

Reference Committee B

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(I-22)

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

Subject: Physician Reimbursement for Interpreter Services

Referred to: Reference Committee B

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

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

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

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

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

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

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

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

Received: 08/04/22

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

RELEVANT AMA POLICY

Certified Translation and Interpreter Services D-385.957

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(1-22)

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

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

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

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

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

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

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

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

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

Received: 08/19/22

References:

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

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

RELEVANT AMA POLICY

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

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

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

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

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

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

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

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

1. It is AMA policy that:

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

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

US Physician Shortage H-200.954

Our AMA:

- (1) explicitly recognizes the existing shortage of physicians in many specialties and areas of the US;
 - (2) supports efforts to quantify the geographic maldistribution and physician shortage in many specialties;
 - (3) supports current programs to alleviate the shortages in many specialties and the maldistribution of physicians in the US;
 - (4) encourages medical schools and residency programs to consider developing admissions policies and practices and targeted educational efforts aimed at attracting physicians to practice in underserved areas and to provide care to underserved populations;
 - (5) encourages medical schools and residency programs to continue to provide courses, clerkships, and longitudinal experiences in rural and other underserved areas as a means to support educational program objectives and to influence choice of graduates' practice locations;
 - (6) encourages medical schools to include criteria and processes in admission of medical students that are predictive of graduates' eventual practice in underserved areas and with underserved populations;
 - (7) will continue to advocate for funding from public and private payers for educational programs that provide experiences for medical students in rural and other underserved areas;
 - (8) will continue to advocate for funding from all payers (public and private sector) to increase the number of graduate medical education positions in specialties leading to first certification;
 - (9) will work with other groups to explore additional innovative strategies for funding graduate medical education positions, including positions tied to geographic or specialty need;
 - (10) continues to work with the Association of American Medical Colleges (AAMC) and other relevant groups to monitor the outcomes of the National Resident Matching Program; and
 - (11) continues to work with the AAMC and other relevant groups to develop strategies to address the current and potential shortages in clinical training sites for medical students.
 - (12) will: (a) promote greater awareness and implementation of the Project ECHO (Extension for Community Healthcare Outcomes) and Child Psychiatry Access Project models among academic health centers and community-based primary care physicians; (b) work with stakeholders to identify and mitigate barriers to broader implementation of these models in the United States; and (c) monitor whether health care payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in programs such as Project ECHO and the Child Psychiatry Access Project; and if confirmed, promote awareness of these benefits among physicians.
 - (13) will work to augment the impact of initiatives to address rural physician workforce shortages.
- Citation: Res. 807, I-03; Reaffirmation I-06; Reaffirmed: CME Rep. 7, A-08; Appended: CME Rep. 4, A-10; Appended: CME Rep. 16, A-10; Reaffirmation: I-12; Reaffirmation A-13; Appended: Res. 922, I-13; Modified: CME Rep. 7, A-14; Reaffirmed: CME Rep. 03, A-16; Appended: Res. 323, A-19; Appended: CME Rep. 3, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(I-22)

Introduced by: Missouri

Subject: International Medical Graduate Employment

Referred to: Reference Committee B

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

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

Received: 09/07/22

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(I-22)

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

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

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

Received: 09/07/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(1-22)

Introduced by: Resident and Fellow Section

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

Referred to: Reference Committee B

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

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

Received: 09/14/22

REFERENCES:

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

RELEVANT AMA POLICY

Physician Assistants and Nurse Practitioners H-160.947

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

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

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

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

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(I-22)

Introduced by: Resident and Fellow Section

Subject: Preserving Physician Leadership in Patient Care

Referred to: Reference Committee B

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

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

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

12 Whereas, The AMA, AAFP, and other physician advocacy groups have policy explicitly rejecting
13 the use of an overarching term such as “provider” that equates the training of physicians with
14 that of non-physician clinicians;¹ therefore be it
15

16 RESOLVED, That our American Medical Association create a national targeted ad campaign to
17 educate the public about the training pathway of physicians compared to non-physician
18 providers (Directive to Take Action); and be it further
19

20 RESOLVED, That our AMA reaffirm our opposition to physicians being referred to as “providers”
21 in healthcare settings (New HOD Policy); and be it further
22

23 RESOLVED, That our AMA conduct a review of the AMA policy compendium and replace
24 conflicting policies referring to physicians as “providers” with the term “physician” when
25 appropriate and report back at the 2023 Annual Meeting. (Directive to Take Action)

Fiscal Note: Estimated cost to implement this resolution is \$255,000

Received: 09/14/22

REFERENCES

1. American Academy of Family Physicians. "NON-PHYSICIAN PROVIDERS (NPPs) Guidelines on the Supervision of Certified Nurse Midwives, Nurse Practitioners and Physician Assistants." 2000-2001 AAFP Policies on Health Issues.

RELEVANT AMA POLICY

Clarification of the Term "Provider" in Advertising, Contracts and Other Communications H-405.968

1. Our AMA supports requiring that health care entities, when using the term "provider" in contracts, advertising and other communications, specify the type of provider being referred to by using the provider's recognized title which details education, training, license status and other recognized qualifications; and supports this concept in state and federal health system reform.
2. Our AMA: (a) considers the generic terms "health care providers" or "providers" as inadequate to describe the extensive education and qualifications of physicians licensed to practice medicine in all its branches; (b) will institute an editorial policy prohibiting the use of the term "provider" in lieu of "physician" or other health professionals for all AMA publications not otherwise covered by the existing JAMA Editorial Governance Plan, which protects editorial independence of the Editor in Chief of JAMA and The JAMA Network journals; and (c) will forward to the editorial board of JAMA the recommendation that the term "physician" be used in lieu of "provider" when referring to MDs and DOs.

Citation: Sub. Res. 712, I-94; Reaffirmed: Res. 226, I-98; Reaffirmation I-99; Res. 605, A-09; Reaffirmed: CLRPD Rep. 1, A-09; Modified: Speakers Rep., A-15; Reaffirmed: BOT Rep. 09, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(I-22)

Introduced by: Resident and Fellow Section

Subject: Comparing Student Debt, Earnings, Work Hours, and Career Satisfaction
Metrics in Physicians v. Other Health Professionals

Referred to: Reference Committee B

1 Whereas, Our healthcare system has had a steady increase in the amount of physician
2 assistants (PAs) and nurse practitioners (NPs) assuming physician duties and responsibilities;
3 and
4
5 Whereas, PAs and NPs have also advocated successfully for increased pay as evidenced in
6 multiple state legislatures and even federal legislation; and
7
8 Whereas, Student debt of physicians is notoriously some of the highest in American education;
9 and
10
11 Whereas, PAs and NPs have access to the same programs as physicians which include public
12 service loan forgiveness, national health service corps, Indian health services loan repayment
13 program, armed forces, income-driven repayment, etc.^{1,2}; and
14
15 Whereas, A recent report on resident salary and debt found that 57% of resident physicians
16 were dissatisfied with their compensation, 81% felt that their compensation did not adequately
17 reflect the number of hours they worked, and 77% felt that their compensation was not
18 comparable to what physician's assistants, nurses, and other medical staff were paid³; and
19
20 Whereas, Today, burnout among physicians in training such as medical students and trainees
21 ranges from 50-70%; and
22
23 Whereas, Within nursing, burnout is discussed in terms of turnover rate at hospitals, as
24 registered nurses (RN) turnover rate ranges between 20-30%⁴; and
25
26 Whereas, Among nurse practitioners, 25% of those in primary care environments have
27 experienced burnout⁵; and
28
29 Whereas, Current research on burnout indirectly being used to measure work-life balance does
30 not account for differences among individuals, especially those with varying socioeconomic,
31 racial and/or sexual minoritized backgrounds; therefore be it
32
33 RESOLVED, That our American Medical Association's advocacy efforts be informed by the fact
34 that student debt burden is higher for physicians when compared to physician assistants and
35 nurse practitioners (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA work with relevant stakeholders to study: (a) how total career
2 earnings of physicians compare to those physician assistants and nurse practitioners in order to
3 specifically discern if there is a financial disincentive to becoming a physician, considering the
4 relatively high student debt burden and work hours of physicians; (b) if resident physicians
5 provide a net financial benefit for hospitals and healthcare institutions; (c) best practices for
6 increasing resident physician compensation so that their services may be more equitably
7 reflected in their earnings; and (d) burnout metrics using a standardized system to compare
8 differences among physicians, physician assistants and nurse practitioners (Directive to Take
9 Action); and be it further
10
11 RESOLVED, That our AMA recognize that burnout-centered metrics do not fully characterize
12 work-life balance, particularly for individuals with varying socioeconomic, racial and/or sexual
13 minoritized backgrounds (New HOD Policy); and be it further
14
15 RESOLVED, That our AMA seek to publish its findings in a peer-reviewed medical journal.
16 (Directive to Take Action)

Fiscal Note: Estimated cost of \$306K to implement this resolution.

Received: 09/14/22

REFERENCES

1. <https://students-residents.aamc.org/financial-aid-resources/postponing-loan-repayment-during-residency>
2. <https://www.aamc.org/news-insights/7-ways-reduce-medical-school-debt#:~:text=According%20to%20a%20recent%20AAMC,debt%20was%20%24200%2C000%20in%202019>
3. <https://www.medscape.com/slideshow/2021-residents-salary-debt-report-6014074#:~:text=As%20in%20previous%20years%2C%20average,making%20about%20the%20same%20salary.>
4. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2775923>
5. <https://pubmed.ncbi.nlm.nih.gov/34519700/>

RELEVANT AMA POLICY

Principles of and Actions to Address Medical Education Costs and Student Debt H-305.925

The costs of medical education should never be a barrier to the pursuit of a career in medicine nor to the decision to practice in a given specialty. To help address this issue, our American Medical Association (AMA) will:

1. Collaborate with members of the Federation and the medical education community, and with other interested organizations, to address the cost of medical education and medical student debt through public- and private-sector advocacy.
2. Vigorously advocate for and support expansion of and adequate funding for federal scholarship and loan repayment programs--such as those from the National Health Service Corps, Indian Health Service, Armed Forces, and Department of Veterans Affairs, and for comparable programs from states and the private sector--to promote practice in underserved areas, the military, and academic medicine or clinical research.
3. Encourage the expansion of National Institutes of Health programs that provide loan repayment in exchange for a commitment to conduct targeted research.
4. Advocate for increased funding for the National Health Service Corps Loan Repayment Program to assure adequate funding of primary care within the National Health Service Corps, as well as to permit: (a) inclusion of all medical specialties in need, and (b) service in clinical settings that care for the underserved but are not necessarily located in health professions shortage areas.
5. Encourage the National Health Service Corps to have repayment policies that are consistent with other federal loan forgiveness programs, thereby decreasing the amount of loans in default and increasing the number of physicians practicing in underserved areas.
6. Work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of trainees with educational debt.
7. Advocate for federal legislation to support the creation of student loan savings accounts that allow for pre-tax dollars to be used to pay for student loans.
8. Work with other concerned organizations to advocate for legislation and regulation that would result in favorable terms and conditions for borrowing and for loan repayment, and would permit 100% tax deductibility of interest on student loans and elimination of taxes on aid from service-based programs.
9. Encourage the creation of private-sector financial aid programs with favorable interest rates or service obligations (such as community- or institution-based loan repayment programs or state medical society loan programs).
10. Support stable funding for medical education programs to limit excessive tuition increases, and collect and disseminate information on medical school programs that cap medical education debt, including the types of debt management education that are provided.
11. Work with state medical societies to advocate for the creation of either tuition caps or, if caps are not feasible, pre-defined tuition increases, so that medical students will be aware of their tuition and fee costs for the total period of their enrollment.
12. Encourage medical schools to (a) Study the costs and benefits associated with non-traditional instructional formats (such as online and distance learning, and combined baccalaureate/MD or DO programs) to determine if cost savings to medical schools and to medical students could be realized without jeopardizing the quality of medical education; (b) Engage in fundraising activities to increase the availability of scholarship support, with the support of the Federation, medical schools, and state and specialty medical societies, and develop or enhance financial aid opportunities for medical students, such as self-managed, low-interest loan programs; (c) Cooperate with postsecondary institutions to establish collaborative debt counseling for entering first-year medical students; (d) Allow for flexible scheduling for medical students who encounter financial difficulties that can be remedied only by employment, and consider creating opportunities for paid employment for medical students; (e) Counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation; (f) Inform students of all government loan opportunities and disclose the reasons that preferred lenders were chosen; (g) Ensure that all medical student fees are earmarked for specific and well-defined purposes, and avoid charging any overly broad and ill-defined fees, such as but not limited to professional fees; (h) Use their collective purchasing power to obtain discounts for their students on necessary medical equipment, textbooks, and other educational supplies; (i) Work to ensure stable funding, to eliminate the need for increases in tuition and fees to compensate for unanticipated decreases in other sources of revenue; mid-year and retroactive tuition increases should be opposed.

13. Support and encourage state medical societies to support further expansion of state loan repayment programs, particularly those that encompass physicians in non-primary care specialties.
14. Take an active advocacy role during reauthorization of the Higher Education Act and similar legislation, to achieve the following goals: (a) Eliminating the single holder rule; (b) Making the availability of loan deferment more flexible, including broadening the definition of economic hardship and expanding the period for loan deferment to include the entire length of residency and fellowship training; (c) Retaining the option of loan forbearance for residents ineligible for loan deferment; (d) Including, explicitly, dependent care expenses in the definition of the “cost of attendance”; (e) Including room and board expenses in the definition of tax-exempt scholarship income; (f) Continuing the federal Direct Loan Consolidation program, including the ability to “lock in” a fixed interest rate, and giving consideration to grace periods in renewals of federal loan programs; (g) Adding the ability to refinance Federal Consolidation Loans; (h) Eliminating the cap on the student loan interest deduction; (i) Increasing the income limits for taking the interest deduction; (j) Making permanent the education tax incentives that our AMA successfully lobbied for as part of Economic Growth and Tax Relief Reconciliation Act of 2001; (k) Ensuring that loan repayment programs do not place greater burdens upon married couples than for similarly situated couples who are cohabitating; (l) Increasing efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students.
15. Continue to work with state and county medical societies to advocate for adequate levels of medical school funding and to oppose legislative or regulatory provisions that would result in significant or unplanned tuition increases.
16. Continue to study medical education financing, so as to identify long-term strategies to mitigate the debt burden of medical students, and monitor the short-and long-term impact of the economic environment on the availability of institutional and external sources of financial aid for medical students, as well as on choice of specialty and practice location.
17. Collect and disseminate information on successful strategies used by medical schools to cap or reduce tuition.
18. Continue to monitor the availability of and encourage medical schools and residency/fellowship programs to (a) provide financial aid opportunities and financial planning/debt management counseling to medical students and resident/fellow physicians; (b) work with key stakeholders to develop and disseminate standardized information on these topics for use by medical students, resident/fellow physicians, and young physicians; and (c) share innovative approaches with the medical education community.
19. Seek federal legislation or rule changes that would stop Medicare and Medicaid decertification of physicians due to unpaid student loan debt. The AMA believes that it is improper for physicians not to repay their educational loans, but assistance should be available to those physicians who are experiencing hardship in meeting their obligations.
20. Related to the Public Service Loan Forgiveness (PSLF) Program, our AMA supports increased medical student and physician benefits the program, and will: (a) Advocate that all resident/fellow physicians have access to PSLF during their training years; (b) Advocate against a monetary cap on PSLF and other federal loan forgiveness programs; (c) Work with the United States Department of Education to ensure that any cap on loan forgiveness under PSLF be at least equal to the principal amount borrowed; (d) Ask the United States Department of Education to include all terms of PSLF in the contractual obligations of the Master Promissory Note; (e) Encourage the Accreditation Council for Graduate Medical Education (ACGME) to require residency/fellowship programs to include within the terms, conditions, and benefits of program appointment information on the PSLF program qualifying status of the employer; (f) Advocate that the profit status of a physicians training institution not be a factor for PSLF eligibility; (g) Encourage medical school financial advisors to counsel wise borrowing by medical students, in the event that the PSLF program is eliminated or severely curtailed; (h) Encourage medical school financial advisors to increase medical student engagement in service-based loan repayment options, and other federal and military programs, as an attractive alternative to the PSLF in terms of financial prospects as well as providing the opportunity to provide care in medically underserved areas; (i) Strongly advocate that the terms of the PSLF that existed at the time of the agreement remain unchanged for any program participant in the event of any future restrictive changes.
21. Advocate for continued funding of programs including Income-Driven Repayment plans for the benefit of reducing medical student load burden.

22. Formulate a task force to look at undergraduate medical education training as it relates to career choice, and develop new policies and novel approaches to prevent debt from influencing specialty and subspecialty choice.

23. Strongly advocate for the passage of legislation to allow medical students, residents and fellows who have education loans to qualify for interest-free deferment on their student loans while serving in a medical internship, residency, or fellowship program, as well as permitting the conversion of currently unsubsidized Stafford and Graduate Plus loans to interest free status for the duration of undergraduate and graduate medical education.

Citation: CME Report 05, I-18; Appended: Res. 953, I-18; Reaffirmation: A-19; Appended: Res. 316, A-19; Appended: Res. 226, A-21; Reaffirmed in lieu of: Res. 311, A-21; Modified: CME Rep. 4, I-21; Reaffirmation: A-22

Competency Based Medical Education Across the Continuum of Education and Practice D-295.317

1. Our AMA Council on Medical Education will continue to study and identify challenges and opportunities and critical stakeholders in achieving a competency-based curriculum across the medical education continuum and other health professions that provides significant value to those participating in these curricula and their patients. 2. Our AMA Council on Medical Education will work to establish a framework of consistent vocabulary and definitions across the continuum of health sciences education that will facilitate competency-based curriculum, andragogy and assessment implementation. 3. Our AMA will continue to explore, with the Accelerating Change in Medical Education initiative and with other stakeholder organizations, the implications of shifting from time-based to competency-based medical education on residents' compensation and lifetime earnings.

Citation: CME Rep. 3, A-14; Appended: CME Rep. 04, A-16

Resident/Fellow Clinical and Educational Work Hours H-310.907

Our AMA adopts the following Principles of Resident/Fellow Clinical and Educational Work Hours, Patient Safety, and Quality of Physician Training: 1. Our AMA supports the 2017 Accreditation Council for Graduate Medical Education (ACGME) standards for clinical and educational work hours (previously referred to as "duty hours"). 2. Our AMA will continue to monitor the enforcement and impact of clinical and educational work hour standards, in the context of the larger issues of patient safety and the optimal learning environment for residents. 3. Our AMA encourages publication and supports dissemination of studies in peer-reviewed publications and educational sessions about all aspects of clinical and educational work hours, to include such topics as extended work shifts, handoffs, in-house call and at-home call, level of supervision by attending physicians, workload and growing service demands, moonlighting, protected sleep periods, sleep deprivation and fatigue, patient safety, medical error, continuity of care, resident well-being and burnout, development of professionalism, resident learning outcomes, and preparation for independent practice. 4. Our AMA endorses the study of innovative models of clinical and educational work hour requirements and, pending the outcomes of ongoing and future research, should consider the evolution of specialty- and rotation-specific requirements that are evidence-based and will optimize patient safety and competency-based learning opportunities. 5. Our AMA encourages the ACGME to: a) Decrease the barriers to reporting of both clinical and educational work hour violations and resident intimidation. b) Ensure that readily accessible, timely and accurate information about clinical and educational work hours is not constrained by the cycle of ACGME survey visits. c) Use, where possible, recommendations from respective specialty societies and evidence-based approaches to any future revision or introduction of clinical and educational work hour rules. d) Broadly disseminate aggregate data from the annual ACGME survey on the educational environment of resident physicians, encompassing all aspects of clinical and educational work hours. 6. Our AMA recognizes the ACGME for its work in ensuring an appropriate balance between resident education and patient safety, and encourages the ACGME to continue to: a) Offer incentives to programs/institutions to ensure compliance with clinical and educational work hour standards. b) Ensure that site visits include meetings with peer-selected or randomly selected residents and that residents who are not interviewed during site visits have the opportunity to provide information directly to the site visitor. c) Collect data on at-home call from both program directors and resident/fellow physicians; release these aggregate data annually; and develop standards to ensure that appropriate education and supervision are maintained, whether the setting is in-house or at-home. d) Ensure that resident/fellow physicians receive education on sleep deprivation and fatigue. 7. Our AMA supports the following statements related to clinical and educational work hours: a) Total clinical and educational work hours must not exceed 80 hours per week, averaged

over a four-week period (Note: "Total clinical and educational work hours" includes providing direct patient care or supervised patient care that contributes to meeting educational goals; participating in formal educational activities; providing administrative and patient care services of limited or no educational value; and time needed to transfer the care of patients). b) Scheduled on-call assignments should not exceed 24 hours. Residents may remain on-duty for an additional 4 hours to complete the transfer of care, patient follow-up, and education; however, residents may not be assigned new patients, cross-coverage of other providers' patients, or continuity clinic during that time. c) Time spent in the hospital by residents on at-home call must count towards the 80-hour maximum weekly hour limit, and on-call frequency must not exceed every third night averaged over four weeks. The frequency of at-home call is not subject to the every-third-night limitation, but must satisfy the requirement for one-day-in-seven free of duty, when averaged over four weeks. d) At-home call must not be so frequent or taxing as to preclude rest or reasonable personal time for each resident. e) Residents are permitted to return to the hospital while on at-home call to care for new or established patients. Each episode of this type of care, while it must be included in the 80-hour weekly maximum, will not initiate a new "off-duty period." f) Given the different education and patient care needs of the various specialties and changes in resident responsibility as training progresses, clinical and educational work hour requirements should allow for flexibility for different disciplines and different training levels to ensure appropriate resident education and patient safety; for example, allowing exceptions for certain disciplines, as appropriate, or allowing a limited increase to the total number of clinical and educational work hours when need is demonstrated. g) Resident physicians should be ensured a sufficient duty-free interval prior to returning to duty. h) Clinical and educational work hour limits must not adversely impact resident physician participation in organized educational activities. Formal educational activities must be scheduled and available within total clinical and educational work hour limits for all resident physicians. i) Scheduled time providing patient care services of limited or no educational value should be minimized. j) Accurate, honest, and complete reporting of clinical and educational work hours is an essential element of medical professionalism and ethics. k) The medical profession maintains the right and responsibility for self-regulation (one of the key tenets of professionalism) through the ACGME and its purview over graduate medical education, and categorically rejects involvement by the Centers for Medicare & Medicaid Services, The Joint Commission, Occupational Safety and Health Administration, and any other federal or state government bodies in the monitoring and enforcement of clinical and educational work hour regulations, and opposes any regulatory or legislative proposals to limit the work hours of practicing physicians. l) Increased financial assistance for residents/fellows, such as subsidized child care, loan deferment, debt forgiveness, and tax credits, may help mitigate the need for moonlighting. At the same time, resident/fellow physicians in good standing with their programs should be afforded the opportunity for internal and external moonlighting that complies with ACGME policy. m) Program directors should establish guidelines for scheduled work outside of the residency program, such as moonlighting, and must approve and monitor that work such that it does not interfere with the ability of the resident to achieve the goals and objectives of the educational program. n) The costs of clinical and educational work hour limits should be borne by all health care payers. Individual resident compensation and benefits must not be compromised or decreased as a result of changes in the graduate medical education system. o) The general public should be made aware of the many contributions of resident/fellow physicians to high-quality patient care and the importance of trainees' realizing their limits (under proper supervision) so that they will be able to competently and independently practice under real-world medical situations. 8. Our AMA is in full support of the collaborative partnership between allopathic and osteopathic professional and accrediting bodies in developing a unified system of residency/fellowship accreditation for all residents and fellows, with the overall goal of ensuring patient safety. 9. Our AMA will actively participate in ongoing efforts to monitor the impact of clinical and educational work hour limitations to ensure that patient safety and physician well-being are not jeopardized by excessive demands on post-residency physicians, including program directors and attending physicians.

Citation: CME Rep. 5, A-14; Modified: CME Rep. 06, I-18; Reaffirmation: A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(I-22)

Introduced by: Resident and Fellow Section

Subject: Comprehensive Solutions for Medical School Graduates Who Are Unmatched or Did Not Complete Training

Referred to: Reference Committee B

- 1 Whereas, Fully trained physicians are in shortage now and forecasted to be in shortage in the
2 future¹; and
3
4 Whereas, This shortage does not extend to all specialties and several specialties such as
5 Emergency Medicine² and Radiation Oncology³ are projected to be in oversupply; and
6
7 Whereas, No current body with direct regulatory oversight over residencies can act to allocate
8 and re-allocate funding and positions from fields projected to be in oversupply to fields in greater
9 shortage due to antitrust restrictions; and
10
11 Whereas, Almost all other countries allocate residency positions based to some extent on the
12 future workforce needs of the nation, instead of local factors; and
13
14 Whereas, The United States population could benefit greatly from available governmental
15 funding for first year categorical positions being allocated in ratio to the projected physician
16 workforce needs of the nation; and
17
18 Whereas, Many US allopathic and osteopathic medical school graduates cannot make the time
19 or location commitment to a residency program due to personal, financial, or other
20 commitments; therefore be it
21
22 RESOLVED, That our American Medical Association work with US Centers for Medicare and
23 Medicaid Services and other relevant stakeholders to create a commission to estimate future
24 physician workforce needs and suggest re-allocation of available residency funding and
25 available first-year positions accordingly (Directive to Take Action); and be it further
26
27 RESOLVED, That our AMA work with relevant stakeholders to study the possibility of alternative
28 pathways to ACGME certification of training, ABMS board certification, and medical practice for
29 unmatched medical school graduates. (Directive to Take Action)

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

Received: 09/14/22

REFERENCES:

1. Zhang et al. Physician workforce in the United States of America: forecasting nationwide shortages. Hum Resour Health. 2020 Feb 6;18(1):8.
2. Reiter M, Allen BW. The Emergency Medicine Workforce: Shortage Resolving, Future Surplus Expected. J Emerg Med. 2020 Feb;58(2):198-202.
3. Falit et al. The Radiation Oncology Job Market: The Economics and Policy of Workforce Regulation. Int J Radiat Oncol Biol Phys. 2016 Nov 1;96(3):501-10

RELEVANT AMA POLICY

Securing Funding for Graduate Medical Education H-310.917

Our American Medical Association: (1) continues to be vigilant while monitoring pending legislation that may change the financing of medical services (health system reform) and advocate for expanded and broad-based funding for graduate medical education (from federal, state, and commercial entities); (2) continues to advocate for graduate medical education funding that reflects the physician workforce needs of the nation; (3) encourages all funders of GME to adhere to the Accreditation Council for Graduate Medical Education's requirements on restrictive covenants and its principles guiding the relationship between GME, industry and other funding sources, as well as the AMA's Opinion 8.061, and other AMA policy that protects residents and fellows from exploitation, including physicians training in non-ACGME-accredited programs; and (4) encourages entities planning to expand or start GME programs to develop a clear statement of the benefits of their GME activities to facilitate potential funding from appropriate sources given the goals of their programs.

Citation: CME Rep. 3, I-09; Modified: CME Rep. 15, A-10; Reaffirmed in lieu of Res. 324, A-12; Reaffirmed: CME Rep. 5, A-13; Appended: CME Rep. 1, I-15

Proposed Revisions to AMA Policy on the Financing of Medical Education Programs D-305.973

Our AMA will work with:

- (1) the federal government, including the Centers for Medicare and Medicaid Services, and the states, along with other interested parties, to bring about the following outcomes:
 - (a) ensure adequate Medicaid and Medicare funding for graduate medical education;
 - (b) ensure adequate Disproportionate Share Hospital funding;
 - (c) make the Medicare direct medical education per-resident cost figure more equitable across teaching hospitals while assuring adequate funding of all residency positions;
 - (d) revise the Medicare and Medicaid funding formulas for graduate medical education to recognize the resources utilized for training in non-hospital settings;
 - (e) stabilize funding for pediatric residency training in children's hospitals;
 - (f) explore the possibility of extending full direct medical education per-resident payment beyond the time of first board eligibility for specialties/subspecialties in shortage/defined need;
 - (g) identify funding sources to increase the number of graduate medical education positions, especially in or adjacent to physician shortage/underserved areas and in undersupplied specialties; and
 - (h) act on existing policy by seeking federal legislation requiring all health insurers to support graduate medical education through an all-payer trust fund created for this purpose; and
- (2) other interested parties to ensure adequate funding to support medical school educational programs, including creating mechanisms to fund additional medical school positions.

Citation: (CME Rep. 7, A-05; Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: Res. 921, I-12; Reaffirmation A-13; Reaffirmed: CME Rep. 5, A-13)

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

1. Our AMA will actively collaborate with appropriate stakeholder organizations, (including Association of American Medical Colleges, American Hospital Association, state medical societies, medical specialty societies/associations) to advocate for the preservation, stability and expansion of full funding for the direct and indirect costs of graduate medical education (GME) positions from all existing sources (e.g. Medicare, Medicaid, Veterans Administration, CDC and others).
2. Our AMA will actively advocate for the stable provision of matching federal funds for state Medicaid programs that fund GME positions.
3. Our AMA will actively seek congressional action to remove the caps on Medicare funding of GME positions for resident physicians that were imposed by the Balanced Budget Amendment of 1997 (BBA-1997).

4. Our AMA will strenuously advocate for increasing the number of GME positions to address the future physician workforce needs of the nation.
5. Our AMA will oppose efforts to move federal funding of GME positions to the annual appropriations process that is subject to instability and uncertainty.
6. Our AMA will oppose regulatory and legislative efforts that reduce funding for GME from the full scope of resident educational activities that are designated by residency programs for accreditation and the board certification of their graduates (e.g. didactic teaching, community service, off-site ambulatory rotations, etc.).
7. Our AMA will actively explore additional sources of GME funding and their potential impact on the quality of residency training and on patient care.
8. Our AMA will vigorously advocate for the continued and expanded contribution by all payers for health care (including the federal government, the states, and local and private sources) to fund both the direct and indirect costs of GME.
9. Our AMA will work, in collaboration with other stakeholders, to improve the awareness of the general public that GME is a public good that provides essential services as part of the training process and serves as a necessary component of physician preparation to provide patient care that is safe, effective and of high quality.
10. Our AMA staff and governance will continuously monitor federal, state and private proposals for health care reform for their potential impact on the preservation, stability and expansion of full funding for the direct and indirect costs of GME.
11. Our AMA: (a) recognizes that funding for and distribution of positions for GME are in crisis in the United States and that meaningful and comprehensive reform is urgently needed; (b) will immediately work with Congress to expand medical residencies in a balanced fashion based on expected specialty needs throughout our nation to produce a geographically distributed and appropriately sized physician workforce; and to make increasing support and funding for GME programs and residencies a top priority of the AMA in its national political agenda; and (c) will continue to work closely with the Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Osteopathic Association, and other key stakeholders to raise awareness among policymakers and the public about the importance of expanded GME funding to meet the nation's current and anticipated medical workforce needs.
12. Our AMA will collaborate with other organizations to explore evidence-based approaches to quality and accountability in residency education to support enhanced funding of GME.
13. Our AMA will continue to strongly advocate that Congress fund additional graduate medical education (GME) positions for the most critical workforce needs, especially considering the current and worsening maldistribution of physicians.
14. Our AMA will advocate that the Centers for Medicare and Medicaid Services allow for rural and other underserved rotations in Accreditation Council for Graduate Medical Education (ACGME)-accredited residency programs, in disciplines of particular local/regional need, to occur in the offices of physicians who meet the qualifications for adjunct faculty of the residency program's sponsoring institution.
15. Our AMA encourages the ACGME to reduce barriers to rural and other underserved community experiences for graduate medical education programs that choose to provide such training, by adjusting as needed its program requirements, such as continuity requirements or limitations on time spent away from the primary residency site.
16. Our AMA encourages the ACGME and the American Osteopathic Association (AOA) to continue to develop and disseminate innovative methods of training physicians efficiently that foster the skills and inclinations to practice in a health care system that rewards team-based care and social accountability.
17. Our AMA will work with interested state and national medical specialty societies and other appropriate stakeholders to share and support legislation to increase GME funding, enabling a state to accomplish one or more of the following: (a) train more physicians to meet state and regional workforce needs; (b) train physicians who will practice in physician shortage/underserved areas; or (c) train physicians in undersupplied specialties and subspecialties in the state/region.
18. Our AMA supports the ongoing efforts by states to identify and address changing physician workforce needs within the GME landscape and continue to broadly advocate for innovative pilot programs that will increase the number of positions and create enhanced accountability of GME programs for quality outcomes.
19. Our AMA will continue to work with stakeholders such as Association of American Medical Colleges (AAMC), ACGME, AOA, American Academy of Family Physicians, American College of Physicians, and

other specialty organizations to analyze the changing landscape of future physician workforce needs as well as the number and variety of GME positions necessary to provide that workforce.

20. Our AMA will explore innovative funding models for incremental increases in funded residency positions related to quality of resident education and provision of patient care as evaluated by appropriate medical education organizations such as the Accreditation Council for Graduate Medical Education.

21. Our AMA will utilize its resources to share its content expertise with policymakers and the public to ensure greater awareness of the significant societal value of graduate medical education (GME) in terms of patient care, particularly for underserved and at-risk populations, as well as global health, research and education.

22. Our AMA will advocate for the appropriation of Congressional funding in support of the National Healthcare Workforce Commission, established under section 5101 of the Affordable Care Act, to provide data and healthcare workforce policy and advice to the nation and provide data that support the value of GME to the nation.

23. Our AMA supports recommendations to increase the accountability for and transparency of GME funding and continue to monitor data and peer-reviewed studies that contribute to further assess the value of GME.

24. Our AMA will explore various models of all-payer funding for GME, especially as the Institute of Medicine (now a program unit of the National Academy of Medicine) did not examine those options in its 2014 report on GME governance and financing.

25. Our AMA encourages organizations with successful existing models to publicize and share strategies, outcomes and costs.

26. Our AMA encourages insurance payers and foundations to enter into partnerships with state and local agencies as well as academic medical centers and community hospitals seeking to expand GME.

27. Our AMA will develop, along with other interested stakeholders, a national campaign to educate the public on the definition and importance of graduate medical education, student debt and the state of the medical profession today and in the future.

28. Our AMA will collaborate with other stakeholder organizations to evaluate and work to establish consensus regarding the appropriate economic value of resident and fellow services.

29. Our AMA will monitor ongoing pilots and demonstration projects, and explore the feasibility of broader implementation of proposals that show promise as alternative means for funding physician education and training while providing appropriate compensation for residents and fellows.

30. Our AMA will monitor the status of the House Energy and Commerce Committee's response to public comments solicited regarding the 2014 IOM report, Graduate Medical Education That Meets the Nation's Health Needs, as well as results of ongoing studies, including that requested of the GAO, in order to formulate new advocacy strategy for GME funding, and will report back to the House of Delegates regularly on important changes in the landscape of GME funding.

31. Our AMA will advocate to the Centers for Medicare & Medicaid Services to adopt the concept of "Cap-Flexibility" and allow new and current Graduate Medical Education teaching institutions to extend their cap-building window for up to an additional five years beyond the current window (for a total of up to ten years), giving priority to new residency programs in underserved areas and/or economically depressed areas.

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

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

care residents that went on to practice in rural or medically underserved areas), and measures related to resident competency and educational quality offered by GME training programs.

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

National Resident Matching Program Reform D-310.977

Our AMA:

- (1) will work with the National Resident Matching Program (NRMP) to develop and distribute educational programs to better inform applicants about the NRMP matching process, including the existing NRMP waiver and violations review policies;
- (2) will actively participate in the evaluation of, and provide timely comments about, all proposals to modify the NRMP Match;
- (3) will request that the NRMP explore the possibility of including the Osteopathic Match in the NRMP Match;
- (4) will continue to review the NRMP's policies and procedures and make recommendations for improvements as the need arises, to include making the conditions of the Match agreement more transparent while assuring the confidentiality of the match;
- (5) will work with the Accreditation Council for Graduate Medical Education (ACGME) and other appropriate agencies to assure that the terms of employment for resident physicians are fair and equitable and reflect the unique and extensive amount of education and experience acquired by physicians;
- (6) does not support the current the "All-In" policy for the Main Residency Match to the extent that it eliminates flexibility within the match process;
- (7) will work with the NRMP, and other residency match programs, in revising Match policy, including the secondary match or scramble process to create more standardized rules for all candidates including application timelines and requirements;
- (8) will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants;
- (9) encourages the National Resident Matching Program to study and publish the effects of implementation of the Supplemental Offer and Acceptance Program on the number of residency spots not filled through the Main Residency Match and include stratified analysis by specialty and other relevant areas;
- (10) will work with the NRMP and ACGME to evaluate the challenges in moving from a time-based education framework toward a competency-based system, including: a) analysis of time-based implications of the ACGME milestones for residency programs; b) the impact on the NRMP and entry into residency programs if medical education programs offer variable time lengths based on acquisition of competencies; c) the impact on financial aid for medical students with variable time lengths of medical education programs; d) the implications for interprofessional education and rewarding teamwork; and e) the implications for residents and students who achieve milestones earlier or later than their peers;
- (11) will work with the Association of American Medical Colleges (AAMC), American Osteopathic Association (AOA), American Association of Colleges of Osteopathic Medicine (AACOM), and National Resident Matching Program (NRMP) to evaluate the current available data or propose new studies that would help us learn how many students graduating from US medical schools each year do not enter into a US residency program; how many never enter into a US residency program; whether there is disproportionate impact on individuals of minority racial and ethnic groups; and what careers are pursued by those with an MD or DO degree who do not enter residency programs;
- (12) will work with the AAMC, AOA, AACOM and appropriate licensing boards to study whether US medical school graduates and international medical graduates who do not enter residency programs may be able to serve unmet national health care needs;
- (13) will work with the AAMC, AOA, AACOM and the NRMP to evaluate the feasibility of a national tracking system for US medical students who do not initially match into a categorical residency program;

(14) will discuss with the National Resident Matching Program, Association of American Medical Colleges, American Osteopathic Association, Liaison Committee on Medical Education, Accreditation Council for Graduate Medical Education, and other interested bodies potential pathways for reengagement in medicine following an unsuccessful match and report back on the results of those discussions;

(15) encourages the Association of American Medical Colleges to work with U.S. medical schools to identify best practices, including career counseling, used by medical schools to facilitate successful matches for medical school seniors, and reduce the number who do not match;

(16) supports the movement toward a unified and standardized residency application and match system for all non-military residencies;

(17) encourages the Educational Commission for Foreign Medical Graduates (ECFMG) and other interested stakeholders to study the personal and financial consequences of ECFMG-certified U.S. IMGs who do not match in the National Resident Matching Program and are therefore unable to get a residency or practice medicine;

(18) encourages the AAMC, AACOM, NRMP, and other key stakeholders to jointly create a no-fee, easily accessible clearinghouse of reliable and valid advice and tools for residency program applicants seeking cost-effective methods for applying to and successfully matching into residency; and

(19) will work with appropriate stakeholders to study options for improving transparency in the resident application process.

Citation: CME Rep. 4, A-05; Appended: Res. 330, A-11; Appended: Res. 920, I-11; Appended: Res. 311, A-14; Appended: Res. 312, A-14; Appended: Res. 304, A-15; Appended: CME Rep. 03, A-16; Reaffirmation: A-16; Appended: CME Rep. 06, A-17; Appended: Res. 306, A-17; Modified: Speakers Rep. 01, A-17; Appended: CME Rep. 3, A-21; Modified: CME Rep. 1, A-22; Appended: Res. 328, A-22

Preliminary Year Program Placement H-310.910

1. Our AMA encourages the Accreditation Council for Graduate Medical Education, the American Osteopathic Association, and other involved organizations to strongly encourage residency programs that now require a preliminary year to match residents for their specialty and then arrange with another department or another medical center for the preliminary year of training unless the applicant chooses to pursue preliminary year training separately.

2. Our AMA encourages appropriate stakeholders to explore options to decrease the burden upon medical students who must apply to separate preliminary PGY-1 and categorical PGY-2 positions.

3. Our AMA will work with the Accreditation Council for Graduate Medical Education to encourage programs with PGY-2 positions in the National Resident Matching Program (NRMP) with insufficient availability of local PGY-1 positions to create local PGY-1 positions that will enable coordinated applications and interviews for medical students.

4. Our AMA encourages the NRMP, the San Francisco Match, the American Urological Association, the Electronic Residency Application Service, and other stakeholders to reduce barriers for medical students, residents, and physicians applying to match into training programs, including barriers to “couples matching,” and to ensure that all applicants have access to robust, informative statistics to assist in decision-making.

5. Our AMA encourages the NRMP, San Francisco Match, American Urological Association, Electronic Residency Application Service, and other stakeholders to collect and publish data on a) the impact of separate matches on the personal and professional lives of medical students and b) the impact on medical students who are unable to successfully “couples match” with their significant others due to staggered entry into residency, utilization of unlinked match services, or other causes.

Citation: Res. 306, A-12; Appended: CME Rep. 03, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(I-22)

Introduced by: Resident and Fellow Section

Subject: Illicit Drug Use Harm Reduction Strategies

Referred to: Reference Committee B

- 1 Whereas, 2021 was the worst year on record for opioid overdoses in the US, with over 75,000
2 reported¹; and
3
- 4 Whereas, The involvement of synthetic opioids, including fentanyl, in drug overdoses across
5 America is rising drastically year after year, and was 11-fold higher in 2019 than 2013^{2,3}; and
6
- 7 Whereas, Fentanyl test strips are a point-of-care test that identifies fentanyl contamination in a
8 drug supply with a specificity of 87.5% and a sensitivity of 95.2%⁴; and
9
- 10 Whereas, Fentanyl test strips are readily available and as inexpensive as \$1 per test⁵; and
11
- 12 Whereas, In a survey of young adults who use drugs, 95% reported that they were willing to use
13 fentanyl test strips to identify fentanyl in their drug supply⁶; and
14
- 15 Whereas, A positive test with a fentanyl test strip has been shown to lead to modification of
16 behaviors in order to reduce risk of overdose^{7,8}; and
17
- 18 Whereas, Possession of fentanyl test strips is explicitly legal in only 22 states⁹; and
19
- 20 Whereas, Our AMA sent a federal correspondence denouncing laws that allow possessors of
21 fentanyl test strips to be subject to civil and/or criminal penalties; and
22
- 23 Whereas, Drug checking services can also serve as a point of contact with users of recreational
24 drugs for other harm reduction services and advice, and that accessibility to these resources
25 through drug checking services is overwhelmingly supported by the target market¹⁰; therefore
26 be it

1 RESOLVED, That our American Medical Association amend current policy D-95.987,
2 "Prevention of Drug-Related Overdose," by addition to read as follows:

3
4 4. Our AMA will advocate for and encourage state and county medical societies
5 to advocate for harm reduction policies that provide civil and criminal immunity
6 for the possession, distribution, and use of "drug paraphernalia" designed for
7 harm reduction from drug use, including but not limited to drug contamination
8 testing and injection drug preparation, use, and disposal supplies.

9
10 5. Our AMA will implement an education program for patients with substance use
11 disorder and their family/caregivers to increase understanding of the increased
12 risk of adverse outcomes associated with having a substance use disorder and a
13 serious respiratory illness such as COVID-19.

14
15 6. Our AMA supports efforts to increase access to fentanyl test strips and other
16 drug checking supplies for purposes of harm reduction. (Modify Current HOD
17 Policy)

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

Received: 09/14/22

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RELEVANT AMA POLICY

Prevention of Drug-Related Overdose D-95.987

1. Our AMA: (a) recognizes the great burden that substance use disorders (SUDs) and drug-related overdoses and death places on patients and society alike and reaffirms its support for the compassionate treatment of patients with a SUD and people who use drugs; (b) urges that community-based programs offering naloxone and other opioid overdose and drug safety and prevention services continue to be implemented in order to further develop best practices in this area; (c) encourages the education of health care workers and people who use drugs about the use of naloxone and other harm reduction measures in preventing opioid and other drug-related overdose fatalities; and (d) will continue to monitor the progress of such initiatives and respond as appropriate.
2. Our AMA will: (a) advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of a drug-related overdose; and (b) encourage the continued study and implementation of appropriate treatments and risk mitigation methods for patients at risk for a drug-related overdose.

3. Our AMA will support the development and implementation of appropriate education programs for persons receiving treatment for a SUD or in recovery from a SUD and their friends/families that address harm reduction measures.
 4. Our AMA will advocate for and encourage state and county medical societies to advocate for harm reduction policies that provide civil and criminal immunity for the use of "drug paraphernalia" designed for harm reduction from drug use, including but not limited to drug contamination testing and injection drug preparation, use, and disposal supplies.
 5. Our AMA will implement an education program for patients with substance use disorder and their family/caregivers to increase understanding of the increased risk of adverse outcomes associated with having a substance use disorder and a serious respiratory illness such as COVID-19.
- Citation: Res. 526, A-06 Modified in lieu of Res. 503, A-12; Appended: Res. 909, I-12; Reaffirmed: BOT Rep. 22, A-16; Modified: Res. 511, A-18; Reaffirmed: Res. 235, I-18; Modified: Res. 506, I-21; Appended: Res. 513, A-22

Increasing Availability of Naloxone H-95.932

1. Our AMA supports legislative, regulatory, and national advocacy efforts to increase access to affordable naloxone, including but not limited to collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community-based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.
 2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.
 3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.
 4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.
 5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.
 6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.
 7. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.
 8. Our AMA supports the widespread implementation of easily accessible Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions) throughout the country following distribution and legislative edicts similar to those for Automated External Defibrillators.
 9. Our AMA supports the legal access to and use of naloxone in all public spaces regardless of whether the individual holds a prescription.
- Citation: BOT Rep. 22, A-16; Modified: Res. 231, A-17; Modified: Speakers Rep. 01, A-17; Appended: Res. 909, I-17; Reaffirmed: BOT Rep. 17, A-18; Modified: Res. 524, A-19; Reaffirmed: BOT 09, I-19; Reaffirmed: Res. 219, A-21

Pilot Implementation of Supervised Injection Facilities H-95.925

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

Citation: Res. 513, A-17

Harmful Drug Use in the United States - Strategies for Prevention H-95.978

- Our AMA: (1) Urges the Substance Abuse and Mental Health Administration to support research into special risks and vulnerabilities, behavioral and biochemical assessments and intervention methodologies most useful in identifying persons at special risk and the behavioral and biochemical strategies that are most effective in ameliorating risk factors.
- (2) Urges the Center for Substance Abuse Prevention to continue to support community-based prevention strategies which include: (a) Special attention to children and adolescents, particularly in schools, beginning at the pre-kindergarten level. (b) Changes in the social climate (i.e., attitudes of community leaders and the public), to reflect support of harmful drug and alcohol use prevention and treatment, eliminating past imbalances in allocation of resources to supply and demand reduction. (c) Development of innovative programs that train and involve parents, educators, physicians, and other community leaders in "state of the art" prevention approaches and skills.
- (3) Urges major media programming and advertising agencies to encourage the development of more accurate and prevention-oriented messages about the effects of harmful drug and alcohol use.

- (4) Supports the development of advanced educational programs to produce qualified prevention specialists, particularly those who relate well to the needs of economically disadvantaged, ethnic, racial, and other special populations.
- (5) Supports investigating the feasibility of developing a knowledge base of comprehensive, timely and accurate concepts and information as the "core curriculum" in support of prevention activities.
- (6) Urges federal, state, and local government agencies and private sector organizations to accelerate their collaborative efforts to develop a national consensus on prevention and eradication of harmful alcohol and drug use.

Citation: Res. 910, I-12

Reduction of Medical and Public Health Consequences of Drug Abuse: Update D-95.999

Our AMA encourages state medical societies to advocate for the expansion of and increased funding for needle and syringe-exchange programs and methadone maintenance and other opioid treatment services and programs in their states.

Citation: CSA Rep. 12, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(I-22)

Introduced by: New York

Subject: Hazard Pay During a Disaster Emergency

Referred to: Reference Committee B

1 Whereas, The US Labor Department defines Hazard Pay as “additional pay for performing a
2 hazardous duty or work involving physical hardship”; and
3

4 Whereas, A 25 percent hazard bonus is authorized for federal employees working directly with
5 or close to substances “of micro-organic nature which when introduced into the body are likely
6 to cause serious disease or fatality and for which protective devices do not afford complete
7 protection”; and
8

9 Whereas, This definition reflects the situation of physicians’ working in emergency departments,
10 intensive care units, and COVID wards; therefore be it
11

12 RESOLVED, That our American Medical Association work with the federation of medicine to
13 advocate for state or federal programs that would provide hazard pay bonuses to physicians
14 and other healthcare staff delivering care during a state or federal disaster emergency.
15 (Directive to Take Action)

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

Received: 09/20/22

RELEVANT AMA POLICY

AMA Leadership in the Medical Response to Terrorism and Other Disasters H-130.946

Our AMA: (1) Condemns terrorism in all its forms and provide leadership in coordinating efforts to improve the medical and public health response to terrorism and other disasters.

(2) Will work collaboratively with the Federation in the development, dissemination, and evaluation of a national education and training initiative, called the National Disaster Life Support Program, to provide physicians, medical students, other health professionals, and other emergency responders with a fundamental understanding and working knowledge of their integrated roles and responsibilities in disaster management and response efforts.

(3) Will join in working with the Department of Homeland Security, the Department of Health and Human Services, the Department of Defense, the Federal Emergency Management Agency, and other appropriate federal agencies; state, local, and medical specialty societies; other health care associations; and private foundations to (a) ensure adequate resources, supplies, and training to enhance the medical and public health response to terrorism and other disasters; (b) develop a comprehensive strategy to assure surge capacity to address mass casualty care; (c) implement communications strategies to inform health care professionals and the public about a terrorist attack or other major disaster, including local information on available medical and mental health services; (d) convene local and regional workshops to share "best practices" and "lessons learned" from disaster planning and response activities; (e) organize annual symposia to share new scientific knowledge and information for enhancing the medical and public health response to terrorism and other disasters; and (f) develop joint educational programs to enhance clinical collaboration and increase physician knowledge of the diagnosis and treatment of depression, anxiety, and post traumatic stress disorders associated with exposure to disaster, tragedy, and trauma.

(4) Believes all physicians should (a) be alert to the occurrence of unexplained illness and death in the

community; (b) be knowledgeable of disease surveillance and control capabilities for responding to unusual clusters of diseases, symptoms, or presentations; (c) be knowledgeable of procedures used to collect patient information for surveillance as well as the rationale and procedures for reporting patients and patient information; (d) be familiar with the clinical manifestations, diagnostic techniques, isolation precautions, decontamination protocols, and chemotherapy/prophylaxis of chemical, biological, and radioactive agents likely to be used in a terrorist attack; (e) utilize appropriate procedures to prevent exposure to themselves and others; (f) prescribe treatment plans that may include management of psychological and physical trauma; (g) understand the essentials of risk communication so that they can communicate clearly and nonthreateningly with patients, their families, and the media about issues such as exposure risks and potential preventive measures (e.g., smallpox vaccination); and (h) understand the role of the public health, emergency medical services, emergency management, and incident management systems in disaster response and the individual health professional's role in these systems.

(5) Believes that physicians and other health professionals who have direct involvement in a mass casualty event should be knowledgeable of public health interventions that must be considered following the onset of a disaster including: (a) quarantine and other movement restriction options; (b) mass immunization/chemoprophylaxis; (c) mass triage; (d) public education about preventing or reducing exposures; (e) environmental decontamination and sanitation; (f) public health laws; and (g) state and federal resources that contribute to emergency management and response at the local level.

(6) Believes that physicians and other health professionals should be knowledgeable of ethical and legal issues and disaster response. These include: (a) their professional responsibility to treat victims (including those with potentially contagious conditions); (b) their rights and responsibilities to protect themselves from harm; (c) issues surrounding their responsibilities and rights as volunteers, and (d) associated liability issues.

(7) Believes physicians and medical societies should participate directly with state, local, and national public health, law enforcement, and emergency management authorities in developing and implementing disaster preparedness and response protocols in their communities, hospitals, and practices in preparation for terrorism and other disasters.

(8) Urges Congress to appropriate funds to support research and development (a) to improve understanding of the epidemiology, pathogenesis, and treatment of diseases caused by potential bioweapon agents and the immune response to such agents; (b) for new and more effective vaccines, pharmaceuticals, and antidotes against biological and chemical weapons; (c) for enhancing the shelf life of existing vaccines, pharmaceuticals, and antidotes; and (d) for improving biological chemical, and radioactive agent detection and defense capabilities.

Citation: (BOT Rep. 26, I-01; Reaffirmed: BOT Rep. 3, I-02; Modified: CSA Rep. 1, I-03; Reaffirmed: CME Rep. 1, I-11; Reaffirmation A-15)

Domestic Disaster Relief Funding D-130.966

1. Our American Medical Association lobby Congress to a) reassess its policy for expedited release of funding to disaster areas; b) define areas of disaster with disproportionate indirect and direct consequences of disaster as "public health emergencies"; and c) explore a separate, less bureaucratic process for providing funding and resources to these areas in an effort to reduce morbidity and mortality post-disaster.

2. Our AMA will lobby actively for the recommendations outlined in the AMA/APHA Linkages Leadership Summit including: a) appropriate funding and protection of public health and health care systems as critical infrastructures for responding to day-to-day emergencies and mass casualty events; b) full integration and interoperable public health and health care disaster preparedness and response systems at all government levels; c) adequate legal protection in a disaster for public health and healthcare responders and d) incorporation of disaster preparedness and response competency-based education and training in undergraduate, graduate, post-graduate, and continuing education programs.

Citation: (Res. 421, A-11; Reaffirmation A-15)

Impact of SARS-CoV-2 Pandemic on Post-Acute Care Services and Long-Term Care and Residential Facilities D-280.983

Our AMA will collaborate with other stakeholders to develop policy to guide federal, state, and local public health authorities to ensure safe operation of Post-Acute Care (PAC) and long-term care (LTC) facilities during public health emergencies and natural disasters with policy recommendations to include but not limited to:

- a) Planning for adequate funding and access to resources;
- b) Planning for emergency staffing of health care and maintenance personnel;
- c) Planning for ensuring safe working conditions of PAC and LTC staff; and
- d) Planning for mitigation of the detrimental effects of increased isolation of residents during a natural disaster, other environmental emergency, or pandemic, or similar crisis.

Citation: Res. 407, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(I-22)

Introduced by: Georgia

Subject: Universal Good Samaritan Statute

Referred to: Reference Committee B

1 Whereas, Good Samaritan statutes exist in all 50 states and the District of Columbia for the
2 purpose of promoting aid to individuals in need of emergency care; and
3

4 Whereas, These statutes widely vary from state to state. This impedes the desired intent of
5 these laws and may prevent physicians from rendering much needed care to patients who are in
6 need of emergency care for a medical condition outside of healthcare settings due to fear of
7 litigation; and
8

9 Whereas, Some states only cover physicians licensed in that state. Physicians without the local
10 state license may be held liable for Good Samaritan acts if physicians are from a different state
11 and may be unfamiliar with the details of the local statutes; and
12

13 Whereas, "Enumeration of Immunity" of Good Samaritan statutes may vary from state to state in
14 such a way that it may not protect every rescuer depending upon the location of the event; and
15

16 Whereas, "Good faith requirement" in the statute may differ from state to state; and
17

18 Whereas, "Specific site of covering" may also vary based on the location of the accident and the
19 rescue; and
20

21 Whereas, "Minimal standard of care" may vary from state to state; and
22

23 Whereas, Federal laws only exist for specific circumstances, such as Aviation Medical
24 Assistance Act and Federal Law Enforcement Officers' Good Samaritan Act of 1998; therefore
25 be it
26

27 RESOLVED, That our American Medical Association help protect patients in need of emergency
28 care and protect physicians and other responders by advocating for a national "universal" Good
29 Samaritan Statute (Directive to Take Action); and be it further
30

31 RESOLVED, That our AMA advocate for the unification of the disparate statutes by creation of a
32 national standard via either federal legislation or through policy directed by the Department of
33 Health and Human Services [HHS] to specify terms that would protect rescuers from legal
34 repercussion as long as the act by the rescuer meets the specified universal minimal standard
35 of conduct and the good faith requirement, regardless of the event location; thus, effectively
36 eliminating variations in the state statutes to facilitate the intent of the Good Samaritan statutes
37 removing barriers that could impede the prompt rendering of emergency care. (Directive to Take
38 Action)

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

Received: 09/26/22

RELEVANT AMA POLICY

Delivery of Health Care by Good Samaritans H-130.937

1. Our AMA will work with state medical societies to educate physicians about the Good Samaritan laws in their states and the extent of liability immunity for physicians when they act as Good Samaritans.
 2. Our AMA encourages state medical societies in states without "Good Samaritan laws," which protect qualified medical personnel, to develop and support such legislation.
 3. Where there is no conflict with state or local jurisdiction protocol, policy, or regulation on this topic, the AMA supports the following basic guidelines to apply in those instances where a bystander physician happens upon the scene of an emergency and desires to assist and render medical assistance. For the purpose of this policy, "bystander physicians" shall refer to those physicians rendering assistance voluntarily, in the absence of pre-existing patient-physician relationships, to those in need of medical assistance, in a service area in which the physician would not ordinarily respond to requests for emergency assistance. (a) Bystander physicians should recognize that prehospital EMS systems operate under the authority and direction of a licensed EMS physician, who has both ultimate medical and legal responsibility for the system. (b) A reasonable policy should be established whereby a bystander physician may assist in an emergency situation, while working within area-wide EMS protocols. Since EMS providers (non-physicians) are responsible for the patient, bystander physicians should work collaboratively, and not attempt to wrest control of the situation from EMS providers. (c) It is the obligation of the bystander physician to provide reasonable self-identification. (d) Where voice communication with the medical oversight facility is available, and the EMS provider and the bystander physician are collaborating to provide care on the scene, both should interact with the local medical oversight authority, where practicable. (e) Where voice communication is not available, the bystander physician may sign appropriate documentation indicating that he/she will take responsibility for the patient(s), including provision of care during transportation to a medical facility. Medical oversight systems lacking voice communications capability should consider the addition of such communication linkages to further strengthen their potential in this area. (f) The bystander physician should avoid involvement in resuscitative measures that exceed his or her level of training or experience. (g) Except in extraordinary circumstances or where requested by the EMS providers, the bystander physician should refrain from providing medical oversight of EMS that results in deviation from existing EMS protocols and standing orders.
 4. Our AMA urges the International Civil Aviation Organization to make explicit recommendations to its member countries for the enactment of regulations providing "Good Samaritan" relief for those rendering emergency medical assistance aboard air carriers and in the immediate vicinity of air carrier operations.
- Citation: (CCB/CLRPD Rep. 3, A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(I-22)

Introduced by: International Medical Graduates Section

Subject: Eliminating Practice Barriers for Immigrant Physicians During Public Health Emergencies

Referred to: Reference Committee B

- 1 Whereas, Minoritized populations, including people of color, immigrants, and people with
2 chronic diseases were disproportionately affected by the pandemic; and
3
4 Whereas, International medical graduates, board-certified and trained in the U.S. institutions,
5 are often the frontline physicians in the federally designated health professional shortage areas
6 (HPSA) for their waiver requirements; and
7
8 Whereas, Physicians in the HPSA serve the lower income and immigrant population, and the
9 older and sicker population covered by Medicare and Medicaid; and
10
11 Whereas, In response to the COVID-19 pandemic, most states took measures to alleviate
12 practice restrictions for in-training, out-of-state, and retired physicians to allow the additional
13 workforce to join hands in managing critical staff shortages during public health emergencies;
14 and
15
16 Whereas, IMG physicians serving in the HPSA are restricted to one healthcare organization,
17 further limited to one geographical location by definition of the work location listed in their Labor
18 Condition Application (ETA Form 9035) as a prerequisite to their work Visa, H1B; and
19
20 Whereas, Except for a few specific instances like that in New York and New Jersey states, IMG
21 physicians were excluded from the special provisions for in and out-of-state expedited
22 physicians licensing, preventing them from helping out the workforce shortage during the public
23 health emergency, and providing urgent access to medical care for underserved patient
24 populations; therefore be it
25
26 RESOLVED, That our American Medical Association advise the state medical boards and other
27 stakeholders to allow physicians in the health professional shortage areas to have temporary
28 access to all unique and expedited licensing options, both inside and outside of the state of their
29 practice during public health emergencies, to facilitate workforce utilization at the time of critical
30 shortage (Directive to Take Action); and be it further
31
32 RESOLVED, That our AMA advocate at the state and national level and advise the Department
33 of Labor and the Department of Homeland Security to allow temporary provisions for such
34 licensing inclusions for the physicians on a Visa during public health emergencies. (Directive to
35 Take Action)

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

Received: 09/27/22

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2. Thompson MJ, Hagopian A, Fordyce M, Hart LG. Do international medical graduates (IMGs) "fill the gap" in rural primary care in the United States? A national study. J Rural Health. 2009;25(2):124-134. doi:10.1111/j.1748-0361.2009.00208.x
3. Foreign-trained doctors are critical to serving many U.S. communities. Americanimmigrationcouncil.org.,2018. <https://www.americanimmigrationcouncil.org/research/foreign-trained-doctors-are-critical-serving-many-us-communities>.
4. Labor Condition Application: <https://www.foreignlaborcert.doleta.gov/preh1bform.cfm>
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(I-22)

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

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

Referred to: Reference Committee B

1 Whereas, The Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Equity
2 Act of 2008 (MHPAEA) requires that coverage of mental health (MH) and substance use
3 disorder (SUD) benefits in health benefit plans be comparable to and no more restrictive than
4 medical and surgical benefits;ⁱ and
5
6 Whereas, The Affordable Care Act of 2010 (ACA) provides that coverage of MH/SUD is an
7 “essential health benefit;”ⁱⁱ requires that non-grandfathered individual and small group market
8 plans cover MH/SUD services, and extends MHPAEA parity protections to plans sold through
9 state health insurance exchanges;ⁱⁱⁱ and
10
11 Whereas, A 2016 final rule of the Centers for Medicare & Medicaid Services applies MHPAEA
12 to Medicaid and the State Children’s Health Insurance Program (CHIP) and requires states and
13 their managed care organizations to analyze limits placed on MH/SUD benefits in Medicaid and
14 CHIP;^{iv} and
15
16 Whereas, Medicare is now the single largest payer not subject to the mandated parity between
17 benefits for the treatment of MH/SUD and benefits for the treatment of other medical
18 conditions;^v and
19
20 Whereas, The Medicare program imposes varying treatment limitations to MH/SUD services to
21 a greater degree than those applied to medical/surgical services;^{vi} and
22
23 Whereas, Some Medicare Advantage and Part D plans impose burdensome and treatment-
24 delaying utilization management controls on MH/SUD care;^{vii} and
25
26 Whereas, Medicare places a 190-day lifetime limit on inpatient psychiatric care and burdensome
27 documentation requirements for psychiatric hospitals that are far more stringent than
28 documentation requirements for all other hospitals; and
29
30 Whereas, Medicare may provide coverage and payment for the least and most intensive levels
31 of MH/SUD care, but does not cover all intermediate levels of such care, such as intensive
32 outpatient services;^{viii} and
33
34 Whereas, Medicare does not cover freestanding community-based SUD treatment facilities,
35 except for opioid treatment programs (OTPs);^{ix} and

1 Whereas, The aforementioned coverage gaps, limitations, and restrictions result in a denial of
2 the full continuum of MH/SUD benefits available to Medicare beneficiaries; and
3

4 Whereas, There has been an observed increase in the number of people seeking MH/SUD
5 services related to the COVID-19 pandemic;^x and
6

7 Whereas, Almost 2 million Medicare beneficiaries report having a SUD, yet only 11% received
8 any SUD treatment in 2021,^{xi} and opioid overdose deaths and hospitalizations continue to
9 increase among older adults;^{xii} and
10

11 Whereas, Black and Hispanic Medicare beneficiaries with SUD have more difficulty accessing
12 care and have worse outcomes than White beneficiaries,^{xiii} and Black and Indigenous Medicare
13 beneficiaries have experienced a significant increase in opioid-related overdoses and have the
14 highest rate of opioid-related fatalities; therefore be it^{xiv}
15

16 RESOLVED, That our American Medical Association amend policy H-185.974, "Parity for
17 Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs," by addition
18 and deletion to read as follows:
19

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

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

24 2. Our AMA supports federal legislation, standards, policies, and funding that expand the
25 parity and non-discrimination protections of the Paul Wellstone and Peter Domenici
26 Mental Health Parity and Addiction Equity Act of 2008 to Medicare (Parts A, B, C, and
27 D).

28 3. Our AMA supports federal legislation, standards, policies, and funding that require
29 Medicare coverage (Parts A, B, C, and D) of all levels of mental health and substance
30 use disorder care, consistent with nationally recognized medical professional
31 organization level of care criteria for mental health or substance use disorders. (Modify
32 Current HOD Policy)

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

Received: 10/07/22

REFERENCES:

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

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

ⁱⁱⁱ Ibid

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

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

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

^{vii} Ibid

^{viii} Ibid

^{ix} Ibid

^x Ibid

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

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

^{xiii} Ibid

^{xiv} Ibid

RELEVANT AMA POLICY

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

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

Maintaining Mental Health Services by States H-345.975

Our AMA:

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

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

Opioid Mitigation H-95.914

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

Citation: BOT Rep. 09, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(I-22)

Introduced by: Mississippi

Subject: Restrictions on the Ownership of Hospitals by Physicians

Referred to: Reference Committee B

1 Whereas, Physician-owned hospitals (POHs) are known for providing some of the highest
2 quality and lowest cost medical care in the nation; and
3
4 Whereas, Medicine has drastically changed over the past two decades with physician
5 stakeholders losing more and more autonomy over patient care; and
6
7 Whereas, Many of the rules and regulations prohibiting physician ownership of hospitals were
8 written years ago when physicians were largely in private practice, and self-referral was of
9 limited though potentially more relevant concern; and
10
11 Whereas, CMS imposes significant requirements upon POHs that make the status difficult to
12 attain and then generally prohibits expansion capability even if a POH is established; and
13
14 Whereas, In the early 2000s there was a concerted lobbying effort by some in the hospital
15 industry who erroneously and some would say intentionally claimed that physicians owning
16 hospitals was a conflict of interest; and
17
18 Whereas, In 2003 Congress imposed an 18-month moratorium on new POH construction, and
19 then upon further persistent lobbying by many in the hospital industry, in 2010, based on
20 specialty hospital data and other confounding and external factors, POHs were banned from
21 participating in the Medicare program; and
22
23 Whereas, The historic and deadly COVID-19 pandemic exposed bare the dangerous practices
24 of allowing business-minded colleagues to run hospitals and not physicians who selflessly
25 served patients on the frontlines of the pandemic, many times with woefully inadequate personal
26 protective equipment (PPE) as drastic as bandanas and garbage bags, and many lost their lives
27 or suffered serious detriment in nobly doing so; and
28
29 Whereas, These “healthcare heroes” hereby decry that physician ownership of hospitals is an
30 innate conflict of interest, and furthermore proclaim that these institutions are in reality known for
31 providing higher quality of medical care at a lower cost as referenced in this resolution above;
32 therefore be it
33
34 RESOLVED, That our American Medical Association advocate to alleviate any restriction upon
35 physicians from owning, constructing and/or expanding any hospital facility type - in the name of
36 patient safety, fiscal responsibility, transparency and in acknowledgment of physicians
37 everywhere who have given of themselves valiantly in the name of patient care. (Directive to
38 Take Action)

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

Received: 10/06/22

References:

<https://www.statnews.com/2021/09/30/covid-19-reveals-blocking-physician-owned-hospitals/>
https://www.cms.gov/Medicare/Fraud-and-Abuse/PhysicianSelfReferral/Physician_Owned_Hospitals

RELEVANT AMA POLICY

Hospital Consolidation H-215.960

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

Citation: CMS Rep. 07, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(I-22)

Introduced by: Mississippi

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

Referred to: Reference Committee B

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

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

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

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

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

Fiscal Note: Not yet determined

Received: 10/06/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(I-22)

Introduced by: Mississippi

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

Referred to: Reference Committee B

- 1 Whereas, “Direct supervision of emergency services” refers to an individual actively practicing
2 clinical medicine in the emergency department and overseeing all medical decisions in the
3 emergency department at the point of care¹; and
4
- 5 Whereas, Direct supervision of emergency care is distinct from medical direction; and
6
- 7 Whereas, Only 10% of nurse practitioners nationwide are trained in emergency care²; and
8
- 9 Whereas, Nursing and medical leaders strongly recommend that, because of variations in
10 training, licensure, and certification, nurse practitioners should not work alone in emergency
11 departments²⁻⁴; and
12
- 13 Whereas, CMS provides clear regulations on the direct supervision of emergency care in
14 hospitals¹; and
15
- 16 Whereas, In the conditions of participation, CMS requires that for a hospital to provide
17 emergency care, all emergency departments must have direct supervision by a qualified
18 member of medical staff present in the hospital at all hours emergency services are provided;
19 and
20
- 21 Whereas, “Direct supervision for emergency services” is defined as being physically in the
22 hospital and not telemedicine; and
23
- 24 Whereas, The word “must” indicates without exception; and
25
- 26 Whereas, The words “qualified member” are clearly proscribed by the American College of
27 Emergency Physicians (ACEP) and American Association of Emergency Medicine (AAEM)^{2,3};
28 and
29
- 30 Whereas, While the words “medical staff,” according to CMS, may include physicians, nurse
31 practitioners, and physicians assistants¹, there is a clear requirement for additional specialized
32 training; and
33
- 34 Whereas, It is the responsibility of the national organizations of emergency medicine physicians
35 ACEP and AAEM to set standards for the practice of emergency medicine^{3,4}; and

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

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

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

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

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

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

Received: 10/06/22

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3. American College of Emergency Physicians. Providers of Unsupervised Emergency Department Care. 2019. <https://www.acep.org/patient-care/policy-statements/providers-of-unsupervised-emergency-department-care/?fbclid=IwAR2utWVu9H9ky400IaC75piNFNw-zVHh0tiaGSL34SfQWmsWjaJBiGVwIfc>. Accessed June 21, 2022.
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(I-22)

Introduced by: Mississippi

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

Referred to: Reference Committee B

- 1 Whereas, Telemedicine has and continues to be a very helpful tool in the ongoing management
2 of a patient’s healthcare; and
3
4 Whereas, The prevalence of mental illness is increasing worldwide; and
5
6 Whereas, In America, one out of five people have some type of mental health condition, and this
7 number seems to be on the rise; and
8
9 Whereas, Among college students specifically, between 25 and 50% of students “meet the
10 criteria” for [at least one mental disorder](#) in a given yearⁱ; and
11
12 Whereas, College student populations are [prone to stress, anxiety, and depression](#). The strain
13 of living away from home for the first time, forming new relationships with peers and teachers,
14 and academic concerns can feel overwhelmingⁱⁱ; and
15
16 Whereas, Additionally, the [mental health crisis at colleges and universities](#) has gone from bad to
17 worse due to COVID-19ⁱⁱⁱ; and
18
19 Whereas, The [Centers for Disease Control and Prevention \(CDC\) reports](#) 1 in 4 people ages 18
20 to 24 “seriously considered suicide” in the last 30 days^{iv}; and
21
22 Whereas, While college students are at a lower risk of experiencing serious symptoms caused
23 by COVID-19, they are at disproportionately high risk for suicide; and
24
25 Whereas, During the COVID-19 pandemic, the utilization of telemedicine particularly in the
26 space of mental health has benefited many patients who have been able to seek ongoing
27 treatment; and
28
29 Whereas, College students from out of state who are enrolled in universities and colleges in
30 Mississippi often establish a patient physician relationship while pursuing academic studies; and
31
32 Whereas, When those college students return home during recess from university studies, it is
33 very difficult when in crisis to seek and establish treatment with a psychiatrist in their local
34 community; and
35
36 Whereas, The utilization of telemedicine for those needed treatment encounters would
37 strengthen the continuity of care for those out of state college student patients and reduce
38 emergency room visits and inpatient psychiatric hospitalization for care; therefore be it

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

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

Received: 10/06/22

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(I-22)

Introduced by: Washington

Subject: Allocate Opioid Funds to Train More Addiction Treatment Physicians

Referred to: Reference Committee B

1 Whereas, There are not enough medical physicians in the U.S. actively prescribing medications
2 for opioid use disorder, especially in rural areas; and
3

4 Whereas, \$26 billion in opioid settlement funds are available nationally from the “Big Three”
5 drug distributors AmerisourceBergen, Cardinal Health, and McKesson, and opioid manufacturer
6 Johnson & Johnson; therefore be it
7

8 RESOLVED, That our American Medical Association amend Policy H-95.918, “Holding the
9 Pharmaceutical Industry Accountable for Opioid-Related Costs,” by addition to read as follows:
10

11 Our AMA will advocate that any monies paid to the states, received as a result of a
12 settlement or judgment, or other financial arrangement or agreement as a result of
13 litigation against pharmaceutical manufacturers, distributors, or other entities alleged to
14 have engaged in unethical and deceptive misbranding, marketing, and advocacy of
15 opioids, be used exclusively for research, education, prevention, and treatment of
16 overdose, opioid use disorder, and pain, as well as expanding physician training
17 opportunities to provide clinical experience in the treatment of opioid use disorders.
18

(Modify Current HOD Policy)

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

Received: 10/10/22

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2. Krawczyk et al. Has the treatment gap for opioid use disorder narrowed in the U.S.? A yearly assessment from 2010 to 2019. International Journal of Drug Policy; Article in press. <https://doi.org/10.1016/j.drugpo.2022.103786>
3. Press Release. “Thousands of U.S. communities to receive opioid recovery funds from \$26 billion global settlements as soon as May 2022.” National Opioid Settlement, https://nationalopioidsettlement.com/wp-content/uploads/2022/02/Opioids_release_20220225.pdf

RELEVANT AMA POLICY

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

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

Citation: Res. 204, A-19;

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

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

Citation: Res. 301, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(I-22)

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

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

Referred to: Reference Committee B

- 1 Whereas, The Supreme Court ruling in *Dobbs vs. Jackson* overruled *Roe vs. Wade*, returning
2 an individual's right to access abortion to state law¹; and
3
4 Whereas, Each year, one in 1,000 pregnant people will be diagnosed with cancer, and there are
5 patients who become pregnant after having been diagnosed with cancer²; and
6
7 Whereas, The most common cancers diagnosed during pregnancy are breast, lymphoma, and
8 cervical cancer³; and
9
10 Whereas, Cancer diagnoses during pregnancy can be delayed, since symptoms like fatigue,
11 anemia, and nausea, can be similar for both conditions⁴; and
12
13 Whereas, Some cancer treatments and diagnostic services can harm a fetus or cause serious
14 birth defects and for that reason, experts recommend avoiding radiation therapy during the
15 entire pregnancy and most chemotherapies during the first trimester; and
16
17 Whereas, Some cancer therapies should not be used during any stage of pregnancy; and
18
19 Whereas, Pregnant individuals diagnosed with cancer, or who become pregnant during cancer
20 treatment, face difficult choices about whether to initiate, delay, or continue life-saving cancer
21 treatment, or whether to terminate their pregnancy; and
22
23 Whereas, These medical decisions are complex because timely cancer treatment improves a
24 person's likelihood of survival; and
25
26 Whereas, Every patient with cancer should receive evidence-based information about all
27 treatment options, including known side effects of those options; and
28
29 Whereas, Every patient should be able to maximize their chance for survival by receiving
30 recommended care promptly; and
31
32 Whereas, A growing number of current and pending laws insert government into the patient-
33 physician relationships by dictating limits or bans on reproductive health services while also

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

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

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

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

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

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

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

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

Received: 10/13/22

RELEVANT AMA POLICY

Criminalization of Medical Judgment H-160.954

(1) Our AMA continues to take all reasonable and necessary steps to insure that errors in medical decision-making and medical records documentation, exercised in good faith, do not become a violation of criminal law. (2) Henceforth our AMA opposes any future legislation which gives the federal government the responsibility to define appropriate medical practice and regulate such practice through the use of criminal penalties.

Citation: Sub. Res. 223, I-93; Reaffirmed: Res. 227, I-98; Reaffirmed: Res. 237, A-99; Reaffirmed and Appended: Sub. Res. 215, I-99; Reaffirmation A-09; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation: I-12; Modified: Sub. Res. 716, A-13; Reaffirmed in lieu of Res. 605, I-13; Reaffirmed: Res. 250, A-22; Reaffirmed: Res. 252, A-22

Preserving Access to Reproductive Health Services D-5.999

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

Citation: Res. 028, A-22

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(I-22)

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

Subject: Fertility Preservation

Referred to: Reference Committee B

- 1 Whereas, Individuals of child-bearing age face unique challenges related to their treatment
2 because of the effects many anti-cancer treatments can have on the reproductive system; and
3
4 Whereas, Chemotherapy can damage reproductive cells, resulting in infertility related to
5 damaged sperm, ovaries, and eggs; and
6
7 Whereas, Radiation therapy to the pelvis and abdomen can damage reproductive organs, and
8 radiation for brain malignancies can have negative impact on fertility if there is damage to the
9 pituitary gland; and
10
11 Whereas, Surgery for cancers of the reproductive system also carries risk, including scarring or
12 other harm to organs that affect fertility; and
13
14 Whereas, Patients receiving bone marrow or stem cell transplants often are exposed to high
15 doses of radiation and chemotherapy, which can cause infertility¹; and
16
17 Whereas, Despite clear risk to fertility posed by cancer treatment, many payers deem fertility
18 care as not medically necessary and either limit or exclude coverage of this benefit; and
19
20 Whereas, Due to coverage gaps and high cost, fertility care in the United States remain
21 inaccessible for many patients with cancer; and
22
23 Whereas, Cost and coverage issues for fertility preservation are particularly acute in populations
24 already facing access to care issues, including Medicaid beneficiaries; and
25
26 Whereas, New findings show that more than 32,000 newly diagnosed adolescent and young
27 adult patients may lose or face compromised fertility preservation care each year due to
28 legislation that has been enacted or is expected to be enacted in some states following the
29 Supreme Court's recent ruling in *Dobbs vs. Jackson Women's Health*²; and
30
31 Whereas, The *Dobbs vs. Jackson Women's Health* ruling could interfere with fertility
32 preservation for adolescent and young adult patients with cancer due to new restrictions on
33 genetic testing, storage, and disposal of embryos; and
34
35 Whereas, Potential fertility preservation restrictions could widen geographical and
36 socioeconomic disparities in access to fertility preservation; therefore be it

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

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

- 1 RESOLVED, That our American Medical Association advocate for state legislation requiring
2 payment for fertility preservation therapy services by all payers when iatrogenic infertility may be
3 caused directly or indirectly by necessary medical treatments as determined by a licensed
4 treating physician (Directive to Take Action); and be it further
5
6 RESOLVED, That our AMA advocate that “fertility preservation therapy services” should include
7 cryopreservation of embryos, sperm, and oocytes (Directive to Take Action); and be it further
8
9 RESOLVED, That our AMA advocate against the prosecution of physicians for eliminating or
10 transporting unused embryos created during and subsequent to the fertility preservation
11 process. (Directive to Take Action)

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

Received: 10/13/22

RELEVANT AMA POLICY

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
 2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.
 3. Our AMA encourages the inclusion of impaired fertility as a consequence of gender-affirming hormone therapy and gender-affirming surgery within legislative definitions of iatrogenic infertility, and supports access to fertility preservation services for those affected.
- Citation: Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14; Appended: Res. 012, A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(I-22)

Introduced by: Women Physicians Section

Subject: Access to Methotrexate Based on Clinical Decisions

Referred to: Reference Committee B

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

3
4 Whereas, Methotrexate has remained a cornerstone in treatment specifically for rheumatoid
5 arthritis (RA) and common rheumatic disorders with 90% of RA patients using methotrexate
6 alone or in combination with other medications at some point in their treatment;⁴ and

7
8 Whereas, Autoimmune disorders are twice as prevalent in women, and RA rates are typically
9 two-to-three times higher in women than men;^{5,6} and

10
11 Whereas, Methotrexate may also be used off-label, alone or in combination with mifepristone as
12 a non-invasive alternative method for early medical pregnancy terminations and treatment of
13 ectopic pregnancies;^{7,8} and

14
15 Whereas, The Supreme Court ruling in *Dobbs v. Jackson Women’s Health Organization*
16 revoked the constitutional right to abortion;⁹ and

17
18 Whereas, Because methotrexate “can cause a pregnancy to terminate, some pharmacists in
19 states that have added further restrictions that limit or ban abortions may hesitate to fill
20 methotrexate prescriptions for women of childbearing age because of legal concerns”;^{10,11} and

21
22 Whereas, Two large United States pharmacy chains have “instructed their pharmacists to
23 confirm methotrexate will not be used to terminate a pregnancy before dispensing it to people in
24 states that ban abortion in many circumstances.”;¹² and

25
26 Whereas, As an example of numerous accounts of refusal of methotrexate, in interviews with
27 CNN, a Maryland woman with Crohn’s disease said her health insurance plan informed her they
28 would no longer cover her methotrexate prescription, and a Virginia woman with lupus said her
29 rheumatologist told her she would need to be weaned off methotrexate and switched to another
30 drug due to legal concerns;^{11,14} and

31
32 Whereas, Restricting access to methotrexate based on non-clinical decisions can lead to
33 unintended consequences, including worsening health conditions, suffering, and death for
34 patients that cannot safely access methotrexate; and

35
36 Whereas, Restricting access to methotrexate may impact the health and safety of female
37 patients, who are disproportionately affected by health conditions that could be treated using
38 methotrexate; and

1 Whereas, Methotrexate is on the World Health Organization's list of essential medicines for a
2 basic health-care system due to efficacy, safety, and cost-effectiveness;¹³ and
3

4 Whereas, Our American Medical Association issued a statement regarding state laws that limit
5 patient access to medically necessary treatment and impede use of professional judgment by
6 physicians;¹⁵ therefore be it
7

8 RESOLVED, That our American Medical Association work to create a formal process to review
9 pharmaceutical practices related to refusal of methotrexate and other drugs on the basis that it
10 could be used off-label for pregnancy termination (Directive to Take Action); and be it further
11

12 RESOLVED, That our AMA work to provide educational guidance on state-specific laws that
13 have impacted the distribution of methotrexate given post Dobbs vs. Jackson Women's Health
14 Organization restrictions. (Directive to Take Action)
15

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

Received: 10/12/22

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RELEVANT AMA POLICY

Patient Access to Treatments Prescribed by Their Physicians H-120.988

1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary.
2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored

promotions remain under FDA regulation.

3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.

4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).

5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.

6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.

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

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

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

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

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

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

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

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

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

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

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

Citation: Res. 621, A-22