

Not for consideration

Resolutions not for consideration

- 001 Updating Physician Job Description for Disability Insurance
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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

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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

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

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

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

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

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

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

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

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

AMA Statement on Family and Medical Leave, H-420.979

Our AMA supports policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave by an employee becomes necessary due to documented medical conditions and/or concerns for safety. 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; and (5) safe leave provisions for those experiencing any instances of violence, including but not limited to intimate partner violence, sexual violence or coercion, and stalking. Such periods of leave may differ with respect to each of the foregoing classifications, and may vary with reasonable categories of employers. Such policies should encourage voluntary programs by employers and may provide for appropriate legislation (with or without financial assistance from government). Any legislative proposals will be reviewed through the Association's normal legislative process for appropriateness, taking into consideration all elements therein, including classifications of employees and employers, reasons for the leave, periods of leave recognized (whether paid or unpaid), obligations on return from leave, and other factors involved in order to achieve reasonable objectives recognizing the legitimate needs of employees and employers. (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: CLRPD Rep. 1, A-08; Reaffirmation A-12; Reaffirmed: CMS Rep. 03, A-16

Paid Sick Leave H-440.823

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

Parental Leave H-405.954

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 204
(I-22)

Introduced by: Missouri

Subject: Elimination of Seasonal Time Change

Referred to: Reference Committee B

1 Whereas, Multiple studies have demonstrated an increased risk for heart attacks, strokes, and
2 fatal car crashes as negative health consequences of moving the clock forward in Spring for
3 Daylight Savings Time; and
4

5 Whereas, The American Academy of Sleep Medicine officially recognizes Daylight Savings
6 Time as a public health problem; and
7

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

12 Whereas, Thirteen states in the past two years have written or enacted legislation to stay on
13 one year-round time zone; therefore be it
14

15 RESOLVED, That our American Medical Association work with state medical associations to
16 enact state legislation in support of remaining in the Standard Time Zone year-round (Directive
17 to Take Action); and be it further
18

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

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

Received: 09/07/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(I-22)

Introduced by: Resident and Fellow Section

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

Referred to: Reference Committee B

1 Whereas, Originally conceived to conserve fuel and reduce power utilization, the annual switch
2 to Daylight Savings Time (DST) has been practiced in the United States since 1918¹; and
3

4 Whereas, For states that use DST, clocks typically “spring forward” one hour in March and then
5 “fall back” one hour in November²; and
6

7 Whereas, The Uniform Time Act of 1966 established a system of uniform DST throughout the
8 United States³; and
9

10 Whereas, Under federal law, states must currently obtain approval to adopt year-round DST¹;
11 and
12

13 Whereas, States choosing to observe year-round standard time, as Arizona and Hawaii do, are
14 not subject to federal approval¹; and
15

16 Whereas, In a response to an oil embargo, the US enacted a trial period of permanent DST
17 from 1974-1975 in an attempt to conserve energy¹; and
18

19 Whereas, Permanent DST proved unpopular in the 1970’s and was not ineffective in conserving
20 oil, and federal law was changed to disallow permanent use of DST^{4,5}; and
21

22 Whereas, The merits of using DST to reduce energy use are debatable^{2,4}; and
23

24 Whereas, The controversy regarding DST has gained increasing notoriety and press coverage
25 over the past several years with 18 states enacting legislation or passing resolutions to provide
26 for permanent DST, should Congress eventually allow for such a change⁵; and
27

28 Whereas, On March 15, 2022, the US Senate passed the Sunshine Protection Act, which would
29 move forward by one hour what is considered standard time within the US, effectively
30 establishing the permanent use of Daylight Savings Time in November 2023⁶; and
31

32 Whereas, Under the Sunshine Protection Act, states would be forced to choose whether to
33 operate either on standard or DST year-round⁵; and
34

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

1 Whereas, Most experts believe that standard time is more suited to the circadian rhythms of the
2 human body than permanent DST⁷; and
3

4 Whereas, Circadian misalignment has been associated with risks of depression, cardiovascular
5 disease, metabolic syndrome⁸; and
6

7 Whereas, The American Academy of Sleep Medicine has published a position statement in
8 support of eliminating seasonal time changes and establishing year-round standard time⁷; and
9

10 Whereas, A 2020 AASM survey found that 63% of adults support the elimination of seasonal
11 time changes⁸; and
12

13 Whereas, Our AMA has multiple policies related to fatigue and sleep, including H-15.958, H-
14 135.932, and H-60.930; and
15

16 Whereas, The stance of our AMA on this subject matter may prove influential in public policy
17 deliberations; therefore be it
18

19 RESOLVED, That our American Medical Association support the elimination of seasonal time
20 changes (New HOD Policy); and be it further
21

22 RESOLVED, That our AMA support the adoption of year-round standard time. (New HOD
23 Policy)

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

Received: 09/14/22

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RELEVANT AMA POLICY

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

Our AMA: (1) recognizes sleepiness behind the wheel as a major public health issue and continues to encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups;

(2) recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions;

(3) recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep;

(4) encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness- testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment;

(5) urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology;

(6) recommends that physicians: (a) become knowledgeable about the diagnosis and management of sleep-related disorders; (b) investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories; (c) inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries; (d) advise patients about possible medication-related effects that may impair their ability to safely operate a motor vehicle or other machinery; (e) inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries; and (f) become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice;

(7) encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state.

(8) recommends that states adopt regulations for the licensing of commercial and private drivers with sleep-related and other medical disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries;

(9) reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.

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

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

Our AMA:

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

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

Insufficient Sleep in Adolescents H-60.930

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(I-22)

Introduced by: Medical Student Section

Subject: SNAP Expansion for DACA Recipients

Referred to: Reference Committee B

1 Whereas, The policy known as Deferred Action for Childhood Arrivals (DACA) has allowed
2 undocumented immigrants brought to the US as minors to remain in this country, receive work
3 authorization, and participate in the Social Security Program¹; and
4

5 Whereas, As of 2021 there were 649,070 active DACA recipients in the US¹; and
6

7 Whereas, The Department of Homeland Security considers more than 200,000 DACA recipients
8 as “essential critical infrastructure workers” contributing to the fields of health care, education,
9 and food-related industries²; and
10

11 Whereas, Data provided by the Department of Homeland Security showed an estimated 96% of
12 DACA recipients were born in the Caribbean and Latin American countries³; and
13

14 Whereas, An estimated range of 30 to 60% of immigrants in the US report food insecurity, and
15 the largest and fastest growing subgroup is foreign-born Latinxs as compared to US-born non-
16 Latinx Whites⁴; and
17

18 Whereas, Food insecurity is defined by the US Department of Agriculture (USDA) as a
19 household-level economic and social condition of limited or uncertain access to adequate food⁵;
20 and
21

22 Whereas, DACA recipients’ ineligibility for federal aid increases risk for food insecurity while
23 complicating budgeting and meal preparation⁶; and
24

25 Whereas, DACA recipients viewed affordable food as unhealthy and limited their intake in order
26 to obtain healthier food⁶; and
27

28 Whereas, Children of immigrant Latinx mothers are at the greatest risk for food insecurity and
29 this population comprises much of the DACA program⁷; and
30

31 Whereas, The expansion of immigration enforcement has been associated with increased food
32 insecurity among Latinx immigrant families⁸; and
33

34 Whereas, The percentage of families reporting very low food security has increased by 20%
35 since the COVID-19 pandemic began⁹; and
36

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

Whereas, Undocumented immigrants in the United States contribute an estimated \$11.6 billion taxes annually, but they remain largely ineligible for public benefits including social security and SNAP¹¹; and

Whereas, The Supplemental Nutrition Assistance Program (SNAP) is the most important tool used in the US to alleviate food insecurity and its subsequent negative health consequences¹²; and

Whereas, SNAP participation is associated with economic benefits including lower healthcare costs¹³; and

Whereas, US Citizenship and Immigration services reports that California has a DACA population of 183,460, as of March 2020¹⁴; and

Whereas, In 2021, California state legislators proposed opening the state-funded food stamp program to all income-eligible Californians, regardless of immigration status, which would cost about \$550 million a year¹⁵; and

Whereas, The food pantry system was initially designed to serve only during emergency scenarios to address starvation¹⁶; and

Whereas, People with very low food security who rely on food pantries have a significantly higher incidence of obesity often attributed to acquired foods that are high in sodium and sugar, while low in fiber, vitamins, and minerals¹⁷; and

Whereas, food pantry recipients are shown to have insufficient intake of up to 16 different key nutrients such as calcium, potassium, and fiber¹⁸; and

Whereas, Those with food insecurity incur greater health care expenditures resulting in an additional \$77.5 billion in healthcare spending annually¹⁹; therefore be it

RESOLVED, That our American Medical Association actively support expansion of SNAP to Deferred Action Childhood Arrivals (DACA) recipients who would otherwise qualify. (Directive to 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: 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

Whereas, According to the American Osteopathic Association, osteopathic manipulative
medicine/treatment (OMM/OMT) is special training for the musculoskeletal system that doctors
of osteopathy receive to provide care that involves using the hands to diagnose, treat, and
prevent illness or injury; and

Whereas, The evidence basis for OMT is quite broad and spans many disease processes and
organ systems and supports its use as an adjunct treatment in a variety of conditions; and

Whereas, In order to train residents in osteopathic practice and principles (OPP) and
osteopathic manipulative treatment (OMT), faculty must be available and qualified; and

Whereas, Osteopathic Recognition (OR) is a “designation conferred by the ACGME’s
Osteopathic Principles Committee upon ACGME-accredited programs that demonstrate,
through a formal application process, the commitment to teaching and assessing Osteopathic
Principles and Practice (OPP) at the graduate medical education level”; and

Whereas, Programs must meet criteria laid out by that committee and apply for recognition¹;
and

Whereas, Residents in a recognized program must be assessed for OPP knowledge and “skill
proficiency in OMT as applicable to [their] specialty”²; and

Whereas, As of the 2021-2022 academic year there are approximately 250 PGY-1 GME
programs with osteopathic recognition out of the 4,780 available programs (roughly 5%)¹¹;
therefore be it

RESOLVED, That our American Medical Association continue to support equal treatment of
osteopathic students, trainees and physicians in the residency application cycle and workplace
through continued education on the training of osteopathic physicians (New HOD Policy); and
be it further

RESOLVED, That our AMA encourage education on the benefits of evidence-based
Osteopathic Manual Therapy for musculoskeletal conditions in medical education of allopathic
students and in primary care residencies. (New HOD Policy)

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

Received: 09/14/22

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RELEVANT AMA POLICY

Definition of a Physician H-405.969

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

Definition and Use of the Term Physician H-405.951

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 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
3

4 Whereas, The number of resolutions submitted has increased over time; and
5

6 Whereas, The rules for submission of resolutions have not been changed in many years
7 including definitions for on time, late and emergency resolutions; and
8

9 Whereas, There are multiple exceptions to the “on time” resolution definition including
10 resolutions from AMA sections and societies who meet after the “on time” deadline; and
11

12 Whereas, The Saturday/Sunday tote contains a significant amount of new resolutions each
13 year; and
14

15 Whereas, The resolutions in the Saturday/Sunday tote cannot be adequately reviewed and
16 vetted by all delegations and delegation staff; and
17

18 Whereas, For the past 2 years, all delegations and sections have met virtually and have been
19 able to work asynchronously to discuss and vote on potential resolutions to submit to the AMA
20 HOD; and
21

22 Whereas, According to Bylaws 2.11.3.1, “To be considered as regular business, each resolution
23 must be introduced by a delegate or organization represented in the House of Delegates and
24 must have been submitted to the AMA not later than 30 days prior to the commencement of the
25 meeting at which it is to be considered”; and
26

27 Whereas, According to Bylaws 2.11.3.1.3, “Late resolutions may be presented by a delegate
28 prior to the recess of the opening session of the House of Delegates, and will be accepted as
29 business of the House of Delegates only upon two-thirds vote of delegates present and voting”;
30 and
31

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

Whereas, The ability to meet virtually and work asynchronously has been enhanced during the pandemic to the point where it is potentially more efficient and convenient for delegations and sections; therefore be it

RESOLVED, That our American Medical Association review the entire process of resolution submission including re-evaluating the definitions of “on time,” late, and emergency resolutions and current exceptions with a report back at the Interim 2023 meeting (Directive to Take Action); and be it further

RESOLVED, That the review committee consider changing the policy so that all on time resolutions must be submitted to the HOD by the same deadlines so that the only resolutions in the Saturday/Sunday tote would be emergency and late resolutions to be voted on for acceptance by the HOD (Directive to Take Action); and be it further

RESOLVED, That the review committee consider changing the rule so that all sections of the AMA will submit their “on time” resolutions by the same deadlines as the rest of the HOD, with only emergency resolutions to be submitted after Section meetings during the week before the annual or interim meetings (Directive to Take Action); and be it further

RESOLVED, That our AMA facilitate virtual meetings of the sections prior to the resolution deadline so that all resolutions can be submitted, reviewed, and discussed prior to the deadline. (Directive to Take Action)

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

Received: 09/28/22

References:

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

RELEVANT AMA POLICY

House of Delegates

Procedure. B-2.11

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

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

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

2.11.3 Introduction of Business.

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

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

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

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

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

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

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

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

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 604
(I-22)

Introduced by: Resident and Fellow Section

Subject: Solicitation Using the AMA Brand

Referred to: Reference Committee F

1 Whereas, Some physicians are turned off by third party solicitation material mailed with the
2 AMA brand, such as regarding disability insurance or student loan refinancing, potentially
3 harming the AMA's reputation and costing physician membership; and
4

5 Whereas, Financial literacy websites such as White Coat Investor detail the flaws in the AMA
6 branded third party disability insurance plan¹; and
7

8 Whereas, There is a financial and environmental cost to printed solicitation; and
9

10 Whereas, Associating the AMA brand to specific third-party products may or may not be in the
11 best interest of the AMA or current and potential AMA members; therefore be it
12

13 RESOLVED, That our American Medical Association study the use of AMA branded solicitation
14 material mailed to physicians, the impact it has on the perception of our AMA by current and
15 potential physician members, and the merits of continuing to use these materials in future
16 communications (Directive to Take Action); and be it further
17

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

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

Received: 09/30/22

References:

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 901
(I-22)

Introduced by: Medical Student Section

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

Referred to: Reference Committee K

1 Whereas, While imprisoned, able-bodied incarcerated people are often required to work and
2 assigned duties if they have not already identified a job for themselves¹; and
3

4 Whereas, Incarcerated people can work in a variety of positions⁴; and
5

6 Whereas, Refusal to perform involuntary prison labor can be punished through various means,
7 including solitary confinement, revocation of family visitation, loss of earned “good behavior”
8 time^{2,3}; and
9

10 Whereas, Work programs operate in 88% of prisons in the United States and employ
11 approximately 775,000 prisoners⁵; and
12

13 Whereas, The prison system was hit especially hard during the initial waves of the COVID-19
14 pandemic in 2020 and since the primary defense against infection is vaccines, which did not
15 reach incarcerated people until 2021, and given prisons’ notoriously crowded environments,
16 COVID-19 rates in prisons soared⁶; and
17

18 Whereas, Staff shortages during this time meant that there were also fewer nurses and guards
19 to ensure the incarcerated people’s health and physical well-being⁷; and
20

21 Whereas, Despite the infection rates, many prison systems did not follow protocols to prevent
22 the spread of COVID-19 and still expected incarcerated workers to work in similar conditions to
23 those prior to the pandemic⁸; and
24

25 Whereas, For example, in the Washington Department of Corrections (WDOC), the prison
26 managers did not enforce post-exposure isolation and did not provide adequate hand sanitizer
27 or social distancing measures⁸; and
28

29 Whereas, California also kept their prison factories running through the pandemic, even as
30 infection rates rose, and incarcerated people report being threatened that their chances for
31 release from prison would be put into jeopardy if they refused to attend work because of
32 COVID-19 safety concerns because although prison representatives report that adequate
33 measures to address COVID-19 were put into place, interviews from across the United States
34 show otherwise^{9,10}; and
35

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

1 Whereas, During the COVID-19 pandemic, prison labor was used to assist front line workers in
2 a national response¹²; and
3

4 Whereas, States such as New York, Missouri, Louisiana, and others, made use of this prison
5 labor to quickly and cheaply make needed products and prisoners were forced to make
6 products used by front-line workers such as hand sanitizer, gowns, masks and even products
7 such as toilet paper, which did not benefit first responders directly, were produced by these
8 workers and wages for this work were far below minimum wage, but many were not paid at all;
9 and
10

11 Whereas, The prison-workplaces did not implement social distancing measures on par with
12 equivalent workplaces in non-carceral settings; and
13

14 Whereas, The Occupational Safety and Health Act of 1970 (OSH Act) requires that employers
15 provide employees with safe working conditions that are free of serious recognized hazards and
16 in compliance with Occupational Safety and Health Administration (OSHA)'s safety and health
17 standards¹³; and
18

19 Whereas, In addition to an employer's "general duty" to provide a safe workplace, OSHA sets in
20 place specific safety standards for certain workplaces, such as providing personal protective
21 equipment (PPE) and limiting exposure to toxic substances such as lead and asbestos and
22 OSHA can inspect private workplaces and workers can file complaints with OSHA regarding
23 unsafe working conditions with protection against retaliation; and
24

25 Whereas, However, the definition of "employer" in the OSH Act specifically excludes States and
26 political subdivisions of States - meaning that federal and state prisons employing prisoners are
27 exempted from the OSH Act¹⁴; and
28

29 Whereas, In federal prisons, the Bureau of Prisons [provides](#) health and safety requirements for
30 incarcerated workers through its occupational health and safety program¹⁵; and
31

32 Whereas, This policy [includes](#) annual safety [training](#) for incarcerated workers, [investigations](#) into
33 work-related injuries, and [compensation](#) for lost wages due to workplace injuries while injury
34 compensation, is [restricted](#) to individuals working through the [Federal Prison Industries](#) and
35 work assignments related to the maintenance of the facility; and
36

37 Whereas, For state prison workers, safety standards are left to the discretion of the state, with
38 some states not granting many protections at all^{14,16}; and
39

40 Whereas, For example, Pennsylvania provides compensation for lost wages for inmate workers
41 who suffer work-related injuries, while Texas explicitly [excludes](#) incarcerated workers from
42 receiving work-related injury compensation in their statute while in another example, the
43 California Prison Industry Authority (CALPIA) is a state agency that oversees the prison work
44 programs in the country's second largest prison system¹⁷; and
45

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

1 Whereas, The issue of prison labor is an ethically nuanced topic with multiple points to consider.
2 There are benefits to providing incarcerated people with jobs, such as providing them a sense of
3 community and purpose because participating in meaningful work can help develop professional
4 skills that can benefit them once released and these jobs also potentially help incarcerated
5 people earn money to support themselves while incarcerated and after release; and
6

7 Whereas, Prison labor can be ethically appropriate when done in the best interest of the
8 prisoner without coercion or influence from exploitative purposes and incarcerated people must
9 be fairly compensated for their work to avoid said exploitation and provide them meaningful
10 resources as a result; and
11

12 Whereas, While it has been the policy to have imprisoned individuals do dangerous tasks, such
13 as working in crowded environments during the COVID-19 pandemic, at times it has been done
14 with inadequate protection and in the case of a pandemic, decreased protection due to
15 inadequate PPE and work conditions inconsistent with guidelines from the CDC and NIH would
16 constitute exploitative labor in addition to prisoners working in prisons where there was a
17 statistically higher level of COVID cases throughout the course of the pandemic, leading to a
18 five-fold greater risk of infection and 30% greater risk of death from infection compared to the
19 general population¹⁹; and
20

21 Whereas, Further, incarcerated people are often not protected by regulatory health and safety
22 standards, such as OSHA, practiced in the non-incarcerated context and without these
23 regulatory mechanisms, it is difficult to ascertain the extent of dangerous working conditions in
24 prisons and offer avenues for recourse for unsafe working conditions; and
25

26 Whereas, If the work being done by prisoners could be considered “essential” then they too
27 would be owed increased compensation²⁰; and
28

29 Whereas, Whether wildfires or a pandemic, no emergency justifies labor exploitation of a
30 population made vulnerable by the state, and any need for labor must also offer fair
31 compensation, preferential benefits (such as official certification and paths to further job
32 opportunities), and of course safety guarantees that are satisfactory with standard workplace
33 safety laws and regulatory bodies^{21,22}; and
34

35 Whereas, Current AMA policy sets a strong precedent for protecting incarcerated populations
36 from communicable diseases and has advocated for stronger protections for incarcerated
37 populations against COVID-19 during the early stages of the pandemic when outbreaks in
38 prisons were commonplace; and
39

40 Whereas, The AMA advocates for safe working conditions for all people through OSHA
41 regulation (D-135.935, D-135.974, H-135.935, H-490.413) and acknowledges that people who
42 are incarcerated are a vulnerable population (H-430.986); and
43

44 Whereas, The AMA supports access to healthcare while incarcerated, programs to help
45 incarcerated people transition to care once released, and promotes acceptable living conditions
46 (H-430.986, H-430.997); and
47

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

1 RESOLVED, That our American Medical Association oppose the use of forced or coercive labor
2 practices for incarcerated populations (New HOD Policy); and be it further
3

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

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

Received: 09/20/22

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RELEVANT AMA POLICY

Support Stricter OSHA Silica Permissible Exposure Limit Standard D-135.974

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

Res. 916, I-13

Advocating for Heat Exposure Protections for All Workers D-135.967

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

Res. 502, I-21

OSHA Standards for Lead H-135.935

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

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

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

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

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

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

Health Care While Incarcerated H-430.986

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

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

Standards of Care for Inmates of Correctional Facilities H-430.997

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

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 903
(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
6 Whereas, Kratom acts on mu-opioid receptors to produce analgesia and euphoria⁴; and

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

10
11 Whereas, A cross-sectional survey of 59,714 U.S. adults found an estimated 0.8% past-year
12 prevalence, with Kratom users having an above-average substance abuse profile⁶; and

13
14 Whereas, A systematic review on the mental health effects of Kratom found that Kratom
15 withdrawal is relatively mild compared to opioids while still significant enough that some users
16 found difficulty maintaining abstinence⁷; and

17
18 Whereas, One study surveyed 500 patients with substance use disorder and found that 68.9%
19 of the respondents were using Kratom to reduce or replace opioid use, suggesting that Kratom
20 may have potential as a harm-reducing agent for substance use disorder¹; and

21
22 Whereas, One study found that the risk of mortality from Kratom overdose is over 1,000 times
23 less than the risk of mortality from overdose with other opioids, and found that other substances
24 like heroin and methamphetamine were usually present in Kratom users who had experienced
25 significant adverse side effects⁸; and

26
27 Whereas, Between 2011 and 2017, there were 11 deaths associated with Kratom exposure,
28 including two deaths associated with Kratom use alone, and 7 reported neonatal exposures with
29 5 neonates experiencing withdrawal symptoms⁹; and

30
31 Whereas, A retrospective review identified 2,312 Kratom exposures reported to the National
32 Poison Control Centers between 2011 and 2018, with 935 cases involving Kratom alone, with
33 serious side effects reported including seizure (6.1%), withdrawal (6.1%), hallucinations (4.8%),
34 respiratory depression (2.8%), coma (2.3%), and cardiac or respiratory arrest (0.6%)¹⁰; and

35
36 Whereas, Research has shown that Kratom can lead to various organ toxicities, including acute
37 liver failure, acute kidney failure, seizure, brain injury, and cardiovascular toxicities^{11,12}; and

38
39 Whereas, Kratom can be purchased on the internet from vendors, often without age
40 verification¹³; and

Whereas, As of 2022, Kratom is legal in 44 states and explicitly banned in six states¹⁴; and

Whereas, Several states are considering banning or regulating Kratom to various degrees¹⁴; and

Whereas, The Controlled Substance Act (CSA) established five tiers of drugs based upon eight distinct criteria, determined primarily by the Drug Enforcement Administration¹⁵; and

Whereas, The first tier, "Schedule 1", is defined to include "drugs with no currently accepted medical use, has a high potential for abuse, and that there is a lack of accepted safety for the use of the drug under medical supervision"¹⁶; and

Whereas, Prescriptions may only be written for Schedule II through V drugs, with Schedule I drugs only available for research purposes^{17,18}; and

Whereas, Drug Enforcement Administration (DEA) scheduling of Kratom could impact physicians' prescribing habits and limit patient access to Kratom, should it be determined to have medical utility, as evidenced by scheduling adjustments of other substances^{19,20}; and

Whereas, One study found that within six months of rescheduling hydrocodone, a 20% decline in prescribing and dispensing was observed in the U.S and Australia²⁰; and

Whereas, In the UK, scheduling of mephedrone in 2011 led to a 49% of mephedrone users increasing MDMA use, a 40% increase in purchasing of mephedrone from illicit sources, and an increase in mephedrone-related deaths from 2011-2015^{20,21}; and

Whereas, Research on Schedule I drugs requires completing an application and registration with the DEA²²; and

Whereas, Schedule I drugs may be difficult to obtain for research as manufacturers and custom synthesis companies are sparse or prohibitively expensive²³; and

Whereas, Funding for the study of Schedule I drugs is limited, with a significant portion of the research focused on potential harms rather than potential clinical applications²³; and

Whereas, LSD was extensively studied for potential in psychotherapy before classification as a Schedule I drug; however, following the scheduling of LSD, research declined sharply²³; and

Whereas, Research into whether the positive characteristics of Kratom use outweigh the potential adverse effects is currently insufficient to draw general conclusions²⁴; and

Whereas, Scheduling Kratom prior to robust research showing that the harms outweigh the potential benefits would limit the conduct of future studies that might identify novel therapies for substance use disorder^{1,2,7,8,23,24}; therefore be it

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

3
4 Kratom and its Growing Use Within the United States, H-95.934
5 Our AMA: supports legislative or regulatory efforts to prohibit the sale or distribution of
6 ~~Kratom in the United States which do not inhibit proper scientific research efforts to~~
7 further study the clinical uses, benefits, and potential harms of Kratom, and oppose
8 efforts that may restrict research. (Modify Current HOD Policy)

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

Received: 09/20/22

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RELEVANT AMA POLICY

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

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

Res. 509, A-16

Cannabis and Cannabinoid Research H-95.952

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

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

FDA H-100.992

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

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

Drugs of Choice H-100.997

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

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

Dietary Supplements and Herbal Remedies H-150.954

- (1) Our AMA supports efforts to enhance U.S. Food and Drug Administration (FDA) resources, particularly to the Office of Dietary Supplement Programs, to appropriately oversee the growing dietary supplement sector and adequately increase inspections of dietary supplement manufacturing facilities.
- (2) Our AMA supports the FDA having appropriate enforcement tools and policies related to dietary supplements, which may include mandatory recall and related authorities over products that are marketed as dietary supplements but contain drugs or drug analogues, the utilization of risk-based inspections for dietary supplement manufacturing facilities, and the strengthening of adverse event reporting systems.
- (3) Our AMA supports continued research related to the efficacy, safety, and long-term effects of dietary supplement products.
- (4) Our AMA will work with the FDA to educate physicians and the public about FDA's Safety Reporting Portal (SRP) and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies.
- (5) Our AMA strongly urges physicians to inquire about patients' use of dietary supplements and engage in risk-based conversations with them about dietary supplement product use.
- (6) Our AMA continues to strongly urge Congress to modify and modernize the Dietary Supplement Health and Education Act to require that:
 - (a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy;
 - (b) dietary supplements meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling;
 - (c) FDA establish a mandatory product listing regime that includes a unique identifier for each product (such as a QR code), the ability to identify and track all products produced by manufacturers who have received warning letters from the FDA, and FDA authorities to decline to add labels to the database if the label lists a prohibited ingredient or new dietary ingredient for which no evidence of safety exists or for products which have reports of undisclosed ingredients; and
 - (d) regulations related to new dietary ingredients (NDI) are clarified to foster the timely submission of NDI notifications and compliance regarding NDIs by manufacturers.
- (7) Our AMA supports FDA postmarketing requirements for manufacturers to report adverse events, including drug interactions; and legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement
- (8) Our AMA will work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements and supports adequate funding and resources for FTC enforcement of violations of the FTC Act.
- (9) Our AMA strongly urges that criteria for the rigor of scientific evidence needed to support a structure/function claim on a dietary supplement be established by the FDA and minimally include requirements for robust human studies supporting the claim.
- (10) Our AMA strongly urges dietary supplement manufacturers and distributors to clearly label all products with truthful and not misleading information and for the product labeling to:
 - (a) not include structure/function claims that are not supported by evidence from robust human studies;
 - (b) not contain prohibited disease claims;
 - (c) eliminate "proprietary blends" and list and accurately quantify all ingredients contained in the product;
 - (d) require advisory statements regarding potential supplement-drug and supplement-laboratory interactions and risks associated with overuse and special populations; and
 - (e) include accurate and useful disclosure of ingredient measurement.
- (11) Our AMA supports and encourages the FDA's regulation and enforcement of labeling violations and FTC's regulation and enforcement of advertisement violations of prohibited disease claims made on dietary supplements and herbal remedies.
- (12) Our AMA urges that in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label.
- (13) Our AMA will continue its efforts to educate patients and physicians about the risks associated with the use of dietary supplements and herbal remedies and supports efforts to increase patient, healthcare

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

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