

Not for consideration

Resolutions not for consideration

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 001
(I-22)

Introduced by: Young Physicians Section

Subject: Updating Physician Job Description for Disability Insurance

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Many disability insurance products contain language and provisions such as “own
2 occupation” and “own specialty” that may not be consistently defined and whose definitions are
3 not readily available in marketing and policy paperwork; and
4
5 Whereas, The Department of Labor (DOL) developed the Dictionary of Occupational Titles
6 (DOT), the main source of occupational information, in 1938; however, the DOL stopped
7 updating the DOT in 1991;¹ and
8
9 Whereas, The DOL and Social Security Administration (SSA) are developing a new
10 Occupational Information System (OIS),² which will replace the DOT as the primary source of
11 occupational information that SSA staff and private insurers commonly use in the disability
12 adjudication process; and
13
14 Whereas, This pandemic has led to many physicians contracting COVID-19 with health care
15 workers and their families, representing up to one-sixth of hospitalized COVID-19 patients³; and
16
17 Whereas, Up to one-third of those infected with COVID-19 will develop Long COVID,^{4,5} which
18 can last for a year or more;⁶ and
19
20 Whereas, Many with Long COVID cannot return to work on a full time basis⁷ requiring reliance
21 on long-term disability insurance to supplement income; and
22
23 Whereas, While the DOT contains discrete and well-established descriptions of the physical
24 demands of occupations, it does not provide sufficiently specific information on associated
25 mental and cognitive requirements; and
26
27 Whereas, Working with the US Bureau of Labor Statistics allows the SSA the unique opportunity
28 to consider including descriptions of the mental and cognitive requirements of work in the new
29 OIS; and
30
31 Whereas, In the absence of more specific definitions in the disability insurance application,
32 many long-term disability insurers use a “national economy” standard to establish a job
33 description; and
34
35 Whereas, Application of such a national standard may lead to long-term disability denials and
36 financial hardship for physicians; therefore be it

1 RESOLVED, That our American Medical Association study the most effective approach to
2 developing specialty-specific job descriptions that reflect the true physical and cognitive
3 demands of each given specialty for use in the Occupational Information System under
4 development by the Social Security Administration so as to ensure that physician disability
5 policies are robust and protective if a coverage trigger occurs. (Directive to Take Action)

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

Received: 08/19/22

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 004
(I-22)

Introduced by: Medical Student Section

Subject: Supporting Intimate Partner and Sexual Violence Safe Leave

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Intimate partner violence (IPV) is defined as any preventable form of physical, sexual, or
2 psychological aggression committed by current or former partners, including but not limited to
3 stalking, sexual harassment, or sexual coercion^{1,2}; and
4
5 Whereas, 1 in 3 women and 1 in 4 men in the United States (U.S.) have experienced some form of
6 IPV, with increased rates of injury and rape reported in sexual and ethnic minority populations^{3,4};
7 and
8
9 Whereas, Up to 61.1% of lesbian and bisexual cisgender women and 37.3% of gay and bisexual
10 cisgender men report experiencing IPV compared to 35% and 29% of heterosexual cisgender
11 women and men, respectively⁵; and
12
13 Whereas, Transgender individuals disclose instances of physical and sexual IPV at 2.5 and 3.4
14 times more frequently than individuals who do not self-identify with a sexual minority group⁵; and
15
16 Whereas, National survey data from the Centers for Disease Control state that 53.8% of multiracial
17 women, 46% of American Indian women, and 43.7% of Black women have experienced IPV,
18 compared to 34.6% of non-Hispanic white women⁶; and
19
20 Whereas, Individuals who experience IPV are also more likely to become victims of other forms of
21 sexual violence and abuse such as stalking, workplace harassment, rape, and trafficking^{7,8}; and
22
23 Whereas, A surge in case numbers of IPV has been recorded, largely due to increased levels of
24 societal stress, panic, and financial and emotional strain resulting from the COVID-19 pandemic⁹;
25 and
26
27 Whereas, IPV has acute effects on physical and mental health, including injury, unintended
28 pregnancy, low fetal birth weight, preterm birth, disorders secondary to trauma, development of
29 substance use disorders, and death by homicide^{10,11}; and
30
31 Whereas, Individuals who experience IPV have a 60% increased risk for asthma, 70% increased
32 risk for heart disease, and 80% increased risk for stroke¹²; and
33
34 Whereas, The healthcare-related costs due to IPV are estimated to be \$104,000 per female victim
35 and \$23,000 per male victim, totaling to \$5.8 billion annually^{13,14}; and
36
37 Whereas, Lifetime economic burden from IPV for all survivors in the U.S. totals nearly \$3.6 trillion,
38 which includes the financing of criminal justice proceedings and replacement of lost or damaged
39 property¹³; and

1 Whereas, Survivors of IPV require sufficient funds to pay for frequent hospital and clinic visits,
2 long-term treatment of physical and emotional injuries, mental health conditions, and substance
3 use disorders, legal proceedings, childcare, and finding safety¹⁵; and

4
5 Whereas, Job loss in the setting of IPV can propagate the cycle of violence, precipitating further
6 reliance on the abuser for living expenses, childcare, and additional resources^{3,9,16}; and

7
8 Whereas, Close to 60% of IPV survivors report employment instability and job loss due to violence-
9 related reasons, including but not limited to stigma, workplace discrimination due to the negative
10 physical and mental effects of IPV, abuse recurrence, decreased productivity, and frequent
11 absences^{3,16}; and

12
13 Whereas, 67% of those who have experienced or are experiencing IPV state that interactions with
14 an abusive partner limited their ability to complete education or job training for future career
15 growth, resulting in over 17% leaving the workforce³; and

16
17 Whereas, On average, IPV survivors experience on average at least 7.2 days of lost productivity
18 per year at work, leading to the loss of over 8 million days of paid work each year across all IPV
19 survivors, thereby decreasing their chances of earning raises or promotions^{3,14}; and

20
21 Whereas, This loss in productivity and workforce attrition translates to an annual cost of over \$9.3
22 billion to the United States¹⁴; and

23
24 Whereas, 55% of companies do not have, publicize, or provide training for a workplace violence
25 prevention policy offering protections in the event of IPV¹⁷; and

26
27 Whereas, 33% of private sector jobs do not offer paid sick leave, and only 13% of jobs have paid
28 family and medical leave¹⁸; and

29
30 Whereas, A lack of access to paid leave causes employers and workers to lose \$22.5 billion
31 annually in wages and profits²⁰; and

32
33 Whereas, Those who have experienced IPV remain more vulnerable to the detrimental
34 consequences of lost wages from limited opportunities for paid leave, due to inability to afford daily
35 costs of living and medical expenses^{18,20}; and

36
37 Whereas, Eleven states, including the District of Columbia, have enacted legislation offering “safe
38 time provisions” that protect employees who are victims of IPV^{21,22}; and

39
40 Whereas, “Safe time provisions” encompass a list of employee rights emerging in the context of
41 experienced violence, including but not limited to safe leave, protection from wrongful termination,
42 and legal assistance stipends in the event of court proceedings²¹; and

43
44 Whereas, Safe leave is defined as a period of paid or unpaid time allotted for physical, mental, and
45 social healing from trauma relating to any form of violence, particularly IPV, stalking, and sexual
46 harassment by non-partners²²; and

47
48 Whereas, Violence-related safe leave is distinct from personal medical or family leave in that it
49 includes extended time for ensuring personal and familial safety from threat of abuse, protection
50 from premature or wrongful termination of employment, stipends for legal aid, and connection to
51 social work or supportive agencies that facilitate physical, mental, and social recovery^{22,23}; and

1 Whereas, States, districts, and cities that have instituted paid or unpaid safe leave or paid family
2 and medical leave policies inclusive of safe time provisions, including Sonoma, Seattle, New York,
3 and Philadelphia, have not found negative economic effects, subsequent decreases in pay for
4 other employees, or increases in unemployment^{18,21,22}; and

5
6 Whereas, Over \$1.1 billion could be saved in emergency department visits through paid safe
7 leave, as its implementation increases the job and financial security of those experiencing IPV
8 while decreasing dependence on the abuser²⁰; and

9
10 Whereas, The implementation of paid safe leave decreases the turnover of employees and
11 healthcare costs for preventable conditions, simultaneously improving productivity and economic
12 growth^{20,24}; and

13
14 Whereas, Survivors of IPV who had access to paid leave were better able to connect to family
15 court, had increased job security, and retained greater protection against the recurrence of any
16 harassment or abuse by current, former, or non-partners^{1,25}; and

17
18 Whereas, The AMA has policy (H-515.965) encouraging physicians to campaign against IPV and
19 violence in all forms; and

20
21 Whereas, The AMA has individual policies on family, medical, and sick leave (H-420.979, H-
22 440.823), though they fall short of providing adequate time for the physical, emotional, and
23 psychiatric healing required following an experience of IPV or non-partner sexual violence;
24 therefore be it

25
26 RESOLVED, That our American Medical Association recognize the positive impact of paid safe
27 leave on public health outcomes and support legislation that offers paid and unpaid safe leave
28 (New HOD Policy); and be it further

29
30 RESOLVED, That our AMA amend policy H-420.979, "AMA Statement on Family and Medical
31 Leave," to promote inclusivity by addition to read as follows:

32
33 **AMA Statement on Family and Medical Leave, H-420.979**

34 Our AMA supports policies that provide employees with reasonable job security and
35 continued availability of health plan benefits in the event leave by an employee becomes
36 necessary due to documented medical conditions and/or concerns for safety. Such
37 policies should provide for reasonable periods of paid or unpaid: (1) medical leave for the
38 employee, including pregnancy; (2) maternity leave for the employee-mother; (3) leave if
39 medically appropriate to care for a member of the employee's immediate family, i.e., a
40 spouse or children; and (4) leave for adoption or for foster care leading to adoption; and
41 (5) safe leave provisions for those experiencing any instances of violence, including but
42 not limited to intimate partner violence, sexual violence or coercion, and stalking. Such
43 periods of leave may differ with respect to each of the foregoing classifications, and may
44 vary with reasonable categories of employers. Such policies should encourage voluntary
45 programs by employers and may provide for appropriate legislation (with or without
46 financial assistance from government). Any legislative proposals will be reviewed through
47 the Association's normal legislative process for appropriateness, taking into consideration
48 all elements therein, including classifications of employees and employers, reasons for the
49 leave, periods of leave recognized (whether paid or unpaid), obligations on return from
50 leave, and other factors involved in order to achieve reasonable objectives recognizing the
51 legitimate needs of employees and employers. (Modify Current HOD Policy)

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

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RELEVANT AMA POLICY

Family and Intimate Partner Violence H-515.965

1. Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society.
2. Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.
3. The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.
4. Within the larger community, our AMA:
 - (a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.
 - (b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.
 - (c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.
5. With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required;

(c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.

6. Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:

(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.

(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.

(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.

(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.

(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence. CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep. 2, I-09; Modified: CSAPH Rep. 01, A-19

AMA Statement on Family and Medical Leave H-420.979

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

Paid Sick Leave H-440.823

Our AMA: (1) recognizes the public health benefits of paid sick leave and other discretionary paid time off; (2) supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member; and (3) supports employer policies that provide employees with unpaid sick days to use to care for themselves or a family member where providing paid leave is overly burdensome. CMS Rep. 03, A-16; Reaffirmed: BOT Rep. 11, A-19

Parental Leave H-405.954

1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.

2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.

3. Our AMA: (a) encourages employers to offer and/or expand paid parental leave policies; (b) encourages state medical associations to work with their state legislatures to establish and promote paid parental leave policies; (c) advocates for improved social and economic support for paid family leave to

care for newborns, infants and young children; and (d) advocates for federal tax incentives to support early child care and unpaid child care by extended family members.

4. Our AMA: (a) encourages key stakeholders to implement policies and programs that help protect against parental discrimination and promote work-life integration for physician parents, which should encompass prenatal parental care, equal parental leave for birthing and non-birthing parents, and flexibility for childcare; and (b) urges key stakeholders to include physicians and frontline workers in legislation that provides protections and considerations for paid parental leave for issues of health and childcare.

Citation: Res. 215, I-16; Appended: BOT Rep. 11, A-19; Appended: Res. 403, A-22;

Policies for Parental, Family and Medical Necessity Leave H-405.960

AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.

2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.

3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

4. Our AMA encourages medical schools, residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.

5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.

6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave,

family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

Citation: CCB/CLRPD Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 010
(I-22)

Introduced by: Medical Student Section

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

Referred to: Reference Committee on Amendments to Constitution and Bylaws

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

4
5 Whereas, These Special Meetings have played a critical role in allowing for our House to adopt
6 policy on key issues such as health equity, telemedicine, and health system reform even under
7 the extenuating circumstances of the pandemic¹⁻³; and

8
9 Whereas, Each of the four recent Special Meetings has involved the introduction of new
10 procedures or alterations of procedures for that meeting; and

11
12 Whereas, Though tremendous efforts have been made at each Special Meeting to ensure the
13 meetings are useful to our organization, Delegates have concerns about the procedures
14 employed, including but not limited to: (1) procedures used in the Special Meeting were not
15 described fully prior to the meetings, (2) some procedures were kept confidential from
16 Delegates, (3) the House was not made aware of any formally established mechanisms by
17 which concerns could be relayed to leadership, (4) there was no independent oversight of these
18 concerns; and

19
20 Whereas, New procedures regulating consideration of items of business have resulted in an
21 unprecedented backlog of policies awaiting consideration by the House of Delegates; and

22
23 Whereas, Our AMA had never held a virtual House of Delegates prior to June 2020, and our
24 Bylaws on Special Meetings were most recently amended at the Interim Meeting in 2009^{4,5}; and

25
26 Whereas, The uncertain course of the COVID-19 pandemic and other natural disasters and
27 national events raise the likelihood that Special Meetings may be imminently necessary in our
28 AMA's future proceedings; and

29
30 Whereas, Our AMA supports individual member participation (G-625.011) and feedback to
31 leadership by members (G-635.011) and Delegates (G-600.031); and

32
33 Whereas, Our AMA has precedent for the creation and release of as-needed reports
34 (G-635.125, G-605.051); therefore be it

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

3

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

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

Received: 10/05/22

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RELEVANT AMA POLICY

Meetings of the House of Delegates. B-2.12

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

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

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

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

2.12.3.1 Invitation from Constituent Association. A constituent association desiring a meeting within its borders shall submit an invitation in writing, together with significant data, to the Board of Trustees. The dates and the city selected may be changed by action of the Board of Trustees at any time, but not later than 60 days prior to the dates selected for that meeting.

2.12.4 Meetings.

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

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

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

Membership and Governance G-635.005

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

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

Statement of Collaborative Intent G-620.030

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Participation of Individual Members in our AMA G-635.011

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

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

AMA Goals, Roles, and Obligations G-625.011

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

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

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

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

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

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

Ancillary Meetings and Conferences of the House G-600.090

The Speakers of our AMA House must be notified prior to any planning for ancillary meetings and conferences to be scheduled in conjunction with the Annual or Interim Meetings of the House of Delegates in sufficient time to assess the impact of the timing and purpose on the deliberations of the House of Delegates. Prior approval of the Speaker and Vice Speaker is required before any meeting other than regular meetings of AMA Councils, Committees, Sections, and other groups that are part of the formal structure of our AMA can be scheduled in conjunction with Meetings of the House of Delegates. Citation: Rep. on Rules and Credentials, A-93; Consolidated: CLRPD Rep. 3, I-01; Reaffirmed: CC&B Rep. 2, A-11; Reaffirmed: Joint CCB/CLRPD Rep. 1, A-21

AMA Membership Demographics G-635.125

1. Stratified demographics of our AMA membership will be reported annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty.
2. Our AMA will immediately release to each state medical and specialty society, on request, the names, category and demographics of all AMA members of that state and specialty.
3. Our AMA will develop and implement a plan with input from the Advisory Committee on LGBTQ Issues to expand demographics collected about our members to include both sexual orientation and gender identity information, which may be given voluntarily by members and will be handled in a confidential manner.

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

Greater Involvement of Medical Students in Federation Organizations G-620.050

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

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

Data Used to Apportion Delegates G-600.016

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

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

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

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

- (1) the Board submits a report to the House when the Board takes actions that differ from current AMA policy;
- (2) consistent with AMA Bylaws, the Board submits a report to the House when the Board determines that the expenditures associated with recommendations and resolves that were adopted by the House would be inadvisable;
- (3) consistent with AMA Bylaws, the Board transmits reports of the SSS to the House and informs the House of important developments with regard to Federation organizations; and
- (4) consistent with Policy G-630.040, the Board reports to the House when the Board's review of the AMA's Principles on Corporate Relationships results in recommendations for changes in the Principles.

In fulfilling its responsibilities to report to the House when certain specified situations develop, the Board should provide succinct reports to the House and, if additional detail is needed, use the AMA web site to provide the additional information to interested members of the House.

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

Improving Medical Student, Resident/Fellow and Academic Physician Engagement in Organized Medicine and Legislative Advocacy G-615.103

Our AMA will: (1) study the participation of academic and teaching physicians, residents, fellows, and medical students in organized medicine and legislative advocacy; (2) study the participation of community-based faculty members of medical schools and graduate medical education programs in organized medicine and legislative advocacy; (3) identify successful, innovative and best practices to engage academic physicians (including community-based physicians), residents/fellows, and medical students in organized medicine and legislative advocacy; and (4) study mechanisms to mitigate costs incurred by medical students, residents and fellows who participate at national, in person AMA conferences.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 014
(I-22)

Introduced by: Medical Student Section

Subject: Gender-Neutral Language in AMA Policy

Referred to: Reference Committee on Amendments to Constitution and Bylaws

1 Whereas, Existing American Medical Association policy inconsistently uses gendered language-
2 in particular, gender pronouns- when referring to physicians, medical students, patients, and
3 others, most often referencing generic individuals with traditionally male and sometimes female
4 pronouns (“he/him/his”, “he or she”, “his or hers”); and
5
6 Whereas, One of many examples of gendered language is AMA Policy H-140.951, which states
7 “Our AMA believes that the primary mission of the physician is to use his best efforts and skill in
8 the care of his patients...”; and
9
10 Whereas, The American medical profession is increasingly gender diverse: 50.5% of all current
11 U.S. medical students are women, and there many medical students and physicians who have
12 other genders that are not male or female, including gender-expansive, gender-fluid, gender-
13 nonconforming, genderqueer, nonbinary, and others^{1,2,7}; and
14
15 Whereas, The frequent default use of male pronouns to describe generic physicians in AMA
16 policy (for example, using “him” and “his” as pronouns for “the physician”) may reinforce
17 patriarchal (pro-male) bias in medicine and disadvantage physicians who do not use such
18 pronouns³⁻⁶; and
19
20 Whereas, The AMA should aspire to use gender-neutral language where feasible, recognizing
21 that American physicians and the patients we serve have diverse gender identities and may use
22 similarly diverse personal pronouns; and
23
24 Whereas, One solution for correcting the bias established by using traditionally male pronouns
25 as default in AMA policy is to replace them with gender-neutral pronouns such as “they”, “them”,
26 “their”, and “theirs”, which are pronouns used by many gender non-binary individuals and may
27 also be used to collectively describe people of all genders⁷; and
28
29 Whereas, The pronouns “they”, “them”, “their”, and “theirs” have long been widely accepted as
30 both singular and plural pronouns, allowing them to be incorporated into AMA policy with great
31 flexibility⁸⁻¹⁰; and
32
33 Whereas, Adopting consistent gender-neutral pronouns and other non-gendered language into
34 AMA policy would be an efficient and adequate way to collectively reference medical students,
35 physicians, patients, and others of all genders; and
36
37 Whereas, Updating the language in our AMA’s policies to be maximally inclusive is a simple act
38 that aligns with our organization’s work to document and appreciate the diversity in sexual
39 orientation and gender identity (SOGI) of our members as well as to champion gender equity
40 and non-discrimination in medicine and society¹¹⁻¹⁶; and

1 Whereas, AMA policy D-65.990, which calls on the AMA to standardize existing and future
2 language relating to LGBTQ people, establishes precedent for this timely action; therefore be it
3
4 RESOLVED, That our American Medical Association (1) revise all relevant policies to utilize
5 gender-neutral pronouns and other non-gendered language in place of gendered language
6 where such text inappropriately appears, and (2) utilize gender-neutral pronouns and other non-
7 gendered language in future policies where gendered language does not specifically need to be
8 used. (Directive to Take Action)

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

Received: 10/13/22

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RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce H-200.951

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

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

Citation: CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08; Reaffirmed: CCB/CLRPD Rep. 4, A-13; Modified: CME Rep. 01, A-16; Reaffirmation A-16; Modified: Res. 009, A-21; Modified: CME Rep. 5, A-21

Principles for Advancing Gender Equity in Medicine H-65.961

Our AMA:

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

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

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

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

Citation: Res. 014, A-18

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

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

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

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

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

Citation: Res. 016, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(I-22)

Introduced by: Missouri

Subject: Elimination of Seasonal Time Change

Referred to: Reference Committee B

1 Whereas, Multiple studies have demonstrated an increased risk for heart attacks, strokes, and
2 fatal car crashes as negative health consequences of moving the clock forward in Spring for
3 Daylight Savings Time; and

4
5 Whereas, The American Academy of Sleep Medicine officially recognizes Daylight Savings
6 Time as a public health problem; and

7
8 Whereas, A survey of 2,000 adults found that 63% of people supported or strongly supported
9 the elimination of a seasonal time change in favor of a national, fixed, year-round time, and only
10 11% opposed; and

11
12 Whereas, Thirteen states in the past two years have written or enacted legislation to stay on
13 one year-round time zone; therefore be it

14
15 RESOLVED, That our American Medical Association work with state medical associations to
16 enact state legislation in support of remaining in the Standard Time Zone year-round (Directive
17 to Take Action); and be it further

18
19 RESOLVED, That our AMA urge Congress to repeal the federal law establishing the annual
20 advancement of time known as "Daylight Saving Time" and leave the U.S. on standard time
21 year-round. (Directive to Take Action)

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

Received: 09/07/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(I-22)

Introduced by: Resident and Fellow Section

Subject: Elimination of Seasonal Time Changes and Establishment of Permanent Standard Time

Referred to: Reference Committee B

1 Whereas, Originally conceived to conserve fuel and reduce power utilization, the annual switch
2 to Daylight Savings Time (DST) has been practiced in the United States since 1918¹; and

4 Whereas, For states that use DST, clocks typically “spring forward” one hour in March and then
5 “fall back” one hour in November²; and

7 Whereas, The Uniform Time Act of 1966 established a system of uniform DST throughout the
8 United States³; and

10 Whereas, Under federal law, states must currently obtain approval to adopt year-round DST¹;
11 and

13 Whereas, States choosing to observe year-round standard time, as Arizona and Hawaii do, are
14 not subject to federal approval¹; and

16 Whereas, In a response to an oil embargo, the US enacted a trial period of permanent DST
17 from 1974-1975 in an attempt to conserve energy¹; and

19 Whereas, Permanent DST proved unpopular in the 1970’s and was not ineffective in conserving
20 oil, and federal law was changed to disallow permanent use of DST^{4,5}; and

22 Whereas, The merits of using DST to reduce energy use are debatable^{2,4}; and

24 Whereas, The controversy regarding DST has gained increasing notoriety and press coverage
25 over the past several years with 18 states enacting legislation or passing resolutions to provide
26 for permanent DST, should Congress eventually allow for such a change⁵; and

28 Whereas, On March 15, 2022, the US Senate passed the Sunshine Protection Act, which would
29 move forward by one hour what is considered standard time within the US, effectively
30 establishing the permanent use of Daylight Savings Time in November 2023⁶; and

32 Whereas, Under the Sunshine Protection Act, states would be forced to choose whether to
33 operate either on standard or DST year-round⁵; and

35 Whereas, Studies have shown that the acute time change from standard time to DST has risks
36 to the public health and safety, including increased risk of cardiovascular events, hospital
37 admission, traffic fatalities, and medical errors⁸; and

1 Whereas, Most experts believe that standard time is more suited to the circadian rhythms of the
2 human body than permanent DST⁷; and
3
4 Whereas, Circadian misalignment has been associated with risks of depression, cardiovascular
5 disease, metabolic syndrome⁸; and
6
7 Whereas, The American Academy of Sleep Medicine has published a position statement in
8 support of eliminating seasonal time changes and establishing year-round standard time⁷; and
9
10 Whereas, A 2020 AASM survey found that 63% of adults support the elimination of seasonal
11 time changes⁸; and
12
13 Whereas, Our AMA has multiple policies related to fatigue and sleep, including H-15.958, H-
14 135.932, and H-60.930; and
15
16 Whereas, The stance of our AMA on this subject matter may prove influential in public policy
17 deliberations; therefore be it
18
19 RESOLVED, That our American Medical Association support the elimination of seasonal time
20 changes (New HOD Policy); and be it further
21
22 RESOLVED, That our AMA support the adoption of year-round standard time. (New HOD
23 Policy)

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

Received: 09/14/22

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RELEVANT AMA POLICY

Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958

Our AMA: (1) recognizes sleepiness behind the wheel as a major public health issue and continues to encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups;
(2) recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions;
(3) recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep;

- (4) encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness- testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment;
- (5) urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology;
- (6) recommends that physicians: (a) become knowledgeable about the diagnosis and management of sleep-related disorders; (b) investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories; (c) inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries; (d) advise patients about possible medication-related effects that may impair their ability to safely operate a motor vehicle or other machinery; (e) inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries; and (f) become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice;
- (7) encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state.
- (8) recommends that states adopt regulations for the licensing of commercial and private drivers with sleep-related and other medical disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries;
- (9) reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.

Citation: CSA Rep. 1, A-96; Appended: Res. 418, I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: CSAPH Rep. 01, A-19; Reaffirmation: A-22

Light Pollution: Adverse Health Effects of Nighttime Lighting H-135.932

Our AMA:

- 1. Supports the need for developing and implementing technologies to reduce glare from vehicle headlamps and roadway lighting schemes, and developing lighting technologies at home and at work that minimize circadian disruption, while maintaining visual efficiency.
- 2. Recognizes that exposure to excessive light at night, including extended use of various electronic media, can disrupt sleep or exacerbate sleep disorders, especially in children and adolescents. This effect can be minimized by using dim red lighting in the nighttime bedroom environment.
- 3. Supports the need for further multidisciplinary research on the risks and benefits of occupational and environmental exposure to light-at-night.
- 4. That work environments operating in a 24/7 hour fashion have an employee fatigue risk management plan in place.

Citation: CSAPH Rep. 4, A-12; Reaffirmation: A-22; Reaffirmed: CSAPH Rep. 1, A-2

Insufficient Sleep in Adolescents H-60.930

- 1. Our AMA identifies adolescent insufficient sleep and sleepiness as a public health issue and supports education about sleep health as a standard component of care for adolescent patients.
- 2. Our AMA: (a) encourages school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep; (b) encourages physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the biologic sleep needs of adolescents; and (c) encourages continued research on the impact of sleep on adolescent health and academic performance.

Citation: Res. 503, A-10; Appended: CSAPH Rep. 06, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(I-22)

Introduced by: Medical Student Section

Subject: SNAP Expansion for DACA Recipients

Referred to: Reference Committee B

1 Whereas, The policy known as Deferred Action for Childhood Arrivals (DACA) has allowed
2 undocumented immigrants brought to the US as minors to remain in this country, receive work
3 authorization, and participate in the Social Security Program¹; and

4 Whereas, As of 2021 there were 649,070 active DACA recipients in the US¹; and

5 Whereas, The Department of Homeland Security considers more than 200,000 DACA recipients
6 as “essential critical infrastructure workers” contributing to the fields of health care, education,
7 and food-related industries²; and

8 Whereas, Data provided by the Department of Homeland Security showed an estimated 96% of
9 DACA recipients were born in the Caribbean and Latin American countries³; and

10 Whereas, An estimated range of 30 to 60% of immigrants in the US report food insecurity, and
11 the largest and fastest growing subgroup is foreign-born Latinxs as compared to US-born non-
12 Latinx Whites⁴; and

13 Whereas, Food insecurity is defined by the US Department of Agriculture (USDA) as a
14 household-level economic and social condition of limited or uncertain access to adequate food⁵;
15 and

16 Whereas, DACA recipients’ ineligibility for federal aid increases risk for food insecurity while
17 complicating budgeting and meal preparation⁶; and

18 Whereas, DACA recipients viewed affordable food as unhealthy and limited their intake in order
19 to obtain healthier food⁶; and

20 Whereas, Children of immigrant Latinx mothers are at the greatest risk for food insecurity and
21 this population comprises much of the DACA program⁷; and

22 Whereas, The expansion of immigration enforcement has been associated with increased food
23 insecurity among Latinx immigrant families⁸; and

24 Whereas, The percentage of families reporting very low food security has increased by 20%
25 since the COVID-19 pandemic began⁹; and

26 Whereas, A 2019 study estimated that the median county-level cost of healthcare associated
27 with food insecurity was \$4,433,000 per year¹⁰; and

1 Whereas, Undocumented immigrants in the United States contribute an estimated \$11.6 billion
2 taxes annually, but they remain largely ineligible for public benefits including social security and
3 SNAP¹¹; and
4
5 Whereas, The Supplemental Nutrition Assistance Program (SNAP) is the most important tool
6 used in the US to alleviate food insecurity and its subsequent negative health consequences¹²;
7 and
8
9 Whereas, SNAP participation is associated with economic benefits including lower healthcare
10 costs¹³; and
11
12 Whereas, US Citizenship and Immigration services reports that California has a DACA
13 population of 183,460, as of March 2020¹⁴; and
14
15 Whereas, In 2021, California state legislators proposed opening the state-funded food stamp
16 program to all income-eligible Californians, regardless of immigration status, which would cost
17 about \$550 million a year¹⁵; and
18
19 Whereas, The food pantry system was initially designed to serve only during emergency
20 scenarios to address starvation¹⁶; and
21
22 Whereas, People with very low food security who rely on food pantries have a significantly
23 higher incidence of obesity often attributed to acquired foods that are high in sodium and sugar,
24 while low in fiber, vitamins, and minerals¹⁷; and
25
26 Whereas, food pantry recipients are shown to have insufficient intake of up to 16 different key
27 nutrients such as calcium, potassium, and fiber¹⁸; and
28
29 Whereas, Those with food insecurity incur greater health care expenditures resulting in an
30 additional \$77.5 billion in healthcare spending annually¹⁹; therefore be it
31
32 RESOLVED, That our American Medical Association actively support expansion of SNAP to
33 Deferred Action Childhood Arrivals (DACA) recipients who would otherwise qualify. (Directive to
34 Take Action)

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

Received: 09/20/22

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RELEVANT AMA POLICY

Opposition to Regulations that Penalize Immigrants for Accessing Health Care Services D-440.927

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

Improvements to Supplemental Nutrition Programs H-150.937

(1)Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.(2) Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC. (3) Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.
Res. 414, A-10, Reaffirmation A-12, Reaffirmation A-13, [Appended: CSAPH Rep. 1, I-13](#), Reaffirmation A-14, Reaffirmation I-14, Reaffirmation A-15, Appended: Res. 407, A-17, Appended: Res. 233, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(I-22)

Introduced by: Medical Student Section

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

Referred to: Reference Committee B

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

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

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

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

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

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

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

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

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

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

1 Whereas, Increased stigma associated with media coverage of the opioid epidemic adversely
2 impacts the ability of patients to seek and receive treatment for opioid addiction, as 25% of
3 individuals report negative impacts on their job or fear of a negative opinion of community
4 members as reasons for not seeking treatment¹¹; and
5
6 Whereas, News media framing of the opioid epidemic in the context of race has contributed to
7 the differentiation of “white from black (and brown) suffering, white from black culpability, and
8 white from black deservingness” in the public discourse¹²; and
9
10 Whereas, Coded language used by the media can also contribute to the framing of issues, for
11 example by establishing “urban” as code for Black or Latino and “suburban”/“rural” as code for
12 White, effectively creating perceived separate spaces for White and Black drug users¹²; and
13
14 Whereas, This difference in framing leads to a system where Black and Brown people who use
15 drugs are more likely to be incarcerated and less likely to be offered access to healthcare
16 providers, addiction treatment, and tools to prevent overdose and infection¹²; and
17
18 Whereas, News media framing of White victims of the opioid epidemic as innocent and their
19 deaths as shocking or out of the ordinary contrasts with persistent framing of the opioid
20 epidemic in Black or Brown communities as normal, contributing to increased stigma¹³; and
21
22 Whereas, Stigmatization and marginalization of victims of opioid addiction are associated with
23 greater support for punitive policies instead of investment in prevention and treatment
24 programs¹⁴; and
25
26 Whereas, Ecological studies have shown a significant tendency for increases in fatal overdoses
27 to follow increased media coverage of opioid-related deaths¹⁵; and
28
29 Whereas, Our AMA supports the development of standards for media coverage of mass
30 shootings to help address the gun violence public health crisis in Policy H-145.971, showing that
31 the precedent exists for the AMA to encourage more thoughtful public engagement with health-
32 related issues; therefore be it
33
34 RESOLVED, That our American Medical Association encourage the Centers for Disease
35 Control and Prevention, in collaboration with other public and private organizations, to develop
36 recommendations or best practices for media coverage and portrayal of opioid overdoses. (New
37 HOD Policy)

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

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RELEVANT AMA POLICY

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(I-22)

Introduced by: Medical Student Section

Subject: Drug Policy Reform

Referred to: Reference Committee B

1 Drug Use in the US

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

8
9 Whereas, In 2019, 20.4 million Americans (9.7% of those who used a substance in the past
10 year) aged 12 and over met substance use disorder (SUD) criteria, including 14.5 million
11 Americans with alcohol use disorder and 8.3 million with an SUD involving an illicit drug¹; and

12 Incarceration for Drug Possession in the US

13
14 Whereas, The US classifies controlled substances into five schedules, but significant
15 controversy exists over the schedules of certain drugs deemed to have "no medical use,"
16 despite research showing that these drugs may have therapeutic potential²⁻⁵; and

17
18 Whereas, Sentences and penalties for federal and state drug offenses vary depending on the
19 drug's schedule, amount of drug, circumstances of arrest, and previous drug convictions and
20 criminal record⁶⁻⁸; and

21
22 Whereas, Drug possession is defined as being found with an amount of a drug small enough for
23 personal use (as determined by the government) without legal justification⁶⁻⁸; and

24
25 Whereas, Under federal statute, drug possession is classified as a criminal misdemeanor and
26 can be punishable by up to 1 year imprisonment and/or at least \$1,000 in fines for a first-time
27 offense and up to 3 years imprisonment and/or \$5,000 in fines for repeat offenses, with greater
28 sentences and penalties depending on amount of drug, previous drug convictions, and criminal
29 record⁷⁻⁸; and

30
31 Whereas, State statutes are most commonly used to charge people with drug possession and
32 these statutes vary significantly, with many states (including Indiana, Kentucky, and Oklahoma)
33 reclassifying possession from felonies to misdemeanors over the last decade, lowering
34 mandatory minimums, and using savings from reduced incarceration to fund social services,
35 while many other states (such as Idaho, Missouri, and Nebraska) continue to charge possession
36 as felonies often punished with multiple years of imprisonment⁹⁻¹³; and

1 Whereas, In some states, multiple drug felony convictions can result in being charged with a
2 "violent offense," despite no physical violence being committed against any person, which can
3 further increase sentences and penalties and limit eligibility for parole¹⁴; and
4
5 Whereas, Drug possession arrests comprise 10% of all arrests in the US and make up over
6 80% of all drug offense arrests, and possession arrests drastically increased alongside
7 changing policies of the War on Drugs from 538,100 in 1982 to over 1.4 million in 2018, even as
8 arrests for drug distribution and manufacture remained relatively stable since 1990¹⁵⁻¹⁶; and
9
10 Whereas, Of the 2.3 million people incarcerated in the US, 450,000 (20%) are incarcerated for
11 "nonviolent drug offenses," including 120,000 unconvicted awaiting trial¹⁶; and
12
13 Whereas, Defelonization refers to the reclassification of an offense from a felony to a
14 misdemeanor, reduces the probability and potential length of imprisonment and decreasing the
15 long-term harms associated with incarceration¹⁷⁻¹⁹; and
16
17 Whereas, "Decriminalization" is distinct from legalization and only refers to the removal of
18 criminal charges associated with drug possession and its reclassification as a civil infraction,
19 which is a prohibited action that results in civil penalties and sanctions against a person¹⁷⁻²⁰; and
20
21 Whereas, "Legalization" would move beyond decriminalization by eliminating civil infractions for
22 drug possession and creating a regulatory system to control legal production and sale of drugs
23 to adults without a prescription, as with alcohol and tobacco¹⁷⁻²⁰; and
24
25 Whereas, AMA Policy H-95.924, "Cannabis Legalization for Adult Use," states that our AMA
26 "supports public health based strategies, rather than incarceration," and the AMA Council on
27 Science and Public Health's Interim 2020 report on cannabis states that "AMA policy supports
28 decriminalization of cannabis (i.e., reduction in the penalty associated with possession of a
29 small amount of cannabis from a criminal offense subject to arrest to a civil infraction)"²¹; and
30
31 Whereas, Various states are considering policies to expunge (destroy) certain offenses (such as
32 drug offenses, especially those due to cannabis) from a person's criminal record after
33 completion of sentences and penalties, but expungement processes can still be costly and
34 complicated, hindering eligible people from applying (for example, expungement in Missouri
35 costs \$250)²²⁻²⁶; and
36
37 Whereas, The Marijuana Opportunity Reinvestment & Expungement Act, which was passed by
38 the US House of Representatives in December 2020 but has not yet been considered in the
39 Senate, contains language to "create an automatic process, at no cost to the individual, for the
40 expungement, destruction, or sealing of criminal records for cannabis offenses; and...eliminate
41 violations or other penalties for persons under parole, probation, pre-trial, or other State or local
42 criminal supervision for a cannabis offense"²⁷⁻²⁸; and
43

44 Detrimental Health Impacts of Drug Criminalization

45
46 Whereas, The US Department of Health & Human Services' Healthy People 2020 initiative
47 considers incarceration a key issue within the broad category of social determinants of health,
48 due to poor physical and mental health outcomes and cross-generational effects on the children
49 of those incarcerated, with evidence demonstrating the disproportionate impact of the "War on
50 Drugs" on minoritized communities²⁹⁻³¹; and

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

5
6 Whereas, Research shows that incarceration is ineffective and does not significantly reduce
7 recidivism, drug use, drug overdose deaths, or drug arrests, with a 2013 Washington state study
8 finding that overdose was the leading cause of death for people previously incarcerated³⁴⁻³⁶; and

9
10 Whereas, Drug criminalization is associated with increased stigma and discrimination against
11 people who use drugs, impairing their mental and physical health and hindering treatment
12 efforts; has fueled the growth of illegal markets, organized crime, and violent injuries; and
13 detrimentally affected public health by increasing overdose deaths due to drug contamination
14 and spreading HIV and hepatitis C³⁷⁻⁴¹; and

15
16 Whereas, Previous incarceration of people who use drugs is associated with lack of access to
17 health insurance, even after the implementation of the Affordable Care Act, while possession
18 arrests, regardless of conviction, can negatively impact employment, housing, and student loan
19 eligibility, leading to widespread and multifactorial health consequences⁴²⁻⁴⁴; and

20
21 Whereas, Drug felony convictions can lead to lifelong bans from receiving government
22 assistance (such as SNAP and TANF), employment and housing discrimination, and loss of the
23 right to vote or serve on a jury^{7,45-48}; and

24
25 Whereas, People who are incarcerated are at higher risk of chronic conditions such as
26 cardiovascular disease, hypertension, and cancer compared to the general population, with an
27 important 2013 New York state study finding that each year spent in prison corresponded with a
28 two-year decline in life expectancy⁴⁹⁻⁵⁰; and

29
30 Outcomes of Drug Decriminalization

31
32 Whereas, Drug criminalization is costly, ineffective, and stigmatizing, exposing people to
33 incarceration, encouraging more dangerous drug consumption methods, and discouraging
34 people from receiving health services⁵¹⁻⁵³; and

35
36 Whereas, 83% of Americans believe that the “War on Drugs” has failed, 66% support
37 “eliminating criminal penalties for drug possession,” and 61% of voters support reducing
38 sentences of people currently incarcerated for drug offenses, with similar findings replicated
39 across multiple states⁵⁴⁻⁵⁸; and

40
41 Whereas, California reclassified drug possession from a felony to misdemeanor in 2014 by
42 passing ballot initiative Proposition 47, “The Safe Neighborhoods and Schools Act,” leading to
43 the release or resentencing of 3,000 people and saving the state \$156 million, with a later study
44 finding no associated increase in crime⁵⁹⁻⁶³; and

45
46 Whereas, A 2018 study on cannabis decriminalization in five U.S. states did not find an increase
47 in the prevalence of youth cannabis use as a result of decriminalization⁶⁴; and

48
49 Whereas, In 2010 the Czech Republic decriminalized personal drug possession after a
50 comprehensive policy review determined that criminal penalties did not reduce use or harm and
51 were instead costly and unjustifiable, with later studies demonstrating net societal benefits
52 without increased rates of drug use⁶⁵⁻⁶⁶; and

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

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

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

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

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

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

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

22 **Received: 10/12/22**

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RELEVANT AMA POLICY

Federal Drug Policy in the United States H-95.981

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

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

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

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

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

Support for Drug Courts H-100.955

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

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

Youth Incarceration in Adult Facilities H-60.916

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

Citation: Alt. Res. 917, I-16

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

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

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

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

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

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

Syringe and Needle Exchange Programs H-95.958

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

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

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

Pilot Implementation of Supervised Injection Facilities H-95.925

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

Citation: Res. 513, A-17

Drug Paraphernalia H-95.989

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(I-22)

Introduced by: Medical Student Section

Subject: Support for Mental Health Courts

Referred to: Reference Committee B

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

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

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

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

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

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

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

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

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

1 Whereas, Because mental health courts are dependent on participation from national, state, and
2 local governmental agencies, justice systems, and mental health service organizations and on
3 the appropriation of public funds, including federal monies for MIOTCRA programs and grants
4 administered by SAMHSA and BJA¹⁰⁻¹², the American Medical Association can play a role in
5 advocating for the continued support and funding of mental health courts by policymakers; and
6

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

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

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

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

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

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

29
30 RESOLVED, That AMA Policy H-100.955, Support for Drug Courts, be amended by addition
31 and deletion to read as follows:

32
33 **Support for Mental Health Drug Courts, H-100.955**

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

43
44 Fiscal Note: Minimal – less than \$1,000

45
46 Received: 10/13/22

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RELEVANT AMA POLICY

Support for Drug Courts H-100.955

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

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

Support for Veterans Courts H-510.979

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

Citation: Res. 202, I-19

Maintaining Mental Health Services by States H-345.975

Our AMA:

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

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

AMA Support for Justice Reinvestment Initiatives H-95.931

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

Citation: Res. 205, A-16

Prevention of Impaired Driving H-30.936

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

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

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

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

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

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

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

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

9.7.2 Court-Initiated Medical Treatment in Criminal Cases

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

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

Individual physicians who provide care under court order should:

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

AMA Principles of Medical Ethics: I,III

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

Citation: Issued: 2016

2.1.2 Decisions for Adult Patients Who Lack Capacity

Respect for patient autonomy is central to professional ethics and physicians should involve patients in health care decisions commensurate with the 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 surrogates decision:

- a. is clearly not what the patient would have decided when the patients preferences are known or can be inferred;
- b. could not reasonably be judged to be in the patients best interest; or
- c. primarily serves the interests of the surrogate or other third party rather than the patient.

AMA Principles of Medical Ethics: I,III,VIII

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

Citation: Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 301
(I-22)

Introduced by: Resident and Fellow Section

Subject: Increasing Musculoskeletal Education in Primary Care Specialties and Medical School Education Through Inclusion of Osteopathic Manual Therapy Education

Referred to: Reference Committee C

1 Whereas, According to the American Osteopathic Association, osteopathic manipulative
2 medicine/treatment (OMM/OMT) is special training for the musculoskeletal system that doctors
3 of osteopathy receive to provide care that involves using the hands to diagnose, treat, and
4 prevent illness or injury; and
5
6 Whereas, The evidence basis for OMT is quite broad and spans many disease processes and
7 organ systems and supports its use as an adjunct treatment in a variety of conditions; and
8
9 Whereas, In order to train residents in osteopathic practice and principles (OPP) and
10 osteopathic manipulative treatment (OMT), faculty must be available and qualified; and
11
12 Whereas, Osteopathic Recognition (OR) is a “designation conferred by the ACGME’s
13 Osteopathic Principles Committee upon ACGME-accredited programs that demonstrate,
14 through a formal application process, the commitment to teaching and assessing Osteopathic
15 Principles and Practice (OPP) at the graduate medical education level”; and
16
17 Whereas, Programs must meet criteria laid out by that committee and apply for recognition¹;
18 and
19
20 Whereas, Residents in a recognized program must be assessed for OPP knowledge and “skill
21 proficiency in OMT as applicable to [their] specialty”²; and
22
23 Whereas, As of the 2021-2022 academic year there are approximately 250 PGY-1 GME
24 programs with osteopathic recognition out of the 4,780 available programs (roughly 5%)¹¹;
25 therefore be it
26
27 RESOLVED, That our American Medical Association continue to support equal treatment of
28 osteopathic students, trainees and physicians in the residency application cycle and workplace
29 through continued education on the training of osteopathic physicians (New HOD Policy); and
30 be it further
31
32 RESOLVED, That our AMA encourage education on the benefits of evidence-based
33 Osteopathic Manual Therapy for musculoskeletal conditions in medical education of allopathic
34 students and in primary care residencies. (New HOD Policy)

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

Received: 09/14/22

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3. ACGME - Accreditation Data System (ADS). <https://apps.acgme.org/ads/Public/Reports>. Accessed April 11, 2022.

RELEVANT AMA POLICY

Definition of a Physician H-405.969

1. The AMA affirms that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine. 2. AMA policy requires anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition above, must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree. 3. Our AMA actively supports the Scope of Practice Partnership in the Truth in Advertising campaign. Citation: CME Rep. 4-A-94; Reaffirmed by Sub. Res. 712, I-94; Reaffirmed and Modified: CME Rep. 2, A-04; Res. 846, I-08; Reaffirmed in lieu of Res. 235, A-09; Reaffirmed: Res. 821, I-09; Appended: BOT Rep. 9, I-09; Reaffirmed: BOT Rep. 9, I-11; Reaffirmation A-13; Reaffirmation A-15; Reaffirmed in lieu of: Res. 225, A-17; Reaffirmed: Res. 228, A-19

Definition and Use of the Term Physician H-405.951

Our AMA: 1. Affirms that the term physician be limited to those people who have a Doctor of Medicine, Doctor of Osteopathic Medicine, or a recognized equivalent physician degree and who would be eligible for an Accreditation Council for Graduate Medical Education (ACGME) residency. 2. Will, in conjunction with the Federation, aggressively advocate for the definition of physician to be limited as defined above: a. In any federal or state law or regulation including the Social Security Act or any other law or regulation that defines physician; b. To any federal and state legislature or agency including the Department of Health and Human Services, Federal Aviation Administration, the Department of Transportation, or any other federal or state agency that defines physician; and c. To any accrediting body or deeming authority including the Joint Commission, Health Facilities Accreditation Program, or any other potential body or authority that defines physician. 3. Urges all physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and to not let the term physician be used by any other organization or person involved in health care. 4. Ensure that all references to physicians by government, payers, and other health care entities involving contracts, advertising, agreements, published descriptions, and other communications at all times distinguish between physician, as defined above, and non-physicians and to discontinue the use of the term provider. 5. Policy requires any individual who has direct patient contact and presents to the patient as a doctor, and who is not a physician, as defined above, must specifically and simultaneously declare themselves a non-physician and define the nature of their doctorate degree. 6. Will review and revise its own publications as necessary to conform with the House of Delegates' policies on physician identification and physician reference and will refrain from any definition of physicians as providers that is not otherwise covered by existing Journal of the American Medical Association (JAMA) Editorial Governance Plan, which protects the editorial independence of JAMA. 7. Actively supports the Scope of Practice Partnership in the Truth in Advertising campaign
Citation: Res. 214, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 312
(I-22)

Introduced by: Medical Student Section

Subject: Reporting of Residency Demographic Data

Referred to: Reference Committee C

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

6
7 Whereas, The AMA's Fellowship and Residency Electronic Interactive Database (FREIDA)
8 offers information on academic background of residents (United States MD, United States DO,
9 International Medical Graduate) and the Male to Female ratio, but largely focuses on the
10 academic and professional experiences of residents¹; and

11
12 Whereas, FREIDA's data is derived from the ACGME's annual survey of all residents, which
13 captures little additional demographic and familial data²; and

14
15 Whereas, AAMC gathers this information, as well as a residency applicant's self-identification,
16 via its Electronic Residency Application Service (ERAS)³; and

17
18 Whereas, ERAS makes it possible for the AAMC to sort this data by specialty, which is of
19 particular importance because of the limited number of professional medical societies that have
20 developed surveys to capture this information^{3,4,5}; and

21
22 Whereas, The National Resident Matching Program (NRMP) stated their intention to capture
23 demographic data following the 2022 Main Residency Match, but has primarily gathered
24 information on residents' attitudes towards the graduate medical education experience to
25 date^{6,7}; and

26
27 Whereas, Studies on diversity and inclusion in graduate medical education have largely relied
28 upon the little demographic data published by these national surveys^{8,9}; and

29
30 Whereas, To date, endeavors to gather information on trends in pregnancy, childbirth, and
31 parenthood among residents have been restricted to academic studies, which typically maintain
32 a limited regional focus^{10,11}; and

33
34 Whereas, A recent study of the residency programs affiliated with *US News & World Report's*
35 top 50 medical schools made some information on national family leave policies available¹²; and

36
37 Whereas, Forty-two percent of the study's residency programs offered unpaid leave in
38 accordance with the Family Medical Leave Act (FMLA), which ensures employees of a company
39 or institution for at least 1 year, with 1250 hours of service, qualify for up to 12 weeks of unpaid
40 job protection for family and medical reasons^{12,13}; and

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

4
5 Whereas, No mention was made of adherence to the additional parental leave guidelines
6 imposed by professional specialty societies¹⁴; and

7
8 Whereas, It is of note that these family leave policies were not necessarily published on each
9 program's website, and the authors of this study conducted a web search to find publicly
10 available information, then contacted schools directly for this data¹²; and

11
12 Whereas, Even after these efforts, there was one school that did not publish family leave
13 information on their website and did not respond to inquiries, indicating this information may not
14 be readily accessible to prospective residency applicants and current residents¹²; and

15
16 Whereas, In addition to gathering and publishing information on the items identified in FREIDA,
17 ACGME surveys, and internal residency program surveys should consider collecting information
18 on ability, religion, and immigration status to identify additional resources necessary to support
19 current residents¹⁵; and

20
21 Whereas, To date, there is a scarcity of information on the demographic and parenthood of
22 residents, and existing surveys from FREIDA, ACGME, and internal residency programs could
23 be used to gather this information, as well as data on factors such as incoming and current
24 residents' ability, religion, and immigration status; and

25
26 Whereas, Gathering this robust array of data on the background of residents has the potential to
27 elucidate the path to equity, diversity, and inclusion in medicine; therefore be it

28
29 RESOLVED, That our American Medical Association work with appropriate stakeholders to
30 encourage that residency programs annually publish and share with FREIDA and other
31 appropriate stakeholders, (a) demographic data, including but not limited to the composition of
32 their program over the last 5 years by age, gender identity, URM status, and LGBTQIA+ status;
33 (b) parental and family leave policies; and (c) the number and/or proportion of residents who
34 have utilized parental or family leave in the past 5 years (Directive to Take Action); and be it
35 further

36
37 RESOLVED, That our AMA encourage the Accreditation Council for Graduate Medical
38 Education and other relevant stakeholders to annually collect data on pregnancy, childbirth, and
39 parenthood from all accredited US residency programs and publish this data with
40 disaggregation by gender identity and specialty. (New HOD Policy)

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

Received: 10/13/22

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RELEVANT AMA POLICY

Strategies for Enhancing Diversity in the Physician Workforce D-200.985

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

Citation: CME Rep. 1, I-06; Reaffirmation I-10; Reaffirmation A-13; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-16; Appended: Res. 313, A-17; Appended: Res. 314, A-17; Modified: CME Rep. 01, A-18; Appended: Res. 207, I-18; Reaffirmation: A-19; Appended: Res. 304, A-19; Appended: Res. 319, A-19; Modified: CME Rep. 5, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 603
(I-22)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: AMA House of Delegates Resolution Process Review

Referred to: Reference Committee F

1 Whereas, Submission of resolutions as items of business is an important process at our AMA
2 House of Delegates (HOD); and

4 Whereas, The number of resolutions submitted has increased over time; and

6 Whereas, The rules for submission of resolutions have not been changed in many years
7 including definitions for on time, late and emergency resolutions; and

9 Whereas, There are multiple exceptions to the “on time” resolution definition including
10 resolutions from AMA sections and societies who meet after the “on time” deadline; and

12 Whereas, The Saturday/Sunday tote contains a significant amount of new resolutions each
13 year; and

15 Whereas, The resolutions in the Saturday/Sunday tote cannot be adequately reviewed and
16 vetted by all delegations and delegation staff; and

18 Whereas, For the past 2 years, all delegations and sections have met virtually and have been
19 able to work asynchronously to discuss and vote on potential resolutions to submit to the AMA
20 HOD; and

22 Whereas, According to Bylaws 2.11.3.1, “To be considered as regular business, each resolution
23 must be introduced by a delegate or organization represented in the House of Delegates and
24 must have been submitted to the AMA not later than 30 days prior to the commencement of the
25 meeting at which it is to be considered”; and

27 Whereas, According to Bylaws 2.11.3.1.3, “Late resolutions may be presented by a delegate
28 prior to the recess of the opening session of the House of Delegates, and will be accepted as
29 business of the House of Delegates only upon two-thirds vote of delegates present and voting”;
30 and

32 Whereas, According to Bylaws 2.11.3.1.4 Emergency Resolutions, “resolutions of an
33 emergency nature may be presented by a delegate any time after the opening session of the
34 House of Delegates is recessed. Emergency resolutions will be accepted as business only upon
35 a three-fourths vote of delegates present and voting, and if accepted shall be presented to the
36 House of Delegates without consideration by a reference committee. A simple majority vote of
37 the delegates present and voting shall be required for adoption”; and

1 Whereas, The ability to meet virtually and work asynchronously has been enhanced during the
2 pandemic to the point where it is potentially more efficient and convenient for delegations and
3 sections; therefore be it
4
5 RESOLVED, That our American Medical Association review the entire process of resolution
6 submission including re-evaluating the definitions of “on time,” late, and emergency resolutions
7 and current exceptions with a report back at the Interim 2023 meeting (Directive to Take Action);
8 and be it further
9
10 RESOLVED, That the review committee consider changing the policy so that all on time
11 resolutions must be submitted to the HOD by the same deadlines so that the only resolutions in
12 the Saturday/Sunday tote would be emergency and late resolutions to be voted on for
13 acceptance by the HOD (Directive to Take Action); and be it further
14
15 RESOLVED, That the review committee consider changing the rule so that all sections of the
16 AMA will submit their “on time” resolutions by the same deadlines as the rest of the HOD, with
17 only emergency resolutions to be submitted after Section meetings during the week before the
18 annual or interim meetings (Directive to Take Action); and be it further
19
20 RESOLVED, That our AMA facilitate virtual meetings of the sections prior to the resolution
21 deadline so that all resolutions can be submitted, reviewed, and discussed prior to the deadline.
22 (Directive to Take Action)

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

Received: 09/28/22

References:

AMA Constitution and Bylaws: <https://www.ama-assn.org/system/files/ama-constitution-and-bylaws.pdf>

RELEVANT AMA POLICY

House of Delegates

Procedure. B-2.11

2.11.1 Order of Business. The Order of Business will be proposed by the Speaker and approved by the House of Delegates.

At any meeting, the House of Delegates, by majority vote, may change the order of business.

2.11.2 Privilege of the Floor. The House of Delegates, by a two-thirds vote of delegates present and voting, may extend to any person an invitation to address the House.

2.11.3 Introduction of Business.

2.11.3.1 Resolutions. To be considered as regular business, each resolution must be introduced by a delegate or organization represented in the House of Delegates and must have been submitted to the AMA not later than 30 days prior to the commencement of the meeting at which it is to be considered, with the following exceptions.

2.11.3.1.1 Exempted Resolutions. If any member organization's house of delegates or primary policy making body, as defined by the organization, adjourns during the 5-week period preceding commencement of an AMA House of Delegates meeting, the organization is allowed 7 days after the close of its meeting to submit resolutions to the AMA. All such resolutions must be received by noon of the day before the commencement of the AMA House of Delegates meeting. The presiding officer of the organization shall certify that the resolution was adopted at its just concluded meeting and that the body directed that the resolution be submitted to the AMA House of Delegates.

2.11.3.1.2 AMA Sections. Resolutions presented from the business meetings of the AMA Sections may be presented for consideration by the House of Delegates no later than the recess of the House of Delegates opening session to be accepted as regular business. Resolutions presented after the recess of the opening session of the House of Delegates will be accepted in accordance with Bylaw 2.11.3.1.4.

2.11.3.1.3 Late Resolutions. Late resolutions may be presented by a delegate prior to the recess of the opening session of the House of Delegates, and will be accepted as business of the House of Delegates only upon two-thirds vote of delegates present and voting.

2.11.3.1.4 Emergency Resolutions. Resolutions of an emergency nature may be presented by a delegate any time after the opening session of the House of Delegates is recessed. Emergency resolutions will be accepted as business only upon a three-fourths vote of delegates present and voting, and if accepted shall be presented to the House of Delegates without consideration by a reference committee. A simple majority vote of the delegates present and voting shall be required for adoption.

2.11.3.1.5 Withdrawal of Resolutions. A resolution may be withdrawn by its sponsor at any time prior to its acceptance as business by the House of Delegates.

2.11.3.1.6 Resolutions not Accepted. Late resolutions and emergency resolutions not accepted as business by the House of Delegates may be submitted for consideration at a future meeting in accordance with the procedure in Bylaw 2.11.3.

2.11.3.2 Business from the Board of Trustees. Reports, recommendations, resolutions or other new business, may be presented by the Board of Trustees at any time during a meeting. Items of business presented before the recess of the opening session of the House of Delegates will be accepted as regular business. Items of business presented after the recess of the opening session of the House of Delegates will be accepted as emergency business and shall be presented to the House of Delegates without consideration by a reference committee. A two-thirds vote of the delegates present and voting shall be required for adoption.

2.11.3.3 Business from the Councils. Reports, opinions or recommendations from a council of the AMA or a special committee of the House of Delegates may be presented at any time during a meeting. Items of business presented before the recess of the opening session of the House of Delegates will be accepted as regular business. Items of business presented after the recess of the opening session of the House of Delegates will be accepted as emergency business and shall be presented to the House of Delegates without consideration by a reference committee. A two-thirds vote of the delegates present and voting shall be required for adoption.

2.11.3.4 Informational Reports of Sections. Informational reports may be presented by the AMA Sections on an annual basis.

2.11.4 Referral to Reference Committee. Reports, recommendations, resolutions or other new business presented prior to the recess of the opening session of the House of Delegates shall be referred to an appropriate reference committee for hearings and report, subject to acceptance as business of the House of Delegates. Items of business presented after the recess of the opening session are not referred to reference committee, but rather heard by the House of Delegates as a whole, subject to acceptance as business of the House of Delegates. Informational items are not referred to a reference committee.

2.11.6 Quorum. A majority of the voting members of the House of Delegates Official Call shall constitute a quorum.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(I-22)

Introduced by: Resident and Fellow Section

Subject: Solicitation Using the AMA Brand

Referred to: Reference Committee F

1 Whereas, Some physicians are turned off by third party solicitation material mailed with the
2 AMA brand, such as regarding disability insurance or student loan refinancing, potentially
3 harming the AMA's reputation and costing physician membership; and

5 Whereas, Financial literacy websites such as White Coat Investor detail the flaws in the AMA
6 branded third party disability insurance plan¹; and

8 Whereas, There is a financial and environmental cost to printed solicitation; and

10 Whereas, Associating the AMA brand to specific third-party products may or may not be in the
11 best interest of the AMA or current and potential AMA members; therefore be it

13 RESOLVED, That our American Medical Association study the use of AMA branded solicitation
14 material mailed to physicians, the impact it has on the perception of our AMA by current and
15 potential physician members, and the merits of continuing to use these materials in future
16 communications (Directive to Take Action); and be it further

18 RESOLVED, That our AMA study our membership on the preferred method to receive third
19 party solicitation material (mail, phone, email, social media) and provide a method to opt-out of
20 certain methods if not desired. (Directive to Take Action)

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

Received: 09/30/22

References:

1. [AMA's Disability Insurance: You Get What You Pay For - White Coat Investor](#)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 605
(I-22)

Introduced by: Melissa Garretson, MD, Delegate

Subject: Decreasing Political Advantage Within AMA Elections

Referred to: Reference Committee F

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

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

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

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

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

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

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

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

Received: 10/12/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 608
(I-22)

Introduced by: Medical Student Section

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

Referred to: Reference Committee F

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

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

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

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

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

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

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

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

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

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

5
6 Whereas, Early analysis of the PIN has identified that early engagement of physicians and
7 respecting a physician’s time and expertise contribute to more meaningful connections between
8 physicians and entrepreneurs⁸; and

9
10 Whereas, The PIN currently experiences limited physician utilization, as evidenced by:

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

16
17 Whereas, Our AMA advocates that our organization, national, and medical specialty societies
18 and state medical associations (H-480.939):

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

23
24 RESOLVED, That our American Medical Association augment the existing Physician Innovation
25 Network (PIN) through the creation of advisors to specifically link physician members of AMA
26 and its associated specialty societies with companies or individuals working on augmented
27 intelligence (AI) research and development, focusing on:

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

39
40 RESOLVED, That our AMA support selection of PIN advisors through an application process
41 where candidates are screened by PIN leadership for interpersonal skills, problem solving,
42 networking abilities, objective decision making, and familiarity with industry. (Directive to Take
43 Action)

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

Received: 10/11/22

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RELEVANT AMA POLICY

Augmented Intelligence in Health Care H-480.940

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

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

Citation: BOT Rep. 41, A-18

Augmented Intelligence in Health Care H-480.939

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 901
(I-22)

Introduced by: Medical Student Section

Subject: Opposing the Use of Vulnerable Incarcerated People in Response to Public Health Emergencies

Referred to: Reference Committee K

1 Whereas, While imprisoned, able-bodied incarcerated people are often required to work and
2 assigned duties if they have not already identified a job for themselves¹; and

4 Whereas, Incarcerated people can work in a variety of positions⁴; and

6 Whereas, Refusal to perform involuntary prison labor can be punished through various means,
7 including solitary confinement, revocation of family visitation, loss of earned “good behavior”
8 time^{2,3}; and

10 Whereas, Work programs operate in 88% of prisons in the United States and employ
11 approximately 775,000 prisoners⁵; and

13 Whereas, The prison system was hit especially hard during the initial waves of the COVID-19
14 pandemic in 2020 and since the primary defense against infection is vaccines, which did not
15 reach incarcerated people until 2021, and given prisons’ notoriously crowded environments,
16 COVID-19 rates in prisons soared⁶; and

18 Whereas, Staff shortages during this time meant that there were also fewer nurses and guards
19 to ensure the incarcerated people’s health and physical well-being⁷; and

21 Whereas, Despite the infection rates, many prison systems did not follow protocols to prevent
22 the spread of COVID-19 and still expected incarcerated workers to work in similar conditions to
23 those prior to the pandemic⁸; and

25 Whereas, For example, in the Washington Department of Corrections (WDOC), the prison
26 managers did not enforce post-exposure isolation and did not provide adequate hand sanitizer
27 or social distancing measures⁸; and

29 Whereas, California also kept their prison factories running through the pandemic, even as
30 infection rates rose, and incarcerated people report being threatened that their chances for
31 release from prison would be put into jeopardy if they refused to attend work because of
32 COVID-19 safety concerns because although prison representatives report that adequate
33 measures to address COVID-19 were put into place, interviews from across the United States
34 show otherwise^{9,10}; and

36 Whereas, As of February 10th, 2022, more than 476,000 people incarcerated in prisons have
37 had confirmed cases of COVID-19 and over 2,900 people have died from COVID-19 behind
38 bars¹¹; and

1 Whereas, During the COVID-19 pandemic, prison labor was used to assist front line workers in
2 a national response¹²; and

3
4 Whereas, States such as New York, Missouri, Louisiana, and others, made use of this prison
5 labor to quickly and cheaply make needed products and prisoners were forced to make
6 products used by front-line workers such as hand sanitizer, gowns, masks and even products
7 such as toilet paper, which did not benefit first responders directly, were produced by these
8 workers and wages for this work were far below minimum wage, but many were not paid at all;
9 and

10
11 Whereas, The prison-workplaces did not implement social distancing measures on par with
12 equivalent workplaces in non-carceral settings; and

13
14 Whereas, The Occupational Safety and Health Act of 1970 (OSH Act) requires that employers
15 provide employees with safe working conditions that are free of serious recognized hazards and
16 in compliance with Occupational Safety and Health Administration (OSHA)'s safety and health
17 standards¹³; and

18
19 Whereas, In addition to an employer's "general duty" to provide a safe workplace, OSHA sets in
20 place specific safety standards for certain workplaces, such as providing personal protective
21 equipment (PPE) and limiting exposure to toxic substances such as lead and asbestos and
22 OSHA can inspect private workplaces and workers can file complaints with OSHA regarding
23 unsafe working conditions with protection against retaliation; and

24
25 Whereas, However, the definition of "employer" in the OSH Act specifically excludes States and
26 political subdivisions of States - meaning that federal and state prisons employing prisoners are
27 exempted from the OSH Act¹⁴; and

28
29 Whereas, In federal prisons, the Bureau of Prisons provides health and safety requirements for
30 incarcerated workers through its occupational health and safety program¹⁵; and

31
32 Whereas, This policy includes annual safety training for incarcerated workers, investigations into
33 work-related injuries, and compensation for lost wages due to workplace injuries while injury
34 compensation, is restricted to individuals working through the Federal Prison Industries and
35 work assignments related to the maintenance of the facility; and

36
37 Whereas, For state prison workers, safety standards are left to the discretion of the state, with
38 some states not granting many protections at all^{14,16}; and

39
40 Whereas, For example, Pennsylvania provides compensation for lost wages for inmate workers
41 who suffer work-related injuries, while Texas explicitly excludes incarcerated workers from
42 receiving work-related injury compensation in their statute while in another example, the
43 California Prison Industry Authority (CALPIA) is a state agency that oversees the prison work
44 programs in the country's second largest prison system¹⁷; and

45
46 Whereas, In California, inmate workers cannot receive workers' compensation while still
47 incarcerated. Furthermore, the shortage of federal regulations has led to a lack of data related
48 to workplace conditions and injuries in corrections facilities and for policymakers to understand
49 the full extent of existing workplace safety standards in prisons, there must be a standard of
50 reporting¹⁸; and

1 Whereas, The issue of prison labor is an ethically nuanced topic with multiple points to consider.
2 There are benefits to providing incarcerated people with jobs, such as providing them a sense of
3 community and purpose because participating in meaningful work can help develop professional
4 skills that can benefit them once released and these jobs also potentially help incarcerated
5 people earn money to support themselves while incarcerated and after release; and

6
7 Whereas, Prison labor can be ethically appropriate when done in the best interest of the
8 prisoner without coercion or influence from exploitative purposes and incarcerated people must
9 be fairly compensated for their work to avoid said exploitation and provide them meaningful
10 resources as a result; and

11
12 Whereas, While it has been the policy to have imprisoned individuals do dangerous tasks, such
13 as working in crowded environments during the COVID-19 pandemic, at times it has been done
14 with inadequate protection and in the case of a pandemic, decreased protection due to
15 inadequate PPE and work conditions inconsistent with guidelines from the CDC and NIH would
16 constitute exploitative labor in addition to prisoners working in prisons where there was a
17 statistically higher level of COVID cases throughout the course of the pandemic, leading to a
18 five-fold greater risk of infection and 30% greater risk of death from infection compared to the
19 general population¹⁹; and

20
21 Whereas, Further, incarcerated people are often not protected by regulatory health and safety
22 standards, such as OSHA, practiced in the non-incarcerated context and without these
23 regulatory mechanisms, it is difficult to ascertain the extent of dangerous working conditions in
24 prisons and offer avenues for recourse for unsafe working conditions; and

25
26 Whereas, If the work being done by prisoners could be considered "essential" then they too
27 would be owed increased compensation²⁰; and

28
29 Whereas, Whether wildfires or a pandemic, no emergency justifies labor exploitation of a
30 population made vulnerable by the state, and any need for labor must also offer fair
31 compensation, preferential benefits (such as official certification and paths to further job
32 opportunities), and of course safety guarantees that are satisfactory with standard workplace
33 safety laws and regulatory bodies^{21,22}; and

34
35 Whereas, Current AMA policy sets a strong precedent for protecting incarcerated populations
36 from communicable diseases and has advocated for stronger protections for incarcerated
37 populations against COVID-19 during the early stages of the pandemic when outbreaks in
38 prisons were commonplace; and

39
40 Whereas, The AMA advocates for safe working conditions for all people through OSHA
41 regulation (D-135.935, D-135.974, H-135.935, H-490.413) and acknowledges that people who
42 are incarcerated are a vulnerable population (H-430.986); and

43
44 Whereas, The AMA supports access to healthcare while incarcerated, programs to help
45 incarcerated people transition to care once released, and promotes acceptable living conditions
46 (H-430.986, H-430.997); and

47
48 Whereas, While current policy addresses the need for healthcare and acknowledges exposure
49 risks related to incarceration itself, there is not a clear policy advocating for protection against
50 work-related exposures while incarcerated because clear gap in policy exists and AMA
51 advocacy could meaningfully improve prison workplace conditions to prevent further exploitation
52 of incarcerated peoples; therefore be it

1 RESOLVED, That our American Medical Association oppose the use of forced or coercive labor
2 practices for incarcerated populations (New HOD Policy); and be it further

3
4 RESOLVED, That our AMA support that any labor performed by incarcerated individuals or
5 other captive populations should include adequate workplace safety and fairness standards
6 similar to those outside of carceral institutions and support their reintegration into the workforce
7 after incarceration. (New HOD Policy)

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

Received: 09/20/22

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RELEVANT AMA POLICY

Support Stricter OSHA Silica Permissible Exposure Limit Standard D-135.974

Our AMA: (1) supports the Department of Labor's Occupational Safety and Health Administration's (OSHA's) proposed rule to establish a stricter permissible exposure limit (PEL) for respirable crystalline silica; (2) supports OSHA's proposed rule to establish a stricter standard of exposure assessment and medical surveillance requirements to identify adverse health effects in exposed populations of workers; and (3) will submit comments, in collaboration with respiratory and occupational health medical societies, in support of a stricter silica PEL.

Res. 916, I-13

Advocating for Heat Exposure Protections for All Workers D-135.967

Our AMA: (1) will advocate for all workers to have access to preventive cool-down rest periods in shaded, ventilated, and/or cooled areas for prevention of injury from sun exposure and heat injury as well as appropriate access to emergency services when signs and symptoms of heat exposure injury; (2) will advocate for legislation that creates federal standards for protections against heat stress and sun exposure specific to the hazards of the workplace; (3) supports policy change at the federal level via legislation or administrative rule changes by the Occupational Safety and Health Administration (OSHA) that would require that workers receive health educational materials about prevention and recognition of heat exhaustion and heat exposure injury that is in the worker's primary language; (4) will work with the United States Department of Labor, OSHA, and other appropriate federal stakeholders to develop and enforce evidence-based policies, guidelines, and protections against heat injury for workers independent of legal status; and (5) recognizes there are particular medical conditions and medications, including but not limited to psychotropics, which increase an individual's vulnerability to the negative impacts of heat and sun exposure and advocate for recognition of this, as well as additional protections as part of any guidelines, legislation or other policies.

Res. 502, I-21

OSHA Standards for Lead H-135.935

Our AMA will advocate with American College of Occupational and Environmental Medicine and other professional organizations to change the Occupational Safety & Health Administration legal standard for temporary medical removal from all lead work environments, regardless of the airborne lead concentrations, which result in workers' blood lead levels exceeding 20 mcg/dL on any two consecutive blood tests, or any single value exceeding 30 mcg/dL, as recommended by a subgroup of an expert panel convened by the Association of Occupational and Environmental Clinics (2007) and by Cal/OSHA (2009).

Res. 423, A-10, Reaffirmed: CSAPH Rep. 01, A-20

Support Public Health Approaches for the Prevention and Management of Contagious Diseases in Correctional and Detention Facilities H-430.979

1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.
2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.
3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.
4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.
5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.
6. Our AMA will advocate: (a) for all employees working in a correctional facility or detention center to be up to date with vaccinations against COVID-19, unless there is a valid medical contraindication; (b) for all employees working in a correctional facility or detention center, not up to date with vaccination for COVID-19 to be COVID rapid tested each time they enter a correctional facility or detention center, as consistent with Centers for Disease Control and Prevention (CDC) or local public health guidelines; (c) for correctional facility or detention center policies that require non-employed, non-residents (e.g. visitors, contractors, etc.) to either show evidence of being up to date for COVID-19 vaccines or show proof of a negative COVID test when they enter a correctional facility or detention center as consistent with CDC or local public health guidelines, at no cost to

the visitor; (d) that all people inside a correctional facility or detention center wear an appropriate mask at all times, except while eating or drinking or at a 6 ft. distance from anyone else if local transmission rate is above low risk as determined by the CDC; and (e) that correctional facilities or detention centers be able to request and receive all necessary funding for COVID-19 vaccination and testing, according to CDC or local public health guidelines.

Alt. Res. 404, I-20, Appended: Res. 406, A-22

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.

CMS Rep. 02, I-16, Appended: Res. 417, A-19, Appended: Res. 420, A-19, Modified: Res. 216, I-19, Modified: Res. 503, A-21, Reaffirmed: Res. 229, A-21, Modified: Res. 127, A-22

Standards of Care for Inmates of Correctional Facilities H-430.997

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance use disorder care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

Res. 60, A-84, Reaffirmed by CLRPD Rep. 3 - I-94, Amended: Res. 416, I-99, Reaffirmed: CEJA Rep. 8, A-09, Reaffirmation I-09, Modified in lieu of Res. 502, A-12, Reaffirmation: I-12, Modified: CSAPH Rep. 1, A-22

Smoke-Free and Vape-Free Environments and Workplaces H-490.913

On the issue of the health effects of environmental tobacco smoke (ETS), passive smoke, and vape aerosol exposure in the workplace and other public facilities, our AMA: (1) (a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free and vape-free campuses for business, labor, education, and government; (2) (a) honors companies and governmental workplaces that go smoke-free and vape-free; (b) will petition the Occupational Safety and Health Administration (OSHA) to adopt regulations prohibiting smoking and vaping in the workplace, and will use active political means to encourage the Secretary of Labor to swiftly promulgate an OSHA standard to protect American workers from the toxic effects of ETS in the workplace, preferably by banning smoking and vaping in the workplace; (c) encourages state medical societies (in collaboration with other anti-tobacco organizations) to support the introduction of local and state legislation that prohibits smoking and vaping around the public entrances to buildings and in all indoor public places, restaurants, bars, and workplaces; and (d) will update draft model state legislation to prohibit smoking and vaping in public places and businesses, which would include language that would prohibit preemption of stronger local laws; (3) (a) encourages state medical societies to: (i) support legislation for states and counties mandating smoke-free and vape-free schools and eliminating smoking and vaping in public places and businesses and on any public transportation; (ii) enlist the aid of county medical societies in local anti-smoking and anti-vaping campaigns; and (iii) through an advisory to state, county, and local medical societies, urge county medical societies to join or to increase their commitment to local and state anti-smoking and anti-vaping coalitions and to reach out to local chapters of national voluntary health agencies to participate in the promotion of anti-smoking and anti-vaping control measures; (b) urges all restaurants, particularly fast food restaurants, and convenience stores to immediately create a smoke-free and vape-free environment; (c) strongly encourages the owners of family-oriented theme parks to make their parks smoke-free and vape-free for the greater enjoyment of all guests and to further promote their commitment to a happy, healthy life style for children; (d) encourages state or local legislation or regulations that prohibit smoking and vaping in stadia and encourages other ball clubs to follow the example of banning smoking in the interest of the health and comfort of baseball fans as implemented by the owner and management of the Oakland Athletics and others; (e) urges eliminating cigarette, pipe and cigar smoking and vaping in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking inhalation; (f) urges state and county medical societies and local health professionals to be especially prepared to alert communities to the possible role of the tobacco industry whenever a petition to suspend a nonsmoking or non-vaping ordinance is introduced and to become directly involved in community tobacco control activities; and (g) will report annually to its membership about significant anti-smoking and anti-vaping efforts in the prohibition of smoking and vaping in open and closed stadia; (4) calls on corporate headquarters of fast-food franchisers to require that one of the standards of operation of such franchises be a no smoking and no vaping policy for such restaurants, and endorses the passage of laws, ordinances and regulations that prohibit smoking and vaping in fast-food restaurants and other entertainment and food outlets that target children in their marketing efforts; (5) advocates that all American hospitals ban tobacco and supports working toward legislation and policies to promote a ban on smoking, vaping, and use of tobacco products in, or on the campuses of, hospitals, health care institutions, retail health clinics, and educational institutions, including medical schools; (6) will work with the Department of Defense to explore ways to encourage a smoke-free and vape-free environment in the military through the use of mechanisms such as health education, smoking and vaping cessation programs, and the elimination of discounted prices for tobacco products in military resale facilities; and (7) collaborates with local and state medical societies and tobacco control coalitions to work with (a) Native American casino and tribal leadership to voluntarily prohibit smoking and vaping in their casinos; and (b) legislators and the gaming industry to support the prohibition of smoking and vaping in all casinos and gaming venues.

CSA Rep. 3, A-04, Appended: Sub. Res. 426, A-04, Modified: CSAPH Rep. 1, I-07, Reaffirmation I-14, Reaffirmation I-15, Modified: Res. 902, I-19, Modified: Res. 417, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 903
(I-22)

Introduced by: Medical Student Section

Subject: Supporting Further Study of Kratom

Referred to: Reference Committee K

1 Whereas, *Mitragyna speciosa* is a plant species commonly known as "Kratom" which is
2 characterized by analgesic, anxiolytic, and stimulatory properties depending on the strain and
3 dose, and is commonly used in Southeast Asia as a remedy for common ailments such as fever
4 and cough, as a stimulant to combat fatigue, and as a social drink¹⁻³; and

5 Whereas, Kratom acts on mu-opioid receptors to produce analgesia and euphoria⁴; and

6 Whereas, Millions of Americans currently use Kratom as an alternative to opioids for its pain-
7 relieving and mood-altering effects⁵; and

8 Whereas, A cross-sectional survey of 59,714 U.S. adults found an estimated 0.8% past-year
9 prevalence, with Kratom users having an above-average substance abuse profile⁶; and

10 Whereas, A systematic review on the mental health effects of Kratom found that Kratom
11 withdrawal is relatively mild compared to opioids while still significant enough that some users
12 found difficulty maintaining abstinence⁷; and

13 Whereas, One study surveyed 500 patients with substance use disorder and found that 68.9%
14 of the respondents were using Kratom to reduce or replace opioid use, suggesting that Kratom
15 may have potential as a harm-reducing agent for substance use disorder¹; and

16 Whereas, One study found that the risk of mortality from Kratom overdose is over 1,000 times
17 less than the risk of mortality from overdose with other opioids, and found that other substances
18 like heroin and methamphetamine were usually present in Kratom users who had experienced
19 significant adverse side effects⁸; and

20 Whereas, Between 2011 and 2017, there were 11 deaths associated with Kratom exposure,
21 including two deaths associated with Kratom use alone, and 7 reported neonatal exposures with
22 5 neonates experiencing withdrawal symptoms⁹; and

23 Whereas, A retrospective review identified 2,312 Kratom exposures reported to the National
24 Poison Control Centers between 2011 and 2018, with 935 cases involving Kratom alone, with
25 serious side effects reported including seizure (6.1%), withdrawal (6.1%), hallucinations (4.8%),
26 respiratory depression (2.8%), coma (2.3%), and cardiac or respiratory arrest (0.6%)¹⁰; and

27 Whereas, Research has shown that Kratom can lead to various organ toxicities, including acute
28 liver failure, acute kidney failure, seizure, brain injury, and cardiovascular toxicities^{11,12}; and

29 Whereas, Kratom can be purchased on the internet from vendors, often without age
30 verification¹³; and

1 Whereas, As of 2022, Kratom is legal in 44 states and explicitly banned in six states¹⁴; and
2
3 Whereas, Several states are considering banning or regulating Kratom to various degrees¹⁴;
4 and
5
6 Whereas, The Controlled Substance Act (CSA) established five tiers of drugs based upon eight
7 distinct criteria, determined primarily by the Drug Enforcement Administration¹⁵; and
8
9 Whereas, The first tier, “Schedule 1”, is defined to include “drugs with no currently accepted
10 medical use, has a high potential for abuse, and that there is a lack of accepted safety for the
11 use of the drug under medical supervision”¹⁶; and
12
13 Whereas, Prescriptions may only be written for Schedule II through V drugs, with Schedule I
14 drugs only available for research purposes^{17,18}; and
15
16 Whereas, Drug Enforcement Administration (DEA) scheduling of Kratom could impact
17 physicians’ prescribing habits and limit patient access to Kratom, should it be determined to
18 have medical utility, as evidenced by scheduling adjustments of other substances^{19,20}; and
19
20 Whereas, One study found that within six months of rescheduling hydrocodone, a 20% decline
21 in prescribing and dispensing was observed in the U.S and Australia²⁰; and
22
23 Whereas, In the UK, scheduling of mephedrone in 2011 led to a 49% of mephedrone users
24 increasing MDMA use, a 40% increase in purchasing of mephedrone from illicit sources, and an
25 increase in mephedrone-related deaths from 2011-2015^{20,21}; and
26
27 Whereas, Research on Schedule I drugs requires completing an application and registration
28 with the DEA²²; and
29
30 Whereas, Schedule I drugs may be difficult to obtain for research as manufacturers and custom
31 synthesis companies are sparse or prohibitively expensive²³; and
32
33 Whereas, Funding for the study of Schedule I drugs is limited, with a significant portion of the
34 research focused on potential harms rather than potential clinical applications²³; and
35
36 Whereas, LSD was extensively studied for potential in psychotherapy before classification as a
37 Schedule I drug; however, following the scheduling of LSD, research declined sharply²³; and
38
39 Whereas, Research into whether the positive characteristics of Kratom use outweigh the
40 potential adverse effects is currently insufficient to draw general conclusions²⁴; and
41
42 Whereas, Scheduling Kratom prior to robust research showing that the harms outweigh the
43 potential benefits would limit the conduct of future studies that might identify novel therapies for
44 substance use disorder^{1,2,7,8,23,24}, therefore be it

1 RESOLVED, That our American Medical Association amend policy H-95.934, "Kratom and its
2 Growing Use Within the United States," by addition and deletion to read as follows:
3

4 Kratom and its Growing Use Within the United States, H-95.934
5 Our AMA: supports ~~legislative or regulatory efforts to prohibit the sale or distribution of~~
6 ~~Kratom in the United States which do not inhibit proper scientific research efforts to~~
7 ~~further study the clinical uses, benefits, and potential harms of Kratom, and oppose~~
8 ~~efforts that may restrict research.~~ (Modify Current HOD Policy)

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

Received: 09/20/22

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RELEVANT AMA POLICY

Kratom and its Growing Use Within the United States H-95.934

Our AMA supports legislative or regulatory efforts to prohibit the sale or distribution of Kratom in the United States which do not inhibit proper scientific research.

Res. 509, A-16

Cannabis and Cannabinoid Research H-95.952

1. Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.
2. Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.
3. Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.
4. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.
5. Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.
6. Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.
7. Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.

CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01; Modified: CSAPH Rep. 3, I-09; Modified in lieu of Res. 902, I-10; Reaffirmed in lieu of Res. 523, A-11; Reaffirmed in lieu of Res. 202, I-12; Reaffirmed: CSAPH Rep. 2, I-13; Modified: CSAPH Rep. 05, I-17; Reaffirmed in lieu of: Res. 434, A-19; Appended: Res. 913, I-19; Appended: Res. 913, I-19; Reaffirmation: A-22

FDA H-100.992

1. Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials, real-world data (RWD) fit for regulatory purpose, and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials, RWD fit for regulatory purpose, and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.
2. The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.
3. It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history.

Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation A-06; Appended: Sub. Res. 509, A-06; Reaffirmation I-07; Reaffirmation I-09; Reaffirmation I-10; Modified: CSAPH Rep. 02, I-18; Modified: CSAPH Rep. 02, I-19; Reaffirmed: BOT Rep. 5, I-20

Drugs of Choice H-100.997

Our AMA opposes any proposal that would establish a classification of drugs of choice for any specific clinical entity through governmental regulation.

Res. 117, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

Dietary Supplements and Herbal Remedies H-150.954

(1) Our AMA supports efforts to enhance U.S. Food and Drug Administration (FDA) resources, particularly to the Office of Dietary Supplement Programs, to appropriately oversee the growing dietary supplement sector and adequately increase inspections of dietary supplement manufacturing facilities.

(2) Our AMA supports the FDA having appropriate enforcement tools and policies related to dietary supplements, which may include mandatory recall and related authorities over products that are marketed as dietary supplements but contain drugs or drug analogues, the utilization of risk-based inspections for dietary supplement manufacturing facilities, and the strengthening of adverse event reporting systems.

(3) Our AMA supports continued research related to the efficacy, safety, and long-term effects of dietary supplement products.

(4) Our AMA will work with the FDA to educate physicians and the public about FDA's Safety Reporting Portal (SRP) and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.

(5) Our AMA strongly urges physicians to inquire about patients' use of dietary supplements and engage in risk-based conversations with them about dietary supplement product use.

(6) Our AMA continues to strongly urge Congress to modify and modernize the Dietary Supplement Health and Education Act to require that:

(a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy;

(b) dietary supplements meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling;

(c) FDA establish a mandatory product listing regime that includes a unique identifier for each product (such as a QR code), the ability to identify and track all products produced by manufacturers who have received warning letters from the FDA, and FDA authorities to decline to add labels to the database if the label lists a prohibited ingredient or new dietary ingredient for which no evidence of safety exists or for products which have reports of undisclosed ingredients; an

(d) regulations related to new dietary ingredients (NDI) are clarified to foster the timely submission of NDI notifications and compliance regarding NDIs by manufacturers.

(7) Our AMA supports FDA postmarketing requirements for manufacturers to report adverse events, including drug interactions; and legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement

(8) Our AMA will work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements and supports adequate funding and resources for FTC enforcement of violations of the FTC Act.

(9) Our AMA strongly urges that criteria for the rigor of scientific evidence needed to support a structure/function claim on a dietary supplement be established by the FDA and minimally include requirements for robust human studies supporting the claim.

(10) Our AMA strongly urges dietary supplement manufacturers and distributors to clearly label all products with truthful and not misleading information and for the product labeling to:

(a) not include structure/function claims that are not supported by evidence from robust human studies;

(b) not contain prohibited disease claims;

(c) eliminate "proprietary blends" and list and accurately quantify all ingredients contained in the product;

(d) require advisory statements regarding potential supplement-drug and supplement-laboratory interactions and risks associated with overuse and special populations; and

(e) include accurate and useful disclosure of ingredient measurement.

(11) Our AMA supports and encourages the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies.

(12) Our AMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.

(13) Our AMA will continue its efforts to educate patients and physicians about the risks associated with the use of dietary supplements and herbal remedies and supports efforts to increase patient, healthcare

practitioner, and retailer awareness of resources to help patients select quality supplements, including educational efforts to build label literacy.

Res. 513, I-98; Reaffirmed: Res. 515, A-99; Amended: Res. 501 & Reaffirmation I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 516, I-00; Modified: Sub. Res. 516, I-00; Reaffirmed: Sub. Res. 518, A-04; Reaffirmed: Sub. Res. 504, A-05; Reaffirmation A-05; Reaffirmed in lieu of Res. 520, A-05; Reaffirmation I-09; Reaffirmed in lieu of Res. 501, A-10; Reaffirmation A-11; Reaffirmation I-14; Modified: Res. 511, A-16; Reaffirmation: A-17; Reaffirmation: A-19; Modified: CSAPH Rep. 3, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 914
(I-22)

Introduced by: Washington

Subject: Greenhouse Gas Emissions from Health Care

Referred to: Reference Committee K

1 Whereas, Climate change is a risk multiplier that threatens to unravel decades of development
2 gains; and

4 Whereas, Nearly 10% of all US greenhouse gas emissions are from health care; and

6 Whereas, The house of medicine has a responsibility to limit its contribution to climate change
7 because of its impact on human health; and

9 Whereas, The use of hydrofluorocarbons is a known contributor to climate change; and

11 Whereas, Metered-dose inhalers (MDIs) use hydrofluorocarbons as a propellant, making a
12 significant contribution to the health care sector's greenhouse gas emissions; and

14 Whereas, MDIs remain an important part of asthma and COPD care and need to still be
15 available, as dry-powdered inhalers are not the best option for everyone, dry-powdered inhalers
16 nonetheless have been shown to have equal or superior efficacy and tolerability to MDIs, and
17 thus should be developed and made available; therefore be it

19 RESOLVED, That our American Medical Association advocate for reducing greenhouse gas
20 emissions from health care as well as strategies for increasing the resilience of our health
21 system to the adverse impacts of climate change (Directive to Take Action); and be it further

23 RESOLVED, That our AMA study the climate effects of metered-dose inhalers, options for
24 reducing hydrofluorocarbon use in the medical sector, and strategies for encouraging the
25 development of alternative inhalers with equal efficacy and less adverse effect on our climate.
26 (Directive to Take Action)

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

Received: 10/10/22

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2. Market Characterization of the US Metered Dose Inhaler Industry. Stratospheric Protection Division of the US EPA. 2021. Access at: https://www.epa.gov/sites/default/files/2021-03/documents/epa-hq-oar-2021-0044-0002_attachment_1-mdis.pdf?versionId=EonCVwZG6UXYmpe9hmej95NIM0B2zUlr
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4. Product Hopping in the Drug Industry - Lessons from Albuterol. *N Engl J Med*. 2022; 387:1153-1156.

RELEVANT AMA POLICY

Global Climate Change and Human Health H-135.938

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.
6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.
7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.

Citation: CSAPH Rep. 3, I-08; Reaffirmation A-14; Reaffirmed: CSAPH Rep. 04, A-19; Reaffirmation: I-19; Modified: Res. 424, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 925
(I-22)

Introduced by: American College of Preventive Medicine

Subject: Incorporation of Social Determinants of Health Concepts into Climate Change Work of the AMA

Referred to: Reference Committee K

1 Whereas, The World Health Organization has asserted that climate change is the single biggest
2 health threat facing humanity;¹ and
3
4 Whereas, Climate change plays a role in the more than 700 Americans dying from heat related
5 illness each year and over 11 million Americans living in counties with unhealthy levels of air
6 pollution (PM2.5);² and
7
8 Whereas, Climate change plays a role in death and illness from increasingly frequent extreme
9 weather events, such as heatwaves, storms and floods, the disruption of food systems,
10 increases in zoonoses and food-, water- and vector-borne diseases, and mental health
11 issues;^{1,3} and
12
13 Whereas, Climate change also plays a role in undermining many of the social determinants for
14 good health, such as livelihoods, equality and access to health care and social support
15 structures.¹ These climate-sensitive health risks are disproportionately suffered by the most
16 vulnerable and disadvantaged;^{1,4,5} and
17
18 Whereas, Like many other social determinants of health, the environmental impacts of climate
19 change are often affected by historical, economic, and sociopolitical factors;⁴ and
20
21 Whereas, The relationship between climate change and social inequality can be characterized
22 by a vicious cycle, whereby initial inequality makes disadvantaged groups suffer
23 disproportionately from the adverse effects of climate change, resulting in greater subsequent
24 inequality;⁶ and
25
26 Whereas, Our AMA has recently prioritized action on climate change by requesting
27 development of a strategic plan (D-135.966, last modified 2022). Furthermore, our AMA policy
28 aims to support “efforts to search for novel, comprehensive, and economically sensitive
29 approaches to mitigating climate change” (H-135.938, last modified 2022); and
30
31 Whereas, While recent policy supports incorporating upstream determinants of health into
32 individual patient care (H-135.938, last modified 2022), no policy exists to explicitly support
33 incorporating social determinants of health considerations into systems level, “novel,
34 comprehensive, and economically sensitive approaches to mitigating climate change”;
35 therefore be it

1 RESOLVED, That our American Medical Association consider climate change, and the
2 environmental impacts thereof, as social determinants of health and modifiers of other social
3 determinants of health in its work on systems level, “novel, comprehensive, and economically
4 sensitive approaches to mitigating climate change”. (New HOD Policy)

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

Received: 10/13/22

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2. CDC. Environmental Justice Dashboard. Accessed October 2022. <https://ephtracking.cdc.gov/Applications/ejdashboard/>
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5. U.S. Global Change Research Program. FOURTH NATIONAL CLIMATE ASSESSMENT CHAPTER 14: HUMAN HEALTH. <https://nca2018.globalchange.gov/chapter/14/>
6. UNITED NATIONS: Department of Economic and Social Affairs. Climate Change and Social Inequality: DESA Working Paper No. 152. October 2017. https://www.un.org/esa/desa/papers/2017/wp152_2017.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 932
(I-22)

Introduced by: Medical Student Section

Subject: Increase Employment Services Funding for People with Disabilities

Referred to: Reference Committee K

1 Whereas, The American Disabilities Act defines “disability” as “a physical or mental impairment
2 that substantially limits one or more major life activities of such individual, a record of such an
3 impairment, or being regarded as having such an impairment”¹; and

5 Whereas, Adults with disabilities experience health disparities related to social determinants of
6 health, as they are less likely to have jobs with competitive wages, more likely to live in poverty,
7 and more likely to experience mental health issues²; and

9 Whereas, People with disabilities have been disproportionately affected by the COVID-19
10 pandemic, in terms of both health outcomes and economically, with unemployment rates that
11 are nearly double the unemployment rates of nondisabled people³⁻⁵; and

13 Whereas, One in five people with disabilities, or approximately one million people in the US, lost
14 their job during the COVID-19 pandemic, compared to one in seven people in the general
15 population⁶; and

17 Whereas, Between 2019 and 2020, the percentage of people with disabilities who were
18 employed fell from 19.2% to 17.9%, whereas non-disabled people saw a decrease in
19 employment from 66.3% to 61.8%⁷; and

21 Whereas, Almost half of unemployed disabled individuals endorse barriers to employment, while
22 less than 10% of individuals with disabilities have been able to use career assistance
23 programs⁸; and

25 Whereas, Existing literature demonstrates that employment training programs are highly
26 beneficial for students with disabilities to gain competitive employment, and many have success
27 rates of 100% employment for their students^{2,9}; and

29 Whereas, The Workforce Innovation and Opportunity Act of 2014 (WIOA) provides state grants
30 through the Department of Labor for employment and training services for people with
31 disabilities, serving over 46,000 adults with disabilities and 26,000 youth with disabilities in
32 2018^{10,11}; and

34 Whereas, WIOA reserves 15% of its budget for Vocational Rehabilitation programs to assist
35 students with disabilities through a transition from school to employment¹⁰; and

37 Whereas, In order to sustain the services provided to the community, Centers for Independent
38 Living (CIL) programs developed by the WIOA independently raised six times the federal
39 appropriation of funds in 2019, contributing to a 27% increase in utilization of resources to assist
40 with transition from youth to adult life²; and

1 Whereas, Lack of funding has been increasingly detrimental during the COVID-19 pandemic,
2 with community programs through WIOA reporting over 30% of employment service
3 programming closed due to COVID-19¹²; and
4
5 Whereas, The Arc, an organization that trains and employs thousands of individuals with
6 disabilities nationally, reported that employment programs have struggled during the COVID-19
7 pandemic due to funding concerns, and 44% of agencies through The Arc had to lay-off or
8 furlough staff^{13,14}; and
9
10 Whereas, Section 188 of WIOA requires that employment services provide equal opportunities
11 for individuals with disabilities to participate in services and receive appropriate
12 accommodations; however, the COVID-19 pandemic has created disparities in receiving these
13 accommodations¹⁵; and
14
15 Whereas, Our AMA Policy H-90.967 and MSS Policy 25.002 encourage government agencies
16 and other organizations to provide psychosocial support for people with disabilities, but do not
17 include employment benefits; and
18
19 Whereas, As employment and socioeconomic status are social determinants of health closely
20 linked to health outcomes, increased resources for employment support programs would
21 provide equitable solutions for the drastic disparities that the COVID-19 pandemic has created
22 for people with disabilities¹⁶, therefore be it
23
24 RESOLVED, That our American Medical Association support increased resources for
25 employment services to reduce health disparities for people with disabilities. (New HOD Policy)

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

Received: 10/13/22

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RELEVANT AMA POLICY

Support for Persons with Intellectual Disabilities H-90.967

Our AMA encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.

Citation: Res. 01, A-16;

Preserving Protections of the Americans with Disabilities Act of 1990 D-90.992

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

Citation: Res. 220, I-17

Enhancing Accommodations for People with Disabilities H-90.971

Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.

Citation: (Res. 705, A-13)

Early Intervention for Individuals with Developmental Delay H-90.969

(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: Res. 315, A-17

SSI Benefits for Children with Disabilities H-90.986

The AMA will use all appropriate means to inform members about national outreach efforts to find and refer children who may qualify for Supplemental Security Income benefits to the Social Security Administration and promote and publicize the new rules for determining disability.

Citation: (Res. 420, A-92; Reaffirmed: CMS Rep. 10, A-03; Reaffirmed: CMS Rep. 4, A-13)

Support for Housing Modification Policies H-160.890

Our AMA supports improved access to housing modification benefits for populations that require modifications in order to mitigate preventable health conditions, including but not limited to the elderly, the disabled and other persons with physical and/or mental disabilities.

Citation: Res. 806, I-19;

Federal Legislation on Access to Community-Based Services for People with Disabilities H-290.970

Our AMA strongly supports reform of the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396) to provide services in the most appropriate settings based upon the individual's needs, and to provide equal access to community-based attendant services and supports.

Citation: Res. 917, I-07; Reaffirmed: BOT Rep. 22, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 934
(I-22)

Introduced by: Medical Student Section

Subject: Denouncing the Use of Solitary Confinement in Correctional Facilities and Detention Centers

Referred to: Reference Committee K

1 Whereas, Correctional facilities, which include prisons and jails, are facilities that house people
2 who have been accused and/or convicted of a crime¹; and
3
4 Whereas, Detention centers refer to facilities that hold undocumented immigrants, refugees,
5 people awaiting trial or sentence, or young offenders for short periods of time²; and
6
7 Whereas, Solitary confinement is the physical and social isolation of an incarcerated individual
8 confined to a cell for 22-24 hours per day, routinely used as a punishment for disciplinary
9 violations in correctional facilities and detention centers³; and
10
11 Whereas, Solitary confinement is often used as a punishment for minor nonviolent infractions,
12 such as not standing up for headcount or not returning a food tray^{3,4}; and
13
14 Whereas, Recent whistleblower accounts describe the use of solitary confinement as a means
15 of reprisal for reporting unsafe and unsanitary conditions^{5,6}; and
16
17 Whereas, Solitary confinement is distinguished from medical isolation and quarantine because
18 solitary confinement is used punitively while medical isolation is used to reduce the spread of
19 infectious disease⁷; and
20
21 Whereas, Solitary confinement consists of extended lengths of social separation, sensory
22 deprivation, and the revocation of prison privileges, while medical isolation is a temporary
23 measure overseen by medical professionals who treat prisoners with compassion and provide
24 prisoners resources to aid their recovery⁷; and
25
26 Whereas, In the United States, approximately 4.5% of incarcerated individuals, or around
27 60,000 people, currently reside in some form of solitary confinement⁸; and
28
29 Whereas, A year in solitary confinement costs three times as much per prisoner, or an average
30 of \$75,000 per prisoner per year⁹; and
31
32 Whereas, Individuals in solitary confinement often suffer from sensory deprivation and are
33 offered few or no educational, vocational, or rehabilitative programs¹⁰; and
34
35 Whereas, Chronic social isolation stress, the causes of which include solitary confinement, is
36 associated with a higher risk of cognitive deterioration, learning deficits, anxiety, depression,
37 post-traumatic stress disorder, and psychosomatic behavior changes¹¹⁻¹³; and

1 Whereas, There is a strong association between solitary confinement and self-harm; for
2 example, one *JAMA* study found persons held in solitary confinement had a 78% higher suicide
3 rate within the first year after release and another study analyzing over 240,000 incarcerations
4 found that prisoners who experienced solitary confinement accounted for over 50% of self-harm
5 incidents despite accounting for only 7.3% of prison admissions^{4,13,14}; and
6
7 Whereas, Individuals who spend time in solitary confinement are 127% more likely to die of an
8 opioid overdose in the first two weeks after release and 24% more likely to die from any cause
9 in the first year after release, even after controlling for potential confounding factors, including
10 substance use and mental health disorders¹⁴; and
11
12 Whereas, Formerly incarcerated individuals who spend time in solitary confinement have a
13 higher overall 5-year mortality than those who do not¹⁵; and
14
15 Whereas, A United States Department of Justice study indicates that inmates with mental
16 illnesses are more likely to be put in solitary confinement and that solitary confinement further
17 exacerbates their mental illnesses¹⁶; and
18
19 Whereas, Solitary confinement increases the likeliness of episodes of psychosis and long-term
20 neurobiological consequences, increasing mentally ill prisoners' need for psychiatric
21 services^{12,13}; and
22
23 Whereas, Prisoners who spend any amount of time in solitary confinement have higher rates of
24 homelessness and unemployment after release, in part due to the lasting psychological stress
25 of confinement¹⁷; and
26
27 Whereas, Solitary confinement increases the risk of recidivism, with some studies finding that
28 spending any amount of time in solitary confinement is associated with two times the risk of
29 being reincarcerated within two weeks of release, and other studies finding a 10-25% increased
30 overall risk of recidivism^{14,18-20}; and
31
32 Whereas, Parolees released from solitary confinement commit new crimes in their community
33 35% more than parolees released from the general prison population, threatening community
34 safety¹⁹; and
35
36 Whereas, Transitioning prisoners from solitary confinement to the general prison population
37 prior to release reduces recidivism rates²⁰; and
38
39 Whereas, A 2018 nationwide survey of correctional facilities found that, in most jurisdictions,
40 certain racial minorities are disproportionately more likely to be placed in solitary confinement
41 while white prisoners are 14% less likely to be placed in solitary confinement⁸; and
42
43 Whereas, A study of over 100,000 prisoners found that the odds that gay and bisexual men will
44 be placed in solitary confinement are 80% greater than heterosexual men, and the odds are
45 190% greater that lesbian and bisexual women will be placed in solitary confinement than
46 heterosexual women²¹; and
47
48 Whereas, The United Nations and The International Convention on the Rights of the Child
49 prohibit the solitary confinement of anyone under the age of 18^{22,23}; and

1 Whereas, In 2015 the United Nations General Assembly adopted “The Standard Minimum
2 Rules for the Treatment of Prisoners,” also known as the “Mandela Rules,” which condemn the
3 use of solitary confinement for prisoners with mental or physical disabilities when their
4 conditions would be exacerbated by such measures²³; and
5
6 Whereas, The same rules call for the prohibition of prolonged solitary confinement, longer than
7 15 days, because it is a “cruel, inhuman or degrading treatment or punishment”²³; and
8
9 Whereas, The Mandela Rules further state that “solitary confinement shall be used only in
10 exceptional cases as a last resort, for as short a time as possible and subject to independent
11 review”²³; and
12
13 Whereas, Solitary confinement is a risk for self-harm and predisposes to a multitude of physical
14 and psychological health issues, and could be considered a cruel and unusual punishment and
15 a human rights violation²⁴; and
16
17 Whereas, At least some United States correctional facilities have managed to reform and
18 reduce their use of solitary confinement in order to better respect the dignity and human rights
19 of inmates while still maintaining the safety of correctional officers and inmates in jails and
20 prisons¹⁸; and
21
22 Whereas, In Colorado, state prisons have reduced their use of solitary confinement by 85%
23 without any other interventions and have seen a concurrent drop in the rate of prisoner on staff
24 violence¹⁸; and
25
26 Whereas, In Mississippi, when correctional facilities reduced their solitary confinement
27 population, violent incidents also dropped by nearly 70%¹⁹; and
28
29 Whereas, A 2015 study found that placing male inmates who were violent in solitary
30 confinement did not effectively deter or alter the probability, timing, or development of future
31 misconduct or violence²⁵; and
32
33 Whereas, Some correctional facilities have created special units to protect vulnerable groups
34 together with similar access to privileges and programs available to the general population
35 without using solitary confinement as a means of protection¹⁸; and
36
37 Whereas, Alternatives to solitary confinement exist for individuals with mental illness and for
38 sexual minorities, such as the Clinical Alternative to Punitive Segregation (CAPS) unit in New
39 York City²⁶; and
40
41 Whereas, AMA policy H-60.922 opposes the use of solitary confinement of juveniles for
42 disciplinary purposes in correctional facilities; therefore be it

1 RESOLVED, That our American Medical Association policy H-430.983, "Reducing the Use of
2 Restrictive Housing in Prisoners with Mental Illness," be amended by addition and deletion to
3 read as follows:

4

5 **Reducing Opposing the Use of Restrictive Housing in for Prisoners with Mental**
6 **Illness H-430.983**

7 Our AMA will: (1) support limiting oppose the use of solitary confinement of any length,
8 with rare exceptions, for incarcerated persons with mental illness, in adult correctional
9 facilities and detention centers, except for medical isolation or to protect individuals
10 who are actively being harmed or will be immediately harmed by a physically violent
11 individual, in which cases confinement may be used for as short a time as possible;
12 and (2) while solitary confinement practices are still in place, support efforts to ensure
13 that the mental and physical health of all individuals placed in solitary confinement are
14 regularly monitored by health professionals; and (3) encourage appropriate
15 stakeholders to develop and implement safe, humane, and ethical alternatives to
16 solitary confinement for incarcerated persons in all correctional facilities; and (3)
17 encourage appropriate stakeholders to develop and implement alternatives to solitary
18 confinement for incarcerated persons in all correctional facilities. (Modify Current HOD
19 Policy)

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

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RELEVANT AMA POLICY

Reducing the Use of Restrictive Housing in Prisoners with Mental Illness H-430.983

Our AMA will: (1) support limiting the use of solitary confinement of any length, with rare exceptions, for incarcerated persons with mental illness, in adult correctional facilities; (2) support efforts to ensure that the mental and physical health of all individuals placed in solitary confinement are regularly monitored by health professionals; and (3) encourage appropriate stakeholders to develop and implement alternatives to solitary confinement for incarcerated persons in all correctional facilities.

Citation: Res. 412, A-18

Solitary Confinement of Juveniles in Legal Custody H-60.922

Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician.

Citation: Res. 3, I-14; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

Discriminatory Policies that Create Inequities in Health Care H-65.963

Our AMA will: (1) speak against policies that are discriminatory and create even greater health disparities in medicine; and (2) be a voice for our most vulnerable populations, including sexual, gender, racial and ethnic minorities, who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.

Citation: Res. 001, A-18

Support of Human Rights and Freedom H-65.965

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity or transgender status, race, religion, disability, ethnic origin, national origin or age; (3) opposes any discrimination based on an individual's sex, sexual orientation, gender identity, race, appearance, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes

pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage for appropriate hate crimes prevention legislation in accordance with our AMA's policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States.

Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed in lieu of: Res. 001, I-16; Reaffirmation: A-17; Modified: Res. 013, A-22

Human Rights and Health Professionals H-65.981

The AMA opposes torture in any country for any reason; urges appropriate support for victims of torture; condemns the persecution of physicians and other health care personnel who treat torture victims.

Citation: (Sub. Res. 615, A-97; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: Sub. Res. 10, A-05; Reaffirmed: CEJA Rep. 5, A-15)

Human Rights H-65.997

Our AMA endorses the World Medical Association's Declaration of Tokyo which are guidelines for medical doctors concerning torture and other cruel, inhuman or degrading treatment or punishment in relation to detention and imprisonment.

Citation: (BOT Rep. M, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: Sub. Res. 12, A-04; Reaffirmed: CEJA Rep. 8, A-14)

Appropriate Placement of Transgender Prisoners H-430.982

1. Our AMA supports the ability of transgender prisoners to be placed in facilities, if they so choose, that are reflective of their affirmed gender status, regardless of the prisoner's genitalia, chromosomal make-up, hormonal treatment, or non-, pre-, or post-operative status.
2. Our AMA supports that the facilities housing transgender prisoners shall not be a form of administrative segregation or solitary confinement.

Citation: BOT Rep. 24, A-18;