shall:

4.4.5.1. Preside over meetings of the MSS Assembly in an impartial manner, organizing and conducting them in accordance with The Standard Code of Parliamentary Procedure, AMA Bylaws, and these MSS Internal Operating Procedures. The Vice Speaker shall officiate for the Speaker in the Speaker's absence or at the request of the Speaker.

4.4.5.2. Provide for oversight and enforcement of the Campaign Rules, including responsibility for investigation of alleged infractions and reporting of substantiated infractions to the Assembly prior to balloting.

4.4.5.3. Organize an orientation ~~at each Assembly Meeting~~ for ~~new~~-MSS Chapter Delegates and Alternate MSS Chapter Delegates to the Assembly.

4.4.5.4. Work with other members of the GC in instructing the Convention Committees regarding their duties prior to each Assembly Meeting.

4.4.5.5. Refer resolutions and reports submitted for consideration at MSS Assembly Meetings to reference committee(s).

4.4.5.6. Prepare a document summarizing parliamentary procedure used in Assembly Meetings to be published in the MSS agenda book that is made available to each Assembly representative prior to Assembly Meetings.

~~4.4.5.7. Review the MSS Digest of Actions for consistency with Assembly action prior to its annual posting to the AMA website.~~

4.4.6. Diversity, Equity, & Inclusion Officer. The Diversity, Equity, & Inclusion Officer shall:

4.4.6.1. Coordinate the AMA-specific activities of the identity-based National Medical Student Organization liaisons (~~as defined in MSS IOP~~Section 10.3.3), identity-based Professional Interest Medical Association liaisons (~~as defined in MSS IOP~~Section 10.3.2), and identity-based MSS Standing Committees within the Section.

4.4.6.2. Serve as the liaison between the AMA's Center for Health Equity, the MSS, and the MSS GC.

4.4.6.3. Serve as the liaison between identity-based National Medical Student Organization leadership and the Section.

4.4.6.4. Support the functions of the MSS liaisons to the Minority Affairs Section (MAS), the Women Physicians Section (WPS), the Advisory Committee on

LGBTQ Issues, and other identity-based sections or groups within the AMA.

4.4.6.5. Track demographics in the Section and direct efforts to recruit and retain a more diverse and representative MSS membership and leadership.

4.4.6.6 Develop and maintain a culture of inclusivity and allyship within the Section.⁷

4.4. ~~67~~ **Chair-elect.** The Chair-elect shall be a non-voting, funded member of the GC. The Chair-elect shall assist the ~~chair-other officers~~ in the discharge of their duties.

4.4. ~~78~~ **Immediate Past Chair.** The Immediate Past Chair shall be a non-voting, unfunded member of the GC.

4.5 **Governing Council Terms.**⁸

4.5.1. The Chair-elect/Chair/Immediate Past Chair of the GC shall serve a two-year term. ~~His or her~~ Their term as Chair-elect will begin at the conclusion of the Interim Meeting at which ~~he or she is~~ they are elected. ~~He or she~~ They will take office as Chair at the conclusion of the following Annual Meeting, and one year later will become Immediate Past Chair. ~~He or she~~ They will serve as Immediate Past Chair until the conclusion of the following Interim Meeting.

4.5.2. The other GC members shall serve one-year terms, beginning at the conclusion of the Annual Meeting at which they are elected and ending at the conclusion of the next Annual Meeting of the AMA HOD, and shall not be eligible for re-election to the same position.⁹

4.5.3. Maximum tenure for members of the MSS GC will be two years in any combination of voting positions.

4.6 **Vacancies.**¹⁰

⁷Discussion on Section 4.4.6 “Diversity, Equity, and Inclusion Officer” centered upon the new leadership role approved by our Section and AMA Board of Trustees. Your Task Force recognized that this position, like all GC roles, should be action-oriented and believes Section 4.4.6.6 provides a firm directive that is geared towards empowerment and a culture of allyship within our section. Additionally, your Task Force sought to avoid a prescriptive definition as this new position for our Section is one we hope to see spirited individuals pursue and innovate from within. Your Task Force looks forward to supporting the work of the inaugural Diversity, Equity, & Inclusion officer in all of their future endeavors.

⁸Discussion throughout the entirety of our convening as a Task Force focused on ensuring the IOPs are inclusive. Thus, your Task Force’s amendments reflect more gender-inclusive language where applicable across these IOPs.

⁹ Your Task Force heard passionate feedback on the issue of GC Term Limits. Some students preferred a one year term limit on GC, noting that such a term limit would allow for more students to participate in national leadership and that previous GC members could serve as unofficial advisers to new GC members. Other students preferred permitting GC members to serve in the same position twice, noting that such a process allowed for sufficient transfer of institutional knowledge and experience. Your Task Force also reviewed data showing that only ten percent of MSS GC members have ever gone on to serve more than one term on GC. Ultimately, your Task Force felt that permitting GC members to serve two terms, but limiting each term to a different GC position, struck the right balance between those two views.

¹⁰Discussion on Section 4.6 “Vacancies” centered on ensuring that any vacancy would have an easy-to-follow pathway for leadership and action within these roles to continue. Your Task Force recognizes that vacancies occur for

~~4.6.1. **Governing Council.** Any vacancy occurring on the MSS Governing Council shall be filled at the next Assembly Meeting of the MSS. The new member shall be elected for the remainder of the unexpired term in the same manner as the original election, as outlined in MSS Internal Operating Procedures. If a vacancy occurs in the Chair position, the Vice Chair shall succeed to the position of Chair for the remainder of the unexpired term.~~

4.6.2. If a vacancy occurs in the Section Delegate position, the Section Alternate Delegate shall succeed to the position of Section Delegate for the remainder of the unexpired term.

4.6.3. If a vacancy occurs in the Speaker position, the Vice Speaker shall succeed to the position of Speaker for the remainder of the unexpired term.

4.6.4. After following these rules of succession, for positions typically elected at the Annual Meeting of the MSS, vacancies occurring at least 60 days prior to the next Interim Meeting of the MSS should be filled via special election at that Interim Meeting.

4.6.5. For positions typically elected at the Interim Meeting of the MSS, vacancies occurring at least 60 days prior to the next Annual Meeting of the MSS should be filled via special election at that Annual Meeting.

4.6.6. Special elections for a vacant position will occur in a manner similar to the original election for that position, adhering to the MSS Internal Operating Procedures for that position's election and the most recent Speakers' Ruling to the extent possible.

4.6.7. The remainder of the unexpired term will not count toward any term limits.

~~4.6.1-18. **Temporary Appointment.** If a vacancy occurs on the Governing Council more than thirty (30) days prior to the next Assembly Meeting of the MSS, the Governing Council may~~ Until a special election can be held to fill a vacancy, or in the event of any other vacancies within 60 days prior to the next Assembly meeting, the GC and Region Chairs will solicit applications for and will vote to appoint a medical student member to fill a vacancy until the next Assembly Meeting of the MSS when an election shall be held pursuant to the above rules.

4.6.8.1. The remainder of the unexpired term will not count toward any term limits.

4.6.8.2. Any member who has already declared their candidacy in the next

a variety of reasons and within a variety of scenarios and provides the following additions to streamline how this is handled within our Section. The order of succession listed is the logical order that has historically been followed within the Section. Regarding the timeline for filling vacancies, your Task Force recognizes that hosting an election to fill positions that may be left unfilled for long periods of time may present logistical challenges. Thus, your Task Force recommends these rules be followed when determining how to fill roles that the rules of succession may not address. Your Task Force selected a 60-day cutoff to ensure that any newly elected official would have adequate time to onboard into the role while maintaining a cutoff for which it may not be feasible to hold an interim election, instead waiting for the next regular election cycle. Your Task Force also included Region Chairs in the temporary appointment process to increase democratic representation and the number of decision makers proffering these selections.

general election for that position will not be eligible for appointment.

4.6.8.3. If a Region Chair applies to fill the vacancy, they will recuse themselves from the temporary appointment process.

~~4.6.2. **Speaker and Vice Speaker.** If the position of Speaker becomes vacant, the Vice Speaker shall succeed to the position of Speaker and serve the remainder of the unexpired term as Speaker. If the Vice Speaker assumes the role of a Speaker for the remainder of the unexpired term, the Representatives to the MSS Assembly Meeting shall elect a Vice Speaker to fill the unexpired term at the next Assembly Meeting, as outlined in Section V of the MSS Internal Operating Procedures. If both Speaker and Vice Speaker positions are vacant, the Chair of the Governing Council shall preside, as specified in IOP Section 4.4.1.2.~~

4.7. Limitation on Total Years of Service.¹¹

~~Students deemed qualified by the other provisions of the AMA Bylaws and these Internal Operating Procedures for election to the positions of:~~

- ~~● MSS Governing Council, or~~
- ~~● Appointment through the MSS to a position on an AMA Council, or~~
- ~~● A committee outside of the AMA that is national in scope and appointed by the Governing Council, the AMA President, the AMA President-elect, or the AMA Board of Trustees (such as the AMA Foundation, American Medical Association Political Action Committee, National Board of Medical Examiners, National Resident Matching Program, Liaison Committee on Medical Education, etc.)~~

~~Shall only be so deemed if they have served three or fewer years in one or a combination of any of the aforementioned positions. The intent of this Section is to limit combined service in all of these positions to four years total. A person may not serve in the same position for more than~~

¹¹Your Task Force representatives heard individual inquiries and public comment from Section members regarding Section 4.7 "Limitation on Total Years of Service" and considered it in conjunction with Section 4.5.2. In order to best fulfill the objectives of our Section within an environment which tangibly values inclusivity, your Task Force came to consensus on this approach after lengthy discussion on the advantages and disadvantages of incumbency in national leadership. Discussion on this topic underscored the importance of experienced members serving on AMA Councils or external national bodies, especially given the learning curve that students may experience, while also recognizing the need to make opportunities available to new voices. Your Task Force highlighted that most Section members spend four to six years as MSS members within the AMA, accounting for master's degrees and gap years, though some such as MD-PhD students may be MSS members for a longer period of time. Your Task Force also reviewed data showing that only one student has ever termed out of national leadership. Your Task Force balanced these considerations and believes a three-year total limit is a reasonable parameter to allow service in national leadership and ensure regular availability of positions across the board. Your Task Force retained the existing two-year limit for service to any AMA Council or external national body, but added a new one-year limit on individual GC positions. We believe these parameters on overall term limitations reduce some of the challenges that arise with a smaller group of individuals serving in multiple major national leadership roles, affording greater opportunity for leadership and engagement to the majority of Section members. Your Task Force also believes that these changes work in tandem with their recommendations in Section 11 "Appointments." Your Task Force also wants to note that our proposed amendments to Section 4.6 "Vacancies" provide that filled vacancies and temporary appointments do not count toward term limits.

~~two years, even if he or she has not reached his or her four year total limit. This Section shall not encompass positions that are not national in scope (i.e. Regional or State Delegates, Regional or State Chairs, etc.) nor shall it encompass appointments to the internal MSS Committees or Task Forces. The exceptions to the Section are as follows:~~

- ~~• Unless otherwise provided in the AMA Bylaws.~~
- ~~• The position of Immediate Past Chair of the Governing Council shall not be denied to a student on the basis of having already served four years pursuant to the foregoing provision, but the service in the position of Chair-elect/Immediate Past Chair shall otherwise count as a year of service.~~

4.7.1. This Section shall not encompass the positions of Chair-elect, Immediate Past Chair, Medical Student Trustee-elect, AMA-HOD Reference Committees, appointments to internal MSS Committees and Task Forces, or positions that are not national in scope (i.e. Regional or State Delegates, Regional or State Chairs, etc.).

4.7.2. This section encompasses students deemed qualified by the AMA Bylaws and these Internal Operating Procedures for election to the positions of:

- A) GC, or
- B) Appointment through the MSS to a position on an AMA Council, or
- C) A committee outside of the AMA that is national in scope and appointed or recommended by the GC, the AMA President, the AMA President-elect, or the AMA Board of Trustees (such as AMA Foundation, American Medical Association Political Action Committee, National Board of Medical Examiners, National Resident Matching Program, Liaison Committee on Medical Education, etc.), or
- D) Medical student BOT member¹²

4.7.3 The intent of this Section is to limit combined service in all of these positions to three (3) years total. A person may not serve more than two (2) years in the same position, with the exception of GC positions (Section 4.5.2.).

¹²Your Task Force included the medical student Trustee in its list of national medical student leadership positions that may be termed out per Section 4.7. Your Task Force noted that the medical student Trustee traditionally does not serve longer than two to three years. While AMA Bylaw 3.5.6.2 permits an existing medical student Trustee to remain eligible for additional terms so long as they remain eligible for MSS membership, your Task Force felt that the MSS IOP's should limit eligibility in accordance with other national leadership positions.

5. Medical Student Trustee.¹³

5.1. Duties and Privileges. ~~A medical student member of AMA shall be elected annually by the MSS Assembly to serve as a member of the AMA Board of Trustees.~~ The student member of the Board of Trustees shall report on the Board's activities to the Assembly before the Annual and Interim Meetings of the MSS. This report will communicate Board Actions related to the concerns of the MSS and will provide the MSS with directives on behalf of the Board.

5.2. Term and Election. The MSS Assembly shall elect the Medical Student Trustee ~~elect~~ at the Interim Meeting for a one-year term beginning at the close of the next AMA HOD Annual Meeting and concluding at the close of the second AMA HOD Annual Meeting following the meeting at which the member was elected.

5.3. ~~Per AMA Bylaw 3.5.6.2, the~~ The Medical Student Trustee is eligible for reelection so long as the Trustee remains eligible for medical student membership in the AMA (AMA Bylaw 3.5.6.2), and they have not reached the MSS term of service limit (Section 4.7.2).

6. Elections.

6.1. Time of Election. The Chair-elect of the GC and Medical Student Trustee shall be elected by the MSS Assembly at the Interim Meeting. The remaining GC members, with the exception of the Immediate Past Chair, shall be elected by the MSS Assembly at the Annual Meeting of the MSS. The GC shall set the day and hour of such elections and shall communicate the day and hour to the medical student members of the AMA at least 30 days prior to each Interim Meeting and Annual Meeting.

6.2. Eligibility. All members of the MSS are eligible to be elected to any office, ~~except:~~

6.2.1. MSS members who serve ~~or will serve~~ in an AMA Council or AMA Liaison position may not also serve in a voting GC position, ~~except for MSS Chair-elect, or as the Medical Student Trustee at the same time for more than two months.~~

6.2.2 MSS members who serve on a Region Executive Council, as Regional Delegates or Region Alternate Delegates, or representatives from other organizations to the MSS Assembly (Section 10.3.2-10.3.5), are eligible to run but may not concurrently hold a GC position, except for MSS Chair-Elect, or hold the Medical Student Trustee position, except for Medical Student Trustee-Elect, if successfully elected.

6.2.2 MSS members who serve on a Region Executive Council, as Regional Delegates or Region Alternate Delegates, or representatives from other organizations to the MSS Assembly (Section 10.3.2-10.3.5), are eligible to run but may not concurrently serve in a voting GC position or as the Medical Student Trustee.

¹³Discussion on Section 5 "Medical Student Trustee" focused on ensuring that the Student Trustee would be selected and proceed with onboarding in a clear manner. Similar to the Chair-elect provision, your Task Force felt it beneficial to ensure the Trustee-elect transitions into the role and is able to independently serve once in their term. Your Task Force acknowledges that much of the work encompassed within the Trustee role is confidential, even within the GC, but recognizes that the current Trustee is still able to include the Trustee-elect in any objectives relevant to their preparation for serving as student Trustee.

~~6.2.3 An MSS member may hold an AMA Council or AMA Liaison, position and the position of Immediate Past Chair simultaneously.~~

6.3. Nominations. Nominations for GC positions shall be received in advance of the Annual Meeting (in advance of the Interim Meeting for the Chair elect and Medical Student Trustee), pursuant to the rules of the MSS. Further nominations may be made from the floor of the Assembly Meeting at a time determined by the GC.

6.4. Speeches. Candidates are allowed to address the Assembly for a period of time determined by the Speakers ~~up to a maximum of three minutes~~ during a general Assembly session, as scheduled by the Speakers. ~~In addition, the Chair of the GC, or his or her designee, shall ask each candidate a number of questions on issues of relevance during a general Assembly session, as scheduled by the Speakers. The Speakers will notify candidates of the maximum length of speeches at least one day prior to their speech.~~

6.5. Campaign Rules.

6.5.1. Candidacy. All MSS members shall be considered potential candidates for all elected offices and shall be bound by all Campaign Rules during the election cycle for each office, where the election cycle for an office is defined as the time between elections for that office.

6.5.2. Campaign Period.

6.5.2.1. Campaigns shall be run only for positions that are electable at the present meeting.

6.5.2.2. Between meetings, campaigns shall be run only for positions that are electable at the upcoming meeting.

6.5.2.3. The official campaign period shall be defined as starting the first day ~~applications~~ the Speakers' Ruling is made available ~~for to~~ MSS members to submit their candidacy. The Speakers will notify all MSS members at least fourteen (14) days in advance of the estimated date of release of the Speakers' Ruling.

6.5.2.4. All activities related to announcement of candidacy, endorsement, or campaigning, including but not limited to distribution of materials, communications, and speaking opportunities shall be limited to the campaign period defined above.

6.5.3. Speakers' Ruling. A Speakers' Ruling for each national meeting and election will be made available to all potential candidates at the start of the campaign period with a document of rulings so that all candidates have equal access to all rules relating to their campaigns. Once released, the Speakers reserve the right to issue addendums or announcements during the campaign period as needed. Any addendums or

amendments to the election rules also shall be shared with all candidates.

6.5.4. Candidate Disclosure Form.

6.5.4.1. The day before the election is scheduled to occur, all candidates nominated, either in advance of the meeting or from the floor at the meeting, shall submit a completed Candidate Disclosure Form to the Speaker, the Vice Speaker, or a member of the Rules Committee no later than the time of day designated by the Speaker. No candidate shall be elected if ~~he or she has~~they have not completed and submitted a Candidate Disclosure Form.

6.5.4.2. The Candidate Disclosure Form shall be prepared by the Speakers and shall consist of three parts:

6.5.4.2.1. A portion, completed by the candidate, for disclosure of campaign leadership and campaign finances.

6.5.4.2.2. A portion, completed by the candidate, affirming that the candidate has read the IOP sections relevant to campaigning and the Speakers' Ruling for that election cycle and agrees to abide by the rules and recommendations contained within those documents.

6.5.4.2.3. A portion, completed by the Speakers, for disclosure of any prior, substantiated infraction(s) of MSS IOPs by the individual declared as a candidate.

6.5.5. ~~Campaign Materials. Candidates may distribute only the following campaign materials:~~

6.5.5.1. ~~Buttons, stickers, and pins less than 2.5 inches in greatest dimension. The MSS election manual shall be used to disseminate information about all candidates. The MSS election manual provides an equal opportunity for each candidate to present the material they consider important to bring before the members of the MSS.~~

6.5.5.2. ~~Standard-size business cards. Physical campaign materials outside of the campaign forum are disallowed. This rule will not apply for pins for AMPAC, the AMA Foundation, specialty societies, state and regional delegations and health related causes that do not include any candidate identifier. These pins should be small, not worn on the badge and distributed only to members of the designated group.~~

6.5.5.3. Curricula vitae and personal statements

6.5.5.3.1. Curricula vitae and personal statements of candidates nominated, pursuant to the ~~rules~~Speakers' Ruling of the MSS, ~~in advance of the national meeting at which the election will be held~~ shall be included in the online version of the MSS Meeting Handbook.

~~6.5.5.3.2. At the Assembly Meeting, distribution of curricula vitae and personal statements shall be limited to the area and medium/media designated by the Speaker and announced at least 30 days prior to the meeting at which the election will be held.~~

~~6.5.5.3.3. While there will be no limit on the length of curricula vitae, personal statements will be limited to one page (front and back).~~

~~6.5.5.3.4. No trinkets, candy, pens, or other items may be displayed or distributed.~~

6.5.6. The total expenditure per candidate per campaign shall not exceed \$~~1,000~~200, including all monetary donations ~~and in-kind donations of goods~~, but not including the candidate's travel to and lodging at the meeting at which the election is held.

6.5.7. Campaign Communications.

6.5.7.1. ~~Advance n~~Non-electronic mailings by candidates or other organizations on behalf of a candidate are not permissible.

6.5.7.2. Candidates should be prudent and courteous regarding the number and content of electronic messages, including but not limited to email, social media, phone, text message, and group chats, sent prior to the election.

6.5.7.3. No mode of MSS- or AMA-sponsored communication, including but not limited to listservs, phone or email lists, or other mass communication methods shall be used for announcements of candidacy, endorsement, or campaigning.

6.5.7.4. Candidates using campaign-specific social media accounts can only invite MSS members to follow said accounts, and provide an appropriate disclaimer to this effect, but may not be penalized for any non-MSS members who follow the account.

6.5.8. **Campaigning.** ~~At MSS Regional, state, or school section meetings prior to the meeting at which the election occurs, including attending social events, is prohibited. The candidate's own Medical Student Region, state, or school section meetings are an exception to this rule. Campaigning includes, but is not limited to, discussing candidacy or displaying or distributing campaign paraphernalia.~~

6.5.8.1 Campaigning includes, but is not limited to, discussing candidate platforms or displaying or distributing campaign materials, but does not include merely stating their candidacy for a position.

6.5.8.2 Campaigning at MSS Regional, State, or School section meetings prior to the meeting at which the election occurs is prohibited.

6.5.8.3 Candidate forums where all candidates are given an equal opportunity to

speakers may commence at the start of the campaign period. Candidates may choose at their discretion to attend, send a representative, or not attend. Any candidate's availability or lack thereof shall not impose a restriction on the attendance of other candidates.

6.5.8.3.1 The Speakers shall coordinate a candidate forum at national meetings.

6.5.9. Campaign Involvement.

6.5.9.1. Only MSS members may be involved in a candidate's campaign. MSS members should not share their opinion in favor of or in opposition to any candidate while acting under any official leadership role on the GC, in a Region, for a Standing Committee, or other organizational or society representative within or outside of the organization and should explicitly state that they are speaking as an individual unless otherwise outlined in these IOPs or by the Speakers' Ruling ~~as explained in~~ (Section 6.5.3).

~~6.5.9.1.1. Exception: Candidates may wear their own campaign paraphernalia at all times during the Assembly Meeting at which their election is held.~~

6.5.9.2. The campaign involvement of AMA staff members, members of the MSS GC, Region Chairs and Acting Chairs, and members of the MSS Rules Committee shall be limited to candidate inquiries regarding election-related matters and AMA-related information so long as that information is made available to all MSS members who request it.

6.5.9.3. Each candidate is allowed the following number and type of public endorsements:

6.5.9.3.1. One (1) optional letter of endorsement by the Dean or Dean's representative from the medical school that the candidate is enrolled in; and one (1) optional letter of endorsement by leadership or staff of the state society from the state where the candidate attends medical school are permitted.

6.5.9.3.1.1. These optional letters of endorsement may be included in the MSS Election Manual and may be displayed ~~at the candidate forum~~ on social media.

6.5.9.3.1.2. During a national meeting, these letters may only be publicly disseminated via the MSS Election Manual and may only be publicly displayed at the candidate forum.

~~6.5.9.3.2. One (1) optional letter of endorsement and a verbal endorsement by the Medical Student Region in which the candidate's~~

~~medical school is located is permitted by vote within the campaign period.~~

~~6.5.9.3.2.1. The endorsing Region must:~~

~~6.5.9.3.2.1.1. Follow the Region's bylaws regarding issuance of public endorsement.~~

~~6.5.9.3.2.1.1.1. If a Region does not have bylaws specifying quorum or rules dictating official support, the Region must contact the AMA-MSS Speakers for guidance.~~

~~6.5.9.3.2.1.2. Document that quorum was met when the voting occurred; and~~

~~6.5.9.3.2.1.3. Document the results of the vote pursuant to Region bylaws.~~

~~6.5.9.3.2.2. The optional letter of endorsement will not be included in the Election Manual but may be displayed on social media.~~

~~6.5.9.3.2.3. During a national meeting, such endorsement may not be publicly disseminated nor displayed except as on social media.~~

6.5.9.3.32. A verbal endorsement of a candidate ~~whose medical school is outside the endorsing by a r~~Region is permissible only ~~at the meeting at which the election is taking place~~ within the campaign period.

6.5.9.3.32.1. The endorsing Region must:

6.5.9.3.32.1.1. Follow the Region's bylaws regarding issuance of public endorsement;

6.5.9.3.32.1.1.1. If a Region does not have bylaws specifying quorum or rules dictating official support, the Region must contact the Speakers for guidance.

6.5.9.3.32.1.2. Document that quorum was met when the voting occurred; and

6.5.9.3.32.1.3. Document the results of the vote pursuant to Region bylaws.

6.5.9.3.32.2. When speaking in official support of a candidate at an MSS Assembly on behalf of a MSS Region, Region Chairs and Acting Chairs must be sure that an official vote by the

Region took place in accordance with the Region's bylaws ~~for quorum and rules dictating official support and document that vote.~~

6.5.9.3. ~~32~~.3. Regions may not vote to oppose any candidate.

6.5.10. Candidates must be allowed to fully participate in candidate interviews and question and answer sessions during the Assembly Meeting.

~~6.5.11. At the national meeting at which the election is taking place, a group that invites any candidate for a particular office to speak must invite and make a reasonable effort to accommodate all candidates for that office. Candidates may choose at their discretion to attend or not or may send a representative to speak for them, but any candidate's availability or lack thereof shall not impose a restriction on the attendance of other candidates.~~

6.5.1 ~~12~~. Receptions and/or hospitality shall not be used for promotion of candidates.

6.5.1 ~~23~~. **Enforcement.**

6.5.1 ~~23~~.1. Alleged infractions, including but not necessarily limited to violations of the Campaign Rules, should be reported in writing to the Speakers, or to any member of the MSS Rules Committee.

6.5.12.1.1. Alleged election infractions shall be reported within a period of fourteen (14) days of discovery, up until seven days before the election, so as to limit a delay in reporting prior to an election that would not allow investigators time to thoroughly undertake their responsibilities delineated below:

6.5.12.1.1.1. In the seven days before an election, any alleged infraction occurring prior to the start of the MSS Assembly must be reported in good faith as soon as possible and no later than 2 hours after the start of the MSS Assembly and shall be evaluated by the Rules Committee. The only infractions that may be reported after this point are those that occur after the start of the MSS Assembly.

6.5.12.1.1.2. Any alleged infractions reported outside of these limits will be evaluated upon by the Rules Committees for investigation.

6.5.1 ~~23~~.2. **Investigators and Investigative Process.** The Speakers shall be the lead investigators of any alleged infraction in conjunction with the Rules Committee. No person who is a candidate ~~for the same position in the same election~~ as the candidate being investigated for alleged infractions may participate in any part of the investigation ~~of those alleged infractions. The~~

~~candidate is required to participate in the investigation.~~

6.5.123.2.1. In the event where both the Speakers are candidates for the election being investigated, the MSS Chair will designate two members of the Rules Committee as investigators to examine the alleged infraction.

6.5.123.2.2. In the event where either the Speaker or Vice Speaker are a candidate for the election being investigated, the MSS Chair will designate one member of the Rules Committee as an investigator to examine the alleged infraction in tandem with the Speaker or Vice Speaker not being investigated.

6.5.12.2.3. The investigators are required to include the candidate in the investigation.

~~6.5.13.3. Following their investigation and the alleged violator's opportunity to rebut the alleged infraction and prior to balloting, the investigators shall report substantiated infractions to the Assembly but shall not make any recommendation to the Assembly.~~

~~6.5.13.4. Enforcement of a campaign infraction shall follow a systematic approach. Each candidate, upon each substantiated infraction of the Campaign Rules, shall be given an official warning letter from the AMA-MSS Speaker. Exceeding three (3) substantiated infractions during a campaign shall render a candidate ineligible for election to any position during that campaign period.~~

6.5.123.3. **Rebuttal Process.** Rebuttal occurs during the course of an investigation where the alleged violator is given the opportunity to defend the actions in the alleged infraction.

6.5.12.3.1. Following their investigation, the investigators shall inform the alleged violator, Region Chairs, and Acting Chairs of the infraction in writing, including the results of the investigation of the alleged infraction.

6.5.12.3.2. The alleged violator shall be offered an opportunity to rebut the alleged infraction in writing. Region Chairs and Acting Chairs shall be offered the opportunity to provide comments on the alleged infraction in writing.

6.5.12.3.3. Following rebuttal and comments, the investigators shall determine whether the alleged infraction is substantiated and shall report their findings in writing to the alleged violator and Region Chairs and Acting Chairs. For all individuals provided with the report, findings of an investigation of an election infraction should be kept confidential.

6.5.12.3.4. Following this, the investigators shall report substantiated infractions to the Assembly but shall not make any recommendation to the

Assembly.

6.5.12.3.5. Upon each substantiated infraction of the Campaign Rules, the candidate shall be given an official warning letter from the Speakers.

~~6.5.12.3.4. Following their investigation and the alleged violator's opportunity to rebut the alleged infraction and prior to balloting, the investigators shall report substantiated infractions to the Assembly but shall not make any recommendations to the Assembly.~~ **Candidate Disqualification Process.** If a candidate exceeds three (3) substantiated infractions, the GC shall convene to determine whether to disqualify the candidate for that election. This meeting will be governed by the following rules:

6.5.12.4.1. All GC members who are candidates for the position under discussion or have significant conflicts of interest shall recuse themselves and be absent from this meeting.

6.5.12.4.2. The investigators shall present all evidence for and against each violation to the GC including the source of the evidence which will allow for GC members to adequately determine the credibility of the allegations.

6.5.12.4.3. The candidate in question will have the opportunity to defend themselves during this proceeding in conjunction with a co-counsel of their choosing, including the ability to directly respond to each allegation and call their own witnesses as needed.

6.5.12.4.4. Region Chairs and Acting Chairs shall be offered the opportunity to provide comments on whether the candidate should be disqualified.

6.5.12.4.5. After all evidence has been presented, the non-investigator members of the GC shall meet in a closed-door session to decide on the disqualification.

6.5.12.4.6. During the closed-door session, the Trustee, Trustee-elect, and Chair-elect/Immediate Past Chair are permitted to attend and speak, but not vote.

6.5.12.4.7. The GC should only consider disqualifying a candidate if they find that greater than three (3) violations are substantiated beyond a reasonable doubt

6.5.12.4.8. A two-thirds ($\frac{2}{3}$) vote of the non-investigator GC members will be required to disqualify the candidate.

6.5.12.5. **Appeals Process.** Appeals occur after a determination of whether an

infraction is substantiated or after a determination of whether a candidate should be disqualified. Appeals focus on the process of the investigation or determination. Should a candidate feel that due process was not followed in either of these cases and that an appeal is warranted, they must submit this in writing to the GC within twenty-four (24) hours of being notified of the result. The GC shall convene to review the appeal and determine whether the previous decision should be reversed. The alleged violator, Region Chairs, and Acting Chairs shall be offered the opportunity to provide comments on whether the appeal is justified. Whenever possible, an appeal should be reviewed prior to the results of the investigation being released to the Assembly.

6.6. Voter Eligibility. Credentialed MSS members acting as MSS Delegates for the meeting will be eligible to vote.

6.7. Method of Election.

6.7.1. When there is no contest, a majority vote without ballot shall elect. All other elections shall be by ballot.

6.7.2. All elections of officers where there is a contest shall be using a system of instant runoff voting without a separate runoff election.

6.7.2.1. The ballot shall give voters the option of ranking candidates in order of preference.

6.7.2.2. If a candidate receives a simple majority of first preferences, that candidate is elected.

6.7.2.3. If no candidate receives a majority of first preferences, an instant runoff retabulation shall be performed. The instant runoff retabulation shall be conducted in rounds. In each round, each voter's ballot shall count as a single vote for whichever continuing candidate the voter has ranked highest. The candidate with the fewest votes after each round shall be eliminated until only two candidates remain, with the candidate then receiving the greatest number of votes being elected.

6.7.23. Voting Periods. There shall be one voting period at the Interim Meeting for the selection of the Chair-elect and Medical Student Trustee. There shall be one voting period at the Annual Meeting for the selection of the Vice Chair, Section Delegate, At-Large Officer, Speaker, and Diversity, Equity, & Inclusion Officer. If no Speaker and/or Section Delegate candidates intend to drop-down to Vice and Alternate elections respectively, the election(s) will be included in the first voting period. If necessary, An additional balloting period ~~will~~ may be held for the elections of the Section Alternate Delegate and/or Vice Speaker.

6.7.34. First Ballot. At the Interim Meeting, ~~one individual~~ one individual ballots shall be used by the credentialed MSS Delegate ~~to cast one vote~~ for the Chair-elect and ~~one vote for~~ the Medical Student Trustee (Section 10.5). At the Annual Meeting, individual ballots for

each position shall be used by the credentialed MSS Delegate ~~to cast one~~ for each of the ~~seven (7) five~~ positions: the Vice Chair, Section Delegate, Alternate Section Delegate, At Large Officer, Speaker, Vice Speaker, and Diversity, Equity, & Inclusion Officer. ~~No ballot should be counted if there is more than one vote for a position. All GC positions will be determined by majority vote, that is, the candidate who has received the largest number of votes shall be elected if that nominee has received a majority of the legal votes cast.~~

6.7.~~34~~.1. Election of Section Alternate Delegate. ~~If necessary, A~~After the election of the Section Delegate, all unsuccessful candidates who were nominated for the office of Section Delegate may be added to the existing Section Alternate Delegate ballot by nomination from the floor of the Assembly. Each MSS Delegate to the Assembly Meeting who is present at the meeting may cast a ~~written~~ ballot for the election of the Section Alternate Delegate from the previously declared candidates and among those so nominated. Election to the office of Section Alternate Delegate requires a majority of the legal votes cast.

6.7.~~34~~.2. Election of Vice Speaker. ~~If necessary, a~~After the election of the Speaker, all unsuccessful candidates who were nominated for the office of Speaker may be added to the existing Vice Speaker ballot by nomination from the floor of the Assembly. Each MSS Delegate to the Assembly Meeting who is present at the meeting may cast a ~~written~~ ballot for the election of the Vice Speaker from the previously declared candidates and among those so nominated. Election to the office of Vice Speaker requires a majority of the legal votes cast.

~~6.7.4. Runoff Election. If no candidate receives a majority of the legal votes cast or there is a tie, a runoff election will be held between the two (or more if necessary because of a tie) candidates receiving the highest number of legal votes cast.~~

6.7.5. **Processing.** No ballots will be cast after the expiration of the voting period. ~~The ballot boxes will be collected by members of the Rules Committee. The Rules Committee and the ballot boxes will be sequestered in a private location. At this time, the Chair of the Rules Committee will open the ballot boxes and the Rules Committee will then count the ballots and tabulate the results. The Rules Committee will validate the election results by determining that each ballot is official, candidate who has received a majority of the legal votes cast is equal to or less than the number distributed and will then certify the results in writing. He or she~~They will then immediately forward these results to the Assembly's Presiding Officer. Upon receipt of the Rules Committee's election results and verification, the Presiding Officer will announce the results to the Assembly.

~~6.7.5.1. First Ballot. The credentialed MSS Delegate will receive one initialed ballot from a designated member of the Credentials Committee at the credentials table during the set voting period.~~

~~6.7.5.2. Runoff Election. If no candidate receives a majority of the legal votes~~

~~cast or there is a tie, additional ballot(s) will be distributed by the Credentials Committee at the request of the Assembly's Presiding Officer. The candidate who receives a majority of the legal votes cast in the runoff election will be declared the winner.~~

6.7.6. Appeals. Appeals of the election process and results must be made in writing to the Assembly's Presiding Officer no later than ~~one~~two hours after the official announcement of the final results.

6.7.6.1. Any appeal of the process of ballot(s) distribution will be considered by the Rules Committee. Consideration of such appeals and merits of said appeals will be determined in whatever manner the committee deems necessary. The results of the committee's recommendations must be forwarded in writing by the Committee Chair to the Assembly's Presiding Officer.

Any appeal of the process of ballot processing, tabulation, and announcement of results, shall be considered by the Credentials Committee. Consideration of such appeals and merits of said appeals will be determined in whatever manner the committee deems necessary. The results of the committee's recommendations must be forwarded in writing by the Committee Chair to the Assembly's Presiding Officer.

6.7.6.2. No person who is a candidate in the election being appealed may participate in any part of the appeals process.

6.7.6.3. The Assembly's Presiding Officer and the GC will consider the appeals report(s) from the Committee(s) dealing with the matter. Final decision on the election results will be the jurisdiction of the GC.

6.8. Endorsements for Diversity, Equity, & Inclusion Officer. Given the importance of ensuring the Diversity, Equity, & Inclusion Officer represents diverse groups, candidates for this position may seek endorsements of their candidacy from the identity-based standing committees, liaisons to identity-based National Medical Student Organizations (~~as defined in MSS IOP~~ Section 10.3.2), and liaisons to identity-based AMA Sections and Advisory Committees (~~as defined in~~ AMA Bylaw 7.0.1).

6.8.1. Candidates are strongly encouraged to seek at least one endorsement, and may seek as many endorsements as they choose.

6.8.2. Committees and liaisons may endorse as many candidates as they choose. Committees and liaisons shall create internal guidelines centered around lived experiences and personal diversity by which to determine endorsements.

7. MSS Standing Committees and Task Forces.

7.1 The MSS Standing Committees leadership and Task Forces members shall be appointed by the GC and shall support the mission of the MSS as outlined in MSS Internal Operating Procedures.

7.2 The GC shall solicit and consider the aggregated and anonymized comments of standing committee members from the previous term in selecting leadership.

7.3 The existence and purview of MSS Standing Committees may be determined by the GC or by action of the MSS Assembly.

7.4 Standing Committee leadership shall have a term limit of service no greater than two years total on any combination of Standing Committees.¹⁴

8. MSS Regions.

8.1. Structure and Purpose of the MSS Regions.

8.1.1. There are seven Medical Student Regions defined for the purposes of electing Regional Delegates to the AMA HOD from Medical Student Regions. The regions are:

Region 1: Washington, Oregon, California, Nevada, Utah, Colorado, Arizona, New Mexico, Montana, North Dakota, South Dakota, Idaho, Wyoming, Alaska, Hawaii.

Region 2: Minnesota, Wisconsin, Nebraska, Iowa, Missouri, Illinois.

Region 3: Kansas, Texas, Oklahoma, Arkansas, Louisiana, Mississippi.

Region 4: Florida, Georgia, Alabama, South Carolina, North Carolina, Tennessee, Puerto Rico.

Region 5: Michigan, Indiana, Ohio, Kentucky, West Virginia.

Region 6: Virginia, Maryland, District of Columbia, Delaware, New Jersey, Pennsylvania.

Region 7: Maine, Vermont, New Hampshire, Massachusetts, Rhode Island, Connecticut, New York

8.1.2. In addition to providing a structure for election of Regional Delegates, the MSS defines the roles of the Regions as follows: ~~to provide a home within the MSS, to serve as a communication unit for the MSS,~~ to provide a means to foster collaboration and communication between local chapters, ~~the~~ sections, and states, and to facilitate interaction and integration of newly developing sections with well-established sections.

8.1.3. Each Region shall be governed by a Region Chair to be elected in accordance with the Region's bylaws. The Region Chair will serve as the liaison for their respective Region to the GC. Other Regional officer positions may be elected in accordance with the Region's bylaws. The role of the Region Chair is as follows:

¹⁴Your Task Force solicited input from a myriad of stakeholders in regards to Standing Committees and Task Forces. Members of the Task Force felt that, similar to proposed changes in Section 11.1 regarding the solicitation of Caucus feedback for Councilor appointments, the Standing Committee leadership process should involve the solicitation of feedback from previous committee members. Section 7.3 was added to clarify that Standing Committees may be created legislatively or by the Governing Council. Section 7.4 was added after discussions in Section 4.5 regarding Governing Council term limits. Your Task Force felt that, in certain situations, Standing Committee leadership may be commandeered by the same individuals, and especially so if those individuals were participating in a dual degree program that extended their time in the MSS. Your Task Force proposed a two-year term limit for leadership across any combination of Standing Committees, consistent with the two-year term limit on members of the MSS Governing Council.

8.1.3.1. Encourage the organization of Regional conferences as well as effective mechanisms ~~to~~^{ing} increase communication among its members.

8.1.3.2. Encourage the development of local university and state MSS ~~chapters~~^{sections} in educational programs accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA) where local and state sections do not exist ~~and the development of state MSS sections in states where they do not exist.~~

8.1.3.3. Involve highly organized MSS ~~chapters~~^{sections} and state ~~chapters~~^{sections} in providing organizational information and assistance to developing ~~chapters~~^{sections}.

8.1.3.4. Encourage MSS ~~chapters~~^{sections} to maintain communication and interaction between medical student members and physician members of state associations and component societies.

8.1.3.5. Provide oversight in appropriate aspects of election governance for the MSS on behalf of their Regions (Section 6.5.13.3).¹⁵

8.1.4. Each Region shall have a Region ~~Governing~~^{Executive} Council, which will be composed of the Region Chair, and other elected or appointed officers of the Region consistent with that Region's bylaws and at the discretion of the Region Chair. The purpose of the Region ~~Governing~~^{Executive} Council shall be to further fulfill the purpose of each Region as defined both in the MSS Internal Operating Procedures and the Region's bylaws.

8.2. Regional Delegates to the AMA ~~House of Delegates~~ HOD.

8.2.1. Regional Delegates and Alternate Regional Delegates are part of the MSS Caucus led by the Section Delegates.

8.2.2. **MSS Responsibilities.** The Regional Delegates and Alternate Regional Delegates will serve as mentors in the MSS and assist the Section Delegates in reviewing MSS resolutions. their responsibilities will include:¹⁶

8.2.2.1. Assisting the Section Delegates in leading the MSS resolution review process. Delegates are also encouraged to attend the MSS Assembly before each HOD meeting, to facilitate communication regarding the policy process with the students in their respective Regions.

¹⁵Discussion and proposed amendments of Section 6.5.13.3 reflects a new role for Region Chairs in receiving reports of allegations in the elections investigative processes. Your Task Force added this clause to Section 8.1.3.5 pertaining to duties of Region Chairs to reflect our recommendations accordingly.

¹⁶Discussion of Section 8.2.2 highlighted a need for some clarity regarding the roles and responsibilities of Regional Delegates and Alternate Delegates to the AMA HOD. Your Task Force reviewed the handbooks provided to the MSS Caucus during each review cycle and used these guidelines to develop broad clauses that reflect the general responsibilities of all Regional Delegates.

8.2.2.2. Serving as an active member of the MSS Caucus, and where permitted, as an active member of their state Caucus. This includes attendance and participation in all MSS Caucus meetings.

8.2.2.3. Representing the MSS at the AMA HOD. This includes attendance at the Annual and the Interim AMA HOD for the full duration of each meeting.

8.2.2.4. Serving on Reference Committee teams for the AMA HOD meetings.

8.2.3. Apportionment and Seating. Each Medical Student Region is entitled to Regional Delegate and Alternate Regional Delegate representation based on the number of seats allocated to it by apportionment, ~~as outlined in~~ (AMA Bylaw 2.3.2). ~~An~~Each elected Regional Delegate will be seated with the state delegation from the jurisdiction in which ~~his or her~~their educational program is located ~~(AMA Bylaws 2.3)~~.

8.2.3.1. If a Regional Delegate cannot fulfill ~~his or her~~their duties, the Alternate Delegate shall assume the position of Regional Delegate and be seated with the state in which the Regional Delegate's educational program is located. ~~(AMA Bylaws 2.3)~~.

8.2.4. Qualifications. Each candidate for Regional Delegate or Alternate Regional Delegate must meet the following minimum qualifications:

8.2.4.1. Any medical student member of the AMA is eligible for a Regional Delegate or Alternate Regional Delegate position, except as prohibited by AMA Bylaws, MSS IOPs, or Region bylaws.

8.2.4.2. All elected Regional Delegates and Alternate Regional Delegates must attend a medical school in the Region they are elected to represent.

8.2.3.4.1. In instances where a medical student member attends a campus in a different state than the main campus, ~~he/she~~they must represent the main campus' state. In instances where the campus falls outside the Region of the main campus, ~~he/she~~they must represent the main campus' Region.

8.3. Elections. The MSS will elect Regional Delegates and Alternate Regional Delegates to the AMA HOD according to the following guidelines:

8.3.1. Each Medical Student Region is responsible for selecting its own Regional Delegates and Alternate Regional Delegates, based on the process identified in each Region's bylaws.

8.3.2. Elections for the Regional Delegates and Alternate Regional Delegates to the AMA HOD will be held at the Interim Meeting of the MSS. Each Region must submit the name of its newly-elected Regional Delegates and Alternate Regional Delegates to the GC before the close of the Interim Meeting.

8.3.3. Candidates will be required to submit a completed application ~~including the to the MSS staff by the published deadline each year. this application is to be kept on file by the MSS. Applicants should include a~~ written endorsement of the state medical society with representation in the AMA-HOD in which their medical school campus is located, ~~approval from the applicant's school, and a curriculum vitae to the Medical Student Section staff by the published deadline each year to be kept on file by the Medical Student Section.~~¹⁷

8.3.3.1. This provision may only be suspended if there are more Regional Delegate or Alternate Regional Delegate positions available than applicants who submitted on time or if there is a state in the Region without an applicant.

8.3.3.1.1. ~~Each Region will determine how to consider Applicants who do not submit their materials by the established application deadlines-may be considered for available seats, but only after applicants who submitted their applications on time have been considered.~~

~~8.3.3.1.2. Each region will determine whether or not to consider a candidate running from the floor from a state with no candidates who submitted on time simultaneously or after candidates from states with applicants who submitted on time.~~¹⁸

8.3.3.2. A Regional Delegate or Alternate Regional Delegate who is elected from the floor without having submitted the application materials by the deadline ~~(Section 8.3.3.)~~ must submit ~~such those~~ materials ~~outlined in Section 8.3.3~~ within ~~thirty (30) to~~ days of the election in order to retain the position.¹⁹

8.3.4. Each state is entitled to a maximum of one Regional Delegate, unless there are fewer candidates than available positions or another state does not have a candidate that submitted their application on time. A state may have an unlimited number of Alternate Regional Delegates up to the maximum number of Regional Delegates.

8.3.5. Medical Student Regional Delegates and Alternate Regional Delegates to the AMA HOD are elected for one-year terms.

8.3.6. All election disputes will be referred to the GC, with the return of a final response

¹⁷Discussion of 8.3.3 included concerns for students in state medical societies that may have limited personnel or resources to respond to student requests for endorsement. Your Task Force recognized that MSS Staff and individual applicants can work together to make reasonable efforts to arrange for these endorsements if possible. Since approval from the applicant's school is already an important component of the applications and future participation, your Task Force added this explicit language to clarify the conditions of eligibility for students seeking these positions.

¹⁸Discussion of Sections 8.3.3.1.1 and 8.3.3.1.2 pertaining to Regional Delegate elections indicated that these clauses did not uniformly align with the needs and reality of individual Region elections. Your Task Force chose to condense this section to provide more flexibility to individual Regions to decide how to handle these situations.

¹⁹Discussion of 8.3.3.2 included concern about the long period of time between Regional and Alternate Regional Delegate elections and the deadline for application materials. Your Task Force felt that a shorter deadline of thirty days would still give newly elected Regional and Alternate Regional Delegates significant time to acquire application materials and provide a cushion for staff should there be a delay in such acquisition.

from the GC within thirty (30) days (Section 13).²⁰

8.3.7. Each Region shall be free to institute more stringent requirements consistent with all other AMA and MSS rules.

8.4. Creation of MSS Regional Delegations to the AMA HOD. Through a mechanism of its own choosing, each Medical Student Region should appoint a member of its Regional dDelegation to the AMA HOD either a Regional Delegate or an Alternate Regional Delegate, to serve in the capacity of Regional Delegation Chair. The responsibilities of the Regional Delegation Chair should include:

8.4.1. Identify Regional Delegates and Alternate Regional Delegates who may be absent at portions of the AMA HOD meetings and suggest replacements in accordance with the MSS IOPs and the Region bylaws.

8.4.2. Take attendance of the Regional Delegates and Alternate Regional Delegates from ~~his or her~~their Region at HOD meetings.

8.4.3. Mentor and orient inexperienced Regional Delegates and Alternate Regional Delegates.

8.4.4. Fulfill any other responsibilities assigned by the region.

8.4.5. ~~Coordinate resolution authorship in the Region for the MSS Assembly.~~ Assist in the coordination of the resolution writing and review process in the Region.²¹

9. MSS Caucus to the HOD.

9.1. MSS Caucus Structure.

~~9.1.1. The MSS Caucus is composed of the following members: The AMA Delegate and Alternate Delegate; the Regional Delegates and Alternate Regional Delegates; and any MSS member serving on any HOD delegation.~~

9.1.1. The MSS Caucus voting membership is comprised of the following members:

9.1.1.1. The Section Delegates:

9.1.1.2 MSS Regional Delegates and Alternate Regional Delegates:

9.1.1.3 Any MSS member serving on any HOD, state, or specialty society

²⁰Discussion of Section 8.3.6 highlighted a need for specification regarding how disputes pertaining to Regional Delegate elections would be resolved and the timeline for doing so. The addition of this clause was felt to address these concerns without limiting the ability of the GC to appropriately address any election disputes.

²¹Discussion of Section 8.4.5 highlighted the fact that approaches to Region authorship or sponsorship varied significantly between Regions and the Regional Delegation Chair was not always responsible for this process. This clause was modified to highlight that the RDC should have a role in this process without being prescriptive about the nature of that role.

delegation who have declared Caucus membership after being contacted by the Section Delegates (Section 4.4.3.2.1.).

9.1.2 Additional non-voting members of the MSS Caucus include those serving on an AMA Council, in an AMA Liaison position (Section 4.7), or in the MSS HOD Coordination Committee (HCC).

9.1.3. Caucus meetings. Caucus meetings shall include all voting and non-voting members of the Caucus, as well as any other member of the AMA-MSS wishing to join unless they are closed.

9.1.3.1 “Closed meetings” may be called at the discretion of the Section Delegates. Attendance at “closed Caucus meetings” is composed of voting Caucus members and any individuals with explicit permission from the Section Delegates.

9.1.3.2 MSS members that are not part of the MSS Caucus are not eligible to vote and may only participate in discussion at MSS Caucus Meetings with explicit permission from the Section Delegates.²²

9.1.42. The ~~MSS-Section~~ Delegates shall be considered the Chair and Vice Chair of the Caucus respectively and their responsibilities in those positions include, but are not limited to:

9.1.4.1 Attempt to contact all members eligible to the MSS Caucus before each AMA HOD meeting.²³

9.1.4.2.2-1: Overseeing debate, discussion, and voting that occurs within the MSS Caucus.

9.1.4.3.2-2: Assigning Regional Delegates, ~~or~~ Alternate Regional Delegates, and members of the MSS HOD Coordination Committee (HCC) to serve on ad hoc Caucus Reference Committees.

9.1.4.4.2-3: Speaking on behalf of the MSS or delegating the responsibility to speak on specific items of business to MSS members of their choosing in Reference Committee hearings and the HOD ~~or delegating the responsibility to~~

²² Your Task Force had robust discussion on the structure of MSS Caucus and the best way to codify this in the IOP's. For clarity your Task Force delineated voting versus non-voting members of the MSS Caucus, as established by current practices. Your Task Force also felt it important to clarify that, while MSS Caucus meetings are generally open to all MSS members who have permission from the Section Delegates, there may be times when MSS Caucus meetings, at the discretion of the Section Delegates are closed, such as during discussion of sensitive topics or strategy that may need to be kept confidential.

²³ Your Task Force received feedback that some members of MSS Caucus, particularly those from state and specialty societies, may not have strong relationships to the MSS. As a result, these individuals may miss important MSS Caucus meetings throughout the policy cycle and during HOD. Because quorum at these meetings can be difficult to obtain given various medical student obligations, your Task Force wanted to ensure that if, after a good faith effort by the Section Delegates to contact potential members of MSS Caucus, these members were able to be engaged, then their potential membership in the MSS Caucus would not count toward quorum.

~~Speak on specific items of business to others of their choosing.~~

9.1.4.5.2.4. Developing general MSS strategy for supporting or opposing HOD items of business~~resolutions and/or reports~~.²⁴

9.1.4.6.2.5. Coordinating and negotiating with the leadership of other groups and sections within the HOD.

9.2. **Determining MSS Caucus Positions**~~on AMA HOD Resolutions~~.

9.2.1. For all MSS Caucus activities requiring a vote, all members of the MSS Caucus shall be given one vote.

9.2.2. A quorum of at least one half of ~~potential~~ voting members must participate for a vote to be valid.

9.2.3. In the AMA HOD, the MSS Caucus must take positions on items of business~~resolutions~~ that are consistent with the existing policy of the MSS as defined in the MSS Digest of Actions whenever relevant MSS policy exists.

9.2.4. In areas where relevant MSS policy exists, but the interpretation is uncertain, a majority vote of a quorum of MSS Caucus delegates will determine the MSS Caucus's interpretation.

9.2.5. When an item of business resolution is before the AMA HOD that is of significant importance to the MSS, but for which no MSS policy exists, any member of the MSS Caucus may move that the MSS take a position on the resolution. Such a motion requires a second by another Caucus member and a two-thirds (2/3) majority vote of a quorum of the MSS Caucus to pass.

9.2.6.5.1. Positions set using these procedures ~~described in s(Section 9.2.5.)~~ are valid for the duration of that meeting of the AMA HOD only and do not apply to future ~~interim or annual~~ meetings.

9.2.6.7. The MSS Caucus may not take positions that are contrary to existing MSS policy.

9.3. **Reporting of Caucus Actions.** The Section Delegates shall be responsible for authoring a report of actions taken, which shall be presented to the MSS Assembly at the next national meeting. This report will list the resolved clauses of all AMA HOD items of business~~resolutions~~ for which the MSS took a position, and will specifically identify those items of business~~resolutions~~ for which the MSS Caucus took a position that was not grounded in existing internal policy.

²⁴ Throughout Section 9, your Task Force felt that "items of business" was more inclusive of the variety of business in the HOD than "resolutions".

10. MSS Assembly Meeting.

10.1. **Date and Location.** There shall be an Assembly Meeting of medical student members of the AMA (MSS) held prior to each meeting of the AMA HOD at a time and place fixed by the Executive Vice President of the AMA.

10.2. **Call to the Meeting.** No later than ~~Forty~~ thirty days prior to the meeting, notice shall be sent to all medical students and medical student organizations detailing the time, place, credentialing process, resolution mechanisms, election procedures, and education programs for the meeting.

10.3. Representatives to the Assembly Meeting.

10.3.1. Educational Programs.

10.3.1.1. Central Campuses. The AMA medical student members of each educational program ~~as defined in~~ (AMA Bylaw 1.1.1) (a “central campus”) may select one MSS Chapter Delegate and one Alternate MSS Chapter Delegate. An educational program ~~as defined in AMA Bylaw 1.1.1~~ that has a total medical student population (excluding students assigned to associated satellite campuses ~~as defined in MSS Internal Operating Procedure (Section~~ 10.3.1.2.) greater than 999, as determined by the AMA on January 1 of each calendar year, may select one additional MSS Chapter Delegate and one additional Alternate MSS Chapter Delegate.

10.3.1.2. Satellite Campuses. The AMA medical student members of an educational program ~~as defined in~~ (AMA Bylaw 1.1.1) that has more than one campus (a “satellite campus”) may select one MSS Chapter Delegate and one Alternate MSS Chapter Delegate from each campus. A satellite campus is defined as an administrative campus separate from the central campus where a minimum of 20 members of the student body are assigned for some portion of their instruction over a period of time not less than an academic year. MSS Chapter Delegates and Alternate MSS Chapter Delegates credentialing under the satellite campus provisions must, at the time of the meeting, reside at the campus they will represent.

10.3.1.2.1. A formal request to seat an MSS Chapter Delegate from a satellite campus for the first time must be submitted by the interested student or State medical student section to the AMA MSS staff of the AMA at least 90 days in advance of the first Meeting at which an MSS Chapter Delegate will be seated. The request must confirm that the satellite campus meets the requirements for representation ~~set forth in MSS Internal Operating Procedure (Section~~ 10.3.1.2. ~~&and in~~ AMA Bylaw 7.3.3.2).

10.3.1.3. Certification. ~~Educational program MSS Delegates and Alternate MSS Delegates shall be certified to the Governing Council of the MSS by either a student officer of the educational program or a State Medical Student Section where it exists. Following registration for each national meeting, certification is~~

the process by which an Assembly member is permitted to vote. Individuals who self identify as MSS Chapter Delegates shall be certified to the MSS GC by MSS staff.²⁵

10.3.2 National Medical Specialty Societies, ~~Federated~~ Services, and Professional Interest Medical Associations.²⁶

10.3.2.1. **Eligibility.** The following criteria have been developed for national medical specialty societies, ~~federal~~federated services, and professional interest medical associations to qualify for representation in the MSS Assembly. Pursuant to AMA Bylaw 7.3.3.3, a national medical specialty society, ~~federal~~federated service, or professional interest medical association seeking representation must:

10.3.2.1.1. Have voting representation in the AMA HOD.

10.3.2.1.2. Allow for medical student membership.

10.3.2.1.3. Have established a mechanism that allows for the ~~regular~~ input of medical student views into the issues before the organization.

10.3.2.2. A national medical specialty society, ~~federal~~federated service, or professional interest medical association that satisfies these criteria may select one MSS Delegate and one Alternate MSS Delegate. MSS Delegates and Alternate MSS Delegates selected from national medical specialty societies, ~~federal~~federated services, or professional interest medical associations must meet the following requirements:

10.3.2.2.1. Not be eligible to simultaneously hold a voting GC position in the MSS (Section 4).

10.3.2.2.2. Not be eligible to simultaneously serve as the Medical Student Trustee, an AMA Councilor, or as a national AMA Liaison (Section 11).

10.3.2.2.3~~4~~. ~~Must be~~ medical student members of the AMA (Section 3) in good standing.²⁷

²⁵Your Task Force amended Section 10.3.1.3 “Certification” to align with current AMA-MSS staff procedures and practices.

²⁶Upon reviewing Sections 10.3.2 and 10.3.3 on MSS representatives from external medical societies, your Task Force was struck by the differences between the policies for MSS delegates and alternate delegates to the MSS from the three categories of societies and organizations (the first category being national medical specialty societies, federated services, and professional interest medical associations; the second category being national medical student organizations; and the third category being “other groups,” defined as only AAMC and AACOM-COSGP). After much discussion, we could not see a strong rationale for differing guidelines and policies, and thus focused our attention on aligning the procedures across all three categories. Most major changes across these three sections are designed to make sure that all processes are clear and, wherever possible, equal across all groups.

²⁷This addition reflects your Task Force’s amendments to Section 3 “Membership” to define good standing in the context of AMA membership to clarify the conditions for eligibility for students seeking these positions.

10.3.2.2.~~42. Should be~~ chosen in a fair and equitable manner allowing open representation and medical student input.

10.3.2.2.~~53. Must be~~ certified in writing by the president, or appropriate staff person, of the organization they will be representing.

10.3.2.2.~~64. Must represent~~ the interests of their organization's medical student constituency.

10.3.2.3. Application Process. An application will be provided to interested national medical specialty societies, ~~federal~~federated services, and professional interest medical associations. The organization should submit the application form, and any other documents demonstrating compliance with these criteria, to the MSS GC at least ninety days prior to the first Meeting at which they wish to seat an MSS Delegate. Upon approval by the GC, the organization will be granted a seat in the MSS Assembly with voting privileges on all matters except elections. The newly seated organization will be placed on probationary status for a period of two years, during which time consistent attendance at a minimum of two of the four national Assembly Meetings is expected. At the conclusion of this probation period, the MSS Delegate selected by the organization will attain full voting privileges, including elections, ~~and will be eligible to run for office~~. The GC will notify the organization of its status at the end of the probation period.²⁸

10.3.2.3.1. The GC will report annually any applications from national medical student organizations for representation in the MSS Assembly, along with the resultant recommendation.²⁹

10.3.2.4. Biennial Review. Each national medical specialty society, ~~federal~~federated service, or professional interest medical association represented in the MSS Assembly will be required to reconfirm biennially that it continues to meet the criteria for representation. Organizations will be notified by the GC of the time of their review and will be asked to submit appropriate documentation. Failure to participate in the biennial review process or to meet the established criteria will be reported to the MSS GC for action (Section 10.3.2.5).

10.3.2.5. The GC may terminate the representation of an organization in the MSS Assembly for failure to verify fulfillment of or to meet these criteria, in which case the organization can reapply for representation.

10.3.2.5.1. In situations where the GC believes an organization in the MSS Assembly has failed to verify fulfillment or meet the criteria for

²⁸Your Task Force confirmed with AMA-MSS staff that these representatives are expected to attend two of four meetings in the probationary period and included this language to clarify expectations for organizations coordinating these positions.

²⁹In discussion of Sections 10.3.2.3 and 10.3.3.2.4, your Task Force noticed that MSS members have no clear method to see what organizations had recently applied for MSS representation. Your Task Force believes it is important for this information to be publicly accessible so members are informed of recent actions taken prior to submitting any new applications for representation in the MSS Assembly.

representation, the organization's leadership, including the current and immediate past Delegate and Alternate Delegate will be emailed with notice of this failure and the timeline for correction to prevent termination.

10.3.2.5.2 An organization will have 30 days from the receipt of the notice to respond and make efforts to address the concerns of the GC.

10.3.2.5.3. If the organization does not respond within 30 days or has not made an effort to address the concerns then their representation in the organization will be terminated.

10.3.2.5.4. Information regarding any organizations that have had their representation in the MSS Assembly terminated and why will be shared with the General Assembly at the next national meeting.³⁰

10.3.3. National Medical Student Organizations.

10.3.3.1. The following criteria have been developed for national medical student organizations to qualify for representation in the MSS Assembly, ~~pursuant to~~ (AMA Bylaw 7.3.3.4.1):

10.3.3.1.1. The organization must be national in scope.

10.3.3.1.2. A majority of the voting members of the organization must be medical students enrolled in educational programs ~~as defined in~~ (AMA Bylaw 1.1.1).

10.3.3.1.3. Membership in the organization must be available to all medical students, without discrimination.

10.3.3.1.4. The purposes and objectives of the organization must be consistent with the AMA's purposes and objectives.

10.3.3.1.5. The organization's code of medical ethics must be consistent with the AMA's Principles of Medical Ethics.

10.3.3.2. **Application process.** A member of the national leadership of the interested national medical student organizations should submit to MSS staff a written application on behalf of the organization containing sufficient information to establish that the organization meets the above criteria. The

³⁰In discussion of Section 10.3.2.5, your Task Force found no clear process listed for termination of representation of an organization in the MSS Assembly in the event appropriate. We believe it is important for this process to be transparent with opportunity for an appeal. This process also includes a timeline in which those representatives could respond and make adjustments that would allow them to remain as representatives in the MSS. The language here is mirrored in Section 10.3.3.4 for consistency.

application must also include the following:³¹

10.3.3.2.1. The organization's governing documents (e.g. charter, constitution, bylaws, ~~and~~ code of medical ethics). If the organization does not have a code of medical ethics, they will be expected to be aligned with the AMA's Principles of Medical Ethics.³²

10.3.3.2.2. A list of the sources of the organization's financial support, other than the dues of its medical student members.

10.3.3.2.3. A list or description of all of the organization's affiliations.

10.3.3.2.4. Any additional information to assist the MSS GC in reviewing applications may be requested. ~~Such additional information as may be requested.~~

10.3.3.2.5. The GC shall review the application. If it recommends that the organization be granted representation in the MSS Assembly Meeting, the recommendation shall be submitted to the AMA Board of Trustees for review. If approved by the AMA Board of Trustees, the organization may be represented in the MSS Assembly Meeting by one MSS Delegate and one Alternate MSS Delegate.

10.3.3.2.6. The GC will annually report any applications from national medical student organizations for representation in the MSS Assembly, along with the resultant recommendation.³³

10.3.3.3. Biennial Review. Each national medical student organization represented in the MSS Assembly will be required to reconfirm biennially that it continues to meet the criteria for eligibility by submitting such information and documentation as may be required by the GC. Organizations will be notified by the GC of the time of their review and will be asked to submit appropriate documentation. Failure to participate in the biennial review process or to meet the established criteria will be reported to the GC for action.

10.3.3.4. The GC may recommend discontinuance of the representation by a national medical student organization on the basis that the organization fails to ~~meet the above criteria, has failed to~~ maintain its responsibilities (Section 10.3.3.5). ~~outlined in these Internal Operating Procedures, or has failed to attend the MSS Assembly Meeting.~~ The recommendation shall be submitted to the AMA

³¹In discussion of Section 10.3.3.2, your Task Force confirmed with MSS staff that organization leadership should submit applications for representation, not just any general individual member of the organization. We amended this explicitly to clarify expectations for organizations seeking representation.

³²Your Task Force recognized that national medical student organizations may not always have their own codes of medical ethics, and included language in accordance with AMA Bylaws for ethical standards in Section representative bodies and with AMA-MSS staff procedure for coordinating these applications.

³³Your Task Force repeated this language from their proposed addition of Section 10.3.3.2.1 (referring to national medical specialty societies, federal services, and professional interest medical associations) to ensure transparency in the application process for national medical student organizations as well.

Board of Trustees for review. If approved by the AMA Board of Trustees, the representation of the national medical student organization in the MSS Assembly Meeting shall be discontinued.³⁴

10.3.3.4.1. In situations where the GC believes that an organization in the MSS Assembly has failed to verify fulfillment or meet the criteria for representation, the organization's leadership, including the current and immediate past Delegate and Alternate Delegate will be emailed with notice of this failure and the timeline for correction to prevent termination.

10.3.3.4.2. An organization will have 30 days from the receipt of the notice to respond and make efforts to address the concerns of the GC.

10.3.3.4.3. If the organization does not respond within 30 days or has not made an effort to address the concerns then their representation in the organization will be terminated.

10.3.3.4.4. Information regarding any organizations that have had their representation in the MSS Assembly terminated and why will be shared with the General Assembly at the next national meeting.³⁵

~~10.3.3.5. The MSS Delegate and Alternate MSS Delegate selected by each national medical student organization granted representation at the Assembly Meeting shall:~~

~~10.3.3.5.1. Have full voting rights including the right to vote in any elections at the conclusion of a two-year probationary period with regular attendance.~~

~~10.3.3.5.2. Not be eligible for election to any office in the MSS.~~

~~10.3.3.5.3. Be able to present his or her organization's policies and opinions in the Assembly Meeting.~~

~~10.3.3.5.4. Report on the actions of the MSS to the national medical student organization.~~

~~10.3.3.5.5. Cooperate in enhancing the MSS membership.~~

~~10.3.3.6. MSS Delegates and Alternate MSS Delegates selected by national~~

³⁴For clarity, your Task Force notes that we confirmed with AMA-MSS staff that the AMA Board of Trustees is involved in the application and termination process for representation of national medical student organizations. This technically differs from the process for MSS representation from national medical specialty societies, federated services, and professional interest medical associations, since these groups also have physician representation in the AMA HOD.

³⁵Your Task Force repeated this language from their proposed addition of Sections 10.3.2.5.1-10.3.2.5.4 (referring to national medical specialty societies, federated services, and professional interest medical associations) to ensure transparency in the termination process for national medical student organizations as well.

~~medical student organizations must meet the following criteria:~~

~~10.3.3.6.1. Must be medical student members of the AMA in good standing.~~

~~10.3.3.6.2. Should be chosen in a fair and equitable manner allowing open representation and medical student input.~~

~~10.3.3.6.3. Must be certified in writing by the president, or appropriate staff person, of the organization they will be representing.~~

~~10.3.3.6.4. Must represent the interests of their organization's medical student constituency.³⁶~~

10.3.3.5. The MSS Delegate and Alternate MSS Delegate selected by each national medical student organization granted representation at the Assembly Meeting shall:

10.3.3.5.1. Be medical student members of the AMA (Section 3).

10.3.3.5.2. Not be eligible for election to any voting office in the MSS, as defined in Section 4, such that they would simultaneously serve in one of those offices.

10.3.3.5.3. Not be eligible to simultaneously serve as the Medical Student Trustee (except for Trustee-elect), on an AMA Council, or as a national AMA Liaison (Section 11).

10.3.3.5.4. Be chosen in a fair and equitable manner allowing open representation and medical student input.

10.3.3.5.5. Be certified in writing by the president, or other appropriate representative, of the organization they will be representing.

10.3.3.5.6. Have full voting rights including the right to vote in any elections at the conclusion of the organization's two-year initial probationary period with regular attendance (AMA Bylaws 7.3.3.4.3).

10.3.3.5.7. Be able to present their organization's policies and opinions as part of representing the interests of their medical student constituency in Assembly Meetings.

10.3.3.5.8. Report on the actions of the MSS to the national medical student organization.

³⁶ Your Task Force reorganized and condensed Section 10.3.3.5. and 10.3.3.6; changing the order of subsections for clarity.

10.3.3.5.9. Cooperate in enhancing the MSS membership.

10.3.4. Other Groups.

10.3.4.1. The Association of American Medical Colleges – Organization of Student Representatives and the American Association of Colleges of Osteopathic Medicine – Council of Osteopathic Student Government Presidents are each entitled to one MSS Delegate and one Alternate MSS Delegate selected by the medical student members of the organization.

10.3.4.2. MSS Delegates and Alternate MSS Delegates selected from these organizations ~~shall must meet the following criteria:~~

10.3.4.2.1 Not be eligible to simultaneously hold a voting GC position in the MSS (Section 4).

10.3.4.2.2. Not be eligible to simultaneously serve as the Medical Student Trustee, an AMA Councilor, or as a national AMA Liaison (Section 11).³⁷

10.3.4.2.~~31~~. ~~Must b~~Be medical student members of the AMA (Section 3)~~in good standing.~~

10.3.4.2.~~42~~. ~~Should b~~Be chosen in a fair and equitable manner allowing open representation and medical student input.

10.3.4.2.~~53~~. ~~Must b~~Be certified in writing by the president, or appropriate staff person, of the organization they will be representing.

10.3.4.2.~~64~~. ~~Must r~~Represent the interests of their organization's medical student constituency.

10.3.5. Official Observers.

10.3.5.1. National student organizations may apply to the MSS GC for official observer status in the MSS Assembly. Applicants and official observers must demonstrate compliance with guidelines for official observers adopted by the MSS Assembly, and the GC shall make a recommendation to the MSS Assembly concerning the application. The MSS Assembly will make the final determination on the conferring or continuation of official observer status.

10.3.5.2. Organizations with official observer status are invited to send one representative to observe the actions of the Assembly at all meetings of the MSS Assembly. Official observers have the right to speak and debate on the

³⁷As noted previously, your Task Force recognizes that the AMA Bylaws already place certain restrictions on national medical student organizations. We sought to apply restrictions to the other two categories of groups as well to equalize rules.

floor of the Assembly upon invitation from the Speaker. Official observers do not have the right to introduce business, introduce an amendment, make a motion, or vote.

10.4. Purposes of the Meeting. The purposes of the meeting shall be:

10.4.1. To hear such reports as may be appropriate.

10.4.2. To elect, at the Assembly Meeting prior to the Interim Meeting of the AMA, the Chair-elect of the GC, and the Medical Student Trustee. To elect at the Assembly Meeting prior to the Annual Meeting of the AMA, the remaining members of the GC, with the exception of the Immediate Past Chair.

10.4.3. To adopt procedures for election of Medical Student Regional Delegates and Alternate Regional Delegates, ~~consistent with~~ (AMA Bylaw 2.3.3).

10.4.4. To elect Medical Student Regional Delegates and Alternate Regional Delegates at the Assembly Meeting prior to the Interim Meeting of the AMA.

10.4.5. To adopt resolutions for MSS policy and for submission to the AMA HOD.

10.4.6. To conduct such other business as may properly come before the meeting.

10.5. Credentialing.

10.5.1. The name of the duly selected MSS Delegate and Alternate MSS Delegate from each educational program, national medical specialty society, federal service, professional interest medical association, national medical student organization, and other group, and the representative from each official observer organization, ~~should~~ shall be formally received by the MSS staff of the AMA by the deadline set by MSS Chair in consultation with MSS staff for that meeting no later than 30 days prior to the Assembly Meeting in writing, as outlined in these Internal Operating Procedures.

10.5.2. On the day of the opening of the Assembly Meeting, credentialing will take place, where voting members must officially identify themselves to the Credentials Committee as having been duly selected by the AMA medical student members of their respective organizations.

10.5.3. The AMA MSS staff will verify active membership in the AMA prior to any voting credentials being issued. Identification will be required to receive a voting badge.

10.5.4. A ~~G~~graduating or recently graduated senior medical students may not simultaneously serve as an MSS Delegate or Alternate MSS Delegate in the MSS Assembly who have been credentialed and as an RFS Delegates or Alternate RFS Delegates in the representative assembly of the AMA Resident and Fellow Section ~~shall not be allowed to serve as MSS Delegates or Alternate MSS Delegates in the MSS~~

~~Assembly.~~³⁸

10.6. Participation.

10.6.1. Only duly selected MSS Delegates to the Assembly Meeting shall have the right to vote, but the meeting floor shall be open to all medical students and ~~AMA members~~ those granted permission to speak at the discretion of the MSS Speakers.³⁹

10.6.2. The Immediate Past Chair of the GC shall have the same speaking privileges, excluding the privilege to make a motion, in the MSS Assembly as any other member of the GC if ~~he or she is~~they are no longer a medical student.

10.6.3. The Presiding Officer shall be entitled to vote only to break a tie.

10.7. Procedure.

10.7.1. **Agenda.** At least 30 days prior to the Assembly Meetings, the agenda shall be sent to MSS Delegates and Alternate MSS Delegates. The order of business will be set by the Speakers prior to the meeting. The Assembly may only change the order of business in accordance with the procedures set in the AMA Bylaws, MSS IOPs, and the parliamentary authority of the AMA outlined in AMA Bylaw 11.1.

10.7.2. **Rules of Order.** The Assembly Meeting shall be conducted pursuant to the established rules of procedure submitted by the Speakers and adopted by the Assembly. The parliamentary authority used by the AMA HOD (AMA Bylaw 11.1), shall govern the Assembly Meeting of the MSS in all matters not outlined in the adopted rules of procedure mentioned above.

10.7.3. **Quorum.** Twenty-five percent of the MSS Delegates shall constitute a quorum, provided that at least ten percent of the MSS Delegates from each of the geographic Regions (Section 8.1.1.) are present. ~~The Regions are defined in MSS Internal Operating Procedures Section 8.1.1.~~ For the purposes of defining a quorum, the MSS Delegate of each national medical specialty society, federal service, professional interest medical association, national medical student organization, and other group is considered part of the Region representing the state in which ~~his or her~~their organization's headquarters are located.

10.8. Resolutions.

10.8.1. Any MSS Region, state medical student section, medical school section, or individual medical student member may submit a resolution for consideration at each MSS Assembly Meeting.

³⁸In discussion of Section 10.5 "Credentialing," your Task Force incorporated revisions that best reflect the present credentialing process conducted in conjunction with AMA-MSS Staff.

³⁹Your Task Force received feedback that, in the past, non-medical student members of the AMA and medical students that are not members of the AMA have been permitted to speak at Assembly. For the former, given Assembly time constraints, your Task Force desired to codify a process by which the Speakers may permit certain non-medical students of the AMA to speak during Assembly.

10.8.2. All resolutions ~~submitted by medical students~~ must be submitted electronically to the MSS staff 50 days prior to the start of each MSS Assembly Annual and Interim Meeting to be included in the MSS agenda.

10.8.2.1. **Virtual Reference Committee.** All reports and resolutions that meet submission criteria will be made available on the Virtual Reference Committee. Any AMA-MSS member can comment on MSS business. Comments can be made on behalf of an individual, a medical student section at a medical school, a state medical student section, an organization represented in the Assembly, and/or an AMA-MSS Region, provided sufficient authority exists for such commentary. All comments will be made available to the Reference Committee(s). The resolutions will be sent to all duly selected and certified MSS Delegates and Alternate MSS Delegates prior to the Assembly Meeting via the meeting Agenda and are debatable on the floor of the MSS Assembly.

10.8.3. **Late Resolution.** Resolutions that are submitted after the deadline but before the beginning of the meeting shall require a two-thirds vote of the Assembly to be debatable on the floor. The Rules Committee shall make recommendations to the Assembly on whether they should be considered as business based on timeliness of the issue and temporality relative to the resolution submission deadline. Late resolutions approved for consideration shall be referred to the Reference Committee, and handled in the same manner as those resolutions introduced before the deadline.

10.8.3.1. Late Resolutions amending the MSS Internal Operating Procedures or proposing to amend AMA Bylaws shall not be considered.

10.8.4. **Emergency Resolutions.** Resolutions that are submitted after the beginning of the meeting shall require a three-fourths ($\frac{3}{4}$) vote of the Assembly to be debatable on the floor. The motion to hear an emergency resolution is not debatable and only a statement on the timeliness of the resolution may be made. Emergency resolutions approved for consideration shall be debated on the floor of the Assembly without referral to the Reference Committee.

10.8.5. Resolutions approved for consideration as business shall require a simple majority vote of the Assembly for adoption, except those amending the MSS Internal Operating Procedures or proposing to amend the AMA Bylaws, which require approval by two-thirds ($\frac{2}{3}$) of the members of the MSS Assembly present and voting.

10.8.6. Extraction of a resolution recommended for reaffirmation by the Reference Committee shall require a one-third vote of delegates present and voting.

10.8.7. Resolutions introduced by the GC into the AMA-MSS Handbook shall be in the name of the MSS-Section Delegate. Such resolutions may only be submitted when there is unanimous approval by all voting members of the GC. They shall be considered by the MSS Assembly as a first priority of business.

10.8.8. Once resolutions are adopted by the MSS Assembly, Resolutions shall they must

be submitted in the name of the MSS to the AMA HOD meeting within 1 year of adoption at the Section Delegates' discretion, unless withdrawn from queue by the MSS Assembly, at the next most appropriate meeting. ~~Transmittals may be delayed up to 1 additional year, by a two-thirds ($\frac{2}{3}$) vote of the MSS Caucus, taken prior to each additional meeting, in the name of the MSS when they have received the prior approval of the MSS Assembly.~~⁴⁰

10.8.9 If external circumstances, including but not limited to a global pandemic, not within the control of the MSS lead to 1) the cancellation of the AMA HOD meeting or the implementation of a Special Meeting (AMA Bylaws 2.12.2); or 2) significantly restricts the number of items that the MSS may submit to the AMA HOD; or 3) is an "emergency" as defined and voted on by three-fourths ($\frac{3}{4}$) of the MSS Caucus, then the transmittal process outlined in 10.8.8 may be suspended for one (1) meeting and an alternative process implemented at the discretion of the Section Delegates. The one (1) meeting suspension of the process outlined in 10.8.8 may be renewed by a three-fourths ($\frac{3}{4}$) vote of the MSS Caucus.⁴¹

10.9. Convention Committees. The Convention Committees shall be appointed by the GC unless otherwise stated in these procedures. These committees are to expedite the conduct of business at each meeting of the MSS Assembly. For each meeting, the GC will appoint the following committees and any others that would facilitate the business of the Assembly.

10.9.1. Credentials Committee. ~~An eight member Credentials Committee, shall be composed of one member per Region, unless there are no candidates from a Region, and one Chair, shall be appointed by the Governing Council.~~ The Committee shall be responsible for consideration of all matters relating to the registration and certification of MSS Delegates including credentialing MSS Delegates for Assembly Meetings, verifying a quorum is present, and distributing ballots for elections. Disputes involving the credentialing of voting delegates will be investigated by the Credentials Committee.⁴²

10.9.2. Rules Committee. A Rules Committee shall be composed of at least three ~~four~~ At-Large-at-large Members and one Chair. The Rules Committee shall review late resolutions and make recommendations to the MSS Assembly on whether to consider them as business of the Assembly. ~~The Rules Committee shall also collect and tabulate ballots for MSS elections, and count hand votes during the Assembly Meeting. The~~

⁴⁰In discussion of Section 10.8.8 regarding the process for adopted resolution transmittal from the MSS to the AMA HOD, and in light of recent restrictions on resolution transmittals during Special Meetings of the AMA, your Task Force felt that specifying the transmittal timetable was important. We believe the relevance of adopted policies and obligation of the Section to carry them forward rests upon their transmittal at an appropriate timeline. The amendments entrust our MSS Caucus with deciding when to transmit a resolution and provide them greater latitude to consider logistical and political factors, while also ensuring resolutions are not delayed indefinitely. The language also aligns with our Assembly's recent process of withdrawing resolutions that have been achieved via other means in our HOD, via the Section Delegate Report.

⁴¹ With a reasonable expectation for a situation to drastically alter the standard policy cycle, as did COVID-19, this new verbiage provides both a mechanism for the Section Delegates and MSS Caucus to determine how to proceed and a framework by which to prioritize items of business.

⁴² The eight member requirement for the Credentials Committee was originally intended to allow for membership from each Region during the credentialing process. However, your Task Force received feedback that the credentialing process has been significantly streamlined in recent years, Given the difficulties in recruitment for Convention Committees, your Task Force felt that this eight member requirement was unduly burdensome and not realistic.

Rules Committee shall assist MSS staff in the voting process for MSS elections and during Assembly Meetings as requested by the Speakers. The Rules Committee is also responsible for ensuring election rules are followed in coordination with the MSS Speaker and Vice Speaker.⁴³

10.9.3. Reference Committee. Each Reference Committee shall be composed of at least five at-large members and one chair ~~voting members~~ unless, in the judgment of the GC, circumstances warrant an adjustment in the number of members on the Reference Committee. The committee shall conduct an open hearing on items of business referred to it (resolutions and reports) via the MSS Virtual Reference Committee, and make recommendations to the Assembly for disposition of its items of business through the preparation of a Reference Committee report for consideration by the MSS Assembly.

10.9.4. Parliamentary Procedures Committee. The Parliamentary Procedures Committee members shall demonstrate a thorough understanding of the parliamentary authority set forth by these Internal Operating Procedures in order to assist students with parliamentary procedures throughout the Assembly Meeting.

10.9.5. AMA HOD Coordinating Committee. Members of the AMA HOD Coordinating Committee (HCC) and at-large members shall be ~~appointed~~invited to coordinate student testimony that will be presented at the AMA HOD Reference Committee hearings. The Coordinators shall work with the AMA Section Delegates in the preparation and presentation of testimony for resolutions being transmitted by the MSS and additional items of relevance to the MSS.

⁴³Your Task Force amended Section 10.9.2 "Rules Committee" to align with current AMA-MSS staff procedures and practices, such as electronic voting. In a similar manner as the proposed changes to the membership requirement of the Credentialing Committee, your Task Force felt that a three-person Rules Committee was more realistic and reflective of Committee membership at recent Assembly meetings.

11. Appointments.

11.1. **GC Responsibilities.** It will be the responsibility of the GC to make appointments of the medical student members of AMA Councils for confirmation by the AMA Board of Trustees and to other bodies of the AMA when requested. It is also the responsibility of the GC to make recommendations for student representation to bodies such as the AMA Foundation, American Medical Association Political Action Committee, National Board of Medical Examiners, National Resident Matching Program, and others after the GC has solicited applications from interested medical students.⁴⁴

11.1.1. When making appointments and recommendations, the GC shall solicit and consider the aggregated and anonymized comments of voting members of the MSS Caucus. The GC shall maintain the confidentiality of all candidate applications.

11.1.2. Candidates may communicate individually with GC members and previous appointees to learn about the responsibilities and expectations of these roles. Candidates may not campaign for positions, including asking other MSS members to appeal on their behalf to members of the GC or voting MSS Caucus members, and may be disqualified.

11.2. **Eligibility.** Eligibility for Council and Liaison positions ~~shall be pursuant to MSS Internal Operating Procedures (Section 6.2).~~

11.3. Medical Student Representation on AMA Councils.

11.3.1. A medical student member of the AMA appointed by the MSS GC with the concurrence of the Board of Trustees shall serve on each of the following AMA Councils:

11.3.1.1. Council on Constitution and Bylaws.

⁴⁴Upon review of Section 11.1 “GC Responsibilities,” your Task Force heard public comment on the appointment process. Discussion highlighted that members of the GC are relatively few and these appointments and recommendations are of great import, therefore your Task Force felt strongly that this process would benefit from the opportunity for input from other Section members. Your Task Force discussed this at length and believed that the voting members of the MSS Caucus are the most appropriate body to provide these comments. The voting members of the MSS Caucus are democratically elected, regionally representative, and often directly collaborate with MSS members holding these positions to further advocacy priorities and implement policy. Your Task Force considered whether other MSS leaders should also be allowed to provide comment. However, since the MSS members holding these positions are non-voting members of the MSS Caucus and work on policy with physician leaders in our AMA and in other organizations, voting MSS Caucus members would have the most appropriate level of expertise and exposure to the effects of these external positions on our broader policy efforts. Your Task Force was wary of this opportunity to comment functionally turning into another form of “campaigning” and sought to place restrictions on this to ensure that candidates for these positions focus on individual conversations rather than more public efforts. We believe that our language balances these varied concerns well. Although we believe this proposed increase in input through the MSS Caucus regarding nominations for these positions is of great value, such input is ultimately a guiding recommendation for the GC, who must make final determinations as per the AMA Bylaws. Your Task Force also believes these amendments work in tandem with our changes to term limits in Section 4.7 and our discussion of the advantages and disadvantages of incumbency. We believe that the new opportunity for voting MSS Caucus members to provide comments would be useful for our GC when considering an incumbent candidate versus a new candidate for the same position.

11.3.1.2. Council on Medical Service

11.3.1.3. Council on Long Range Planning and Development

11.3.1.4. Council on Scientific Affairs and Public Health

11.3.1.5. Council on Medical Education

11.3.2. A student is recommended by the MSS GC to the AMA President-elect for consideration for appointment to the student seat on the Council on Ethical & Judicial Affairs.

11.3.3. A student is recommended by the MSS GC to the AMA Board of Trustees for consideration for appointment to the student seat on the Council on Legislation.

11.3.4. A student is recommended by the MSS GC to the AMA Board of Trustees for consideration for appointment to the student seat on the Liaison Committee on Medical Education (an AMA/Association of American Medical Colleges joint committee).

11.3.5. In any discussion or selection of candidates for appointment to or recommendation for Council or Liaison positions, all GC members who are candidates for the position under discussion or have significant conflicts of interest shall recuse themselves and be absent from this discussion.

11.3.5.1. The MSS Chair, or their designee, shall be responsible for ensuring a fair and thorough evaluation process by the GC.

11.3.5.2. To ensure that appointments are free from conflicts of interest, the Medical Student Trustee will be present for all discussions of candidates as an ex officio member. The Medical Student Trustee will not possess a vote in the GC's recommendation process.

11.3.6. All applicants for Council and Liaison positions shall be informed of the GC's decision to appoint or not appoint them as soon as the appointments are confirmed by the AMA Board of Trustees, President, or President-elect.

11.3.7. Terms. Students appointed to Councils shall serve for a one-year term with the exception of the student appointed to the Council on Ethical and Judicial Affairs, who will serve for a two-year term. If the medical student member of a Council ceases to be enrolled in an approved program, a participant in a dual degree program, engaged in an approved leave or sabbatical, or is no longer unable to fulfill the duties of their position, their his or her service on the Council shall thereupon terminate, and the position shall be declared vacant.

11.3.8. Limitation on Total Years of Service: ~~See MSS Internal Operating Procedures~~ (Section 4.7).

12. Miscellaneous.

12.1. Financial Responsibility. The funding of GC is appropriated by the AMA. A listing of all meetings attended by each member of the GC and members of MSS funded by the section, along with an account of pertinent actions taken, will be made available to MSS members upon request.

13. Dispute Resolution.

13.1. All disputes of these Internal Operating Procedures shall be resolved by the AMA Board of Trustees (BOT) with provision for input from other parties as deemed necessary by the BOT, except in the following instances as defined elsewhere in these Internal Operating Procedures.

13.1.1. All disputes involving Regional Delegate or Alternate Delegate elections shall be resolved by the GC.

13.1.2. All disputes involving Campaign Rules as related to the MSS shall be resolved by the MSS Speaker and Vice Speaker.

13.2. All IOPs are subject to the AMA Bylaws, and the AMA Bylaws will prevail in the event of a conflict.

14. Amendments to the Internal Operating Procedures.

14.1. **Requirements.** ~~Per AMA Bylaw 7.0.7, a~~ All rules, regulations, and procedures adopted by the MSS are subject to the approval of the Board of Trustees (AMA Bylaw 7.0.7). Amendments to the Internal Operating Procedures may also be contingent upon corresponding changes to the AMA Bylaws, which require approval of two-thirds of the members of the AMA HOD.

14.2. Regular Review of the Internal Operating Procedures. Every 4 years, the Speakers will direct the Committee on Long Range Planning (COLRP), an MSS Standing Committee, to submit a report proposing necessary amendments to the IOPs.

14.2.1 COLRP will design and implement a protocol for IOP review and report writing.

14.2.1.1 This protocol may be updated as necessary by COLRP. A review of IOPs may occur asynchronously from the COLRP report; however, any amendments should be detailed in the quadrennial report. COLRP shall include the student Councilor from the Council on Constitution & Bylaws as an ex-officio member during IOP review and report writing. COLRP may recruit additional voting representatives for IOP review to promote representation from all regions

14.2.1.2. IOP review and report writing shall be co-chaired by the Speakers as non-voting members.

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE AND MINORITY ISSUES
COMMITTEE

MSS CEQM MIC Report A
(I-22)

Introduced by: MSS Committee on Economics and Quality in Medicine and Minority Issues
Committee

Subject: Laying the First Steps Towards a Transition to a Financial and Citizenship
Need Blind Model for Organ Procurement and Transplantation

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

INTRODUCTION

At the 2019 MSS Annual meeting, MSS Resolution 46 asked the AMA to support and advocate for federal laws that remove financial barriers to transplant recipients, a 2020 national taskforce for organ procurement that would be renewed every 20 years, to research a fiscal federal strategy that would cover annual transplant costs, and to make amendments to 6.2.1. in the Code of Ethics and AMA existing policy H-370.982 that would alter statements to not regard immigration status. The A-19 Reference Committee referred MSS Resolution 46 for report. The MSS Assembly and Reference Committee specifically stated concerns over:

- 1) including criteria for having established a “physical presence” in the United States;
- 2) the resource intensive nature and feasibility of advocating and creating such a taskforce;
- 3) the limited feasibility of the AMA researching a fiscal federal strategy to cover annual transplantation costs given the AMA is not a body that commonly conducts such research; and
- 4) the fact that the HOD cannot amend the AMA Ethical Opinion, and would have to be referred to the Council on Ethical and Judicial Affairs (CEJA).

Below is the language of the original Resolution 46 from A-19:

RESOLVED, That our AMA support and advocate for federal laws that remove financial barriers to transplant recipients such as provisions for expenses involved in the transplantation of organs incurred by the uninsured regardless of a legally defined United States Citizenship and Immigration Service (USCIS) status in the country as long as the person can show physical presence in the U.S. prior to needing the organ; and

RESOLVED, That our AMA promote and advocate for a 2020 national taskforce for organ procurement and transplant. Task force to be renewed every 20 years to access the needs of the generation and account for change in demographics and technology; and

RESOLVED, That our AMA research a fiscal federal strategy to cover annual transplant costs in the U.S. for patients without insurance distributed among the over 200 transplant centers in the U.S.; and

RESOLVED, That our AMA amend 6.2.1 in the Code of Ethics explicitly state that organs should be allocated to recipients on the basis of ethically sound criteria without

1 regard to a legally defined United States Citizenship and Immigration Service (USCIS)
2 status as long as the recipient can show physical presence in the U.S. prior to needing
3 the organ, thereby keeping the overall equitability of the system for donating and
4 receiving parties intact.

5 GUIDELINES FOR ORGAN TRANSPLANTATION FROM
6 DECEASED DONORS, 6.2.1 AMA CODE OF MEDICAL ETHICS

7 6.2.1 in the Code of Ethics states "Physicians who participate in
8 transplantation of organs from deceased donors should: ... (e)
9 Except in situations of directed donation, ensure that organs for
10 transplantation are allocated to recipients on the basis of ethically
11 sound criteria, including but not limited to likelihood of benefit,
12 urgency of need, change in quality of life, duration of benefit, and,
13 in certain cases, amount of resources required for successful
14 treatment without regard to a legally defined United States
15 Citizenship and Immigration Service (USCIS) status; and let it be
16 further

17 RESOLVED, That our AMA amend H-370.982 to also clarify its stance of not regarding
18 immigration status as long as the person lives in the U.S. thereby keeping the overall
19 equitability of the system for organ donation and receiving parties intact.

20 ETHICAL CONSIDERATIONS IN THE ALLOCATION OF ORGAN
21 AND OTHER SCARCE MEDICAL RESOURCES AMONG
22 PATIENTS, H-370.982

23 Our AMA has adopted the following guidelines as policy: (1)
24 Decisions regarding the allocation of scarce medical resources
25 among patients should consider only ethically appropriate criteria
26 relating to medical need. (a) These criteria include likelihood of
27 benefit, urgency of need, change in quality of life, duration of
28 benefit, and, in some cases, the amount of resources required for
29 successful treatment without regard to a legally defined United
30 States Citizenship and Immigration Service (USCIS). (b) Research
31 should be pursued to increase knowledge of outcomes and
32 thereby improve the accuracy of these criteria. (c) Non-medical
33 criteria, such as ability to pay, social worth, perceived obstacles to
34 treatment, patient contribution to illness, or past use of resources
35 should not be considered. ...

36 The first iteration of this report at I-19 suggested the following:

37 Your Minority Issues Committee (MIC) and Committee on Economics and Quality in Medicine
38 (CEQM) recommend that the following recommendations be adopted and the remainder of the
39 report be filed:

40 1) That the first resolve clause of MSS Resolution 46 (A-19) be amended by addition
41 and deletion as follows:

1 RESOLVED, That our AMA support and advocate for federal ~~laws~~ mechanisms that
2 ~~remove~~ decrease financial barriers to transplant recipients, such as provisions for
3 expenses involved in the transplantation of organs incurred by the uninsured or those
4 who do not qualify for health care coverage regardless of a legally defined United States
5 Citizenship and Immigration Service (USCIS) status in the country as long as the person
6 ~~can show physical presence~~ lives in the U.S. ~~prior to needing the organ~~; and be it further

7 2) That the second resolve clause of MSS Resolution 46 (A-19) be amended by addition
8 and deletion as follows:

9 RESOLVED, That our AMA ~~promote and advocate~~ support the creation of ~~for~~ a 2020
10 national taskforce for organ procurement and transplant, that will be renewed every 20
11 10 years to assess the needs of the generation and account for changes in
12 demographics and technology; and be it further

13 3) That the third resolve clause of MSS Resolution 46 (A-19) be amended by addition as
14 follows:

15 RESOLVED, That our AMA support the research of a fiscal federal strategy to cover
16 annual transplant costs in the U.S. for patients without or are ineligible for insurance
17 distributed among the over 200 transplant centers in the U.S.; and be it further

18 4) That the fifth resolve clause of MSS Resolution 46 (A-19) be amended by addition
19 and deletion as follows:

20 RESOLVED, That our AMA amend H-370.982 ~~to also clarify its stance of not regarding~~
21 ~~immigration status as long as the person lives in the U.S. thereby keeping the overall~~
22 ~~equitability of the system for organ donation and receiving parties intact~~ by addition to
23 read as follows:

24 **H-370.982 – ETHICAL CONSIDERATIONS IN THE**
25 **ALLOCATION OF ORGAN AND OTHER SCARCE MEDICAL**
26 **RESOURCES AMONG PATIENTS**

27 Our AMA has adopted the following guidelines as policy: (1)
28 Decisions regarding the allocation of scarce medical resources
29 among patients should consider only ethically appropriate criteria
30 relating to medical need. (a) These criteria include likelihood of
31 benefit, urgency of need, change in quality of life, duration of
32 benefit, and, in some cases, the amount of resources required for
33 successful treatment without regard to a legally defined United
34 States Citizenship and Immigration Service (USCIS).

35 5) That the fourth resolve clause of Resolution 46 (A-19) not be adopted.

36 There was no testimony on the I-19 Virtual Reference Committee and the Reference Committee
37 recommended it for adoption. The committees were unable to identify or corroborate the
38 rationale for why the Assembly recommended re-referral of the item at that time.

39 Next the report was submitted at N-20 with the following recommendations:

Your Minority Issues Committee and Committee on Economics and Quality in Medicine recommend that the following recommendations be adopted and the remainder of the report be filed:

1) That the first resolved clause of MSS Resolution 46 be amended by addition and deletion as follows:

RESOLVED, That our AMA support and advocate for federal ~~laws~~ mechanisms that ~~remove~~ decrease financial barriers to transplant recipients, such as provisions for expenses involved in the transplantation of organs incurred by the uninsured and underinsured regardless of a legally defined United States Citizenship and Immigration Service (USCIS) status in the country as long as the person ~~can show physical presence~~ lives in the U.S. prior to needing the organ; and

2) That the second resolved clause of MSS Resolution 46 be amended by deletion as follows:

RESOLVED, That our AMA ~~promote and advocate~~ support the creation of a 2020 national taskforce for organ procurement and transplant, that will be renewed every ~~20~~ 10 years to ~~access~~ assess the needs of the generation and account for changes in demographics and technology; and

3) That the third resolved clause of MSS Resolution 46 be amended by addition as follows:

RESOLVED, That our AMA support the research of a federal fiscal strategy to cover annual transplant costs in the U.S. for patients without or are ineligible for insurance distributed among the over 200 transplant centers in the U.S.; and

4) That the fifth resolved clause of MSS Resolution 46 be amended by deletion as follows:

RESOLVED, That our AMA amend H-370.982 ~~to also clarify its stance of not regarding immigration status as long as the person lives in the U.S. thereby keeping the overall equitability of the system for organ donation and receiving parties intact~~ by addition to read as follows:

Ethical Considerations in the Allocation of Organ and Other Scarce Medical Resources Among Patients, H-370.982

Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment without regard to a legally defined United States Citizenship and Immigration Service (USCIS).

5) That the fourth resolved clause not be adopted.

The reference committee recommended the report for re-referral due to the following concerns:

Your Reference Committee found CEQM MIC Report A to be well-researched, however, there are several concerns we feel need to still be addressed. We believe the proposed amendments are helpful, but do not assuage all concerns raised. Your Reference Committee does not believe there is enough evidence in the report to support the recommendation calling for a task force, and we would like to see specific enumeration of the purpose of such a task force and we note that the creation of a task force within the AMA is typically reserved for issues having very broad and far-reaching impacts, such as the AMA Opioid Task Force and the AMA Health Equity Task Force. We would like to see greater consideration and justification of the need for a task force, and we would like to see specific recommendations on who would be included in this task force. Your Reference Committee also believes that the research called for in the third recommendations is fairly specific and as a result may not end up being impactful. We recognize the time and effort put into the creation of this report and thank the members of the Committee on Economics and Quality in Medicine (CEQM) and the Minority Issues Committee (MIC) for their hard work.

The report was extracted for discussion, however, it was not considered at N-20 due to time constraints.

The report was submitted again at N-21 with the following recommendations:

Your Minority Issues Committee and Committee on Economics and Quality in Medicine recommend that the following recommendations be adopted and the remainder of the report be filed:

1) That the first resolve clause of MSS Resolution 46 be amended by addition and deletion as follows:

RESOLVED, That our AMA support and advocate for federal ~~laws~~ mechanisms that ~~remove~~ decrease financial barriers to transplant recipients, such as provisions for expenses involved in the transplantation of organs incurred by the uninsured or those who do not qualify for health care coverage regardless of a legally defined United States Citizenship and Immigration Service (USCIS) status in the country as long as the person ~~can show physical presence~~ lives in the U.S. ~~prior to needing the organ~~; and

2) That the second resolve clause of MSS Resolution 46 be amended by deletion as follows:

~~RESOLVED, That our AMA support the creation of a 2020 national taskforce for organ procurement and transplant, that will be renewed every 10 years to assess the needs of the generation and account for changes in demographics and technology; and~~

3) That the third resolve clause of MSS Resolution 46 be amended by addition as follows:

RESOLVED, That our AMA support the research of a federal fiscal strategy to cover annual transplant costs in the U.S. for patients who without or are ineligible for the

insurance distributions distributed among the over 200+ ~~transplant centers in the U.S.~~
transplant centers; and

4) That the fourth resolve clause of MSS Resolution 46 be amended by deletion as follows:

~~RESOLVED, That our AMA amend 6.2.1 in the Code of Ethics to explicitly state that organs should be allocated to recipients on the basis of ethically sound criteria without regard to a legally defined United States Citizenship and Immigration Service (USCIS) status as long as the recipient can show physical presence in the U.S. prior to needing the organ, thereby keeping the overall equitability of the system for donating and receiving parties intact:~~

~~Guidelines for Organ Transplantation from Deceased Donors, 6.2.1 AMA code of Medical Ethics, 6.2.1 AMA code of Medical Ethics~~

~~6.2.1 in the Code of Ethics states "Physicians who participate in transplantation of organs from deceased donors should: ... (e) Except in situations of directed donation, ensure that organs for transplantation are allocated to recipients on the basis of ethically sound criteria, including but not limited to likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in certain cases, amount of resources required for successful treatment without regard to a legally defined United States Citizenship and Immigration Service (USCIS) status.; and let it be further~~

5) That the fifth resolve clause of MSS Resolution 46 be amended by addition and deletion as follows:

~~RESOLVED, That our AMA amend H-370.982 to also clarify its stance of not regarding immigration status as long as the person lives in the U.S. thereby keeping the overall equitability of the system for organ donation and receiving parties intact~~ by addition to read as follows:

~~Ethical Considerations in the Allocation of Organ and Other Scarce Medical Resources Among Patients, H-370.982~~

~~Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment~~ without regard to a legally defined United States Citizenship and Immigration Service (USCIS). 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

1 outcomes are avoided; then, patients should be prioritized
2 according to change in quality of life, but only when there are very
3 substantial differences among patients. (b) Research should be
4 pursued to increase knowledge of outcomes and thereby improve
5 the accuracy of these criteria. (c) Non-medical criteria, such as
6 ability to pay, social worth, perceived obstacles to treatment,
7 patient contribution to illness, or past use of resources should not
8 be considered.

9 Per Reference Committee recommendation, the report was re-referred at N-21 and is slated to
10 be discussed at I-22. A draft of this report was submitted to the N-21 AMA-MSS Meeting, and
11 the Reference Committee requested the following clarifications:

12 There was no VRC testimony on CEQM MIC Report A. During Reference Committee
13 deliberations there were several questions raised:

14 1) Is there a standardized definition of what it means to “live” in the United States?

15 2) What are the United Network for Organ Sharing (UNOS) guidelines with respect to
16 consideration of the “ability to receive follow-up treatment” and is that affected by
17 citizenship status?

18 3) What is the previous AMA policy mentioned in the report that supports equal access
19 in receiving transplants regardless of citizenship status?

20 Your Reference Committee believes these questions are crucial and need to be
21 addressed before the recommendations in this report can be accepted. We recommend
22 the recommendations in CEQM MIC Report A be referred.
23

24 **BACKGROUND**

25
26 The Department of Homeland Security (DHS) estimates there were 11.4 million undocumented
27 immigrants in the United States as of 2018.^{1,2} It is estimated that of this population there were
28 5,500 - 8,857 living with end-stage renal disease (ESRD).³ Many of these patients, however, are
29 unable to access appropriate care largely due to financial and institutional barriers. The average
30 cost of chronic hemodialysis per patient is \$91,795/year for Medicare in 2017.⁴ A recent analysis
31 suggested \$40,368/year for Medicare and \$121,788/year for individual market plans in the year
32 2016.⁵ Patients with ESRD who are citizens or in some cases documented non-citizens are
33 eligible for therapy through the 1972 Public Law 92–603 amendment to the Social Security Act,
34 that provides financial coverage to those who qualify for Social Security benefits.^{6,7}
35 Unfortunately, undocumented immigrants are often excluded from these benefits and must rely
36 on emergent-only hemodialysis, and only after they develop life-threatening metabolic
37 disturbances.⁸ Undocumented immigrants are able to receive emergent hemodialysis because
38 the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) mandates that all
39 states must provide federally funded emergency medical treatment. However, few federal, state,
40 or local funds (exceptions noted below) are available for maintenance therapy for
41 undocumented immigrants with ESRD, as dictated by the 1996 Personal Responsibility and
42 Work Opportunity Reconciliation Act.^{9,10,11} EMTALA also explicitly excludes solid organ
43 transplantation from the list of approved interventions: “Payment ... shall not be made for organ
44 transplant procedures unless the State plan provides for written standards respecting the
45 coverage of such procedures.”¹²
46

47 Notable state exceptions to immigrants relying on emergent-only hemodialysis under EMTALA
48 are California, New York, Illinois, Washington, and Colorado, who have passed laws for ESRD
49 to be recognized as an emergency medical condition, which allows Medicaid to be extended to
50 patients with ESRD for dialysis in outpatient clinics.^{13,14,15,16,17}

1
2 The question of state-based insurance coverage (e.g. Medicaid) for persons of low-income
3 regardless of citizenship and immigration status is the subject of another CEQM-MIC report due
4 at A-23. Briefly, state-based Medicaid funds are generally restricted to citizens and legal
5 residents; however, in some states policies allow for state-based funds alone to be used and
6 applied for Medicaid/CHIP options or equivalents regardless of immigration status. This enables
7 coverage without using federal dollars that are not permitted to go to undocumented immigrants.
8 Notable examples include California, Illinois, Massachusetts, New York, Oregon, Washington,
9 and D.C.¹⁸

10
11 The rate of uninsurance estimated in 2020 is significantly higher for lawfully-present non-citizens
12 (26%) compared to citizens (8%), and increased for those that are undocumented (42%).¹⁹ This
13 suggests barriers beyond legal status to seeking insurance. While the Biden Administration has
14 taken steps to disconnect social benefits from future citizenship evaluations as was instituted in
15 the Public Charge Rule by the Trump Administration, skepticism and confusion continues to
16 prevail amongst non-citizens. Legally present non-citizens become qualified to obtain health
17 insurance via Medicaid and CHIP after five years, but there are some exceptions for asylees
18 and other qualified individuals. In addition, 35 states have expanded Medicaid and CHIP
19 benefits to children and pregnant lawfully-present immigrants regardless of the five-year
20 qualification.¹⁹ Lawfully-present immigrants may also purchase policies on ACA marketplaces
21 and are eligible for subsidies.¹⁹ Undocumented immigrants are mostly not eligible for Medicaid
22 benefits, CHIP benefits, or to purchase from marketplaces.¹⁹ Exceptions are listed above. Our
23 committees plan to address this issue further in the forthcoming report.

24
25 The alternative treatment option for ESRD is kidney transplantation. Not only is this approach
26 curative, it also has lower associated annual costs, averaging \$39,939 for HLA-compatible living
27 donor transplantation per QALY (compared to \$72,476 for dialysis per QALY).^{20,21,22} Current
28 ethical and legal guidelines dictate that medical need alone should determine how organs are
29 allocated for transplant, including the AMA Code of Ethics 11.1.3: Allocating Limited Health
30 Care Resources. However, only 1% of all kidney transplant recipients per year are non-citizens,
31 which is grossly out of proportion to the 2-3% annual contribution to the donor organ pool made
32 by this same population.²³ While organs may be allocated to undocumented immigrants, current
33 policy excludes this patient population from receiving federal funding (and often state and local
34 funding) to cover their transplantation and post-transplantation care.^{10,24,25,26} Of note, state and
35 local funds, through the resources delineated above that provides Medicaid/CHIP options or
36 equivalents, could potentially be diverted to transplantation costs but this was poorly outlined in
37 a cursory review of the literature. Generally, undocumented persons are not only unable to
38 afford these potentially curative transplants, they are also unable to pay for costly post-
39 transplant immunosuppressive medications, which may lead to graft failure over time.
40 Consequently, thousands of patients with ESRD are forced to go without a potentially lifesaving
41 transplant because of their legal status. These patients continue to receive costly dialysis
42 treatment paid for by state emergency health care funds.

43
44 Patients with other forms of organ failure also need to be considered for transplant eligibility.^{9,27}
45 A recent study of liver transplant indicates that undocumented persons rarely have access to
46 liver transplantation and experience long wait times that may negatively affect outcomes in the
47 recipients.^{28,29} An undocumented person's access to organ transplantation is further
48 complicated by location. Access to transplantation varies by state, with almost a quarter of all
49 liver transplants occurring at two transplant centers in California.^{28,29} Each transplant center sets
50 their own rules for organ waiting list eligibility.³⁰ These rules, which also take into account
51 patient's health and risk factors for transplant, also consider financial status. Without insurance,

1 an undocumented patient is less likely to be considered a good candidate, thus reducing
2 likelihood of accessing an organ transplant.³¹

3
4 The United Network for Organ Sharing (UNOS) is a private non-profit that contracts with federal
5 and oversight governments (most importantly, the U.S. Department of Health and Human
6 Services) to oversee the Organ Procurement Transplant Network (OPTN) in the U.S.^{32,33} The
7 main role of the OPTN is to manage and maintain a national registry for organ matching.³³
8 Members of the OPTN include transplant hospitals participating in Medicaid/Medicare programs,
9 organ procurement organizations, and other stakeholders (organizations, institutions,
10 individuals) who have an interest in organ transplantation.³⁴

11
12 The Organ Procurement Transplant Network (OPTN) has gradually changed its guidelines over
13 time related to the collection of citizenship and residency data. An important precedent within
14 these guidelines starting in 1994 was that a given transplant center may not have >5% of its
15 transplants involve non-citizens or else this would trigger an audit of the center, but this policy
16 was replaced in 2012 by a commitment to publish a report of all data annually.³⁵ These policies
17 were largely put in place to study but also prevent medical transplant tourism, defined by the
18 World Health Organization as “organ trafficking and/or transplant commercialism, or if resources
19 (organs, professionals and transplant centers) devoted to providing transplant to patients from
20 outside a country undermine the country’s ability to provide transplant services for its own
21 population”.³⁶

22
23 OPTN currently only includes a few categories for citizenship status: US Citizen/US Resident,
24 non-US Citizen/US Resident, and non-US Citizen/non-US Resident.³⁵ All of these categories
25 are self-reported, and do not align well with immigration status categories from the US
26 Immigration and Naturalization service, such as asylum seekers that have different access to
27 services than asylees (Table 1). Transplant candidates are further asked to identify their
28 purpose in coming to the US if they are non-US Citizen/non-US Residents, whether it be
29 traveling for the purpose of transplant or other reasons. The correlation between these
30 categories and health coverage is highly variable depending upon state Medicaid plans or other
31 eligibility.³⁵ There are no ways to adequately monitor how long a person has been in the country
32 or verify their reason for travel. The question is simply phrased as “is the US your permanent
33 abode?” The goal of these questions is to improve equity, but they are largely misunderstood by
34 immigrants being asked.

35
36 OPTN recently provided guidance on the data collection and classification of citizenship status
37 in August 2021:³⁷

38
39 OPTN data collection for citizenship status does not address the legal status of
40 an individual’s place of residency. Primary place of residency is solely intended
41 to capture where an individual lives, regardless of their legal status. It is not
42 within the scope of the OPTN’s function to discern transplant candidates, living
43 donors, and deceased donors’ legal citizenship status, therefore, it is a not a
44 factor when collecting citizenship status data.

45
46 There are many direct and indirect benefits to ascertaining the citizenship status
47 of both living organ donors, deceased organ donors, and organ recipients. For
48 instance, accurate tracking of citizenship status helps determine the non-U.S.
49 citizens/non-U.S. resident’s deceased organ donor to organ recipient ratio. As
50 organ transplantation is a cost-efficient way of managing end-stage organ failure,
51 ascertaining the citizenship status can help shed some light on the net healthcare
52 cost of the non-U.S. citizens/non- U.S. residents’ and non-U.S. citizens/U.S.

1 residents' beneficiaries. Additionally, the citizenship status data element is the
2 sole data element that allows the OPTN to review citizenship, residency, and
3 country of origin of its patient and donor population.

4 The concern for ascertaining the citizenship status among living organ donors
5 and organ recipients has been explored in the past. In 2012, the terminology of
6 citizenship status reporting was changed to replace "resident alien" and "non-
7 resident alien", with "non-U.S. citizen/U.S. resident", "non-U.S. citizen/non-U.S.
8 resident who traveled to the U.S. for transplant", and "non-U.S. citizen/non-U.S.
9 resident who traveled to the U.S. for reason other than transplant".⁷ The basis for
10 this change was to properly analyze transplant tourism, as outlined in the
11 *Declaration of Istanbul*, within the U.S.⁸

12 Ascertaining citizenship status can be a complex task. Some of the complexities
13 may be related to the inexperience of the transplant professional asking the
14 questions, language barriers, or fear of immigration-related punitive
15 consequences, especially in regions of the U.S. that do not routinely
16 accommodate undocumented immigrants. Finally, the lack of policies to guide
17 transplant programs and [organ procurement organizations] OPOs reporting the
18 documentation status further complicate the matter.

19 OPTN further identified four major barriers to accurate data collection by transplant centers: 1)
20 lacking clarity on the citizenship status definitions (see Table 1), 2) inconsistent sources of data,
21 3) challenges with legal barriers and legal status, 4) inconsistent data collection procedures.³⁷
22 While mostly administrative, point 3 speaks to the social and legal challenges that non-citizens
23 face even when seeking essential and life-saving interventions. OPTN raised concerns
24 regarding data collection due to a perceived rate of low follow-up. The citation they provided
25 was only considering rates of living-donor follow-up among "international" living kidney donors,
26 which was on average 60% lower than for "domestic" living kidney donors at 6, 12, and 24
27 months.³⁸ These data, while important for adequate surveillance and monitoring of transplant
28 program outcomes, has little bearing on the question of appropriate use of the national resource
29 of donated organs since the outcomes of the recipients and graft rejection were no different and
30 immigration status of the recipients was not reported. International donors may not have the
31 means or convenience to pursue adequate follow-up but require less monitoring than recipients
32 needing monitoring for organ rejection. OPTN cites that in 2018 Non-Citizen/Non-Residents
33 were 1.3% of candidate registrations and 1.4% of organ recipients, but did not mention the
34 proportion of deceased donors meeting this criterion - which was 2.8% (Table 2).^{39,40}

35 OPTN does not have policies that limit access to follow-up services for non-citizens. However,
36 there are follow-up reporting guidelines. All transplant centers must be able to provide OPTN
37 with data of recipient outcomes at 90 days following transplant, again at the one year
38 anniversary.⁴⁴ Transplant hospitals must complete the Organ Specific Transplant Recipient
39 Follow-up (TRF) "Either of the following: 1) 90 days after the six-month and annual anniversary
40 of the transplant date until the recipient's death or graft failure OR 2) 14 days from notification of
41 the recipient's death or graft failure."⁴⁴ It is not clear whether these policies affect transplant
42 centers' decisions on who to accept. It should be noted that doing so would be inconsistent with
43 current OPTN policy.⁴⁴

44
45 A candidate's citizenship or residency status in the United States must not be
46 considered when allocating deceased donor organs to candidates for
47 transplantation. Allocation of deceased donor organs must not be influenced
48 positively or negatively by political influence, national origin, ethnicity, sex,
49 religion, or financial status.

Table 1 - Immigration Status and OPTN Citizenship Category (Cervantes et al. 2021)³⁵

Immigration Status	Description	OPTN Citizenship Category (All Self-Reported)	Transplant Healthcare Coverage
US citizen	Born in the US or a parent is a US citizen	US Citizen/US Resident	Medicare, Medicaid, and/or Health Insurance Marketplace
Undocumented immigrant	Does not have permission to live or work in the US and is at risk of deportation.	Non-US Citizen/US Resident	Some states allow transplant under Medicaid or other state-funded health coverage Off Marketplace or private insurance
Lawful permanent resident or "green card"	Received permission to live and work in the U.S.. Can be obtained by family petitions, employer petitions, and violence against women act self-petitions.		In most states, there is a 5-year waiting period before qualifying for Medicaid and Medicare. Health Insurance Marketplace
Refugee	Received permission prior to entering the US based upon persecution or fear of persecution in one's home country because of race, religion, nationality, membership in a particular social group, or political opinion.		Medicare and Medicaid Health Insurance Marketplace
Asylee	Meets the definition of refugee as above, but seeks or obtains protection from persecution from inside the US or at the border.		Medicare and Medicaid Health Insurance Marketplace
Asylum seeker	A person seeking asylum under the criteria above but has not been granted asylum status by USCIS or immigration courts.		Same as undocumented immigrant
Non-Immigrant	Received permission from the government (usually in the form of a 'visa') to live in the US for a limited period of time and for a specific purpose (e.g. study, work, visit family, or tourism).		Health Insurance Marketplace
Conditional Permanent resident	Received permission from the government because the individual is married to a US citizen or they have an employment-based green card as an entrepreneur. Valid for 2 years and then must apply for removal of conditional status 90 days before green card expires.		Same benefits as lawful permanent resident; however, they receive conditional status.
Temporary Protected status	Permission from the government granted to nationals of countries whose conditions prevent people from returning home safely (e.g. due to national disasters or other extraordinary conditions).		Health Insurance Marketplace
Tourist	Visiting the US and does not reside in the US	Non-US Citizen/non-US Resident Traveling for transplant or traveling for reasons other than transplant	None

Table 2 - Data on Organ Transplantation and Deceased Donation from OPTN Annual Reports:

	2015	2018 ⁴⁰	2019 ⁴²	2020 ⁴³
Non-Citizen / Non-Resident Recipients	1.3% ⁴¹	1.4% ³⁹		
Non-Citizen Deceased Donors (Unclear if including non-resident or not)		2.8%	3.2%	2.3%
Unknown Deceased Donor Citizenship Status		7.6%	9.8%	9.1%

Decisions on offering transplants as mentioned are up to individual transplant center boards.⁴⁵ However, there are also regional trends. Texas and California both have a high percentage of immigrants in their populations. The majority of known undocumented immigrants receiving transplants (400) has taken place in California since 2005.⁴⁵ However, in Texas the lack of expanded Medicaid and reported though not confirmed institutional policies limit undocumented immigrants receiving transplants.⁴⁵ In a study of liver transplants for undocumented immigrants the absolute proportion of transplants compared to those in the general population ranged from +20% in California to -12% in Texas.²⁸ These regional trends further limit accessibility of transplants for non-citizens.

There are a variety of reasons why transplant centers are skeptical of non-citizens receiving transplants. These include concerns of their financial stability, residential stability, the nature of distributing the scarce resource of organs, and concerns that they may lose their grafts or be lost to follow-up.⁴⁶ Evidence generated to date has failed to adequately substantiate such concerns. From 2013 - 18 heart and lung transplant outcomes were equivalent to or even better among non-citizens compared to citizens at one year.⁴⁷ Non-citizens also had a lower non-adjusted risk of graft loss with kidney transplant which remained significant after adjusting for various demographic factors.⁴⁸ Similar findings have also been observed in liver transplants with no increased risk of graft failure in those with unauthorized immigration status.²⁸ It should be noted that all of these are retrospective studies relying upon self-reported immigration status, but represent the best available data that can be gathered to date due to the challenge of creating a randomized trial in this context.

The stances of relevant societies like the American Society of Transplant Surgeons (ASTS), the American Society of Transplantation (AST), the American Association for the Study of Liver Diseases (AASLD), and American Society of Nephrology (ASN) need to be considered to lead to passage of this policy in the AMA House of Delegates. Last August, 2021, when the OPTN released its most recent guidance regarding documentation of citizenship status (cited and quoted above), the AST stated the following:⁴⁹

The American Society of Transplantation is supportive of this proposal in concept and offers the following comments for consideration by the sponsoring committee:

The AST believes transparency and clarity in reporting information and a clear picture of the population we serve is valuable. However, we share concerns regarding the politicization of this topic related to the recent census process and results. We acknowledge that candidates may be reluctant to provide this information. Since most transplant programs need proof of financial support, care plan, and other objective data, it was felt that citizenship was a natural data element that should be collected considering the national resource of organs. However, we believe messaging is critical to clearly explain that these data will be used to assess equity in access to transplant healthcare, and not be used to determine transplant decisions, suitability, OPO or transplant program metrics, or resource allocation. Additionally, reassurance regarding the security of the data is important for both transplant professionals as well as patients.

We also believe it is important to clearly state the “why” up front, as these are not new data collection, but rather focus on how to most accurately complete the patient demographic fields. Additionally, we believe there is merit in sharing how the data has been used to date, including tying it to strategic goals of addressing disparities in transplant access and care.

Further, we believe it is critical that clarification be offered regarding the definition of a United States citizen. We believe that this is currently incomplete. For example, citizenship of pediatric candidates by virtue of adoption or a parent being a U.S. citizen is not currently included.

We strongly suggest that guidance be given related to the expected process in order to standardize this process operationally so that transplant programs know what is expected to answer the citizenship question without seeking to verify an individual's legal immigration status in the U.S. Finally, we understand the goal of this effort is to understand transplant tourism.

To that end, we suggest that more clarity is needed regarding how this applies to deceased donation. Requesting citizenship status or date of entry could create barriers to deceased donation.

DISCUSSION

There is an ethical obligation to provide the best medical care to this underserved population. From an economic standpoint, it is important to provide the most cost-effective medical care – in the setting of organ transplants being associated with lower costs for the healthcare system as a whole. Even pragmatically speaking, it is important to note that the majority of non-citizens are young, healthy, and contribute to the public good through various jobs and their role in economic development and even taxes (as an estimate, approximately \$11 billion per year) that contribute to Social Security.^{46,50} In this population, one large barrier to organ transplant is financial in nature, so it is important to continue to consider methods to better insure and cover the cost of care for these patients. It is promising that recent evidence has emerged that uninsured undocumented immigrants have similar transplant outcomes as insured U.S. citizens.

The language above seems to indicate that the AST appreciates citizenship not being used to determine eligibility for transplant which is already an OPTN policy. The AST has also made statements on Trump-era policies that threatened immigration of physicians with expertise in the transplant field, but not on other topics regarding immigration in letters or other announcements.⁵¹ The position of the ASTS, AASLD, and ASN have been more difficult to

1 identify from an external perspective as there are no documented opinions, letters, or policies
2 we could identify. Your committees have actively coordinated with section delegates and staff to
3 solicit this feedback.

4
5 Organ procurement is an issue that affects over 100,000 people each year, and equitable
6 access is not available across all communities. While the AMA has numerous policies
7 supporting removal of disincentives against organ donation, there is very limited existing policy
8 that addresses removal of barriers against organ transplant reception. AMA policy D-370.980
9 supports inclusion of transplant eligibility for persons with disabilities. AMA policy H-370.962
10 supports funding of organ transplants for Medicaid patients. While it is not necessary to be a
11 citizen in order to be eligible for Medicaid coverage, this criterion varies significantly from state
12 to state. AMA policy H-370.99 opposes any favoritism of transplant recipients in regards to their
13 geo-political residence. However, it is questionable whether this policy also applies to
14 individuals who are not citizens. This addresses the N-21 reference committee's third question
15 regarding relevant AMA policy.

16
17 With regard to the first resolved clause of MSS Resolution 46, while the spirit of the clause is
18 certainly in the interest of ensuring equality for organ transplant recipients, the phrase "physical
19 presence in the U.S. prior to needing the organ" is vague, raising questions about what
20 "physical presence" means and how it is confirmed. While the intention of ensuring that non-
21 citizens are not excluded from this process is clear and in line with previous AMA policy, such
22 as H-370.990, there is concern that by keeping this phrase vague, "physical presence" is left
23 open to interpretation and could possibly work against the overall goal of equal access.
24 Regardless, there is limited evidence that would provide a concrete definition or timeline of what
25 it means to "live" in the United States as was requested by the N-21 Reference committee.
26 Overall, it would be arbitrary and potentially unfair to include a specific definition in the final
27 resolved clauses. A reference to existing code of ethics policy on medical tourism has been
28 added as an exclusion criteria, granted that the scope and extent of this issue is poorly
29 understood but is a reason why citizenship data are collected by OPTN. Your committees also
30 considered alternatives like a 5-year residency requirement to make an immigrant eligible for
31 naturalization but this seemed too restrictive or susceptible to changing policies. Your
32 committees also considered simply using the term "Resident" but this was discussed as being
33 ambiguous due to the distinctions between Federal legal immigration status like "permanent
34 resident", individual state-defined criteria for residency and potential state-benefits, and OPTN-
35 defined criteria (Table 1).

36
37 Your committees also found that there are not only financial barriers to receiving transplants, but
38 also possible institutional policies lead to state-by-state differences in transplant rates and
39 concerns around the clarity of why citizenship is being requested in transplant evaluations to
40 name a few. We have added this language to the first resolved clause. Your committees also
41 sought to clarify that this policy addresses uninsured and insurance-ineligible patients
42 specifically, as there is existing policy for the Medicaid population. As discussed above, non-
43 citizens must be qualified and lawfully present to receive Medicaid benefits with Federal funding,
44 although there are state-based funding alternatives being proposed and exceptions for pregnant
45 individuals and children. Finally, this clause was simplified to remove mention of the United
46 States Citizenship and Immigration Service (USCIS) in favor of the simpler language
47 "immigration status" that does not reference an external organization.

48 With regard to the second resolve clause, the intention of keeping policies regarding organ
49 procurement up to date is reasonable given our changing demographics and technologies.
50 However, it is neither the place of the AMA to create task forces on this subject, nor to dictate
51 the timing and content of OPTN updating its policies as the AMA does not have appropriate
52 expertise in this area. Additionally, the OPTN, which oversees transplantation allocation

1 policies, already has an established Minority Affairs Committee which may or may not fulfill the
2 advocacy needs of such a task force. In recent meetings, proposed task forces have also met
3 with considerable pushback from AMA leadership.

4
5 Regarding resolve clause 3, we believe that the AMA actions on federal fiscal strategies will be
6 better informed pending the report on Medicaid eligibility for non-citizens that is planned to be
7 presented at Annual 2023. Your committees believe that the creation of alternative “federal
8 fiscal strategies” would likely encounter significant challenges in the political climate, and may
9 be better addressed through ensuring insurance access broadly for the non-citizen population.
10 The AMA is not well equipped to create a federal fiscal strategy to recommend to the
11 government. So we recommend removing this clause, but plan to address the access and cost
12 implications in the forthcoming dedicated report.

13
14 For the fourth resolved clause, noting that amendments to the Code of Ethics must be made by
15 the Council on Ethical and Judicial Affairs (CEJA), we provided a recommendation that CEJA
16 reconsider their guidance. A direct amendment would likely contribute to referral of the entire
17 item.

18
19 The Minority Issues Committee and the Committee on Economics and Quality in Medicine did
20 consider the suggested amendment by addition to the Code of Ethics 6.2.1 to be appropriate for
21 an amendment by addition in H.370.982 in resolve clause 5. As written, this amendment
22 strengthens the current policy, clarifying that a citizenship blind approach to organ
23 transplantation is ethical in accordance with legal precedent. We note that the specific clause
24 suggested 1(a) is not the best place to add it in the policy as an exception to the medical need
25 criteria, but rather to clarify that “immigration status” is a non-medical criterion that should not
26 exclude patients like the other criteria in 1(c).

27
28 While the OPTN requests data from follow-up visits, this data is sometimes less available
29 among Non-citizens. As such, the organization has sought to clarify the goal of these collection
30 efforts by amending its collections practices. These guidelines do not place limitations on
31 citizenship status for follow-up, to answer the N-21 reference committee’s second question.
32 Your committees have also clarified the language to be less prescriptive. Any perceived barriers
33 to follow-up should not be considered in the transplant process, and so your committees have
34 also added this as an amendment.

35
36 It is within the scope of the AMA and the AMA-MSS to support the removal of financial and
37 institutional barriers to access organ transplantation because:

- 38 1) It improves equitable access to a benefit to a marginalized population to reduce health
39 disparities, where one of the major hurdles to receiving a transplant is financial cost and
40 another is access at individual transplant centers.
- 41 2) Health care costs associated with emergent temporizing measures for chronic conditions
42 (for example, dialysis for ESRD) outweigh the costs associated with organ
43 transplantation

44 45 46 47 48 **CONCLUSION**

49
50 It is evident that there exists a disparity in terms of access and affordability for organ
51 transplantation. Specifically, this report has found that there is a significant disparity in
52 adequate long-term treatment options for undocumented persons with ESRD and other

conditions needing transplants. Not only is there a moral imperative to advocate for the improved health outcomes of these persons, there is an economic benefit to improving access and affordability to transplants for non-citizens who contribute to the public good and economic development of this country. For example, kidney transplantation is a curative and cost-effective long-term treatment option for ESRD, and thus efforts should be made to facilitate access regardless of immigration status. Non-citizens face a variety of financial and institutional barriers, which this resolution is seeking to address.

RECOMMENDATIONS

Your Minority Issues Committee and Committee on Economics and Quality in Medicine recommend that the following recommendations be adopted and the remainder of the report be filed:

- 1) That the first resolved clause of MSS Resolution 46 be amended by addition and deletion as follows:
RESOLVED, That our AMA support and advocate for federal laws initiatives that remove decrease financial and institutional barriers to for organ transplantation to uninsured or insurance-ineligible recipients, such as provisions for expenses involved in the transplantation of organs incurred by the uninsured regardless of a legally defined United States Citizenship and Immigration Service (USCIS) immigration status, excluding medical tourism as defined in the AMA code of ethics 1.2.13 in the country as long as the person can show physical presence in the U.S. prior to needing the organ; and be it further

- 2) That the second resolved clause of MSS Resolution 46 not be adopted.

- 3) That the third resolved clause of MSS Resolution 46 not be adopted.

- 4) That the following clause be adopted in lieu of the fourth resolved clause of MSS Resolution 46:

RESOLVED, That the AMA Council on Ethical and Judicial Affairs reconsider its Guidelines for Organ Transplantation from Deceased Donors to consider the concerns of differential access based upon immigration status; and be it further

- 5) That the fifth resolved clause of MSS Resolution 46 be amended by addition and deletion as follows:

RESOLVED, That our AMA amend H-370.982 to also clarify its stance of not regarding immigration status as long as the person lives in the U.S. thereby keeping the overall equitability of the system for organ donation and receiving parties intact by addition to read as follows:

Ethical Considerations in the Allocation of Organ and Other Scarce Medical Resources Among Patients, H-370.982

Our AMA has adopted the following guidelines as policy: (1)
Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a)
These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for

1 successful treatment ~~without regard to a legally defined United States Citizenship~~
2 ~~and Immigration Service (USCIS)~~. In general, only very substantial differences
3 among patients are ethically relevant; the greater the disparities, the more
4 justified the use of these criteria becomes. In making quality of life judgments,
5 patients should first be prioritized so that death or extremely poor outcomes are
6 avoided; then, patients should be prioritized according to change in quality of life,
7 but only when there are very substantial differences among patients. (b)
8 Research should be pursued to increase knowledge of outcomes and thereby
9 improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to
10 pay, social worth, immigration status, perceived obstacles to treatment or follow-
11 up, patient contribution to illness, or past use of resources should not be
12 considered.

13
14 (2) Allocation decisions should respect the individuality of patients and the
15 particulars of individual cases as much as possible. (a) All candidates for
16 treatment must be fully considered according to ethically appropriate criteria
17 relating to medical need, as defined in Guideline 1. (b) When very substantial
18 differences do not exist among potential recipients of treatment on the basis of
19 these criteria, a "first-come-first-served" approach or some other equal
20 opportunity mechanism should be employed to make final allocation decisions.
21 (c) Though there are several ethically acceptable strategies for implementing
22 these criteria, no single strategy is ethically mandated. Acceptable approaches
23 include a three-tiered system, a minimal threshold approach, and a weighted
24 formula.

25
26 (3) Decision making mechanisms should be objective, flexible, and consistent to
27 ensure that all patients are treated equally. The nature of the physician-patient
28 relationship entails that physicians of patients competing for a scarce resource
29 must remain advocates for their patients, and therefore should not make the
30 actual allocation decisions.

31
32 (4) Patients must be informed by their physicians of allocation criteria and
33 procedures, as well as their chances of receiving access to scarce resources.
34 This information should be in addition to all the customary information regarding
35 the risks, benefits, and alternatives to any medical procedure. Patients denied
36 access to resources have the right to be informed of the reasoning behind the
37 decision.

38
39 (5) The allocation procedures of institutions controlling scarce resources should
40 be disclosed to the public as well as subject to regular peer review from the
41 medical profession.

42
43 (6) Physicians should continue to look for innovative ways to increase the
44 availability of and access to scarce medical resources so that, as much as
45 possible, beneficial treatments can be provided to all who need them.

46
47 (7) Physicians should accept their responsibility to promote awareness of the
48 importance of an increase in the organ donor pool using all available means.
49

50 For clarity, the final language without strikeouts and underlines is reproduced below:

51 RESOLVED, That our AMA support initiatives that decrease financial and institutional
52 barriers for organ transplantation to uninsured or insurance-ineligible recipients,

1 regardless of immigration status, excluding medical tourism as defined in the AMA code
2 of ethics 1.2.13; and be it further

3 RESOLVED, That the AMA Council on Ethical and Judicial Affairs reconsider its
4 Guidelines for Organ Transplantation from Deceased Donors to consider the
5 concerns of differential access based upon immigration status; and be it further
6

7 RESOLVED, That our AMA amend H-370.982 by addition to read as follows:
8

9 **Ethical Considerations in the Allocation of Organ and Other Scarce**
10 **Medical Resources Among Patients, H-370.982**
11

12 Our AMA has adopted the following guidelines as policy: (1)
13 Decisions regarding the allocation of scarce medical resources among patients
14 should consider only ethically appropriate criteria relating to medical need. (a)
15 These criteria include likelihood of benefit, urgency of need, change in quality of
16 life, duration of benefit, and, in some cases, the amount of resources required for
17 successful treatment. In general, only very substantial differences among
18 patients are ethically relevant; the greater the disparities, the more justified the
19 use of these criteria becomes. In making quality of life judgments, patients
20 should first be prioritized so that death or extremely poor outcomes are avoided;
21 then, patients should be prioritized according to change in quality of life, but only
22 when there are very substantial differences among patients. (b) Research should
23 be pursued to increase knowledge of outcomes and thereby improve the
24 accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social
25 worth, immigration status, perceived obstacles to treatment or follow-up, patient
26 contribution to illness, or past use of resources should not be considered.
27

28 (2) Allocation decisions should respect the individuality of patients and the
29 particulars of individual cases as much as possible. (a) All candidates for
30 treatment must be fully considered according to ethically appropriate criteria
31 relating to medical need, as defined in Guideline 1. (b) When very substantial
32 differences do not exist among potential recipients of treatment on the basis of
33 these criteria, a "first-come-first-served" approach or some other equal
34 opportunity mechanism should be employed to make final allocation decisions.
35 (c) Though there are several ethically acceptable strategies for implementing
36 these criteria, no single strategy is ethically mandated. Acceptable approaches
37 include a three-tiered system, a minimal threshold approach, and a weighted
38 formula.
39

40 (3) Decision making mechanisms should be objective, flexible, and consistent to
41 ensure that all patients are treated equally. The nature of the physician-patient
42 relationship entails that physicians of patients competing for a scarce resource
43 must remain advocates for their patients, and therefore should not make the
44 actual allocation decisions.

45 (4) Patients must be informed by their physicians of allocation criteria and
46 procedures, as well as their chances of receiving access to scarce resources.
47 This information should be in addition to all the customary information regarding
48 the risks, benefits, and alternatives to any medical procedure. Patients denied
49 access to resources have the right to be informed of the reasoning behind the
50 decision.
51

(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.

References:

1. *Estimates of the Unauthorized Immigrant Population Residing in the United States: January 2015-January 2018*. United States Department of Homeland Security; 2021. Accessed October 7, 2022.
https://www.dhs.gov/sites/default/files/publications/immigration-statistics/Pop_Estimate/UnauthImmigrant/unauthorized_immigrant_population_estimate_s_2015_-_2018.pdf
2. Kamarck E, Stenglein C. How many undocumented immigrants are in the United States and who are they? Brookings. Published November 12, 2019.
<https://www.brookings.edu/policy2020/votervital/how-many-undocumented-immigrants-are-in-the-united-states-and-who-are-they/>
3. Rodriguez R, Cervantes L, Raghavan R. Estimating the prevalence of undocumented immigrants with end-stage renal disease in the United States. *Clin Nephrol*. 2020;93(1):108-112. doi:10.5414/CNP92S119
4. *2019 USRDS Annual Data Report: Epidemiology of Kidney Disease in the United States*. United States Renal Data System; 2019. Accessed October 7, 2022.
<https://www.usrds.org/annual-data-report/>
5. Trish E, Fiedler M, Ning N, Gascue L, Adler L, Lin E. Payment for Dialysis Services in the Individual Market. *JAMA Intern Med*. 2021;181(5):698-699.
doi:10.1001/jamainternmed.2020.7372
6. Statistics | The Kidney Project | UCSF. [pharm.ucsf.edu](https://pharm.ucsf.edu/kidney/need/statistics).
<https://pharm.ucsf.edu/kidney/need/statistics>
7. Lee D, Kanellis J, Mulley WR. Allocation of deceased donor kidneys: A review of international practices. *Nephrology (Carlton)*. 2019;24(6):591-598.
doi:10.1111/nep.13548
8. Raghavan R. Caring for Undocumented Immigrants With Kidney Disease. *American Journal of Kidney Diseases*. 2018;71(4):488-494. doi:10.1053/j.ajkd.2017.09.011
9. Ackah RL, Sigireddi RR, Murthy BVR. Is Organ Retransplantation Among Undocumented Immigrants in the United States Just?. *AMA J Ethics*. 2019;21(1):E17-E25. Published 2019 Jan 1. doi:10.1001/amajethics.2019.17
10. Lee D, Kanellis J, Mulley WR. Allocation of deceased donor kidneys: A review of international practices. *Nephrology (Carlton)*. 2019;24(6):591-598.
doi:10.1111/nep.13548
11. Ward A, Klassen DK, Franz KM, Giwa S, Lewis JK. Social, economic, and policy implications of organ preservation advances. *Curr Opin Organ Transplant*. 2018;23(3):336-346. doi:10.1097/MOT.0000000000000532
12. SSA O. Payment to States. [www.ssa.gov](https://www.ssa.gov/OP_Home/ssact/title19/1903.htm). Accessed September 22, 2022.
https://www.ssa.gov/OP_Home/ssact/title19/1903.htm
13. Colwell J. Getting dialysis for undocumented patients. [acpinternist.org](https://acpinternist.org/archives/2021/02/getting-dialysis-for-undocumented-patients.htm).
<https://acpinternist.org/archives/2021/02/getting-dialysis-for-undocumented-patients.htm>

14. Dialysis Billing Manual | Colorado Department of Health Care Policy & Financing. hcpf.colorado.gov. Accessed October 7, 2022. <https://hcpf.colorado.gov/dialysis-manual>
15. *MEDI-CAL ELIGIBILITY PROCEDURES MANUAL ARTICLE 17*. Accessed October 7, 2022. <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/Article17-Medi-CalTreatmentPrograms.pdf>
16. Welles CC, Cervantes L. Hemodialysis care for undocumented immigrants with end-stage renal disease in the United States. *Curr Opin Nephrol Hypertens*. 2019;28(6):615-620. doi:10.1097/MNH.0000000000000543
17. Noncitizens | Washington State Health Care Authority. www.hca.wa.gov. Accessed October 7, 2022. <https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-medical-dental-or-vision-care/noncitizens>
18. *Supporting Health Equity and Affordable Health Coverage for Immigrant Populations: State-Funded Affordable Coverage Programs for Immigrants*. State Health and Value Strategies: Driving Innovation Across States; 2021. Accessed October 7, 2022. <https://www.shvs.org/wp-content/uploads/2021/10/State-Funded-Affordable-Coverage-Programs-for-Immigrants.pdf>
19. Kaiser Family Foundation. Health coverage of immigrants. KFF. Published March 18, 2020. <https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/>
20. Axelrod DA, Schnitzler MA, Xiao H, et al. An economic assessment of contemporary kidney transplant practice. *Am J Transplant*. 2018;18(5):1168-1176. doi:10.1111/ajt.14702
21. O'Neill E. Transplants A Cheaper, Better Option For Undocumented Immigrants With Kidney Failure. *NPR.org*. <https://www.npr.org/2019/05/12/721800514/transplants-a-cheaper-better-option-for-undocumented-immigrants-with-kidney-fail>. Accessed September 22, 2022.
22. Lafranca JA, Spoon EQW, van de Wetering J, IJzermans JNM, Dor FJMF. Attitudes among transplant professionals regarding shifting paradigms in eligibility criteria for live kidney donation. *PLoS One*. 2017;12(7):e0181846. Published 2017 Jul 21. doi:10.1371/journal.pone.0181846
23. *2014 Report of Non-U.S. Resident Transplant Activity*. OPTN Ad Hoc International Relations Committee; 2014. Accessed September 21, 2022. https://optn.transplant.hrsa.gov/media/1854/irc_annual_report.pdf
24. Grubbs V. Undocumented immigrants and kidney transplant: costs and controversy. *Health Aff (Millwood)*. 2014;33(2):332-335. doi:10.1377/hlthaff.2013.0462
25. Tilney NL. *Transplant : From Myth to Reality*. Yale University Press; 2003.
26. Gordon EJ, Gill JS. US Transplant Policy Should Strengthen Bridges, Not Build Walls. *Am J Transplant*. 2016;16(6):1645-1646. doi:10.1111/ajt.13713
27. HRSA. Organ Donation Statistics | organdonor.gov. www.organdonor.gov. Published May 2021. <https://www.organdonor.gov/learn/organ-donation-statistics>
28. Lee BP, Terrault NA. Liver Transplantation in Unauthorized Immigrants in the United States. *Hepatology*. 2020;71(5):1802-1812. doi:10.1002/hep.30926
29. Maier S. Undocumented Immigrants' Transplant Survival Rates on Par with U.S. Citizens' | UC San Francisco. www.ucsf.edu. Accessed September 22, 2022. <https://www.ucsf.edu/news/2019/09/415451/undocumented-immigrants-transplant-survival-rates-par-us-citizens#:~:text=A%20risk%20analysis%20found%20similar>
30. United Network for Organ Sharing. Frequently asked questions - UNOS. UNOS. Published 2014. <https://unos.org/transplant/frequently-asked-questions/>
31. Gonzalez, N., Murphy, B, and Zhang, J. For undocumented immigrants, it's easier to donate a kidney than to receive one. Univision. Accessed September 22, 2022. <https://www.univision.com/univision-news/health/for-undocumented-immigrants-its-easier-to-donate-a-kidney-than-to-receive-one>

32. About the OPTN - OPTN. [optn.transplant.hrsa.gov](https://optn.transplant.hrsa.gov/about/).
<https://optn.transplant.hrsa.gov/about/>
33. History and NOTA - OPTN. [optn.transplant.hrsa.gov](https://optn.transplant.hrsa.gov/about/history-nota/). Accessed October 7, 2022.
<https://optn.transplant.hrsa.gov/about/history-nota/>
34. OPTN charter - OPTN. [optn.transplant.hrsa.gov](https://optn.transplant.hrsa.gov/about/optn-charter/). Accessed October 7, 2022.
<https://optn.transplant.hrsa.gov/about/optn-charter/>
35. Cervantes L, Rizzolo K, Klassen D. Organ Procurement and Transplant Equity Among US Residents: The 5% Guideline. *Am J Kidney Dis*. 2022;80(1):139-142.
doi:10.1053/j.ajkd.2021.11.006
36. The declaration of Istanbul on organ trafficking and transplant tourism. *Indian J Nephrol*. 2008;18(3):135-140. doi:10.4103/0971-4065.43686
37. *Notice of OPTN Guidance Document Guidance for Data Collection Regarding Classification of Citizenship Status Purpose of Guidance Document*. Accessed October 7, 2022. https://optn.transplant.hrsa.gov/media/15yaohhl/policy-notice_ahirc_guidance-document.pdf
38. Al Ammary F, Thomas AG, Massie AB, et al. The landscape of international living kidney donation in the United States. *Am J Transplant*. 2019;19(7):2009-2019.
doi:10.1111/ajt.1525
39. *2019 Summary of Non-U.S. Resident Transplant Activity*. OPTN Ad Hoc International Relations Committee Accessed October 7, 2022.
<https://optn.transplant.hrsa.gov/media/3035/june-2019-irc-annual-report-summary.pdf>
40. DOD. [srtr.transplant.hrsa.gov](https://srtr.transplant.hrsa.gov/annual_reports/2018/DOD.aspx). Accessed October 7, 2022.
https://srtr.transplant.hrsa.gov/annual_reports/2018/DOD.aspx
41. *2016 Summary of Non-U.S. Resident Transplant Activity*. OPTN Ad Hoc International Relations Committee Accessed October 7, 2022.
https://optn.transplant.hrsa.gov/media/1869/irc_annual_report_summary_201606.pdf
42. DOD. [srtr.transplant.hrsa.gov](https://srtr.transplant.hrsa.gov/annual_reports/2019/DOD.aspx). Accessed October 7, 2022.
https://srtr.transplant.hrsa.gov/annual_reports/2019/DOD.aspx
43. DOD. [srtr.transplant.hrsa.gov](https://srtr.transplant.hrsa.gov/annual_reports/2020/DOD.aspx). Accessed October 7, 2022.
https://srtr.transplant.hrsa.gov/annual_reports/2020/DOD.aspx
44. Organ Procurement Transplantation Network Policies. Published online September 6, 2022. Accessed September 25, 2022.
https://optn.transplant.hrsa.gov/media/eavh5bf3/optn_policies.pdf
45. Pullen LC. Transplantation and Undocumented Immigrants: A Tale of Two States. *American Journal of Transplantation*. 2019;19(10):2665-2667. doi:10.1111/ajt.15587
46. Rizzolo K, Cervantes L. Barriers and Solutions to Kidney Transplantation for the Undocumented Latinx Community with Kidney Failure. *Clin J Am Soc Nephrol*. 2021;16(10):1587-1589. doi:10.2215/CJN.03900321
47. Sinnenberg L, Machado SR, Ostrominski JW, Stehlik J, Mehra MR, Vaduganathan M. Citizenship Status and Cardiothoracic Organ Transplantation in the United States. *Circ Heart Fail*. 2020;13(12):e007788. doi:10.1161/CIRCHEARTFAILURE.120.007788
48. Shen JI, Hercz D, Barba LM, et al. Association of Citizenship Status With Kidney Transplantation in Medicaid Patients. *Am J Kidney Dis*. 2018;71(2):182-190.
doi:10.1053/j.ajkd.2017.08.014
49. *Guidance for Data Collection Regarding Classification of Citizenship Status*. American Society of Transplantation; 2021:3. Accessed September 25, 2022.
<https://www.myast.org/sites/default/files/AST%20Fall%202021%20OPTN%20Public%20Comment%20Responses-FINAL.pdf>
50. Gee LC, Gardner M, Hall ME, Wiehe M. *Undocumented Immigrants' State & Local Tax Contributions*. Institute on Taxation & Economic Policy; 2017. Accessed September 25, 2022. <https://itep.sfo2.digitaloceanspaces.com/ITEP-2017-Undocumented-Immigrants-State-and-Local-Contributions.pdf>

51. AST Statement on President Trump's Executive Order on Immigration. American Society of Transplantation. Published February 8, 2017. Accessed September 25, 2022.
<https://www.myast.org/ast-statement-president-trumps-executive-order-immigration>

RELEVANT AMA AND AMA-MSS POLICY

UNOS Kidney Paired Donation Program H-370.960

Our AMA: (1) encourages the continued expansion of the United Network for Organ Sharing's (UNOS) Kidney Paired Donation program which provides a national registry of living donors, carries out ongoing data collection on key issues of concern in transplantation from living donors, and through its operational guidelines provides consistent, national standards for the transplant community; and (2) encourages voluntary coordination among private donor registries and UNOS to enhance the availability of organs for transplantation.

Organ Transplant Equity for Persons with Disabilities D-370.980

1. Our AMA supports: (a) equitable inclusion of people with Intellectual and Developmental Disabilities (IDD) in eligibility for transplant surgery; (b) individuals with IDD who can fulfill transplant center protocols having equal access to organ transplant services and protection from discrimination in rendering these services; and (c) the goal of the Organ Procurement and Transplantation Network (OPTN) in adding disability status to their Nondiscrimination policy under the National Organ Transplant Act of 1984.

2. Our AMA will work with relevant stakeholders to distribute antidiscrimination education materials for healthcare providers related to equitable inclusion of people with IDD in eligibility for transplant surgery.

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.

6.2.2 Directed Donation of Organs for Transplantation

Efforts to increase the supply of organs available for transplant can serve the interests of individual patients and the public and are in keeping with physicians' obligations to promote the welfare of their patients and to support access to care. Although public solicitations for directed donation—that is, for donation to a specific patient—may benefit individual patients, such solicitations have the potential to adversely affect the equitable distribution of organs among patients in need, the efficacy of the transplant system, and trust in the overall system.

Donation of needed organs to specified recipients has long been permitted in organ transplantation. However, solicitation of organs from potential donors who have no pre-existing relationship with the intended recipient remains controversial. Directed donation policies that produce a net gain of organs for transplantation and do not unreasonably disadvantage other transplant candidates are ethically acceptable.

Physicians who participate in soliciting directed donation of organs for transplantation on behalf of their patients should:

(a) Support ongoing collection of empirical data to monitor the effects of solicitation of directed donations on the availability of organs for transplantation.

(b) Support the development of evidence-based policies for solicitation of directed donation.

- (c) Ensure that solicitations do not include potentially coercive inducements. Donors should receive no payment beyond reimbursement for travel, lodging, lost wages, and the medical care associated with donation.
- (d) Ensure that prospective donors are fully evaluated for medical and psychosocial suitability by health care professionals who are not part of the transplant team, regardless of any relationship, or lack of relationship, between prospective donor and transplant candidate.
- (e) Refuse to participate in any transplant that he or she believes to be ethically improper and respect the decisions of other health care professionals should they choose not to participate on ethical or moral grounds.

Equal Access to Organ Transplantation for Medicaid Beneficiaries H-370.962

Our AMA supports federal funding of organ transplants for Medicaid patients.

Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool H-370.958

1. Our AMA supports the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation.
2. Our AMA supports well-designed studies investigating the use of incentives, including valuable considerations, to increase living and deceased organ donation rates.
3. Our AMA will seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living and deceased organ donation.

(30.011MSS) Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements:

AMA-MSS will ask the AMA to encourage transplant centers to expand potential recipient evaluation criteria to include patients that may not satisfy center-specific alcohol sobriety requirements on a case-by-case basis, using medically appropriate criteria supportable by peer-reviewed and published research.

(370.003SS) Organ Donors and Transplants:

AMA-MSS will ask the AMA to: (1) use public service announcements to enhance the general public's understanding of the procedures surrounding organ donation and transplant and increase the number of people who consent to be organ donors; and (2) research other ways of increasing the organ donor pool. (AMA Res 141, I-87 Referred) (BOT Rep ZZ, A-88 Adopted) (Reaffirmed: MSS Rep D, I-97) (Reaffirmed: MSS Rep B, I-02) (Amended: MSS Rep C, I-07) (Reaffirmed: MSS GC Rep B, I-12) (Reaffirmed: MSS GC Report A, I-17)

(370.005MSS) Working Toward an Increased Number of Minorities Registered as Potential Bone Marrow Donors:

AMA-MSS will ask the AMA to support efforts to increase the number of all potential bone marrow donors, especially minority donors, registered in national bone marrow registries to improve the odds of successful HLA matching and bone marrow transplantation. (AMA Res 501, I-94 Adopted [H-370.974]) (Reaffirmed: MSS Rep B, I-00) (Reaffirmed: MSS Rep E, I-

05) (Reaffirmed: MSS GC Rep F, I-10) (Reaffirmed: MSS GC Rep D, I-15) (Reaffirmed: MSS GC Rep B, A-21)

(370.015MSS) Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool:

AMA-MSS will ask (1) that our AMA support the efforts of the National Living Donor Assistance Center, Health Resources Services Administration, American Society of Transplantation, American Society of Transplant Surgeons, and other relevant organizations in their efforts to eliminate disincentives serving as barriers to living and deceased organ donation, (2) that our AMA support well- designed studies investigating the use of incentives, including valuable considerations, to increase living and deceased organ donation rates, and (3) that our AMA seek legislation necessary to remove legal barriers to research investigating the use of incentives, including valuable considerations, to increase rates of living and deceased organ donation. (MSS Res 08, I-15 Immediate Transmittal to HOD) (AMA Res 007, I-15 Adopted) (Reaffirmed: MSS GC Rep B, A-21)

(370.019MSS) Support for the Use of Evidence-Based Guidelines for Determining Liver Transplant Waiting Periods in Alcohol-Related Liver Disease:

AMA-MSS supports the use of evidence-based guidelines for determining liver transplant waiting periods in alcohol- related liver disease. (MSS Res 08, A-18)

REPORT OF THE MEDICAL STUDENT SECTION
COMMITTEE ON ECONOMICS AND QUALITY IN MEDICINE AND WOMEN IN MEDICINE
COMMITTEE

MSS CEQM WIM Report A
(I-22)

Introduced by: MSS Committee on Economics and Quality in Medicine and Women in
Medicine Committee

Subject: Expansion of Medicaid Coverage of HPV Screening

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

INTRODUCTION

On behalf of CEQM and WIM, we are submitting this report to highlight our recommendations regarding Resolution 054 N-21: Expansion of Medicaid Coverage of HPV Screening.

Resolution 54 was initially introduced to the AMA-MSS at the November 2021 meeting. We thank the authors for their hard work on advocacy for this important topic and for their efforts to gather a diverse perspective that is representative of the AMA-MSS body. When presented to the Virtual Reference Committee, there were a number of amendments presented from our AMA-MSS on this resolution. The Committee on Economics and Quality in Medicine (CEQM) provided support for this resolution with some proposed amendments. The Massachusetts Delegation and our MSS Section Delegates proposed a different set of amendments to assist with the asks of this resolution. Our colleagues from Region 2 appreciated the spirit of the proposed resolution, though thought that it would have more success at HOD if proposed by ACOG.

Resolution 054 calls for three separate action items.

RESOLVED, That our AMA submit a formal request to the Centers for Medicare and Medicaid Services to expand coverage of primary HPV testing without cytology, and be it further

RESOLVED, That our AMA request the CMS to endorse national incentives for states to cover primary HPV testing by Medicaid, and be it further

RESOLVED, That our AMA support further research of HPV self-sampling in the U.S. for cervical cancer screening.

Taking into account these testimonies, our Reference Committee referred Resolution 054 to CEQM and WIM for further study regarding the feasibility and opportunity of the proposed resolution and amendments. Specifically, our Reference Committee hopes to identify additional clarity on the United States Preventive Service Task Force (USPSTF) guidelines on cervical cancer and HPV testing. We will also address each resolved clause with our own independent

literature review to highlight the feasibility of this resolution if passed. It is our goal to present an independent and unbiased view of the asks in this resolution to provide our AMA-MSS with the necessary information to make a decision.

BACKGROUND

Demographics of Cervical Cancer Patients

Human Papillomavirus (HPV), predominantly high-risk HPV (hrHPV) types 16 and 18, causes 90% of cervical cancers. From 2011-2015, annual age-adjusted cervical cancer incidence was 7.4 cases per 100,000 women with 2.3 deaths per 100,000 women.¹ Despite high total population screening rates, there are screening disparities that disproportionately affect certain population subgroups including racial and ethnic minorities, rural areas, low socioeconomic status, sexual and gender minorities, particular religious beliefs, limited English proficiency, people with disabilities or certain comorbidities, and people with mental health concerns.² Black women have one of the highest incidence rates of cervical cancer at 8.4 per 100,000 and the highest mortality rate at 3.7 deaths per 100,000 women. Hispanic women have the highest incidence rate of cervical cancer at 8.9 per 100,000.¹

In a 2019 analysis from the US National Health Interview Survey guideline-concordant cervical cancer screening which assessed rates of screening not up-to date by USPSTF's 2018 guidelines, non-Hispanic white women had the lowest rate of overdue (not currently up-to-date with guideline-recommended frequency and >age 21) screening at 20.1% while Asian women had the highest rate at 31.4%. Those identifying as LGBTQ+ had a higher overdue screening rate (32.0%) compared to those identifying heterosexual (22.2%). Rural residents had an overdue screening rate of 26.2% while urban residents had an overdue screening rate of 22.6%.³ These disparities in cervical cancer screening result in lack of timely diagnosis and treatment for cervical pre-cancers, leading to worse outcomes and disparities in mortality from cervical cancer.^{1,4} Black women had a 19% increase in mortality risk compared to white women despite controlling for age, stage, histology, and treatment.⁴ Recent studies indicate that controlling for rates of hysterectomy indicates up to 44% underestimate in mortality between Black and White women.⁵ Barriers to screening include personal and structural barriers such as distrust in the healthcare system, transportation, cost, time off work, and lack of access to facilities equipped for cervical cancer screening.^{1,4}

Current Guidelines for Cervical Cancer Screening

The United States Preventive Services Task Force (USPSTF) recommends cervical cancer screening for all persons with a cervix that are at average risk, including those that are not immunocompromised, have no history of cervical cancer, do not have a recent abnormal result, or have no history of in-utero diethylstilbestrol exposure. The USPSTF recommends testing between the ages of 21 and 65.⁶ From 21 to 29, cervical cytology should be conducted every 3 years. From 30 to 65, testing options include cytology every 3 years, hrHPV every 5 years, or hrHPV and cytology co-testing every 5 years.⁶ The USPSTF in 2018 concluded with high certainty that the benefits of cervical cancer screening with HPV testing alone every 5 years in ages 30-65 outweigh the harms.⁶

Starting in 2021, the American College of Obstetricians and Gynecologists (ACOG) supported the USPSTF recommendation on cervical cancer screening along with the American Academy of Family Physicians (AAFP) and the Society of Gynecologic Oncology (SGO).^{7,8}

However, the USPSTF recommendations differ from the American Cancer Society's (ACS) 2020 recommendations.⁹ The ACS no longer recommends screening for patients younger than 25 and for ages 25-65 recommends an FDA-approved primary HPV test alone every 5 years as the preferred method of cervical cancer screening.^{9,10} Alternative options include Pap test with HPV co-testing every 5 years or a Pap test alone every 3 years.⁹ The ACS also acknowledges that the United States is in a transition to primary HPV testing, and as such make an allowance in their guideline for co-testing or cytology alone where access to primary HPV testing is limited.¹⁰ Of note, they point out that the use of co-testing or cytology alone will be eliminated from future guidelines when access to primary HPV testing is widely available.¹⁰ Both the USPSTF and the ACS recommendations suggest discontinuing testing in those over the age of 65 or with a total hysterectomy with a low future risk of cancer.^{6,9}

Table 1. Summary of Cervical Cancer Screening Guidelines⁶⁻¹⁰

	Age 21 - 24	Age 25 - 29	Age ≥30
USPSTF (2018)	Pap every 3 years	Pap every 3 years	One of these methods: - Pap every 3 years - Primary HPV testing every 5 years - Co-testing* every 5 years
ACOG (2016)	Pap every 3 years	One of these methods: - Pap every 3 years - Can consider primary HPV testing every 3 years	One of these methods: - Co-testing* every 5 years (preferred) - Pap test every 3 years - Can consider primary HPV testing every 3 years
ACS (2020)		One of these methods: - Primary HPV testing every 5 years (preferred) - Co-testing* every 5 years - Pap test every 3 years	

*Co-testing: Papanicolaou test and HPV testing

History of HPV Screening

In 1995 The International Agency for Research on Cancer (IARC) performed the seminal study on HPV in cervical cancers, with more than 1,000 specimens from patients with invasive cervical cancer from 32 hospitals in 22 countries assessed using polymerase chain reaction-based assays to detect HPV DNA in 93% of the tumors.¹¹ As a follow-up, a 1999 study based on new analyses found that 99.7% of the 1,000 cases with histologically confirmed invasive

cervical cancer were shown to be HPV DNA positive using the GP5+/GP6+ or E7 primers, indicating HPV as a necessary cause of cervical cancer.¹² These combined studies formed the basis of HPV prevention and screening programs. Furthermore, a 2010 study of 10,575 cases of invasive cervical cancer found 8,977 (85%) of these were positive for HPV DNA, of which 6,885 (77%) were HPV types 16, 18, or 45, suggesting that hrHPV DNA-based screening tests and protocols should focus these types.¹³ Recent studies have built upon evidence of causal association between HPV and cervical cancers. A 2020 Swedish study found that, among Swedish girls and women 10 to 30 years old, quadrivalent HPV vaccination administration covering HPV types 6, 11, 16, and 18 was associated with a substantially (IR 0.37 (95% CI, 0.21 to 0.57)) reduced risk of invasive cervical cancer in their population.¹⁴

Methods of Cervical Cancer Screening

Screening coupled with vaccination remains the cornerstone of prevention of cervical cancer.¹⁵ The screening methods for cervical cancer are summarized below. hrHPV testing is more commonly referred to as HPV testing, and cytology is also more commonly referred to as Pap smear, but for the purpose of this report, we will use hrHPV testing and cytology.

consist of primary hrHPV testing, which is referred to as primary screening, cytology alone, which does not include hrHPV testing, reflex cytology (triage HPV testing), which is hrHPV testing after abnormal cytology, or co-testing, which is a combination of hrHPV testing and cytology.¹

Table 2. Review of cancer screening methodologies

Method of Screening	Definition
Primary hrHPV (Primary screening) ¹⁰	Examination of presence of DNA for high-risk HPV in a sample from cervix
Cytology Alone (Pap smear only) ¹⁰	Examination of samples from cervix under microscope for presence of neoplasia (abnormal cells)
Co-Testing (Pap smear + hrHPV) ¹⁰	hrHPV test with cytology, examines cells under the microscope and tests for hrHPV DNA in sample from cervix
Reflex Cytology (Triage HPV Testing) ¹⁵	Cytology only. If cytology is abnormal, it is followed up with hrHPV testing.
Self-Sampling	Type of primary screening where patients self-collect a vaginal sample at home or in a clinic ¹⁶

hrHPV and cervical cytology samples are both collected through speculum examination and use a thin layer preparation from the cervix exterior (ectocervix) and the cervical canal (endocervix).¹⁰ Cytology can be examined either through conventional or liquid-based cytology.

In conventional cytology, the ectocervical spatula and the endocervical brush are put onto a single slide. In liquid-based cytology, a thin layer preparation is placed into a liquid fixative solution and vigorously swirled or rotated ten times in the solution. Loose cells are trapped onto a filter and plated in a monolayer on a glass slide. The use of liquid-based, thin layer preparation technique over conventional allows for dual testing of HPV to gather further information about cervical cancer risk.¹⁷

Self-sampling is a type of primary screening where patients collect a vaginal sample using various collection methods including tampon, brush, swag, lavage, or vaginal patch. Individuals obtain a kit and collect their own samples either at home or at a clinic. The samples are sent to a laboratory for testing, and the results are returned to the individual. The process of self-sampling However, this method is not yet FDA approved for use.¹⁶

Efficacy of Primary HPV Testing

In a systematic review of over 40 studies in the literature, the authors found that pooled estimated sensitivity measuring cervical intraepithelial neoplasia (CIN) 2+ of primary HPV testing, conventional cytology testing alone, or liquid-based cytology alone was 89.9%, 62.5%, and 72.9%, respectively.¹⁸ The pooled specificity of the tests were 89.9%, 96.6%, and 90.3%.¹⁸

To detect CIN 3+, a comparison of primary testing compared to conventional cytology found a relative sensitivity of 1.46 (95% CI: 1.12 to 1.91) and a relative specificity of 0.95 (95% CI, 0.93 to 0.97).¹⁸ A comparison of primary hrHPV testing to liquid-based cytology in measuring CIN 3+ was found to have a relative sensitivity of 1.17 (95% CI, 1.07 to 1.28) and a relative specificity of 0.96 (95% CI: 0.95 to 0.97).¹⁸ Randomized comparisons to co-testing appear to be lacking as co-testing may be used as a gold-standard in randomized trials.

Primary HPV testing is highly sensitive and less likely to miss CIN 2+ and CIN 3+, which is why the interval between testing can be extended to 5 years, but the tests do lead to more false positives, which may increase the amount of referrals for colposcopy.¹⁸ Cytology tests have a greater chance of producing false negatives due to the lower sensitivity, which requires a shorter interval of 3 years and could lead to treatment delays.¹⁸ It is unknown if the lower sensitivity of cytology would be improved by repeated cytological examinations.¹⁸

Efficacy of Self-Sampling HPV Testing

Data on the efficacy of the self-sampling method for CIN >2+ is limited, with the sensitivity and specificity of the test largely relying on the quality of the clinical specimen. In a meta-analysis of 36 studies, HPV testing on self-samples had a pooled sensitivity of 76% (85%, CI 69-82) for CIN 2+ and 84% (95% CI, 72-92) for CIN 3+.¹⁹ The pooled specificity were 86% (95%, 83-89) and 87% (95%, 84-90) to exclude CIN 2+ and CIN 3+ respectively.¹⁹ Self-testing was found to have lower sensitivity and specificity in a comparison of clinician-taken samples— ratio 0.88 (95% CI, 0.85-0.91) for CIN 2+ and ratio 0.96 (95% CI, 0.95-0.97) for CIN 2+.¹⁹ In a comparison of the downstream analysis of the self-sampling methods, PCR-based HPV tests showed similar sensitivity of self-sample and clinical-based samples, whereas signal-based assays had less sensitivity and less specificity for self-sampled versus clinician-based samples.¹⁹

One 2013 review reported that hrHPV testing on self-collected specimens was at least, if not more, sensitive in comparison to Pap smears taken by a health professional in detecting CIN2+ pathology.²⁰ However, a 2013 meta-analysis reported testing for hrHPV on self-collected vaginal samples is not as specific as cytologic examination of clinician-collected cervical samples.¹⁶

Cost Effectiveness of Primary HPV Testing

Primary HPV testing is shown in several analyses to cause an increase in detection of HPV and a decrease in cost burden.²¹ In a model based upon a retrospective cohort of 99,549 women from 2004 - 2010, primary HPV testing was less expensive on a population basis (\$3.47 M vs \$4.79 M) and identified more CIN3+ cases than cytology (294 vs. 285).²² While co-testing did identify more CIN3+ cases than primary HPV testing (308) it was considerably more expensive (\$5.85 M), which is intuitive given the inherent nature of reducing the number of cytology tests performed.²² These data conflict with prior simulation that was not based upon retrospective data indicating within a population of one million 30-year-olds projected to age 70 primary HPV testing would lead to 2,141 more cases of cervical cancer and cost the medical system \$39 M more than co-testing.²³ A systematic review of data from many countries indicated that primary HPV is cost-effective especially compared to co-testing, but there is variability depending upon the amount of the population screened.²⁴

Given the increased sensitivity of HPV tests compared to cytology and therefore expanded time interval between screenings, England has already set HPV testing to replace cytology by 2019-2020. As such there has been interest overseas in cost comparisons. In one British model, it was predicted that switching from cytology with a 3-year interval to primary HPV testing with a 5-year interval would lead to a total healthcare cost saving of £33 million.²⁵ Another analysis predicted a one-year delay in implementation of HPV screening would cost £32 million.²⁶ Although there are significant differences in our healthcare systems and populations, the principle of cost-savings due to longer interval between tests certainly applies.

Cost Effectiveness of Self-Sampling HPV Testing

One 2020 study found self-sampling tests to be at a lower cost than Pap smears collected by midwives in primary cervical screening, while increasing participation and detection of CIN2+. ^{21,}
²⁷ A 2020 systematic review, again international, found 14 of the 16 included studies reported self-sampling could be a cost-effective strategy for cervical cancer screening.²⁸ This review did span countries of different income levels, though the majority were from England. Reasons cited for cost-savings included lower material and testing costs and higher sensitivity for early as opposed to late detection. The ongoing study of self-sampling by the NIH may help address the question of its cost-effectiveness within the US.²⁹

Increased Participation with Self-Sampling

Studies show low rates of screening among in low-income women.³⁰ It is estimated that HPV self-sampling can help improve global cervical cancer screening coverage to 70% by 2030.³¹ Compared to physician-administered testing, HPV self-sampling has been shown to increase equity in cervical cancer screening by offering a greater reach to ethnic minority women, sexual

minority women, as well as women from lower socioeconomic backgrounds.³² Ease of use, privacy, convenience, and physical and emotional comfort have all been cited as major reasons for preference of self-sampling over office-based screening by women.³³ A literature review reported that in 8 out of 13 studies, women preferred self-sampling rather than clinician-collected sampling.³⁴

While self-sampling has the potential to increase screening participation and may draw marginalized groups into the healthcare system for preventive care, it may introduce additional challenges to care in the United States. Self-sampling could decrease the number of face-to-face interactions between the clinician and the patient who was previously being screened in-office, creating the potential for decreased follow-up, as well as preventive care visits and important services including breast exams, vaginal exams, and screening for abuse and mental illness.² Additionally, without appropriate follow-up or clear instructions on how to interpret a positive result, self-sampling also has the potential to increase patient anxiety.³² Granted, these gaps may occur with routine in-office care as well.

Research in self-sampling has been conducted primarily in low-income populations and/or low-resource clinical settings. In the US, a recent randomized controlled trial offered underscreened women either clinic reminders or home-delivered self-sampling kits in addition to usual visits.³² While the results are not yet published, this trial is the first within the US to evaluate whether self-screening could increase cervical cancer participation and be a part of future preventive care. More research within the United States is necessary to not only determine the efficacy of self-sampling, but for which patients it would be indicated.

Current Medicaid Screening Coverage

Traditional Medicaid includes mandatory family planning service benefits for individuals of childbearing age, though it provides no formal definition for “family planning,” leading to state-to-state variation in the services covered by this benefit.³⁵ The Affordable Care Act (ACA) expanded Medicaid by creating a new eligibility category which has federally-specified coverage requirements for family planning (including screening services), but these requirements do not apply to states with a traditional Medicaid program only.³⁵ As a result, there are different coverage standards for different Medicaid eligibility pathways, including traditional Medicaid available before the ACA, ACA Medicaid Expansion, as well as expansion via individual state waivers and State Plan Amendments.³⁵ Through waivers or State Plan Amendments, some states have created limited scope “family planning programs” for those who are not eligible for traditional Medicaid.³⁶ Coverage for services that help prevent cervical cancer is not required in traditional Medicaid or family planning programs, but is mandatory in Medicaid expansion states.³⁵

All states provide Medicaid coverage or public assistance programs for cervical cancer screening.³⁷ In a 2021 KFF survey of 41 states plus the District of Columbia, every responding state reported coverage in their traditional Medicaid program for cytology, HPV testing alone, and co-testing for cervical cytology and hrHPV.³⁵ Arkansas, Georgia, Kentucky, Mississippi, Minnesota, Nebraska, New Mexico, Ohio, and South Dakota did not respond to the survey.³⁵ Table 1 below details the extent of these states’ coverage of cervical cancer screening. In these

states, an individual typically qualifies for free cervical screening programs if they lack health insurance (including Medicaid or Medicare) and have a household income of less than 200-250% of the federal poverty level. Some states, including Minnesota and Georgia, allow individuals to participate in their state programs if they are insured but meet a financial barrier.

Table 3. Cervical Cancer Screening in States not Represented in the 2021 KFF Survey.

State	Medicaid Expansion State? ³⁸	Service Name	Ages Covered	Cervical Screening
Arkansas	Yes	BreastCare	21 to 64	Diagnostic services including pap test ³⁹
Georgia	No	Breast and Cervical Cancer Program	21 to 64	Includes pap test and HPV test ⁴⁰
Kentucky	Yes	Kentucky Women's Cancer Screening Program	21+	Includes pap test and HPV test ⁴¹
Minnesota	Yes	Sage Cancer Screening Program	21-64	Pap smear every 3 years, (or every 5 years if Pap accompanied by HPV co-testing) ⁴²
Nebraska	Yes	Every Woman Matters Screening Program	40-74, but women under 40 can enroll in the State Pap Plus Program for screening	Office visit and pap test with pelvic exam ⁴³
New Hampshire	Yes	Breast & Cervical Cancer Program	21-64	21-29: Pap every 3 years 30-64: Includes co-testing every 5 years or primary HPV testing every 5 years ⁴⁴
New Mexico	Yes	Breast and Cervical Cancer Early Detection Program	21-65	21-65: Pap test every 3 years 30-65: Co-testing or primary HPV testing every 5 years ⁴⁵

Ohio	Yes	Medicaid Breast and Cervical Cancer Project	21-64	21-29: Pap every 3 years 30-64: Pap every 3 years or co-testing every 5 years ⁴⁶
South Dakota	No	All Women Count!	30-64	Pap Testing, Primary HPV Testing, Co-Testing ⁴⁷

For US citizens not included in Medicaid expansion programs, the CDC also operates the National Breast and Cervical Cancer Early Detection Program (AKA the Early Detection Program) to provide cancer screening and diagnostic services to people who are low-income, uninsured, or underinsured.⁴⁸ This program provides eligible individuals with cervical screening using Pap smear and subsequent HPV testing as indicated.⁴⁸

Current Medicare Screening Coverage

Medicare covers all possible screening options currently recommended by the AAFP, ACS, ACOG, and USPSTF with the exception of primary HPV testing.⁴⁹ However, in their 2015 decision memo to cover co-testing, the Center for Medicare and Medicaid Services (CMS) acknowledged that ongoing studies were evaluating HPV for primary, stand alone screening.⁵⁰

Feedback from Specialty Societies

Your committees requested feedback from staff of the American College of Obstetricians and Gynecologists (ACOG). After checking their membership portal they did not find any questions or mentions of Medicaid claims denials for cervical cancer screening, and added that Medicare Part B covers for cervical cancer screening as outlined above and in the Medicare National Coverage Determination in 2016.⁵⁰

Regarding ACOG's position on self-sampling HPV testing: the "VP of Practice said that ACOG certainly is supportive of continued research into self-sampling HPV testing. Much of the current research demonstrating the benefits of self-sampling HPV testing is from the international environment, so ACOG is definitely supportive of more research to identify its usefulness in the U.S. because it has the potential to increase access to cervical cancer screening and overall testing rates."

DISCUSSION

Your committees have undertaken a thorough review of this issue and found that there is a compelling but distinct argument for both primary HPV testing and self-sampling. We have found that in addition to being endorsed by clinical guidelines (ACOG, USPSTF, ACS, etc.), in-office primary HPV has increased sensitivity to identify the majority of patients that would go on

to develop cervical cancer, and may even have a favorable cost-benefit to the overall healthcare system. Importantly, our review did find that there are many marginalized groups with disproportionately lower screening rates. For this reason, encouraging adequate coverage of various screening methods is important to improving screening overall. However, we recognize that primary HPV testing was not exclusively endorsed as superior and should co-exist with previous screening practices as there is some resistance to change and concern that primary HPV testing has a lower sensitivity than co-testing in clinical practice.

Existing AMA policy largely supports global vaccination efforts for HPV (H-440.872), vaccine coverage (D-440.955), and groups together screening for cervical and breast cancer (H-55.971). There is also extensive policy regarding racial inequities in healthcare (H-350.974; D-350.995). There is also a pending transmittal from the MSS to amend H-440.872 to include non-cervical HPV-associated cancers and incorporate gender-neutral language with screening regardless of sex (55.008MSS). None of these policies address coverage of primary HPV screening or HPV self-sampling, so these recommendations would be novel additions.

The argument for primary HPV testing is similar to that for fecal occult blood testing and colonoscopy. Both screenings are available and recommended after considerable review by screening recommendation organizations.^{6,51} Although the result of one may lead to the other being necessary, fecal occult blood testing expands the pool of patients who follow a consistent screening regimen that they are comfortable with, thereby increasing detection of treatable cancers.⁵²

The argument for self-sampling HPV testing is distinct, based upon emerging rather than established evidence, and firmly rooted in the principles of health equity. There is incomplete data on its efficacy and not FDA approval for use. However, it does have the potential to improve health equity by avoiding the costs associated with office visits and screening and creating avenues for screening among those with prior trauma, religious or cultural preferences that preclude in-office testing and other groups that experience barriers to cervical cancer screening. It has the convenience of an at-home test like fecal occult blood testing or fecal immunochemical testing for colon cancer screening, while offering additional health equity benefits. The position of your committees is that evidence remains insufficient and more is needed. Currently, the NIH is spearheading a study to test the effectiveness of at-home screening for HPV versus the traditional Pap smear.⁵³

Since the arguments, level of evidence, and advocacy objectives for in-office primary HPV testing are distinct from self-sampling HPV testing, your committees submit this recommendation with appropriate reservation considering the current backlog of Medical Student Section resolutions, but with a careful eye towards maximizing the success of each policy.

For the first resolved clause, your committees discussed that “a formal request” read as a time-limited intervention that could stagnate future advocacy on the issue. Therefore we supported the Centers for Medicare and Medicaid Services in reviewing their current policy to make a broader coverage determination possible. CMS policy is currently based upon old 2012 guidance, but your committees did not wish to exclude the possibility that these are actively

being updated. ACOG did not note any barriers to coverage encountered by their members, but a reasonable step would be to encourage CMS to update its guidance. Your committees felt that this was most in-line with existing policy “Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971” so the suggested language was added as a third resolved clause. The first resolved clause also lacked inclusive language using the term “women” for cervical cancer and breast screening, so made relevant amendments.

For the second resolved clause, your committees recommend striking it in its entirety. National incentives were not considered to be a viable strategy for increasing one modality of screening over another. Previous examples of incentives in Medicaid programs have rather been isolated to value-based care initiatives to improve screening overall, such as for colon cancer screening, or to encourage individual beneficiaries to adopt healthy practices.^{54,55} These are distinct from larger efforts to incentivize Medicaid expansion. Also, these incentives would run the risk of violating anti-kickback statutes depending on the manufacturers of the HPV tests. There is neither sufficient evidence to support incentives for primary HPV testing over other methods in clinical practice nor a compelling precedent in Medicaid. Rather, incentives and ACO-based quality metrics do and should continue to include cancer screening. Our belief is that a CMS review of policy will encourage more Medicaid programs to follow suit and expand primary HPV in-office testing coverage.

For the final resolved clause, your committees appreciated the intent of additional research and seeking to promote health equity. We did note that the AMA is not a primary research organization nor a research funding organization. For these reasons we added clarification to encourage research from relevant stakeholders as there is precedent for doing this in other policies. We also added clarifying language of the compelling reason for further research. Your committees briefly discussed adopting internal MSS policy to this effect, but decided that the health equity implications were too great to not transmit.

CONCLUSION

In summary, your committees propose that the MSS advance the important issue of additional screening methods for cervical cancer as there are meaningful inequities between patient populations. This is in line with the MSS internal policy objective of “cultivating the delivery of equitable health care to diverse patient populations in a dynamic environment...” Recognizing that the arguments for primary HPV testing and self-sampling HPV testing are distinct, we propose the uncommon step of separating this report into two resolutions delineated by sub-sections.

RECOMMENDATIONS

Your Committee on Economics and Quality in Medicine and the Women in Medicine Committee recommend that the following recommendations be adopted and transmitted as separate resolutions to the AMA HOD and the remainder of this report is filed:

1) Your committees recommend amendment to existing policy Screening and Treatment for Breast and Cervical Cancer Risk Reduction H-55.971 in lieu of the first resolved clause:

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

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

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

3. Our AMA encourages efforts by the Centers for Medicare and Medicaid Services to evaluate and review their current cervical cancer screening policies in an effort to expand coverage for HPV testing including but not limited to primary HPV testing.

2) Your committees recommend amending by deletion of the second resolved clause as follows:

~~RESOLVED, That our AMA request the CMS to endorse national incentives for states to cover primary HPV testing by Medicaid, and be it further~~

3) Your committees recommend amending by addition and deletion of the third resolved clause as follows:

RESOLVED, That our AMA support further research by relevant stakeholders of HPV self-sampling in the U.S. to decrease health care disparities in ~~for~~ cervical cancer screening.

REFERENCES

1. Melnikow J, Henderson JT, Burda BU, Senger CA, Durbin S, Weyrich MS. Screening for Cervical Cancer With High-Risk Human Papillomavirus Testing: Updated Evidence Report and Systematic Review for the US Preventive Services Task Force. *JAMA*. 2018;320(7):687-705. doi:10.1001/jama.2018.10400
2. Fuzzell LN, Perkins RB, Christy SM, Lake PW, Vadaparampil ST. Cervical cancer screening in the United States: Challenges and potential solutions for underscreened groups. *Prev Med*. 2021;144:106400. doi:10.1016/j.ypmed.2020.106400
3. Suk R, Hong YR, Rajan SS, Xie Z, Zhu Y, Spencer JC. Assessment of US Preventive Services Task Force Guideline-Concordant Cervical Cancer Screening Rates and Reasons for Underscreening by Age, Race and Ethnicity, Sexual Orientation, Rurality, and Insurance, 2005 to 2019. *JAMA Netw Open*. 2022;5(1):e2143582. Published 2022 Jan 4. doi:10.1001/jamanetworkopen.2021.43582
4. Buskwofie A, David-West G, Clare CA. A Review of Cervical Cancer: Incidence and Disparities. *J Natl Med Assoc*. 2020;112(2):229-232. doi:10.1016/j.jnma.2020.03.002

5. Beavis AL, Gravitt PE, Rositch AF. Hysterectomy-corrected cervical cancer mortality rates reveal a larger racial disparity in the United States. *Cancer*. 2017;123(6):1044-1050. doi:10.1002/cncr.30507
6. United States Preventive Services Taskforce. Cervical cancer: Screening. Recommendation: Cervical Cancer: Screening. [https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening#:~:text=For%20women%20aged%2030%20to,combination%20with%20cytology%20\(cotesting\)](https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening#:~:text=For%20women%20aged%2030%20to,combination%20with%20cytology%20(cotesting)). Published August 21, 2018. Accessed March 27, 2022.
7. ACOG. Updated cervical cancer screening guidelines. <https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2021/04/updated-cervical-cancer-screening-guidelines>. Accessed March 27, 2022.
8. Foundation ABIM. American Academy of Family Physicians: Choosing wisely. Choosing Wisely | Promoting conversations between providers and patients. <https://www.choosingwisely.org/societies/american-academy-of-family-physicians/>. Published June 14, 2021. Accessed March 27, 2022.
9. American Cancer Society. The American Cancer Society Guidelines for the prevention and early detection of cervical cancer. <https://www.cancer.org/cancer/cervical-cancer/detection-diagnosis-staging/cervical-cancer-screening-guidelines.html>. Accessed March 27, 2022
10. Fontham ETH, Wolf AMD, Church TR, et al. Cervical cancer screening for individuals at average risk: 2020 guideline update from the American Cancer Society. *CA Cancer J Clin*. 2020;70(5):321-346. doi:10.3322/caac.21628
11. Bosch FX, Manos MM, Muñoz N, et al. Prevalence of human papillomavirus in cervical cancer: a worldwide perspective. International biological study on cervical cancer (IBSCC) Study Group. *J Natl Cancer Inst*. 1995;87(11):796-802. doi:10.1093/jnci/87.11.796
12. Walboomers JM, Jacobs MV, Manos MM, et al. Human papillomavirus is a necessary cause of invasive cervical cancer worldwide. *J Pathol*. 1999;189(1):12-19. doi:10.1002/(SICI)1096-9896(199909)189:1<12::AID-PATH431>3.0.CO;2-F
13. de Sanjose S, Quint WG, Alemany L, et al. Human papillomavirus genotype attribution in invasive cervical cancer: a retrospective cross-sectional worldwide study. *Lancet Oncol*. 2010;11(11):1048-1056. doi:10.1016/S1470-2045(10)70230-8
14. Lei J, Ploner A, Elfström KM, et al. HPV Vaccination and the Risk of Invasive Cervical Cancer. *N Engl J Med*. 2020;383(14):1340-1348. doi:10.1056/NEJMoa1917338
15. US Preventive Services Task Force, Curry SJ, Krist AH, et al. Screening for Cervical Cancer: US Preventive Services Task Force Recommendation Statement. *JAMA*. 2018;320(7):674-686. doi:10.1001/jama.2018.10897
16. Yeh PT, Kennedy CE, de Vuyst H, Narasimhan M. Self-sampling for human papillomavirus (HPV) testing: a systematic review and meta-analysis. *BMJ Glob Health*. 2019;4(3):e001351. Published 2019 May 14. doi:10.1136/bmjgh-2018-001351
17. Kamal M. Pap Smear Collection and Preparation: Key Points. *Cytojournal*. 2022;19:24. Published 2022 Mar 29. doi:10.25259/CMAS_03_05_2021
18. Koliopoulos G, Nyaga VN, Santesso N, et al. Cytology versus HPV testing for cervical cancer screening in the general population. *Cochrane Database Syst Rev*. 2017;8(8):CD008587. Published 2017 Aug 10. doi:10.1002/14651858.CD008587.pub2
19. Arbyn M, Verdoodt F, Snijders PJ, et al. Accuracy of human papillomavirus testing on self-collected versus clinician-collected samples: a meta-analysis. *Lancet Oncol*. 2014;15(2):172-183. doi:10.1016/S1470-2045(13)70570-9
20. Snijders PJ, Verhoef VM, Arbyn M, et al. High-risk HPV testing on self-sampled versus clinician-collected specimens: a review on the clinical accuracy and impact on population

- attendance in cervical cancer screening. *Int J Cancer*. 2013;132(10):2223-2236. doi:10.1002/ijc.27790
21. Bhatla N, Singhal S. Primary HPV screening for cervical cancer. *Best Pract Res Clin Obstet Gynaecol*. 2020;65:98-108. doi:10.1016/j.bpobgyn.2020.02.008
 22. Jin XW, Lipold L, Foucher J, et al. Cost-Effectiveness of Primary HPV Testing, Cytology and Co-testing as Cervical Cancer Screening for Women Above Age 30 Years. *J Gen Intern Med*. 2016;31(11):1338-1344. doi:10.1007/s11606-016-3772-5
 23. Felix JC, Lacey MJ, Miller JD, Lenhart GM, Spitzer M, Kulkarni R. The Clinical and Economic Benefits of Co-Testing Versus Primary HPV Testing for Cervical Cancer Screening: A Modeling Analysis. *J Womens Health (Larchmt)*. 2016;25(6):606-616. doi:10.1089/jwh.2015.5708
 24. Sefuthi T, Nkonki L. A systematic review of economic evaluations of cervical cancer screening methods. *Syst Rev*. 2022;11(1):162. Published 2022 Aug 9. doi:10.1186/s13643-022-02017-z
 25. Bains I, Choi YH, Soldan K, Jit M. Clinical impact and cost-effectiveness of primary cytology versus human papillomavirus testing for cervical cancer screening in England [published online ahead of print, 2019 Apr 24]. *Int J Gynecol Cancer*. 2019;ijgc-2018-000161. doi:10.1136/ijgc-2018-000161
 26. Castañón A, Rebolj M, Sasieni P. Is a delay in the introduction of human papillomavirus-based cervical screening affordable?. *J Med Screen*. 2019;26(1):44-49. doi:10.1177/0969141318800355
 27. Aarnio R, Östensson E, Olovsson M, Gustavsson I, Gyllenstein U. Cost-effectiveness analysis of repeated self-sampling for HPV testing in primary cervical screening: a randomized study. *BMC Cancer*. 2020;20(1):645. Published 2020 Jul 13. doi:10.1186/s12885-020-07085-9
 28. Malone C, Barnabas RV, Buist DSM, Tiro JA, Winer RL. Cost-effectiveness studies of HPV self-sampling: A systematic review. *Prev Med*. 2020;132:105953. doi:10.1016/j.ypmed.2019.105953
 29. Huff C. NIH Spearheads Study to Test At-Home Screening for HPV and Cervical Cancer. KHN. (2020). <https://khn.org/news/nih-spearheads-study-to-test-at-home-screening-for-hpv-and-cervical-cancer/>
 30. Biddell CB, Spees LP, Smith JS, et al. Perceived Financial Barriers to Cervical Cancer Screening and Associated Cost Burden Among Low-Income, Under-Screened Women. *J Womens Health (Larchmt)*. 2021;30(9):1243-1252. doi:10.1089/jwh.2020.8807
 31. Human papillomavirus (HPV) self-sampling as part of cervical cancer screening. World Health Organization. <https://www.who.int/publications-detail-redirect/WHO-SRH-2012>. Accessed March 27, 2022.
 32. Gupta S, Palmer C, Bik EM, et al. Self-Sampling for Human Papillomavirus Testing: Increased Cervical Cancer Screening Participation and Incorporation in International Screening Programs. *Front Public Health*. 2018;6:77. Published 2018 Apr 9. doi:10.3389/fpubh.2018.00077
 33. Nishimura H, Yeh PT, Oguntade H, Kennedy CE, Narasimhan M. HPV self-sampling for cervical cancer screening: a systematic review of values and preferences. *BMJ Glob Health*. 2021;6(5):e003743. doi:10.1136/bmjgh-2020-003743
 34. Huynh J, Howard M, Lytwyn A. Self-collection for vaginal human papillomavirus testing: systematic review of studies asking women their perceptions. *J Low Genit Tract Dis*. 2010;14(4):356-362. doi:10.1097/LGT.0b013e3181dc115b
 35. KFF. Medicaid Coverage of Family Planning Benefits: Findings from a 2021 State Survey. <https://files.kff.org/attachment/medicaid-coverage-of-family-planning-benefits-findings-from-a-2021-state-survey.pdf>. Updated 2022. Accessed September 21, 2022
 36. KFF. States That Have Expanded Eligibility for Coverage of Family Planning Services Under Medicaid. <https://www.kff.org/medicaid/state-indicator/family-planning-services->

- [waivers/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D">waivers/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D](#) Updated 2021. Accessed September 21, 2002
37. American Cancer Society. Cervical Cancer Prevention and Screening: Financial Issues. <https://www.cancer.org/cancer/cervical-cancer/detection-diagnosis-staging/prevention-screening-financial-issues.html#:~:text=By%20statute%20or%20agency%20policy,or%20on%20a%20doctor%27s%20recommendation>. Updated 2020. Accessed September 21, 2022
 38. KFF. Status of State Medicaid Expansion Decisions: Interactive Map. <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>. Updated 2022. Accessed September 21, 2022
 39. Arkansas Department of Health. Breastcare Eligibility and Services . <https://www.healthy.arkansas.gov/programs-services/topics/breastcare-eligibility-and-services>. Accessed September 21, 2022
 40. Georgia Department of Public Health. Breast and Cervical Program. <https://dph.georgia.gov/BCCP#:~:text=Eligibility,ages%20of%2040%20and%2064>. Updated 2021. Accessed September 21, 2022
 41. Team Kentucky. Women's Cancer Screening. <https://chfs.ky.gov/agencies/dph/dwh/Pages/cancerscreening.aspx>. Accessed September 21, 2022.
 42. Minnesota Department of Public Health. Sage Cancer Screenings Covered Services and Eligibility. <https://www.health.state.mn.us/diseases/cancer/sage/services/index.html>. Updated 2022. Accessed September 21, 2022
 43. Nebraska Department of Health and Human Services. Every Woman Matters State Pap Plus Program. <https://dhhs.ne.gov/Pages/EWM-Pap-Plus.aspx>. Access September 21, 2022
 44. NH Health Live Breast and Cervical Cancer Program. New Hampshire Breast and Cervical Cancer Program Policy and Procedure Manual <https://dhhs.ne.gov/Pages/EWM-Pap-Plus.aspx>. Published 2021. Accessed September 21, 2022
 45. New Mexico Department of Health. Breast and Cervical Cancer Early Detection Program. <https://www.nmhealth.org/about/phd/pchb/bcc/>. Accessed September 21, 2022.
 46. Ohio Department of Health. BCCP Direct Services. <https://odh.ohio.gov/know-our-programs/breast-cervical-cancer-project/direct-services>. Accessed September 21, 2022
 47. AWC!. All Women Count! Program- December 2021 FAQ. https://getscreened.sd.gov/documents/AWC_FAQs.pdf. Updated 2021. Accessed September 21, 2022
 48. US Department of Health and Human Services. National breast and cervical cancer early detection program. Atlanta, GA: US Department of Health and Human Services, Centers for disease control and prevention. 1997
 49. Centers for Medicaid and Medicare Services. Screening Pap Tests & Pelvic Exams. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Screening-papPelvic-Examinations.pdf>. Updated 2021. Accessed September 21, 2022
 50. Centers for Medicaid and Medicare Services. Screening for Cervical Cancer with Human Papillomavirus (HPV). <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCID=365&NCDver=1>. Updated 2016. Accessed September 21, 2022
 51. USPSTF. Colorectal Cancer: Screening. <https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening>. Updated 2021. Accessed September 21, 2022

52. Hol L, van Leerdam ME, van Ballegooijen M, et al. Screening for colorectal cancer: randomised trial comparing guaiac-based and immunochemical faecal occult blood testing and flexible sigmoidoscopy. *Gut*. 2010;59(1):62-68. doi:10.1136/gut.2009.177089
53. Huff C. NIH Spearheads Study to Test At-Home Screening for HPV and Cervical Cancer. KHN. (2020). <https://khn.org/news/nih-spearheads-study-to-test-at-home-screening-for-hpv-and-cervical-cancer/>
54. National Colorectal Cancer Roundtable. Improving Colorectal Cancer Screening Rates A Promising Practices Guide for State-Medicaid Agencies. https://nc crt.org/wp-content/uploads/dlm_uploads/Promising-Practices-for-State-Medicaid-Agencies-v08.pdf. Updated 2018. Accessed September 21, 2022.
55. Health and Human Services. Medicaid Incentives for Prevention of Chronic Disease Evaluation. https://innovation.cms.gov/files/reports/mipcd_rtc.pdf. Updated 2013. Accessed September 21, 2022.

Relevant AMA Policy

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.

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

1. Our AMA supports programs to screen all women for breast and cervical cancer and that government funded programs be available for low income women; the development of public information and educational programs with the goal of informing all women about routine cancer screening in order to reduce their risk of dying from cancer; and increased funding for comprehensive programs to screen low income women for breast and cervical cancer and to assure access to definitive treatment.
2. Our AMA encourages state and local medical societies to monitor local public health screening programs to ensure that they are linked to treatment resources in the public or private sector.

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.

Cancer and Health Care Disparities Among Minority Women D-55.997

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

Health Insurance Differences Contribute to Health Care Disparities and Poorer Outcomes H-185.943

Our AMA affirms its support for elimination of health care disparities caused by differential treatment based on insurance status of Americans.

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.

Reducing Racial and Ethnic Disparities in Health Care D-350.995

Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations:

- (1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care.
- (2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities.
- (3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities.

Non-Cervical HPV Associated Cancer Prevention 55.008MSS

Our AMA-MSS will ask our AMA to: (1) support legislation and funding for research aimed towards discovering screening methodology and early detection methods for other non-cervical HPV associated cancers; and (2) amend policy H-440.872, HPV Vaccine and Cervical Cancer Prevention Worldwide, by addition and deletion as follows:

HPV VACCINE AND ~~CERVICAL~~-CANCER PREVENTION WORLDWIDE, H-440.872

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine ~~cervical~~ cancer screening for those at risk; 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, in all individuals regardless of sex, such as, but not limited to cervical cancer, head and neck cancer, anal cancer, and penile cancer, 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 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.
4. Our AMA encourage appropriate stakeholders to investigate means to increase HPV vaccinations by: (a) facilitating administration of HPV vaccinations in community-based setting including school settings, and (b) supporting state mandates for HPV vaccination for school attendance.

Increasing HPV Education 170.008MSS

AMA-MSS will ask the AMA to: (1) support specific teaching concerning transmission and sequelae in STD education; and (2) reaffirm a commitment to specific HIV and general STD education.

Human Papillomavirus (HPV) Inclusion in High School Health Education Curricula 170.011MSS

AMA-MSS will ask the AMA to strongly urge existing school health education programs to emphasize the high incidence of human papillomavirus and to discuss the importance of routine pap smears in the prevention of cervical cancer.

Comprehensive Human Papillomavirus (HPV) and Vaccination Education in School Health Curricula 170.019MSS

(1) AMA-MSS encourages school health education programs to emphasize not only HPV association with cervical cancer and genital warts, but also penile, vaginal, vulvar, oropharyngeal, and anal cancers; and (2) AMA-MSS encourages HPV and HPV vaccination school education be more targeted to students at the recommended age of vaccination.

HPV Vaccination Access for Minors 440.038MSS

AMA-MSS will ask the AMA to develop and support model legislation allowing HPV vaccination consent by an unemancipated minor, independent of parental involvement.

Emphasizing the Human Papillomavirus Vaccine as Anti-Cancer Prophylaxis for a Gender-Neutral Demographic 440.065MSS

AMA-MSS will ask the AMA to 1) acknowledge HPV Vaccines as beneficial to all genders as anti-cancer and anti-STI; and (2) support appropriate stakeholders to increase public awareness of HPV vaccines effectiveness against both HPV-related cancers and STIs.

REPORT OF THE MEDICAL STUDENT SECTION
Committee on Medical Education

MSS CME Report A
I-22

Introduced by: MSS Committee on Medical Education

Subject: Residency Application Support for Students of Low-Income Backgrounds

Referred to: MSS Reference Committee
(Revati Gummaluri and Bennett Vogt, Co-Chairs)

INTRODUCTION

At the 2021 MSS Interim Meeting, resolution 55 asked the AMA for the creation of a Fee Assistance Program for ERAS and/or funding opportunities for students of low income backgrounds as they apply for residency. The resolved clause referred to study was as follows:

RESOLVED, That our AMA supports 1) The creation of a Fee Assistance Program for ERAS and or funding opportunities for students of low-income backgrounds as they apply for residency. 2) Encouraging medical schools to provide similar funding opportunities and or scholarships for students of low-income backgrounds for their residency applications.

The AMA-MSS supported the spirit of the resolution. However, testimony on the VRC was generally supportive, with notable concern regarding the logistics of the AMA developing this type of program. The Medical Student Section Reference Committee asked the 2022-2023 Committee of Medical Education (CME) to conduct a study and produce a report for the 2022 MSS Interim Meeting.

BACKGROUND

Fee assistance programs in medical training

The Association of American Medical Colleges (AAMC) and American Association of Colleges of Osteopathic Medicine (AACOM) have long offered fee assistance programs (FAPs) to mitigate costs of medical school applications for students from low-socioeconomic status (low-SES). Each association's FAP typically covers primary application service fees and access to online databases of medical school information or interview advice.¹ The AAMC program goes further, subsidizing the not-insignificant prices of test preparation as well as applications to ≤ 20 medical schools.²

These programs have been critical in increasing the number of applicants and matriculants to medical school who normally face economic barriers to entering medicine.³ The eligibility criteria has expanded over the years: as of 2022, the AAMC's US-based FAP requires applicants to have a permanent US address (includes deferred action for childhood arrival (DACA) students), to make less than 400% of Federal Poverty Level as a household, and if under 26 years of age, to submit parental financial documents.⁴ There is a separate AAMC program for Canadians planning to take the MCAT.⁵ AAMC staff review applications for both, which are funded privately by the AAMC. AACOM's FAP is first-come, first-serve with similar income criteria, though individual schools may provide coupon codes to help subsidize application costs.⁶

In contrast to medical school applications, there has never been a fee assistance program for the undergraduate medical education (UME) to graduate medical education (GME) transition.

Applying for residency is a multi-step process with multifactorial costs, including board exam fees from the National Board of Medical Examiners (NBME) and National Board of Osteopathic Medical Examiners (NBOME), away rotations expenses, fees for the Electronic Residency Application Service (ERAS), National Resident Matching Program (NRMP), SF (ophthalmology) Match, or Urology Match, and overall interview costs.^{7,8}

NBME and NBOME have both offered rescheduling-fee waivers, made temporarily available to all examinees at the beginning of the COVID-19 pandemic. Neither, however, fully waive the cost of the United States Medical Licensing Examination (USMLE) Step 1-3 nor the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 1-3, respectively, and NBME no longer offers the waiver for rescheduling. Costs of away rotations, often required by competitive specialties, are also borne by applicants. Those who are interested in away rotations must find funding earmarked visiting students, such as the Emergency Medicine Residents' Association (EMRA) away scholarship or the Ohio State University Underrepresented in Medicine Ear, Nose, Throat (OSU URM ENT) rotation scholarship.^{9,10} For direct application, interview, or match costs, neither the AAMC nor NRMP provide any form of financial assistance. Applicants must budget for these expenses by taking out extra student loans, applying for general medical student scholarships, or incurring credit card debt.¹¹

ERAS Application/Visiting Rotation Expenses

ERAS applications fees follow a stepwise model as the number of programs per specialty increases: the cost is a flat \$99 for the first ten programs, and every set of additional ten programs comes with a higher price per each.⁸ According to a survey of M.D. students analyzed by the AAMC FIRST team, interview costs range from \$1,000 to \$13,225, including travel, lodging, meals, etc., with a median value of approximately \$4,000. A separate survey of allopathic students found a single interview costs between \$250 and \$499 and the majority of respondents spent at least \$2500 in total.¹² It has been reported that around 72% of applicants have taken out some type of loan to finance residency application costs.

Speciality applications may operate on a different fee system than ERAS. The SF Match utilized a \$100 registration fee and a per-program fee that increased with additional program applications, ranging from \$6-\$35 per program. The urology match reports a \$75 registration fee. Of course, these are application-specific fees, and there will be similar outside costs, such as interviewing, to the main match. After a baseline fee, this trend of scaling application costs per program is a method to de-incentivize too many applications from one applicant.

Recently, many residency programs have begun to incorporate virtual interviews, which has benefited applicants and programs alike. In the past, many applicants have reported turning down interviews due to financial reasons. With the emergence of virtual interviews, 90% of applicants have reported lower spending and, on average, savings of \$3,000-\$8,000 per applicant. Program directors have also disclosed that virtual interviews have saved on expenses for the program. While virtual interviews do not affect the initial cost of applying, it does ultimately decrease the overall cost burden for applicants. According to one study of dermatology residency applicants, total residency application costs dropped from an average of \$8541 to \$1759 after the emergence of virtual interviews.

Preference signaling is being introduced for applicants to signal their top programs. Although there may be speculation of this helping reduce application numbers, the AAMC has stated "preference signaling does not affect the number of applications you submit". Based on current information, this is unlikely to reduce application numbers.

1 In regards to away rotations, a survey of applicants in the 2014-2015 academic year found that
2 the estimated cost of a single visiting rotation was \$958, including travel, housing, and
3 transportation.¹³ The average applicant spent around \$2000, and there many who spent
4 upwards of \$5,000 and \$10,000 on visiting rotations. The cost of applying to away rotations with
5 the AAMC's Visiting Student Learning Opportunities (VSLO) is \$15 for each application.¹⁴
6

7 Both the NRMP and AAMC have non profit 501(c)(3) status, making their tax information public.
8 From 2019 documentation, the NRMP has a \$1,966,237 net income. The AAMC reported a net
9 income of \$8,345,133 and a notable \$1,336,989 salary for their president/CEO. The AAMC's
10 ERAS fee revenue came to a total of \$116,670,173 in 2021.
11

12 **Current Policy**

13 In 2022, our AMA attests, "The costs of medical education should never be a barrier to the
14 pursuit of a career in medicine nor to the decision to practice in a given specialty" [H-305.925],
15 setting a foundation for financial support for medical students. Similarly, our AMA acknowledges
16 the financial burden of applying to residency programs [H-310.966]. Our AMA also makes a
17 commitment to support minorities in the health professions [H-350.978, D-295.963]. Policies [D-
18 200.985] and [H-350.979] specifically address the financial barriers that often ensue for
19 minorities and underrepresented populations in medicine.
20

21 Our AMA-MSS encourages equitable NRMP Match fee structure that appropriately reflects
22 actual costs [295.110MSS] and specifically supports adequate financial aid packages for
23 minority students which can include combinations of grants, loans, scholarships, or service-
24 obligated programs [295.005MSS]. Our AMA-MSS recognizes the financial burden associated
25 with applying to residency programs and thus supports study on mitigating costs associated with
26 residency interviews and the creation of resources for 4th year medical students aimed at
27 reducing the cost of interviewing for residency programs [305.083 MSS].
28

29 However, there currently does not exist any policies specifically addressing the costs of the
30 ERAS application that medical students are required to pay each year or any potential
31 frameworks to help alleviate those costs.
32

33 **DISCUSSION**

34 The ERAS earns the AAMC over \$116 million per year while costing each student an average of
35 \$1,600 for applications alone. This is a small part of the true cost of applying to residency, and
36 prior to virtual interviews this included everything from headshots and meals to flights and
37 hotels, with totals averaging approximately \$5,000.

38 While providing fee assistance for ERAS would provide little respite, financial support should be
39 expanded for students applying to specialties that require away rotations. The majority of
40 students doing these rotations are required to fund their own housing, meals, and transportation
41 and this comes at a significant burden and cost of up to thousands of dollars. Medical school
42 programs do not include these additional costs in their financial aid packages. This financial
43 barrier contributes to the lack of diversity in specialties such as orthopedic surgery,
44 neurosurgery, urology, emergency medicine, and otolaryngology. Individual residency programs
45 should work to increase their funding opportunities for away rotation applicants.
46

47 Additionally, as the AMA is mainly a lobbying body, it cannot create a fee assistance program
48 for the ERAS, which is housed by the AAMC. Nor can it exert influence over individual medical
49 schools to create their own funding avenues. In its current role, the AMA would be unable to
50 feasibly devote resources to the inception of a new program. However, the AMA is able to push
51 for relevant stakeholders to create a fee assistance program, such as the NRMP, AAMC, and
52 ERAS. Current AMA policy recognizes the increased cost of residency applications and

maintains that this cost should not hinder a student's access to medical education. AMA policy supports measures to lower the cost of a medical education, but cannot directly call for the creation of a new funding method either through ERAS or individual medical schools. Instead, the AMA can encourage stakeholders to create a fee assistance program, and hope that medical schools will reconsider their financial resource allocations, potentially opening up the avenue to fund away rotations and/or residency applications.

CONCLUSION

The cost of applying to residency programs and conducting away rotations represent a few of the several financial barriers that medical students experience throughout medical school. The average cost of applying to residency, with in-person interviews, may range between \$1,000 to \$13,225 and each away rotation may cost up to \$2000. With virtual interviews, the costs have greatly decreased to an average of \$2000 per applicant. Despite these costs, there are no fee assistance programs to help with the transition from undergraduate medical education to graduate medical education. The AMA recognizes the financial burden of residency applications and current policy is established that focuses on mitigating the cost of residency interviews. As such, it is important that there is a policy in place to financially support students from low-income backgrounds during the residency application process.

RECOMMENDATION

Your Committee on Medical Education recommends that the following recommendations are *adopted* as amended as follows and the remainder of this report is filed:

1. 1. RESOLVED, That our AMA ~~supports~~ advocate to relevant stakeholders for
1) The creation of a fee assistance or fee waiver program ~~Fee Assistance~~
~~Program for ERAS and or funding opportunities for to support~~ students of low-
income backgrounds as they apply for residency. 2) ~~Encouraging medical~~
~~schools to provide similar funding opportunities and or scholarships for students~~
~~of low income backgrounds for their residency applications.~~

References:

1. American Association of Colleges of Osteopathic Medicine. AACOMAS Application Fee Waiver .<https://www.aacom.org/become-a-doctor/how-to-apply-to-osteopathic-medical-college/application-fee-waiver>.
2. American Association of Medical Colleges. What are the benefits of fee assistance programs? <https://students-residents.aamc.org/fee-assistance-program/what-are-benefits-fee-assistance-program>.
3. Grbic D., Hafner-Eaton J. The AAMC Fee Assistance Program and Access to US Medical School. AAMC Analysis in Brief. 2014. <https://www.aamc.org/media/7576/download>.
4. American Association of Medical Colleges. Who is eligible to participate in fee assistance programs?<https://students-residents.aamc.org/fee-assistance-program/who-eligible-participate-fee-assistance-program>.
5. American Association of Medical Colleges. Fee assistance program for Canadian examinees. <https://students-residents.aamc.org/fee-assistance-program/fee-assistance-program-canadian-examinees>
6. American Association of Colleges of Osteopathic Medicine. AACOMAS application fees and fee waivers.https://help.liaisonedu.com/AACOMAS_Applicant_Help_Center/Starting_Your_A

ACOMAS_Application/Getting_Started_with_Your_AACOMAS_Application/02_AACOMAS_Application_Fees_and_Fee_Waivers.

7. American Association of Family Physicians. Money and the match.
<https://www.aafp.org/students-residents/medical-students/begin-your-medical-education/debt-management/the-match.html>.
8. American Association of Medical Colleges. The cost of applying for medical residency.
<https://students-residents.aamc.org/financial-aid-resources/cost-applying-medical-residency>.
9. Emergency Medicine Residents' Association. Diversity oriented away/scholarship applications. <https://www.emra.org/students/advising-resources/apply-for-away-rotations/diversity-oriented-scholarship-programs/>.
10. The Department of Otolaryngology-Head and Neck Surgery at The Ohio State University Wexner Medical Center. Underrepresented in medicine away rotation scholarships.
https://medicine.osu.edu/-/media/files/medicine/departments/otolaryngology/medical-education/ent_212835074_awayrotationscholarshipflyer.pdf?la=en&hash=2044BEFEC6AFA7FCBF2A56E2D833E712383F29A7.
11. American Medical Association. Ways students can control residency application costs.
<https://www.ama-assn.org/medical-students/preparing-residency/ways-students-can-control-residency-application-costs>.
12. Fogel H., Liskutin T., Wu K., Nystrom L., Martin B., Schiff A. The Economic Burden of Residency Interviews on Applicants. Iowa Orthop J. 2018; 38:9-15.
13. Winterton M., Ahn J., Bernstein J. The prevalence and cost of medical student visiting rotations. BMC Med Educ. 2016 Nov 14;16(1):291.
14. American Association of Medical Colleges. VSLO frequently asked questions.
<https://students-residents.aamc.org/visiting-student-learning-opportunities/vslo-frequently-asked-questions>.

AMERICAN MEDICAL ASSOCIATION MEDICAL STUDENT SECTION ASSEMBLY

MSS Delegate Report B
(I-22)

Introduced by: Ryan Englander, Section Delegate; Brittany Ikwuagwu, Alternate Section Delegate

Subject: Policy Proceedings of the Annual 2022 House of Delegates Meeting

Pursuant to our Medical Student Section IOP 9.3, the following informational report details the actions taken by your Medical Student Section Delegates, MSS regional delegates and alternate delegates, and MSS Caucus (hereby described as “MSS Delegates”) at the Annual 2022 Meeting. MSS Delegates are advised to take a position on a business item where guided by our Section’s Compendium of Actions (“internal policy”). Should no relevant internal policy exist, our Caucus may decide to vote to take a stance based on internal discussion. Those particular instances are detailed in the report below.

RESOLUTIONS INTRODUCED BY THE MEDICAL STUDENT SECTION

1. Res. 004 - Encouraging LGBTQ+ Representation in Medicine

MSS Action: MSS Delegates supported the resolution. Friendly amendments to the title of the resolution were proposed by the Reference Committee and MSS Delegates supported the resolution as amended.

HOD Action: Resolution 004 was adopted as amended with a change to the title. Please see the [annotated AC&B Reference Committee Report](#) for additional information.

2. Res. 005 - Supporting the Study of Reparations as a Means to Reduce Racial Inequalities

MSS Action: MSS Delegates supported the original language in Resolution 005. The Reference Committee recommended referral for study. MSS Delegates extracted the resolution to try to adopt it or to ask for an earlier report back date.

HOD Action: Referred for study.

3. Res. 006 - Combating Natural Hair and Cultural Headwear Discrimination in Medicine and Medical Professionalism

MSS Action: MSS Delegates supported the resolution. Friendly amendments were proposed by the Reference Committee and MSS Delegates supported the amended language.

HOD Action: Resolution adopted as amended. Please see the [annotated AC&B Reference Committee Report](#) for additional information.

4. Res. 007 - Equal Access to Adoption for the LGBTQ Community

MSS Action: MSS Delegates supported the resolution in Reference Committee.

HOD Action: The Reference Committee recommended the resolution for adoption and it was adopted. Please see the [annotated AC&B Reference Committee Report](#) for additional information.

5. Res. 008 - Student-Centered Approaches for Reforming School Disciplinary Policies

MSS Action: MSS Delegates supported the resolution and an amendment was proffered in Reference Committee.

HOD Action: The amended language was adopted. Please see the [annotated AC&B Reference Committee Report](#) for additional information.

6. Res. 010 - Improving the Health and Safety of Sex Workers

MSS Action: MSS Delegates supported amendments offered by the Reference Committee and the final language.

HOD Action: The amended language was adopted. Please see the [annotated AC&B Reference Committee Report](#) for additional information.

7. Res. 011 - Evaluating Scientific Journal Articles for Racial and Ethnic Bias

MSS Action: MSS Delegates testified in support of the resolution in Reference Committee. The Reference Committee proposed an editorial amendment which was supported by MSS Delegates.

HOD Action: The amended language was adopted. Please see the [annotated AC&B Reference Committee Report](#) for additional information.

8. Res. 012 - Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions

MSS Action: MSS Delegates supported the language as initially transmitted during the Reference Committee. The Reference Committee recommended adoption of the first resolved clause and reaffirmation of the second resolved clause.

HOD Action: The amended language was adopted as recommended by the Reference Committee. Please see the [annotated AC&B Reference Committee Report](#) for additional information.

9. Res. 025 - Use of Social Media for Product Promotion and Compensation

MSS Action: MSS Delegates supported the original language, and the Reference Committee proffered a friendly amendment to broaden the language. This language was extracted and referred for study.

HOD Action: The resolution was referred for study. Please see the [annotated AC&B Reference Committee Report](#) for additional information.

10. Res. 027 - Expanding the Definition of Iatrogenic Infertility to Include Gender Affirming Interventions

MSS Action: MSS Delegates supported the language as initially transmitted during the Reference Committee. The Reference Committee recommended adoption of the resolution with amendments to keep sections of current policy that were struck by the resolution. These amendments did not affect the intent of the resolution, which MSS Delegates supported.

HOD Action: The amended language was adopted as recommended by the Reference Committee. Please see the [annotated AC&B Reference Committee Report](#) for additional information.

11. Res. 116 - Reimbursement of School-Based Health Centers

MSS Action: MSS Delegates supported the resolution as proposed and supported the amendments proffered by the Reference Committee.

HOD Action: Resolution 116 was adopted as amended. Please see the [annotated Reference Committee A Report](#) for additional information.

12. Res. 117 - Expanding Medicaid Transportation to Include Healthy Grocery Destinations

MSS Action: MSS Delegates supported the language as initially transmitted during the Reference Committee. Testimony was mixed, with concerns raised for feasibility and legality. The Reference Committee recommended reaffirmation, and the MSS extracted the item to propose alternative language that was designed to implement the spirit of the original language while addressing stakeholder concerns.

HOD Action: The alternative language proposed by the MSS was adopted by the HOD. Please see the [annotated Reference Committee A Report](#) for additional information.

13. Res. 118 - Caps on Insulin Co-Payments for Patients with Insurance

MSS Action: MSS Delegates supported the language as initially transmitted during the Reference Committee. The Reference Committee recommended amendments to broaden the resolved clauses to look at *all* costs associated with high insulin costs, including patient cost-sharing, which MSS Delegates supported.

HOD Action: The HOD adopted the amended language as proposed by the Reference Committee. Please see the [annotated Reference Committee A Report](#) for additional information.

14. Res. 119 - Medicare Coverage of Dental, Vision, and Hearing Services

MSS Action: MSS Delegates supported the resolution as originally transmitted. The Reference Committee recommended consideration of Resolution 113 (regarding hearing impairment, from SPS) and Resolution 114 (regarding dental benefits, also from SPS) alongside Resolution 119, and ultimately recommended substitute language for all three resolutions that did not include the bulk of the asks from Resolution 119. MSS Delegates noted that private testimony was in favor of the spirit of Resolution 119, but concerns over cost and how advocacy on Medicare benefit expansion might impact the AMA's push on improving

Medicare physician reimbursement in 2022 complicated the route to passage. MSS Delegates ultimately decided to refer an amendment that summarized the original asks of Resolution 119 to study.

HOD Action: The amendment to reflect the original resolved clauses of Resolution 119 was referred to study. Please see the [annotated Reference Committee A Report](#) for additional information.

15. Res. 203 - Ban the Gay/Trans (LGBTQ+) Panic Defense

MSS Action: MSS Delegates supported the resolution. The Reference Committee proffered minor amendments, which MSS Delegates also supported.

HOD Action: Resolution 203 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

16. Res. 209 - Supporting Collection of Data on Medical Repatriation

MSS Action: MSS Delegates supported the resolution. Testimony on the first resolved clause was mixed, and led to the Reference Committee recommending striking the first resolved clause.

HOD Action: Resolution 209 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

17. Res. 210 - Reducing the Prevalence of Sexual Assault by Testing Sexual Assault Evidence Kits

MSS Action: MSS Delegates supported the resolution. The Reference Committee proposed clarifying amendments, which MSS Delegates supported.

HOD Action: Resolution 209 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

18. Res. 216 - Advocating for the Elimination of Hepatitis C Treatment Restrictions

MSS Action: MSS Delegates supported the resolution. The Reference Committee proposed clarifying amendments to strengthen the original intent of the resolution, which MSS Delegates supported.

HOD Action: Resolution 216 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

19. Res. 230 - Advancing the Role of Outdoor Recreation in Public Health

MSS Action: MSS Delegates supported the resolution. The Reference Committee proposed amendments to the resolution, which MSS Delegates supported.

HOD Action: Resolution 230 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

20. Res. 231 - Amending Policy H-155.955: Increasing Accessibility to Incontinence Products to include Diaper Tax Exemption

MSS Action: MSS Delegates supported the resolution. The Reference Committee proposed clarifying amendments to the resolution, which MSS Delegates supported.

HOD Action: Resolution 231 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

21. Res. 232 - Expansion of Epinephrine Entity Stocking Legislation

MSS Action: MSS Delegates supported the resolution. The Reference Committee proposed clarifying amendments to the resolution, which MSS Delegates supported.

HOD Action: Resolution 232 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

22. Res. 233 - Support for Warning Labels on Firearm Ammunition Packaging

MSS Action: MSS Delegates supported the resolution. The Reference Committee proposed an amendment to support research instead of legislation. MSS Delegates extracted the resolution to oppose the amendment, and successfully led to passage of the original language.

HOD Action: Resolution 233 was adopted by the HOD. Please see the [annotated Reference Committee B Report](#) for additional information.

23. Res. 246 - Further Action to Respond to the Gun Violence Public Health Crisis

MSS Action: MSS Delegates supported the resolution. The Reference Committee proposed referring to decision. MSS Delegates extracted to oppose referral for decision. After defeating referral for decision, a subsequent motion was made to refer the item. MSS Delegates opposed referral, but were unsuccessful on an extremely close vote. Subsequent attempts were made to rally support for reconsideration of the item, but these efforts were unsuccessful and no allies or MSS Delegates moved to reconsider the item.

HOD Action: Resolution 246 was referred for report back at I-22.

24. Res. 247 - Recognizing Child Poverty and the Racial Wealth Gap as Public Health Issues and Extending the Child Tax Credit for Low-Income Families

MSS Action: MSS Delegates supported the resolution, which was considered alongside Resolution 228. The Reference Committee recommended adoption of Resolution 247 with clarifying amendments in lieu of Resolution 228, which MSS Delegates supported.

HOD Action: Resolution 247 was adopted as amended in lieu of Resolution 228. Please see the [annotated Reference Committee B Report](#) for additional information.

25. Res. 308 - University Land Grant Status in Medical School Admissions

MSS Action: MSS Delegates supported the resolution, which was recommended for referral for decision.

HOD Action: Resolution 308 was referred for decision. Please see the [annotated Reference Committee C Report](#) for additional information.

26. Res. 309 - Decreasing Bias in Evaluations of Medical Student Performance

MSS Action: MSS Delegates supported the resolution. The Reference Committee recommended clarifying amendments to the first resolved clause and referral of the second resolved clause, which originally asked for a study. MSS Delegates supported the amendments.

HOD Action: Resolution 309 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee C Report](#) for additional information.

27. Res. 310 - Decreasing Bias in Evaluations of Medical Student Performance

MSS Action: MSS Delegates supported the resolution, which the Reference Committee recommended for adoption..

HOD Action: Resolution 310 was adopted by the HOD. Please see the [annotated Reference Committee C Report](#) for additional information.

28. Res. 314 - Support for Institutional Policies for Personal Days for Undergraduate Medical Students

MSS Action: MSS Delegates supported the resolution. Concerns regarding feasibility and the impact on the quality of education were raised in Reference Committee testimony, which led to the item being recommended for referral.

HOD Action: Resolution 314 was referred for study. Please see the [annotated Reference Committee C Report](#) for additional information.

29. Res. 315 - Modifying Eligibility Criteria for the Association of American Medical Colleges' Financial Assistance Program

MSS Action: MSS Delegates supported the resolution. The Council on Medical Education offered clarifying amendments in Reference Committee testimony, which were ultimately recommended by the Reference Committee. MSS Delegates supported these amendments.

HOD Action: Resolution 315 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee C Report](#) for additional information.

30. Res. 323 - Cultural Leave for American Indian Trainees

MSS Action: MSS Delegates supported the resolution. Clarifying amendments were offered by the MSS Committee on American Indian Affairs and the Council on Medical Education, which were recommended by the Reference Committee. MSS Delegates supported these amendments.

HOD Action: Resolution 323 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee C Report](#) for additional information.

31. Res. 324 - Sexual Harassment Accreditation Standards for Medical Training Programs

MSS Action: MSS Delegates supported the resolution. The Reference Committee recommended clarifying amendments, which MSS Delegates supported.

HOD Action: Resolution 324 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee C Report](#) for additional information.

32. Res. 325 - Single Licensing Exam Series for Osteopathic and Allopathic Medical Students

MSS Action: MSS Delegates supported the resolution. The Reference Committee recommended clarifying amendments, which MSS Delegates supported.

HOD Action: Resolution 325 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee C Report](#) for additional information.

33. Res. 326 - Standardized Wellness Initiative Reporting

MSS Action: MSS Delegates supported the resolution, which was considered alongside Resolution 317. The Reference Committee recommended amendments to Resolution 326 and its adoption in lieu of Resolution 317. MSS Delegates supported the amendments.

HOD Action: Resolution 326 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee C Report](#) for additional information.

34. Res. 405 - Universal Childcare and Preschool

MSS Action: MSS Delegates supported the resolution. The Reference Committee proffered amendments to broaden the resolved clause. MSS Delegates supported these amendments.

HOD Action: Resolution 405 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

35. Res. 412 - Advocating for the Amendment of Chronic Nuisance Ordinances

MSS Action: MSS Delegates supported the resolution in Reference Committee testimony.

HOD Action: Resolution 412 was adopted by the HOD. Please see the [annotated Reference Committee D Report](#) for additional information.

36. Res. 413 - Expansion on Comprehensive Sexual Health Education

MSS Action: MSS Delegates supported the resolution, for which clarifying amendments were proffered by the Reference Committee. MSS Delegates supported these amendments.

HOD Action: Resolution 413 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

37. Res. 428 - Amending H-90.968 to Expand Policy on Medical Care of Persons with Disabilities

MSS Action: MSS Delegates supported the resolution in Reference Committee testimony.

HOD Action: Resolution 428 was adopted by the HOD. Please see the [annotated Reference Committee D Report](#) for additional information.

38. Res. 429 - Increasing Awareness and Reducing Consumption of Food and Drink of Poor Nutritional Quality

MSS Action: MSS Delegates supported the resolution in Reference Committee testimony.

HOD Action: Resolution 429 was adopted by the HOD. Please see the [annotated Reference Committee D Report](#) for additional information.

39. Res. 430 - Longitudinal Capacity-Building to Address Climate Action and Justice

MSS Action: MSS Delegates supported the resolution, which was considered alongside Resolution 420. The Reference Committee recommended adoption of Alternate Resolution 420, which contained key elements of Resolution 420 and 430. MSS Delegates supported these amendments.

HOD Action: Alternate Resolution 420 was adopted by the HOD. Please see the [annotated Reference Committee D Report](#) for additional information.

40. Res. 431 - Protections for Incarcerated Mothers and Infants in the Perinatal Period

MSS Action: MSS Delegates supported the resolution, for which clarifying amendments were proffered by the Reference Committee. MSS Delegates supported these amendments.

HOD Action: Resolution 431 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

41. Res. 432 - Recognizing Loneliness as a Public Health Issue

MSS Action: MSS Delegates supported the resolution in Reference Committee testimony.

HOD Action: Resolution 432 was adopted by the HOD. Please see the [annotated Reference Committee D Report](#) for additional information.

42. Res. 433 - Support for Democracy

MSS Action: MSS Delegates supported the resolution in Reference Committee testimony.

HOD Action: Resolution 433 was adopted by the HOD. Please see the [annotated Reference Committee D Report](#) for additional information.

43. Res. 434 - Support for Pediatric Siblings of Chronically Ill Children

MSS Action: MSS Delegates supported the resolution in Reference Committee testimony.

HOD Action: Resolution 434 was adopted by the HOD. Please see the [annotated Reference Committee D Report](#) for additional information.

44. Res. 435 - Support Removal of BMI as a Standard Measure in Medicine and Recognizing Culturally-Diverse and Varied Presentations of Eating Disorders

MSS Action: MSS Delegates supported the resolution in Reference Committee testimony. Reference Committee testimony was extremely mixed, and the Reference Committee recommended not adoption. MSS Delegates extracted the resolution and successfully argued for referral.

HOD Action: Resolution 435 was referred for study. Please see the [annotated Reference Committee D Report](#) for additional information.

45. Res. 436 - Training and Reimbursement for Firearm Safety Counseling

MSS Action: MSS Delegates supported the resolution, for which clarifying amendments were proffered by the Reference Committee. MSS Delegates supported these amendments.

HOD Action: Resolution 436 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

46. Res. 441 - Addressing Adverse Effects of Active Shooter Drills on Children's Healths

MSS Action: MSS Delegates supported the resolution, for which clarifying amendments were proffered by the Reference Committee. The Reference Committee also proffered an additional resolved clause to support research into the impact of active shooter drills on children's health. MSS Delegates supported these amendments.

HOD Action: Resolution 441 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

47. Res. 442 - Opposing the Censorship of Sexual and Gender Identity Discussions in Public Schools

MSS Action: MSS Delegates supported the resolution in Reference Committee testimony.

HOD Action: Resolution 442 was adopted by the HOD. Please see the [annotated Reference Committee D Report](#) for additional information.

48. Res. 443 - Addressing the Longitudinal Healthcare Needs of American Indian Children in Foster Care

MSS Action: MSS Delegates supported the resolution in Reference Committee testimony. A minor amendment was proffered by the Reference Committee, which MSS Delegates supported.

HOD Action: Resolution 443 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

49. Res. 520 - Addressing Informal Milk Sharing

MSS Action: MSS Delegates supported the resolution, for which amendments were proffered by the Reference Committee to clarify the language's intent. MSS Delegates supported these amendments.

HOD Action: Resolution 520 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee E Report](#) for additional information.

50. Res. 521 - Encouraging Brain and Other Tissue Donation for Research and Educational Purposes

MSS Action: MSS Delegates supported the resolution, for which clarifying amendments were proffered by the Reference Committee. MSS Delegates supported these amendments.

HOD Action: Resolution 521 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee E Report](#) for additional information.

51. Res. 522 - Encouraging Research of Testosterone and Pharmacological Therapies for Post-Menopausal Individuals with Decreased Libido

MSS Action: MSS Delegates supported the resolution in Reference Committee testimony.

HOD Action: Resolution 522 was adopted by the HOD. Please see the [annotated Reference Committee E Report](#) for additional information.

52. Res. 523 - Improving Research Standards, Approval Processes, and Post-Market Surveillance Standards for Medical Devices

MSS Action: MSS Delegates supported the resolution. Reference Committee testimony was mixed, with support offered for the spirit of the language but concerns raised about whether the original language was optimal or feasible. The Reference Committee recommended referral.

HOD Action: Resolution 523 was referred for study. Please see the [annotated Reference Committee E Report](#) for additional information.

53. Res. 524 - Increasing Access to Traumatic Brain Injury Resources in Primary Care Settings

MSS Action: MSS Delegates supported the resolution, for which amendments were proffered by the Reference Committee to clarify the language's intent. MSS Delegates supported these amendments.

HOD Action: Resolution 524 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee E Report](#) for additional information.

54. Res. 525 - Reforming the FDA Accelerated Approval Process

MSS Action: MSS Delegates supported the resolution, for which amendments were proffered by the Reference Committee to clarify the language's intent and reduce the prescriptivity of the first resolved clause. MSS Delegates supported these amendments.

HOD Action: Resolution 525 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee E Report](#) for additional information.

55. Res. 526 - Adoption of Accessible Medical Diagnostic Equipment Standards

MSS Action: MSS Delegates supported the resolution, for which amendments were proffered by the Reference Committee to clarify the language's intent and reduce the prescriptivity of the first resolved clause. MSS Delegates supported these amendments.

HOD Action: Resolution 526 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee E Report](#) for additional information.

56. Res. 615 - Anti-Harassment Training

MSS Action: MSS Delegates supported the resolution in Reference Committee testimony.

HOD Action: Resolution 615 was adopted by the HOD. Please see the [annotated Reference Committee F Report](#) for additional information.

57. Res. 616 - Medical Student, Resident/Fellow, and Physician Voting in Federal, State and Local Elections

MSS Action: MSS Delegates supported the resolution, for which amendments were proffered by the Reference Committee to clarify the intent of the first resolved clause. The Reference Committee also recommended striking the second resolved clause altogether. MSS Delegates extracted the resolution to add the second resolved clause back in, and also included residents, fellows, and other physicians alongside medical students in the new language.

HOD Action: Resolution 616 was adopted as amended, including the amendments to the first resolved clause proffered by the Reference Committee and the amendments proffered on the floor to add a second resolved clause (which was in the original language but had been recommended to be removed by the Reference Committee). Please see the [annotated Reference Committee F Report](#) for additional information.

58. Res. 617 - Study a Need-Based Scholarship to Encourage Medical Student Participation in the AMA

MSS Action: MSS Delegates supported the resolution, for which amendments were proffered by the Reference Committee to clarify the language's intent. MSS Delegates supported these amendments.

HOD Action: Resolution 617 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee F Report](#) for additional information.

59. Res. 625 - AMA Funding of Political Candidates who Oppose Research Backed Firearm Regulations

- MSS Action: MSS Delegates supported the resolution. The Reference Committee recommended referral of the item. MSS Delegates extracted this item and successfully argued for adoption of the original language.
- HOD Action: Resolution 625 was adopted by the HOD with a minor clarifying amendment to require that the public health measures referenced in the resolution must be evidence-based. Please see the [annotated Reference Committee F Report](#) for additional information.

ACTIONS ON ALL CONSIDERED REPORTS**1. BOT Report 1 – Annual Report**

- MSS Action: MSS Delegates took no position on this report.
- HOD Action: BOT Report 1 was filed. Please see the [annotated Reference Committee F Report](#) for additional information.

2. BOT Report 2 – New Specialty Organizations Representation in the House of Delegates

- MSS Action: MSS Delegates took no position on this report authorizing new specialty society representation in the House of Delegates.
- HOD Action: BOT Report 2 was adopted and filed. Please see the [annotated Reference Committee F Report](#) for additional information.

3. BOT Report 3 (informational) – 2021 Grants and Donations

- MSS Action: MSS Delegates supported this informational report.
- HOD Action: This report was filed.

4. BOT Report 4 – AMA 2023 Dues

- MSS Action: MSS Delegates took no position on this report.
- HOD Action: BOT Report 4 was filed and the recommendations were adopted. Please see the [annotated Reference Committee F Report](#) for additional information.

5. BOT Report 5 (informational) – Update on Corporate Relationships

- MSS Action: MSS Delegates took no position on this informational report.
- HOD Action: BOT Report 5 was filed.

6. BOT Report 6 (informational) – Redefining AMA's Position on ACA and Healthcare Reform

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: BOT Report 6 was filed.

7. BOT Report 7 (informational) – AMA Performance, Activities and Status in 2021

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: BOT Report 7 was filed.

8. BOT Report 8 (informational) – Annual Update on Activities and Progress in Tobacco Control: March 2021 through February 2022

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: BOT Report 8 was filed.

9. BOT Report 9 – Council on Legislation Sunset Review of 2012 House Policies

MSS Action: MSS Delegates took no position on this report.

HOD Action: The recommendations of BOT Report 9 were adopted. The remainder of the report was filed. Please see the [annotated Reference Committee B Report](#) for additional information.

10. BOT Report 10 (informational) – American Medical Association Center for Health Equity Annual Report

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: BOT Report 10 was filed.

11. BOT Report 11 – Procedure for Altering the Size or Composition of Section Governing Councils

MSS Action: MSS Delegates opposed the recommendations of this report.

HOD Action: BOT Report 11 was not adopted and the remainder of the report was filed. Please see the [annotated Reference Committee F Report](#) for additional information.

12. BOT Report 12 (informational) – Disaggregation of Demographic Data for Individuals of Middle Eastern and North African (MENA) Descent

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: BOT Report 12 was filed.

13. BOT Report 13 – Use of Psychiatric Advance Directives

MSS Action: MSS Delegates testified in Reference Committee to advocate for the inclusion of the original language that had been referred to the Board in Resolution 1-I-19, which was authored by the Medical Student Section. The Reference Committee

recommended that the original language be included in the Board's recommendations.

HOD Action: The recommendations of BOT Report 13 were adopted as amended by the Reference Committee and the remainder of the report was filed. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

14. BOT Report 14 – Amendment to Truth and Transparency in Pregnancy Counseling Centers, H-420.954

MSS Action: MSS Delegates testified in Reference Committee in support of this report, which was originally referred to the Board through Resolution 8-N-21, authored by the Medical Student Section. The Reference Committee proffered minor amendments to the fifth resolved clause.

HOD Action: The recommendations of BOT Report 14 were adopted as amended by the Reference Committee and the remainder of the report was filed. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

15. BOT Report 15 – Addressing Public Health Disinformation

MSS Action: MSS Delegates supported the recommendations of this report. The Reference Committee recommended re-referral, but the item was extracted and MSS Delegates supported the original recommendations.

HOD Action: The recommendations of BOT Report 15 were adopted. The remainder of the report was filed. Please see the [annotated Reference Committee F Report](#) for additional information.

16. BOT Report 16 – Language Proficiency Data of Physicians in the AMA Masterfile

MSS Action: MSS Delegates did not take a position on this report.

HOD Action: The recommendations of BOT Report 16 were adopted as amended by the Reference Committee. The remainder of the report was filed. Please see the [annotated Reference Committee F Report](#) for additional information.

17. BOT Report 17 – Expungement, Destruction, and Sealing of Criminal Records for Legal Offenses Related to Cannabis Use or Possession

MSS Action: This report was produced as a result of MSS-authored policy at the N-20 Special Meeting. MSS Delegates generally supported the recommendations of the report in Reference Committee but drew attention to the importance of including decriminalization as a trigger for expungement and specifically mentioning parole/probation, as these court-ordered requirements are distinct from expungement/record sealing. MSS Delegates extracted the report to amend these parameters from the original resolution into the language of the report.

HOD Action: The recommendations of BOT Report 17 were adopted by the HOD with MSS Delegate amendments and the remainder of the report was filed. Please see the [annotated Reference Committee B Report](#) for additional information.

18. BOT Report 18 – Addressing Inflammatory and Untruthful Online Ratings

MSS Action: MSS Delegates took no position on this report.

HOD Action: The recommendations of BOT Report 18 were adopted as amended by the Reference Committee. Please see the [annotated Reference Committee G Report](#) for additional information.

19. BOT Report 19 (informational) – Demographic Report of the House of Delegates and AMA Membership

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: BOT Report 19 was filed.

20. BOT Report 20 – Delegate Apportionment and Pending Members

MSS Action: MSS Delegates supported this report, which was considered alongside Resolution 618. MSS Delegates testified to include sections in the recommendations, which was not recommended by the reference committee.

HOD Action: Recommendation 1 of BOT Report 20 was referred for decision, which Recommendations 2, 4, 5, and 6 were referred for study. Recommendation 3 of BOT Report 20 was adopted as amended in lieu of Resolution 618 and the remainder of the report was filed. Please see the [annotated Reference Committee F Report](#) for additional information.

21. BOT Report 21 – Opposition to Requirements for Gender-Based Treatments for Athletes

MSS Action: MSS Delegates supported this report. The Reference Committee recommended referral, which MSS Delegates also supported.

HOD Action: BOT Report 21 was referred for study. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

22. BOT Report 22 – Nonconsensual Audio/Video Recording at Medical Encounters

MSS Action: MSS Delegates took no position on this report.

HOD Action: BOT Report 22 was adopted by the HOD and the remainder of the report was filed. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

23. BOT Report 23 – Specialty Society Representation in the House of Delegates - Five-Year Review

MSS Action: MSS Delegates took no position on this report.

HOD Action: BOT Report 23 was adopted by the HOD and the remainder of the report was filed. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

24. Speakers Report 1 (informational) – Recommendations for Policy Reconciliation

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: The reconciliations of Speakers Report 1 were accomplished, and the remainder of the report was filed.

25. Compensation Committee Report 1 – Report of the House of Delegates Committee on the Compensation of the Officers

MSS Action: MSS Delegates took no position on this report.

HOD Action: The report was adopted by the HOD and the remainder filed. Please see the [annotated Reference Committee F Report](#) for additional information.

26. CCB Report 1 – Clarification to the Bylaws: Delegate Representation

MSS Action: MSS Delegates supported the report's recommendations, which made clarifying amendments to the Bylaws regarding MSS Regional Delegate representation but avoided making MSS Regional Delegates beholden to their endorsing state medical society.

HOD Action: CCB Report 1 was adopted as amended by the Reference Committee and the remainder of the report was filed. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

27. Joint CCB/CLRPD Report 1 – Joint Council Sunset Review of 2012 House Policies

MSS Action: MSS Delegates spoke to this report in Reference Committee to highlight some of the policies recommended to be rescinded. MSS Delegates supported the report as amended by the Reference Committee.

HOD Action: Joint CCB/CLRPD Report 1 was adopted as amended by the Reference Committee, and the remainder of the report was filed. Please see the [annotated Reference Committee F Report](#) for additional information.

28. CEJA Report 1 – Short-Term Medical Service Trips

MSS Action: MSS Delegates supported referral of this report.

HOD Action: CEJA Report 1 was referred for study. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

29. CEJA Report 2 – Amendment to Opinion 10.8, Collaborative Care

MSS Action: MSS Delegates took no position on the report.

HOD Action: CEJA Report 2 was referred for study. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

30. CEJA Report 3 – Amendment to E-9.3.2, Physician Responsibilities to Colleagues with Illness, Disability or Impairment

MSS Action: MSS Delegates took no position on the report.

HOD Action: CEJA Report 3 was adopted by the HOD and the remainder of the report was filed. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

31. CEJA Report 4 – CEJA's Sunset Review of 2012 House Policies

MSS Action: MSS Delegates took no position on the report.

HOD Action: CEJA Report 4 was adopted by the HOD and the remainder of the report was filed. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

32. CEJA Report 5 (informational) – Pandemic Ethics and the Duty of Care (D-130.960)

MSS Action: MSS Delegates took no position on this informational report.

HOD Action: CEJA Report 5 was filed.

33. CEJA Report 6 (informational) – Judicial Function of the Council on Ethical and Judicial Affairs - Annual Report

MSS Action: MSS Delegates took no position on the report.

HOD Action: CEJA Report 6 was filed.

34. CEJA Opinion 1 – Amendment to E-1.1.6, Quality

MSS Action: MSS Delegates took no position on the opinion.

HOD Action: CEJA Opinion 1 was filed.

35. CEJA Opinion 2 – Amendment to E-1.2.11, Ethical Innovation in Medical Practice

MSS Action: MSS Delegates took no position on the opinion.

HOD Action: CEJA Opinion 2 was filed.

36. CEJA Opinion 3 – Amendment to E-11.1.2, Physician Stewardship of Health Care Resources

MSS Action: MSS Delegates took no position on the opinion.

HOD Action: CEJA Opinion 3 was filed.

37. CEJA Opinion 4 – Amendment to E-11.2.1, Professionalism in Health Care Systems

MSS Action: MSS Delegates took no position on the opinion.

HOD Action: CEJA Opinion 4 was filed.

38. CME Report 1 – Council on Medical Education Sunset Review of 2012 House Policies

MSS Action: MSS Delegates supported this report.

HOD Action: CME Report 1 was adopted by the HOD and the remainder of the report was filed. Please see the [annotated Reference Committee C Report](#) for additional information.

39. CME Report 2 – An Update on Continuing Board Certification

MSS Action: MSS Delegates took no position on this report.

HOD Action: CME Report 2 was adopted as amended by the Reference Committee and the remainder of the report was filed. Please see the [annotated Reference Committee C Report](#) for additional information.

40. CME Report 3 – Onsite and Subsidized Childcare for Medical Students, Residents and Fellows

MSS Action: MSS Delegates supported this report, which was generated from language introduced by the RFS (Resolution 304-J-21, Resolve 3) at the J-21 Special Meeting.

HOD Action: CME Report 3 was adopted by the HOD and the remainder of the report was filed. Please see the [annotated Reference Committee C Report](#) for additional information.

41. CME Report 4 – Protection of Terms Describing Physician Education and Practice

MSS Action: MSS Delegates supported this report.

HOD Action: CME Report 4 was adopted as amended by the Reference Committee and the remainder of the report was filed. Please see the [annotated Reference Committee C Report](#) for additional information.

42. CME Report 5 – Education, Training and Credentialing of Non-Physician Health Care Providers and Their Impact on Physician Education and Training

MSS Action: MSS Delegates supported this report.

HOD Action: CME Report 5 was adopted as amended by the Reference Committee and the remainder of the report was filed. Please see the [annotated Reference Committee C Report](#) for additional information.

43. CME Report 6 – Clinical Applications of Pathology and Laboratory Medicine for Medical Students, Residents and Fellows

MSS Action: MSS Delegates supported this report, which had resolved clauses that were similar to a pending MSS transmittal.

HOD Action: CME Report 6 was adopted as amended by the Reference Committee and the remainder of the report was filed. Please see the [annotated Reference Committee C Report](#) for additional information.

44. CMS Report 1 – Council on Medical Service Sunset Review of 2012 House Policies

MSS Action: MSS Delegates supported this report.

HOD Action: CMS Report 1 was adopted and the remainder of the report was filed. Please see the [annotated Reference Committee G Report](#) for additional information.

45. CMS Report 2 – Prospective Payment Model Best Practices for Independent Private Practice

MSS Action: MSS Delegates supported the recommendations of this report.

HOD Action: The recommendations of CMS Report 2 were adopted as amended by the Reference Committee and the remainder of the report was filed. Please see the [annotated Reference Committee G Report](#) for additional information.

46. CMS Report 3 – Preventing Coverage Losses After the Public Health Emergency Ends

MSS Action: MSS Delegates supported this report.

HOD Action: CMS Report 3 was adopted as amended by the Reference Committee and the remainder of the report was filed. Please see the [annotated Reference Committee A Report](#) for additional information.

47. CMS Report 4 – Parameters of Medicare Drug Price Negotiation

MSS Action: MSS Delegates supported amending this report to remove limitations on international reference price (IRP) basket countries not being from countries utilizing single payer or price controls, as amended in a pending MSS transmittal. MSS Delegates also supported amendments proffered by California that would have provided support for specific IRP schema in Medicare Parts B and D. The Reference Committee recommended removing limitations on IRP basket countries, which MSS Delegates supported.

HOD Action: CMS Report 4 was adopted as amended by the Reference Committee and the remainder of the report was filed. Please see the [annotated Reference Committee A Report](#) for additional information.

48. CMS Report 5 – Poverty-Level Wages and Health

MSS Action: MSS Delegates supported the spirit of the report, but proffered amendments in Reference Committee testimony to strengthen the language supporting inflation adjustments for the minimum wage, and to remove language that would have over-emphasized potential disadvantages with supporting the minimum wage. The Reference Committee proffered suitable amendments which MSS Delegates supported.

HOD Action: CMS Report 5 was adopted as amended by the Reference Committee and the remainder of the report was filed. Please see the [annotated Reference Committee G Report](#) for additional information.

49. CSAPH Report 1 – Council on Science and Public Health Sunset Review of 2012 HOD Policies

MSS Action: MSS Delegates supported this report.

HOD Action: CSAPH Report 1 was adopted and the remainder of the report was filed. Please see the [annotated Reference Committee D Report](#) for additional information.

50. CSAPH Report 2 – Transformation of Rural Community Public Health Systems

MSS Action: MSS Delegates supported this report via Caucus vote, as there was insufficient supportive MSS policy to support the report otherwise.

HOD Action: CSAPH Report 2 was adopted by the HOD and the remainder of the report was filed. Please see the [annotated Reference Committee D Report](#) for additional information.

51. CSAPH Report 3 – Correcting Policy H-120.958

MSS Action: MSS Delegates supported this report.

HOD Action: CSAPH Report 3 was adopted by the HOD and the remainder of the report was filed. Please see the [annotated Reference Committee D Report](#) for additional information.

ACTIONS ON ALL OTHER RESOLUTIONS**1. Res. 001 – Increasing Public Umbilical Cord Blood-Donations in Transplant Centers**

MSS Action: MSS Delegates supported this resolution proffered by the YPS.

HOD Action: Resolution 001 was adopted with amendments proffered by the Reference Committee. In addition, the first resolved clause was referred. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

2. Res. 002 - Opposition to Discriminatory Treatment of Haitian Asylum Seekers

MSS Action: MSS Delegates supported this resolution.

HOD Action: Resolution 002 was adopted by the HOD. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

3. Res. 003 - Gender Equity and Female Physician Work Patterns During the Pandemic

MSS Action: MSS Delegates supported this resolution.

HOD Action: Resolution 003 was adopted by the HOD. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

4. Res. 009 - Privacy Protection and Prevention of Further Trauma for Victims of Distribution of Intimate Videos and Images Without Consent

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Resolution 009 was adopted by the HOD. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

5. Res. 013 - Recognition of National Anti-Lynching Legislation as a Public Health Initiative

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 013 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

6. Res. 014 - Healthcare Equity Through Informed Consent and a Collaborative Healthcare Model for the Gender Diverse Population

MSS Action: MSS Delegates supported this resolution.

HOD Action: Resolution 014 was adopted as amended by the Reference Committee via an alternate resolution. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

7. Res. 015 - Increasing Mental Health Screenings by Refugee Resettlement Agencies and Improving Mental Health Outcomes for Refugee Women

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 015 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

8. Res. 016 - Addressing and Banning Unjust and Invasive Medical Procedures Among Migrant Women at the Border

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 016 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

9. Res. 017 - Humanitarian and Medical Aid Support to Ukraine

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 017 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

10. Res. 018 - Hardship for International Medical Graduates from Russia and Belarus

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Resolution 018 was adopted by the HOD. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

11. Res. 019 - Hardship for International Medical Graduates from Ukraine

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Resolution 019 was adopted by the HOD. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

12. Res. 020 - Council on Ethical and Judicial Affairs Guidelines for Treating Unvaccinated Individuals

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Resolution 020 was not adopted by the HOD. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

13. Res. 021 - National Cancer Research Patient Identifier

MSS Action: MSS Delegates supported the resolution due to tangentially supportive MSS policy.

HOD Action: Resolution 021 was referred for study. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

14. Res. 022 - Organ Transplant Equity for Persons with Disabilities

MSS Action: MSS Delegates supported the resolution after a Caucus vote.

HOD Action: Resolution 022 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

15. Res. 023 - Promoting and Ensuring Safe, High Quality, and Affordable Elder Care Through Examining and Advocating for Better Regulation of and Alternatives to the Current, Growing ForProfit Long Term Care Options

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 023 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

16. Res. 024 - Pharmaceutical Equity for Pediatric Populations

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 024 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

17. Res. 026 - Establishing Ethical Principles for Physicians Involved in Private Equity Owned Practices

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 024 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

18. Res. 028 - Preserving Access to Reproductive Health Services

MSS Action: MSS Delegates supported this resolution, which was prepared in response by RFS and several other Sections, including input from several MSS members, to the Supreme Court's decision to overturn *Roe v. Wade* in *Dobbs v. Jackson Women's Health Organization*.

HOD Action: Resolution 028 was adopted by the HOD. Please see the [annotated Reference Committee AC&B Report](#) for additional information.

19. Res. 101 - Fertility Preservation Benefits for Active-Duty Military Personnel

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 101 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee A Report](#) for additional information.

20. Res. 102 - Bundling Physician Fees with Hospital Fees

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 102. Please see the [Reaffirmation Consent Calendar](#) for additional information.

21. Res. 103 - COBRA for College Students

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Resolution 103 was not adopted by the HOD. Please see the [annotated Reference Committee A Report](#) for additional information.

22. Res. 104 - Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for Health Care Financing

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 104. Please see the [Reaffirmation Consent Calendar](#) for additional information.

23. Res. 105 - Health Insurance that Fairly Compensates Physicians

MSS Action: MSS Delegates supported this resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 105. Please see the [Reaffirmation Consent Calendar](#) for additional information.

24. Res. 106 - Hospice Recertification for Non-Cancer Diagnosis

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 106. Please see the [Reaffirmation Consent Calendar](#) for additional information.

25. Res. 107 - Medicaid Tax Benefits

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 107. Please see the [Reaffirmation Consent Calendar](#) for additional information.

26. Res. 108 - Payment for Regadenoson (Lexiscan)

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: The HOD adopted an alternate resolution in lieu of Resolution 108. Please see the [annotated Reference Committee A Report](#) for additional information.

27. Res. 109 - Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits

MSS Action: MSS Delegates supported this resolution.

HOD Action: Resolution 109 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee A Report](#) for additional information.

28. Res. 110 - Private Payor Payment Integrity

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Resolution 110 was referred for study. Please see the [annotated Reference Committee A Report](#) for additional information.

29. Res. 111 - Bundled Payments and Medically Necessary Care

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Resolution 111 was referred for study. Please see the [annotated Reference Committee A Report](#) for additional information.

30. Res. 112 - Support for Easy Enrollment Federal Legislation

MSS Action: MSS Delegates supported this resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 112. Please see the [Reaffirmation Consent Calendar](#) for additional information.

31. Res. 113 - Prevention of Hearing Loss-Associated-Cognitive-Impairment Through Earlier Recognition and Remediation

MSS Action: MSS Delegates supported this resolution. Supportive testimony was provided in Reference Committee, where this item was considered with Resolution 114 and Resolution 119. MSS Delegates supported the Alternate Resolution 113 proffered by the Reference Committee, except as pertaining to the asks specific to Resolution 119 which are documented elsewhere in this report.

HOD Action: Alternate Resolution 113 was adopted in lieu of Resolution 113. Please see the [annotated Reference Committee A Report](#) for additional information.

32. Res. 114 - Oral Healthcare IS Healthcare

MSS Action: As noted above, Resolution 114 was considered with Resolution 113 and Resolution 119. MSS Delegates supported the spirit of this resolution, but mostly spoke to the asks of Resolution 119.

HOD Action: Alternate Resolution 113 was adopted in lieu of Resolution 114. Please see the [annotated Reference Committee A Report](#) for additional information.

33. Res. 115 - Support for Universal Internet Access

MSS Action: MSS Delegates supported this resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 115. Please see the [Reaffirmation Consent Calendar](#) for additional information.

34. Res. 120 - Expanding Coverage for and Access to Pulmonary Rehabilitation

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Resolution 120 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee A Report](#) for additional information.

35. Res. 121 - Increase Funding, Research and Education for Post-Intensive Care Syndrome

MSS Action: MSS Delegates supported this resolution.

HOD Action: Resolution 121 was adopted by the HOD. Please see the [annotated Reference Committee A Report](#) for additional information.

36. Res. 122 - Medicaid Expansion

MSS Action: MSS Delegates supported this resolution.

HOD Action: Resolution 122 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee A Report](#) for additional information.

37. Res. 123 - Advocating for All Payer Coverage of Cosmetic Treatment for Survivors of Domestic Abuse and Intimate Partner Violence

MSS Action: MSS Delegates supported this resolution, and the alternate language proffered by the Reference Committee.

HOD Action: Alternate Resolution 123 was adopted in lieu of Resolution 123. Please see the [annotated Reference Committee A Report](#) for additional information.

38. Res. 124 - To Require Insurance Companies Make the "Coverage Year" and the "Deductible Year" Simultaneous for Their Policies

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 124. Please see the [annotated Reference Committee A Report](#) for additional information.

39. Res. 125 - Education, Forewarning and Disclosure Regarding Consequences of Changing Medicare Plans

MSS Action: MSS Delegates supported this resolution.

HOD Action: Resolution 125 was adopted by the HOD. Please see the [annotated Reference Committee A Report](#) for additional information.

40. Res. 126 - Providing Recommended Vaccines Under Medicare Parts B and C

MSS Action: MSS Delegates supported this resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 126. Please see the [Reaffirmation Consent Calendar](#) for additional information.

41. Res. 127 - Continuity of Care Upon Release from Correctional Systems

MSS Action: MSS Delegates supported this resolution.

HOD Action: Resolution 127 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee A Report](#) for additional information.

42. Res. 128 - Continuity of Care Upon Release from Correctional Systems

MSS Action: MSS Delegates supported this resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 128. Please see the [Reaffirmation Consent Calendar](#) for additional information.

43. Res. 201 - The Impact of Midlevel Providers on Medical Education

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Resolution 201 was referred for study. Please see the [annotated Reference Committee B Report](#) for additional information.

44. Res. 202 - Redefining the Definition of Harm

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 202. Please see the [annotated Reference Committee B Report](#) for additional information.

45. Res. 203 - Ban the Gay/Trans (LGBTQ+) Panic Defense

MSS Action: MSS Delegates supported this resolution, which mirrored a pending MSS transmittal. Minor amendments were proffered by the Reference Committee, which MSS Delegates also supported.

HOD Action: Resolution 203 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

46. Res. 204 - Insurance Claims Data

MSS Action: MSS Delegates supported this resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 204. Please see the [Reaffirmation Consent Calendar](#) for additional information.

47. Res. 205 - Insurers and Vertical Integration

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Resolution 205 was not adopted by the HOD. Please see the [annotated Reference Committee B Report](#) for additional information.

48. Res. 206 - Medicare Advantage Plan Mandates

MSS Action: MSS Delegates supported this resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 206. Please see the [Reaffirmation Consent Calendar](#) for additional information.

49. Res. 207 - Physician Tax Fairness

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Resolution 207 was not adopted by the HOD. Please see the [annotated Reference Committee B Report](#) for additional information.

50. Res. 208 - Prohibit Ghost Guns

MSS Action: MSS Delegates supported this resolution in Reference Committee.

HOD Action: Resolution 208 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

51. Res. 211 - Repeal or Modification of the Medicare Appropriate Use Criteria (AUC) Program

MSS Action: MSS Delegates took no position on this resolution.

HOD Action: Alternate Resolution 211 was adopted in lieu of Resolution 211. Please see the [annotated Reference Committee B Report](#) for additional information.

52. Res. 212 - Medication for Opioid Use Disorder in Physician Health Programs

MSS Action: MSS Delegates supported this resolution.

HOD Action: Resolution 212 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

53. Res. 213 - Resentencing for Individuals Convicted of Marijuana-Based Offenses

MSS Action: MSS Delegates supported this resolution. The resolution was considered alongside BOT Report 17. MSS Delegates supported including the spirit of Resolution 213's resolved clauses in BOT Report 17.

HOD Action: BOT Report 17 as amended by the Reference Committee was adopted in lieu of Resolution 213. Please see the [annotated Reference Committee B Report](#) for additional information.

54. Res. 214 - Eliminating Unfunded or Unproven Mandates and Regulations

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 214. Please see the [Reaffirmation Consent Calendar](#) for additional information.

55. Res. 215 - Transforming Professional Licensure to the 21st Century

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 215. Please see the [annotated Reference Committee B Report](#) for additional information.

56. Res. 217 - Preserving the Practice of Medicine

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 217 was considered alongside Resolution 251. Resolves 2-6 of Resolution 217 and Resolves 1-3 of Resolution 251 were referred for decision. Resolution 217 was adopted as amended by the Reference Committee in lieu of Resolution 251. Please see the [annotated Reference Committee B Report](#) for additional information.

57. Res. 218 - Expedited Immigrant Green Card Visa for J-1 Visa Waiver Physicians Serving in Underserved Areas

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 218 was considered alongside Resolution 229. Resolution 218 was adopted as amended by the Reference Committee in lieu of Resolution 229. Please see the [annotated Reference Committee B Report](#) for additional information.

58. Res. 219 - Due Process and Independent Contractors

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 219 was adopted by the HOD. Please see the [annotated Reference Committee B Report](#) for additional information.

59. Res. 220 - Vital Nature of Board-Certified Physicians in Aerospace Medicine

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 220 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

60. Res. 221 - Strategies to Mitigate Racial and Ethnic Disparities in Maternal and Fetal Morbidity and Mortality at the Grassroots Level

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 221 was withdrawn by its sponsors.

61. Res. 222 - To Study the Economic Impact of Mid-Level Provider Employment in the United States of America

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 222 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

62. Res. 223 - National Drug Shortages of Lidocaine and Saline Preparations

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 223 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

63. Res. 224 - HPSA and MUA Designation for SNFs

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 224 was referred for study. Please see the [annotated Reference Committee B Report](#) for additional information.

64. Res. 225 - Public Listing of Medical Directors for Nursing Facilities

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 225 was adopted by the HOD. Please see the [annotated Reference Committee B Report](#) for additional information.

65. Res. 226 - Coverage for Clinical Trial Ancillary Costs

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 226 was adopted by the HOD. Please see the [annotated Reference Committee B Report](#) for additional information.

66. Res. 227 - Supporting Improvements to Patient Data Privacy

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 227 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

67. Res. 228 - Expanded Child Tax Credit

MSS Action: MSS Delegates supported the spirit of the resolution, which was considered alongside Resolution 247.

HOD Action: Resolution 247 was adopted as amended by the Reference Committee in lieu of Resolution 228. Please see the [annotated Reference Committee B Report](#) for additional information.

68. Res. 229 - Expedited Immigrant Green Card for J-1 Visa Waiver Physicians Serving in Underserved Areas

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 218 was adopted as amended in lieu of Resolution 229. Please see the [annotated Reference Committee B Report](#) for additional information.

69. Res. 235 - Improving the Veterans Health Administration Referrals for Veterans for Care Outside the VA System

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 235. Please see the [Reaffirmation Consent Calendar](#) for additional information.

70. Res. 236 - Out-of-Network Care

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 236 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

71. Res. 237 - Prescription Drug Dispensing Policies

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 227 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

72. Res. 238 - COVID-19 Economic Injury Disaster Loan (EIDL) Forgiveness for Physician Groups of Five or Fewer Physicians

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Alternate Resolution 238 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

73. Res. 239 - Virtual Services When Patients Are Away From Their Medical Home

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 239. Please see the [annotated Reference Committee B Report](#) for additional information.

74. Res. 240 - Physician Payment Reform and Equity

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Alternate Resolution 240 was adopted in lieu of Resolutions 240, 242, 243, and 253. Please see the [annotated Reference Committee B Report](#) for additional information.

75. Res. 241 - Unmatched Graduate Physician Workforce

MSS Action: MSS Delegates opposed the resolution.

HOD Action: Resolution 241 was not adopted by the HOD. Please see the [annotated Reference Committee B Report](#) for additional information.

76. Res. 242 - Public Awareness and Advocacy Campaign to Reform the Medicare Physician Payment System

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Alternate Resolution 240 was adopted in lieu of Resolutions 240, 242, 243, and 253. Please see the [annotated Reference Committee B Report](#) for additional information.

77. Res. 243 - Appropriate Physician Payment for Office-Based Services

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Alternate Resolution 240 was adopted in lieu of Resolutions 240, 242, 243, and 253. Please see the [annotated Reference Committee B Report](#) for additional information.

78. Res. 244 - Prohibit Reversal of Prior Authorization

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 244. Please see the [Reaffirmation Consent Calendar](#) for additional information.

79. Res. 245 - Definition and Encouragement of the Appropriate Use of the Word "Physician"

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 249 was adopted as amended by the Reference Committee in lieu of Resolution 245. Please see the [annotated Reference Committee B Report](#) for additional information.

80. Res. 248 - Promoting Proper Oversight and Reimbursement for Specialty Physician Extenders and Non-Physician Practitioners

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 248 was referred for study. Please see the [annotated Reference Committee B Report](#) for additional information.

81. Res. 249 - Clarification of Healthcare Physician Identification: Consumer Truth & Transparency

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 249 was adopted as amended by the Reference Committee in lieu of Resolution 245. Please see the [annotated Reference Committee B Report](#) for additional information.

82. Res. 250 - Prohibit Reversal of Prior Authorization

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 250. Please see the [annotated Reference Committee B Report](#) for additional information.

83. Res. 251 - Physician Medical License Use in Clinical Supervision

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 217 was considered alongside Resolution 251. Resolves 2-6 of Resolution 217 and Resolves 1-3 of Resolution 251 were referred for decision. Resolution 217 was adopted as amended by the Reference Committee in lieu of Resolution 251. Please see the [annotated Reference Committee B Report](#) for additional information.

84. Res. 252 - The Criminalization of Health Care Decision Making and Practice

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 252. Please see the [annotated Reference Committee B Report](#) for additional information.

85. Res. 253 - Physician Payment Reform & Equity

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Alternate Resolution 240 was adopted in lieu of Resolutions 240, 242, 243, and 253. Please see the [annotated Reference Committee B Report](#) for additional information.

86. Res. 254 - Stakeholder Engagement in Medicare Administrative Contractor Policy Processes

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 254 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee B Report](#) for additional information.

87. Res. 301 - Medical Education Debt Cancellation in the Face of a Physician Shortage During the COVID-19 Pandemic

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 301 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee C Report](#) for additional information.

88. Res. 302 - Resident and Fellow Access to Fertility Preservation

MSS Action: MSS Delegates supported the resolution. MSS Delegates attempted to amend the resolution to include equal coverage protections for fertility preservation for medical students, but were unsuccessful due to concerns that insurance options in medical school may be more complex than for residents.

HOD Action: Resolution 302 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee C Report](#) for additional information.

89. Res. 303 - Fatigue Mitigation Respite for Faculty and Residents

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 303. Please see the [Reaffirmation Consent Calendar](#) for additional information.

90. Res. 304 - Organizational Accountability to Resident and Fellow Trainees

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 304 was referred for study. Please see the [annotated Reference Committee C Report](#) for additional information.

91. Res. 305 - Reducing Overall Fees and Making Costs for Licensing Exam Fees, Application Fees, Etc., Equitable for IMGs

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 305 was referred for study. Please see the [annotated Reference Committee C Report](#) for additional information.

92. Res. 306 - Creating a More Accurate Accounting of Medical Education Financial Costs

MSS Action: MSS Delegates offered an amendment to this item in Reference Committee to improve the specificity of the asks.

HOD Action: Resolution 306 was referred for study. Please see the [annotated Reference Committee C Report](#) for additional information.

93. Res. 307 - Parental Leave and Planning Resources for Medical Students

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 307 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee C Report](#) for additional information.

94. Res. 311 - Discontinue State Licensure Requirement for COMLEX Level 2 PE

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 311. Please see the [Reaffirmation Consent Calendar](#) for additional information.

95. Res. 312 - Reduce Financial Burden to Medical Students of Medical Licensure Examinations

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 311. Please see the [Reaffirmation Consent Calendar](#) for additional information.

96. Res. 313 - Decreasing Medical Student Debt and Increasing Transparency in Cost of Medical School Attendance

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 311. Please see the [Reaffirmation Consent Calendar](#) for additional information.

97. Res. 316 - Providing Transparent and Accurate Data Regarding Students and Faculty at Medical Schools

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 316 was adopted by the HOD. Please see the [annotated Reference Committee C Report](#) for additional information.

98. Res. 317 - Medical Student, Resident and Fellow Suicide Reporting

MSS Action: MSS Delegates opposed the resolution in Reference Committee, highlighting concerns regarding confidentiality and privacy. This resolution was considered alongside Resolution 326, an MSS item, which MSS Delegates supported after the Reference Committee proposed an amended Resolution 326 be adopted in lieu of Resolution 317.

HOD Action: Resolution 326 was adopted as amended in lieu of Resolution 317 by the HOD. Please see the [annotated Reference Committee C Report](#) for additional information.

99. Res. 318 - CME for Preceptorship

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 318. Please see the [Reaffirmation Consent Calendar](#) for additional information.

100. Res. 319 - Senior Living Community Training for Medical Students and Residents

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 319 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee C Report](#) for additional information.

101. Res. 320 - Tuition Cost Transparency

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 318. Please see the [Reaffirmation Consent Calendar](#) for additional information.

102. Res. 321 - Improving and Standardizing Pregnancy and Lactation Accommodations for Medical Board Examinations

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 321 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee C Report](#) for additional information.

103. Res. 322 - Standards in Cultural Humility Training Within Medical Education

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 322 was adopted by the HOD. Please see the [annotated Reference Committee C Report](#) for additional information.

104. Res. 327 - Leadership Training Must Become an Integral Part of Medical Education

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 327 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee C Report](#) for additional information.

105. Res. 328 - Increasing Transparency of the Resident Physician Application Process

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 328 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee C Report](#) for additional information.

106. Res. 329 - Use of the Terms "Residency" and "Fellowship" by Health Professionals Outside of Medicine

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 329 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee C Report](#) for additional information.

107. Res. 401 - Air Quality and the Protection of Citizen Health

MSS Action: MSS Delegates had concerns about the redundancy of the asks of this resolution but ultimately supported the resolution.

HOD Action: Resolution 401 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

108. Res. 402 - Support for Impairment Research

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 402 was not adopted by the HOD. Please see the [annotated Reference Committee D Report](#) for additional information.

109. Res. 403 - Addressing Maternal Discrimination and Support for Flexible Family Leave

MSS Action: MSS Delegates supported this resolution.

HOD Action: Resolution 403 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

110. Res. 404 - Weapons in Correctional Healthcare Facilities

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 404 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

111. Res. 406 - COVID-19 Preventive Measures for Correctional Facilities: AMA Policy Position

MSS Action: MSS Delegates supported the resolution and proffered an amendment to include “detention centers”, which was recommended by the Reference Committee.

HOD Action: Resolution 406 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

112. Res. 407 - Study of Best Practices for Acute Care of Patients in the Custody of the Law

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 406 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

113. Res. 408 - Supporting Increased Research on Implementation of Nonviolent De-escalation Training and Mental Illness Awareness in Law Enforcement

MSS Action: MSS Delegates supported the resolution. MSS Delegates also proposed a friendly amendment to change verbiage to person-first language in Reference Committee, which the Committee then recommended.

HOD Action: Resolution 408 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

114. Res. 409 - Increasing HPV Vaccination Rates in Rural Communities

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 409. Please see the [Reaffirmation Consent Calendar](#) for additional information.

115. Res. 410 - Increasing Education for School Staff to Recognize Prodromal Symptoms of Schizophrenia in Teens and Young Adults to Increase Early Intervention

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 410 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

116. Res. 411 - Anonymous Prescribing Option for Expedited Partner Therapy

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 411 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

117. Res. 414 - Improvement of Care and Resource Allocation for Homeless Persons in the Global Pandemic

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 411 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

118. Res. 415 - Creation of an Obesity Task Force

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 415 was referred for decision. Please see the [annotated Reference Committee D Report](#) for additional information.

119. Res. 416 - School Resource Officer Violence De-Escalation Training and Certification

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 416 was referred for study. Please see the [annotated Reference Committee D Report](#) for additional information.

120. Res. 417 - Tobacco Control

MSS Action: MSS Delegates took no position on the resolution due to its likely low impact on AMA advocacy.

HOD Action: Resolution 417 was adopted by the HOD. Please see the [annotated Reference Committee D Report](#) for additional information.

121. Res. 418 - Lung Cancer Screening Awareness

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 418 was adopted by the HOD. Please see the [annotated Reference Committee D Report](#) for additional information.

122. Res. 419 - Advocating for the Utilization of Police and Mental Health Care Co-Response Teams for 911 Mental Health Emergency Calls

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 419. Please see the [Reaffirmation Consent Calendar](#) for additional information.

123. Res. 420 - Declaring Climate Change a Public Health Crisis

MSS Action: MSS Delegates supported the resolution, which was considered alongside Resolution 430.

HOD Action: Alternate Resolution 420 was adopted in lieu of Resolution 420 and 430. Please see the [annotated Reference Committee D Report](#) for additional information.

124. Res. 421 - Screening for HPV-Related Anal Cancer

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 421 was adopted by the HOD. Please see the [annotated Reference Committee D Report](#) for additional information.

125. Res. 422 - Voting as a Social Determinant of Health

MSS Action: MSS Delegates initially hesitated to support this resolution due to a lack of supportive policy, but ultimately voted to support it.

HOD Action: Resolution 422 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

126. Res. 423 - Awareness Campaign for 988 National Suicide Prevention Lifeline

MSS Action: MSS Delegates supported the resolution.

HOD Action: Alternate Resolution 423 was adopted in lieu of Resolution 423. Please see the [annotated Reference Committee D Report](#) for additional information.

127. Res. 424 - Physician Interventions Addressing Environmental Health and Justice

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 424 was adopted by the HOD. Please see the [annotated Reference Committee D Report](#) for additional information.

128. Res. 425 - Mental Health Crisis

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 425 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

129. Res. 426 - Mental Health First Aid Training

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 426. Please see the [Reaffirmation Consent Calendar](#) for additional information.

130. Res. 427 - Pictorial Health Warnings on Alcoholic Beverages

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 427 was adopted by the HOD. Please see the [annotated Reference Committee D Report](#) for additional information.

131. Res. 437 - Air Pollution and COVID: A Call to Tighten Regulatory Standards for Particulate Matter

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 437. Please see the [annotated Reference Committee D Report](#) for additional information.

132. Res. 438 - Informing Physicians, Health Care Providers, and the Public of the Health Dangers of Fossil-Fuel Derived Hydrogen

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 438 was adopted by the HOD. Please see the [annotated Reference Committee D Report](#) for additional information.

133. Res. 439 - Informing Physicians, Health Care Providers, and the Public that Cooking with a Gas Stove Increases Household Air Pollution and the Risk of Childhood Asthma

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 439 was adopted by the HOD. Please see the [annotated Reference Committee D Report](#) for additional information.

134. Res. 440 - Addressing Social Determinants of Health Through Health IT

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 440 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee D Report](#) for additional information.

135. Res. 501 - Marketing Guardrails for the "Over-Medicalization" of Cannabis Use

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 501 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee E Report](#) for additional information.

136. Res. 502 - Ensuring Correct Drug Dispensing

MSS Action: MSS Delegates supported the resolution but did not provide testimony.

HOD Action: Resolution 502 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee E Report](#) for additional information.

137. Res. 503 - Pharmacy Benefit Managers and Drug Shortages

MSS Action: MSS Delegates supported the resolution.

HOD Action: Alternate Resolution 503 was adopted in lieu of Resolution 503. Please see the [annotated Reference Committee E Report](#) for additional information.

138. Res. 504 - Scientific Studies Which Support Legislative Agendas

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 504 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee E Report](#) for additional information.

139. Res. 505 - CBD Oil Use and the Marketing of CBD Oil

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 505 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee E Report](#) for additional information.

140. Res. 506 - Drug Manufacturing Safety

MSS Action: MSS Delegates took no position on the resolution due to concerns over it potentially being a reaffirmation of existing policy.

HOD Action: Resolution 506 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee E Report](#) for additional information.

141. Res. 507 - Federal Initiative to Treat Cannabis Dependence

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 507. Please see the [annotated Reference Committee D Report](#) for additional information.

142. Res. 508 - Supplemental Resources for Inflight Medical Kit

MSS Action: MSS Delegates supported the resolution.

HOD Action: Alternate Resolution 508 was adopted in lieu of Resolution 508. Please see the [annotated Reference Committee E Report](#) for additional information.

143. Res. 509 - Regulation and Control of Self-Service Labs

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 509 was adopted by the HOD. Please see the [annotated Reference Committee E Report](#) for additional information.

144. Res. 510 - Evidence-Based Deferral Periods for MSM Cornea and Tissue Donors

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 510 was adopted by the HOD. Please see the [annotated Reference Committee E Report](#) for additional information.

145. Res. 511 - Over the Counter (OTC) Hormonal Birth Control

MSS Action: MSS Delegates supported the resolution.

HOD Action: Alternate Resolution 518 was adopted in lieu of Resolutions 511 and 518. Please see the [annotated Reference Committee E Report](#) for additional information.

146. Res. 512 - Scheduling and Banning the Sale of Tianeptine in the United States

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 512 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee E Report](#) for additional information.

147. Res. 513 - Education for Patients on Opiate Replacement Therapy

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 513 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee E Report](#) for additional information.

148. Res. 514 - Oppose Petition to the DEA and FDA on Gabapentin

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 503 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee E Report](#) for additional information.

149. Res. 515 - Reducing Polypharmacy as a Significant Contributor to Senior Morbidity

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 515 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee E Report](#) for additional information.

150. Res. 516 - Oppose "Mild Hyperbaric" Facilities from Delivering Unsupported Clinical Treatments

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Alternate Resolution 516 was adopted in lieu of Resolution 516 and 517. Please see the [annotated Reference Committee E Report](#) for additional information.

151. Res. 517 - Safeguard the Public from Widespread Unsafe Use of "Mild Hyperbaric Oxygen Therapy"

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Alternate Resolution 516 was adopted in lieu of Resolution 516 and 517. Please see the [annotated Reference Committee E Report](#) for additional information.

152. Res. 518 - Over-the-Counter Access to Oral Contraceptives

MSS Action: MSS Delegates supported the resolution.

HOD Action: Alternate Resolution 518 was adopted in lieu of Resolutions 511 and 518. Please see the [annotated Reference Committee E Report](#) for additional information.

153. Res. 519 - ARPA-H Advanced Research Projects Agency for Health

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 519 was adopted by the HOD. Please see the [annotated Reference Committee E Report](#) for additional information.

154. Res. 601 - Development of Resources on End-of-Life Care

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 601 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee F Report](#) for additional information.

155. Res. 602 - Report on the Preservation of Independent Medical Practice

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 602 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee F Report](#) for additional information.

156. Res. 603 - September 11th as a National Holiday

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 603 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee F Report](#) for additional information.

157. Res. 604 - UN International Radionuclide Therapy Day Recognition

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 624 was adopted in lieu of Resolution 604. Please see the [annotated Reference Committee F Report](#) for additional information.

158. Res. 605 - Fulfilling Medicine's Social Contract with Humanity in the Face of the Climate Health Crisis

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 605 was referred for study. Please see the [annotated Reference Committee F Report](#) for additional information.

159. Res. 606 - Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology System

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 606 was referred for decision. Please see the [annotated Reference Committee F Report](#) for additional information.

160. Res. 607 - AMA Urges Health and Life Insurers to Divest of Investments of Fossil Fuels

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 607 was adopted by the HOD. Please see the [annotated Reference Committee F Report](#) for additional information.

161. Res. 608 - Transparency of Resolution Fiscal Notes

MSS Action: MSS Delegates initially took no position on the resolution due to a lack of internal policy, but ultimately elected to support it due to the importance of transparency for the function of the AMA..

HOD Action: Resolution 608 was referred for study. Please see the [annotated Reference Committee F Report](#) for additional information.

162. Res. 609 - Surveillance Management System for Organized Medicine Policies and Reports

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 609 was referred for study. Please see the [annotated Reference Committee F Report](#) for additional information.

163. Res. 610 - Making AMA Meetings Accessible

MSS Action: MSS Delegates supported the resolution in Reference Committee testimony. MSS Delegates also supported Reference Committee recommendations.

HOD Action: The first, third, and fourth resolves of Resolution 610 were adopted as amended by the Reference Committee. The second resolve, which had been recommended for deletion by the Reference Committee, was referred for study. Please see the [annotated Reference Committee F Report](#) for additional information.

164. Res. 611 - Continuing Equity Education

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 611 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee F Report](#) for additional information.

165. Res. 612 - Identifying Strategies for Accurate Disclosure and Reporting of Racial and Ethnic Data Across the Medical Education Continuum and Physician Workforce

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 612 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee F Report](#) for additional information.

166. Res. 613 - Timing of Board Report on Resolution 605 from N-21 Regarding a Permanent Resolution Committee

MSS Action: MSS Delegates opposed this resolution, which asked that the Board of Trustees report on a permanent Resolution Committee be presented at Interim 2022. MSS Delegates felt that it would be easier to handle a report/item of that magnitude at the Annual meeting.

HOD Action: Resolution 613 was not adopted by the HOD. Please see the [annotated Reference Committee F Report](#) for additional information. Interestingly, the Board of Trustees report on a permanent Resolution Committee is being presented to the House at the Interim 2022 meeting anyway.

167. Res. 614 - Allowing Virtual Interviews on Non-Holiday Weekends for Candidates for AMA Office

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 614 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee F Report](#) for additional information.

168. Res. 618 - Extending the Delegate Apportionment Freeze During COVID-19 Pandemic

MSS Action: MSS Delegates supported the spirit of the resolution, but raised concerns about sections not being included in the language in Reference Committee testimony. MSS Delegates took no position on the Reference Committee's recommendations.

HOD Action: Recommendation 3 of BOT Report 20 was adopted in lieu of Resolution 618 (see BOT Report 3 above). Please see the [annotated Reference Committee F Report](#) for additional information.

169. Res. 619 - Focus and Priority for the AMA House of Delegates

MSS Action: MSS Delegates opposed the resolution in Reference Committee testimony, and supported the Reference Committee recommendation to refer it for study.

HOD Action: Resolution 619 was referred for study. Please see the [annotated Reference Committee F Report](#) for additional information.

170. Res. 620 - Review of Health Insurance Companies and Their Subsidiaries' Business Practices

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 620. Please see the [Reaffirmation Consent Calendar](#) for additional information.

171. Res. 621 - Establishing A Task Force to Preserve the Patient-Physician Relationship When Evidence-Based, Appropriate Care Is Banned or Restricted

MSS Action: MSS Delegates supported the resolution due to its relevance to MSS policy on abortion.

HOD Action: Resolution 621 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee F Report](#) for additional information.

172. Res. 622 - HOD Modernization

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 622 was referred for study. Please see the [annotated Reference Committee F Report](#) for additional information.

173. Res. 623 - Virtual Attendance at AMA Meetings

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 623 was not adopted by the HOD. Please see the [annotated Reference Committee F Report](#) for additional information.

174. Res. 624 - Creation of United Nations "Dr. Saul Hertz Theranostic Nuclear Medicine" International Day

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 624 was adopted in lieu of Resolution 604. Please see the [annotated Reference Committee F Report](#) for additional information.

175. Res. 701 - Appeals and Denial - CPT Codes for Fair Compensation

MSS Action: MSS Delegates supported the resolution.

HOD Action: Alternate Resolution 701 was adopted in lieu of Resolutions 701 and 710. Please see the [annotated Reference Committee G Report](#) for additional information.

176. Res. 702 - Health System Consolidation

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 702 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee G Report](#) for additional information.

177. Res. 703 - Mandatory Reporting of All Antipsychotic Drug Use in Nursing Home Residents

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 703 was not adopted by the HOD. Please see the [annotated Reference Committee G Report](#) for additional information.

178. Res. 704 - Employed Physician Contracts

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 704. Please see the [Reaffirmation Consent Calendar](#) for additional information.

179. Res. 705 - Fifteen Month Lab Standing Orders

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 705 was adopted by the HOD. Please see the [annotated Reference Committee G Report](#) for additional information.

180. Res. 706 - Government Imposed Volume Requirements for Credentialing

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 706. Please see the [Reaffirmation Consent Calendar](#) for additional information.

181. Res. 707 - Insurance Coverage for Scalp Cooling (Cold Cap) Therapy

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 707. Please see the [Reaffirmation Consent Calendar](#) for additional information.

182. Res. 708 - Physician Burnout is an OSHA Issue

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 708 was not adopted by the HOD. Please see the [annotated Reference Committee G Report](#) for additional information.

183. Res. 709 - Physician Well-Being as an Indicator of Health System Quality

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 709. Please see the [Reaffirmation Consent Calendar](#) for additional information.

184. Res. 710 - Prior Authorization - CPT Codes for Fair Compensation

MSS Action: MSS Delegates supported the resolution.

HOD Action: Alternate Resolution 701 was adopted in lieu of Resolutions 701 and 710. Please see the [annotated Reference Committee G Report](#) for additional information.

185. Res. 711 - Reducing Prior Authorization Burden

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 711. Please see the [Reaffirmation Consent Calendar](#) for additional information.

186. Res. 712 - The Quadruple Aim - Promoting Improvement in the Physician Experience of Providing Care

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 712. Please see the [Reaffirmation Consent Calendar](#) for additional information.

187. Res. 713 - Enforcement of Administrative Simplification Requirements

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 713. Please see the [Reaffirmation Consent Calendar](#) for additional information.

188. Res. 714 - Prior Authorization Reform for Specialty Medications

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 714. Please see the [Reaffirmation Consent Calendar](#) for additional information.

189. Res. 715 - Prior Authorization - CPT Codes for Fair Compensation

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 715. Please see the [Reaffirmation Consent Calendar](#) for additional information.

190. Res. 716 - Discharge Summary Reform

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Alternate Resolution 716 was adopted in lieu of Resolution 716. Please see the [annotated Reference Committee G Report](#) for additional information.

191. Res. 717 - Expanding the AMA's Study on the Economic Impact of COVID-19

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 717 was not adopted by the HOD. Please see the [annotated Reference Committee G Report](#) for additional information.

192. Res. 718 - Degradation of Medical Records

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 718. Please see the [Reaffirmation Consent Calendar](#) for additional information.

193. Res. 719 - System Wide Prior and Post-Authorization Delays and Effects on Patient Care Access

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 719. Please see the [Reaffirmation Consent Calendar](#) for additional information.

194. Res. 720 - Mitigating the Negative Impact of Step Therapy Policies and Nonmedical Switching of Prescription Drugs on Patient Safety

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 720. Please see the [Reaffirmation Consent Calendar](#) for additional information.

195. Res. 721 - Amend AMA Policy H-215.981 Corporate Practice of Medicine

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 721 was referred for study. Please see the [annotated Reference Committee G Report](#) for additional information.

196. Res. 722 - Eliminating Claims Data for Measuring Physician and Hospital Quality

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 722. Please see the [Reaffirmation Consent Calendar](#) for additional information.

197. Res. 723 - Physician Burnout

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 723. Please see the [Reaffirmation Consent Calendar](#) for additional information.

198. Res. 724 - Ensuring Medical Practice Viability Through Reallocation of Insurance Savings During the COVID-19 Pandemic

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 724 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee G Report](#) for additional information.

199. Res. 725 - Compensation to Physicians for Authorizations and Preauthorizations

MSS Action: MSS Delegates supported the resolution.

HOD Action: Existing policy was reaffirmed in lieu of Resolution 725. Please see the [Reaffirmation Consent Calendar](#) for additional information.

200. Res. 726 - Payment for the Cost of Electronic Prescription of Controlled Substances and Compensation for Time Spent Engaging State Prescription Monitoring Programs

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 726 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee G Report](#) for additional information.

201. Res. 727 - Utilization Review, Medical Necessity Determination, Prior Authorization Decisions

MSS Action: MSS Delegates supported the resolution.

HOD Action: Resolution 727 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee G Report](#) for additional information.

202. Res. 728 - Maintaining an Open and Equitable Hospital Work Environment for Specialists

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Alternate Resolution 728 was adopted in lieu of Resolutions 728 and 730. Please see the [annotated Reference Committee G Report](#) for additional information.

203. Res. 729 - Protecting Physician Wellbeing on Board Certification Applications

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 729 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee G Report](#) for additional information.

204. Res. 730 - Maintaining an Open and Equitable Hospital Work Environment for Specialists

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Alternate Resolution 728 was adopted in lieu of Resolutions 728 and 730. Please see the [annotated Reference Committee G Report](#) for additional information.

205. Res. 731 - Prior Authorization-Patient Autonomy

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 731 was adopted as amended by the Reference Committee. Please see the [annotated Reference Committee G Report](#) for additional information.

206. Res. 732 - Advocacy of Private Practice Options for Healthcare Operations in Large Corporations

MSS Action: MSS Delegates took no position on the resolution.

HOD Action: Resolution 732 was adopted by the HOD. Please see the [annotated Reference Committee G Report](#) for additional information.