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# REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-I-22

Subject: Drug Shortages: 2022 Update

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee K

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## INTRODUCTION

American Medical Association (AMA) Policy H-100.956, “National Drug Shortages,” directs the Council on Science and Public Health (CSAPH) to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and report back at least annually to the House of Delegates (HOD) on progress made in addressing drug shortages in the United States. This report provides an update on continuing trends in national drug shortages and ongoing efforts to further evaluate and address this critical public health issue.

## METHODS

English-language reports were selected from a PubMed and Google Scholar search from September 2019 to August 2022, using the text term “drug shortages.” Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the internet sites of the U.S. Food and Drug Administration (FDA), National Academies of Sciences, Engineering, and Medicine (NASEM), U.S. Department of Health and Human Services (HHS), American Society of Health-System Pharmacists (ASHP), and Duke Margolis Center for Health Policy.

## BACKGROUND

CSAPH has issued twelve reports on drug shortages, with the most recent published at the November 2021 Special Meeting.<sup>1</sup> The findings and conclusions of the first five reports are summarized in CSAPH Report 2-I-15, “National Drug Shortages: Update.” The remainder of this report will provide an update on drug shortages since the 2021 report was developed, including specific comment on issues associated with the role of pharmacy benefit managers (PBMs).

## CURRENT TRENDS IN DRUG SHORTAGES

Drug shortages remain an ongoing public health concern in the United States and the AMA continues to monitor the situation and take action when appropriate. Overall, new drug shortages are decreasing; however, a large number of shortages are still ongoing and pose continued problems for patient care. Additionally, new shortages may occur as manufacturing capacity in the pharmaceutical industry is prioritized during the continuing COVID-19 and monkeypox public health emergencies, specifically for the production of vaccines and treatments.

The two primary data sources for information on drug shortages in the United States continue to be the Drug Shortage Program at the FDA and the Drug Shortage Resource Center maintained by

ASHP in cooperation with the University of Utah Drug Information Service (see Box 1 for links to these resources).<sup>2,3</sup> It should be noted that FDA resources also include guidance on drugs which have had their use dates extended while a known shortage is ongoing.

According to current ASHP statistics (see Appendix 1), the downward trend in new drug shortages over the last few years has continued. At its peak in 2011, there were 267 new drug shortages reported; in 2021, there were 114. For the first 6 months of 2022, there have been 81 newly reported shortages. However, while the number of new shortages may be decreasing each year, the number of active drug shortages has stayed relatively steady (282 active shortages in Q2 2019, 264 shortages in Q2 2022), indicating that individual shortages are taking longer to resolve. For the first two quarters of 2022, the five classes of drugs with the most ongoing shortages include: central nervous system drugs (40 total), fluids and electrolytes (36), antimicrobials (30), cardiovascular (27), and hormones (19). Fluids and electrolytes were not present in last year's top five classes of drug shortages, indicating a surge in products currently facing shortage.

In addition, the number of manufacturers reporting the underlying cause of the drug shortage as "unknown" has continued to decrease, from 82 percent in 2019 to 42 percent in 2021. Compared to 2020, "business decision" has decreased as well from 14 percent to 4 percent in 2021. Behind "unknown," "supply/demand" was listed as the second most common reason (27 percent) for drug shortages by manufacturers in 2021. Beyond issues with manufacturing, ASHP has also reported that hospitals are having difficulty staffing their pharmacies with experienced staff to proactively identify, prevent and alleviate gaps in supply.<sup>4</sup>

#### *The Food and Drug Administration*

The FDA continues to utilize a mobile app to provide up-to-date access to information about drugs in shortage as well as notifications about new and resolved drug shortages. This mobile app also gives physicians the ability to report a drug shortage. The FDA Drug Shortages webpage includes a current shortages list, a link to the mobile app, and additional information (Box 1).

The ninth annual report on drug shortages from the FDA to Congress published in early 2022 summarizes the major actions the FDA took in calendar year 2021 related to drug shortages.<sup>5</sup> During the COVID-19 public health emergency, the FDA continued to closely monitor the medical product supply chain and as expected, the supply chain was impacted by the pandemic, leading to supply disruptions or shortages of drug products in the United States. Appendix 2 includes a breakdown of the FDA's calendar year 2021 metrics, including the number of expedited reviews (274) and expedited inspections (29).

#### *The Essential Medicines Report*

In May 2022, HHS and the Assistant Secretary for Preparedness and Response (ASPR) released the first Essential Medicines Supply Chain and Manufacturing Resilience Assessment.<sup>6</sup> A critical function of this report was to prioritize drugs for increased scrutiny from a previously developed list of essential medicines.<sup>7</sup> In their report, a group of stakeholders identified 86 medications as critical or important for minimum acute patient care with no other alternative available. Of the drugs identified, 56 drugs (65 percent) at the time of publication were in shortage as described by the ASHP database. Within their report, the group outlines six challenges for addressing drug shortages: market structure, global competition, labor/workforce, manufacturing processes, supply chain/distribution, and regulatory barriers.

## *The Drug Enforcement Administration*

Outside of the FDA, HHS and ASPR, the Drug Enforcement Administration (DEA) is another critical federal agency that impacts drug shortages. As part of its regulatory authority under the Controlled Substances Act, the DEA maintains a closed system around the manufacturing of Schedule I and II drugs, as well as List I chemicals (ephedrine, pseudoephedrine and phenylpropanolamine). This closed system means that the DEA requires the registration and continuous oversight of any entity involved in the manufacturing and distribution supply chain of these drugs, including a strict quota on the volume and quantity of a controlled substance that can be manufactured at a given time. Per the DEA, this quota is intended “prevent, detect, and investigate the diversion of controlled pharmaceuticals and listed chemicals from legitimate sources while ensuring an adequate and uninterrupted supply for legitimate medical, commercial, and scientific needs.”<sup>8</sup> The FDA and DEA have an ongoing memorandum of understanding to share information regarding information that may impact drug shortages.<sup>9</sup>

However, there have been several instances where DEA quotas have either directly or indirectly caused a drug shortage of a critically necessary medication. For example, in 2019 the DEA proposed a 53 percent decrease to the overall quota of Schedule II opioids that could be manufactured in 2020.<sup>10</sup> However, by the spring of 2020, there was a surge in demand for injectable opioids to help patients on ventilators fighting COVID-19.

In response to a 2020 joint letter from AMA, ASHP and other stakeholders,<sup>11</sup> the DEA increased the manufacturing quota by 15 percent, yet injectable fentanyl, hydromorphone, and morphine are all still classified as active shortages by ASHP in 2022.<sup>12</sup> Other drugs, such as mixed amphetamine salts for the treatment of attention deficit hyperactivity disorder, are similarly facing decreases in DEA manufacturing quotas while under an active drug shortage.

In light of the opioid crisis, in which medications that help prevent overdose are underprescribed nationwide, supply restrictions may have significant unintended consequences. The potential benefit of supply reduction is that it may discourage the diversion of controlled substances. The potential harm of supply reduction is that patients may suffer serious harm when needed medications are unavailable for any reason. Your Council on Science and Public Health is currently unaware of any evidence that the overall benefits of supply reductions outweigh the overall harms.

## *Pharmacy Benefit Managers*

At the AMA 2022 Annual Meeting, the topic of PBMs and their role in driving drug shortages was specifically raised. PBMs, which serve as an intermediary between health insurers and pharmaceutical companies, have long been a source of scrutiny by our AMA, with a multitude of policies directly calling for oversight or reform of PBM activities.

Concern around PBMs and drug shortages is the potential for manipulating price and access to medications. However, these claims cannot be tested as PBM pricing information has historically been opaque, but that may be changing. On June 7, 2022, the Federal Trade Commission (FTC) announced that it has launched an investigation into vertically integrated PBMs and has specifically cited issues around PBM-owned pharmacies and prior authorizations.<sup>13</sup> In April 2022, prior to the FTC’s decision, the AMA sent a letter urging the FTC to take action and increase PBM transparency.<sup>14</sup> Additional bipartisan legislation, the Pharmacy Benefit Manager Transparency Act of 2022, was introduced on May 24, 2022, and at the time of writing is pending review by the Senate Commerce, Science and Transportation committee. In its current form, the PBM

Transparency Act would require, among other things, for PBMs to file annual reports with the FTC on many of their practices.<sup>15</sup>

Beyond possible manipulations of cost and access, other PBM practices may exacerbate drug shortages or otherwise impact the ability of a practice to mitigate shortages. For example, PBMs may utilize techniques known as “brown bagging,” in which a health plan requires a patient to obtain a medication from a PBM-owned specialty pharmacy and then bring it to the clinic for the practitioner to administer. Previously, the Council on Medical Service has investigated the issue of brown bagging medications in the context of patient care.<sup>16</sup> In the context of drug shortages, brown bagging decreases visibility of the supply chain for hospitals and practices; they are unable to predict which medications are to be needed when, and as such may be unable to procure or adequately plan for future demand.

### *Monkeypox Vaccines*

Amidst the monkeypox public health emergency, there is currently a shortage of vaccinations available in the United States. Two vaccines may be used for the prevention of monkeypox disease.<sup>17</sup> The JYNNEOS vaccine, a third-generation vaccine produced by a small European biotech company, Bavarian Nordic, is approved for the prevention of monkeypox and smallpox disease and the ACAM2000 vaccine, produced by Baxter, is approved for immunization against smallpox disease and made available for use against monkeypox under an Expanded Access Investigational New Drug (EA-IND) protocol. In the United States, there is a large supply of ACAM2000, but this vaccine has more known side effects and contraindications.<sup>18</sup> JYNNEOS is the primary vaccine being used in the U.S monkeypox outbreak.

After its FDA approval in 2019, the Strategic National Stockpile (SNS) was reportedly supposed to procure 120 million doses of JYNNEOS, enough to immunize sixty million people as one element of the U.S. government’s smallpox preparedness efforts.<sup>19</sup> However, as with other supplies in the national stockpile, JYNNEOS inventory was not maintained to an appropriate level due to chronic underfunding as well as the redirection of funds to other purposes, such as shelter for 20 thousand unhoused migrant children at the southern border.<sup>20,21</sup> With a shelf-life of 3 years, millions of doses of JYNNEOS in the SNS had expired.<sup>22</sup> Only 2,400 doses of the JYNNEOS vaccine were available in the immediate holdings of the SNS at the onset of the current monkeypox outbreak.<sup>23</sup> More than 1.1 million doses of the vaccine purchased by the U.S. government were at Bavarian Nordic’s facility in Denmark and required authorization from an on-site FDA inspection before they could be shipped to the U.S.<sup>24</sup>

To help alleviate the shortage, the FDA granted emergency use authorization for intradermal administration of JYNNEOS, which utilizes approximately one-fifth of the total volume of vaccine compared to currently approved subcutaneous administration.<sup>25</sup> In addition, the administration has increased efforts to boost domestic manufacturing, including partnerships with Michigan-based facilities to perform filling and finishing to expedite the distribution of previously ordered vaccines.<sup>26</sup>

### CURRENT AMA DRUG SHORTAGE ACTIVITIES

AMA staff continue to remain engaged in drug shortage activities. Staff are involved in a multi-stakeholder effort to remain current on policies, drug shortage and supply chain issues, and to develop group recommendations on the topics. The effort includes our AMA, the ASHP, the American Hospital Association (AHA), the United States Pharmacopeia (USP), the American Society of Anesthesiologists (ASA), and the American Society of Clinical Oncology (ASCO).

Earlier this year, our AMA additionally sent a letter to leadership of the Senate Committee on Health, Education, Labor and Pensions to advocate for legislation modernizing the medical supply chain.<sup>27</sup> In the letter, the AMA called upon Congress to, among other things:

- Incentivize advanced manufacturing technology and develop new continuous manufacturing technology for critical drugs and active pharmaceutical ingredients;
- Improve the function and composition of the Strategic National Stockpile;
- Improve multinational cooperation on supply chain resilience;
- Incentivize quality and resilience; and
- Replicate asks for critical drug manufacturing transparency and oversight for medical devices and ancillary supplies (e.g., PPE).

## CONCLUSION

The rate of new medical product shortages is decreasing, but individual shortages are lasting longer. Due to the ongoing COVID-19 and monkeypox public health emergencies, the medical supply chain has been under intense, increased scrutiny. The AMA's drug shortage policy is timely and already addresses a variety of issues that are under consideration by the White House, FDA, and other stakeholders. Additional policy modifications have been recommended to reflect ongoing efforts by other organizations interacting with the drug manufacturing space, such as the DEA and FTC.

## RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed.

1. Policy H-100.956, "National Drug Shortages" be amended by addition to read as follows:

1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.
2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.
3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.
4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.

- 1 5. The Council on Science and Public Health shall continue to evaluate the drug shortage  
2 issue, including the impact of group purchasing organizations and pharmacy benefit  
3 managers on drug shortages, and report back at least annually to the House of Delegates on  
4 progress made in addressing drug shortages.  
5
- 6 6. Our AMA urges continued analysis of the root causes of drug shortages that includes  
7 consideration of federal actions, evaluation of manufacturer, Group Purchasing  
8 Organization (GPO), pharmacy benefit managers, and distributor practices, contracting  
9 practices by market participants on competition, access to drugs, pricing, and analysis of  
10 economic drivers, and supports efforts by the Federal Trade Commission to oversee and  
11 regulate such forces.  
12
- 13 7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs  
14 by ensuring that such products are not removed from the market or caused to stop  
15 production due to compliance issues unless such removal is clearly required for significant  
16 and obvious safety reasons.  
17
- 18 8. Our AMA supports the view that wholesalers should routinely institute an allocation  
19 system that attempts to fairly distribute drugs in short supply based on remaining inventory  
20 and considering the customer's purchase history.  
21
- 22 9. Our AMA will collaborate with medical specialty society partners and other stakeholders  
23 in identifying and supporting legislative remedies to allow for more reasonable and  
24 sustainable payment rates for prescription drugs.  
25
- 26 10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving  
27 pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to  
28 determine whether such an activity has the potential to worsen drug shortages.  
29
- 30 11. Our AMA urges the FDA to require manufacturers to provide greater transparency  
31 regarding the pharmaceutical product supply chain, including production locations of  
32 drugs, and provide more detailed information regarding the causes and anticipated duration  
33 of drug shortages.  
34
- 35 12. Our AMA supports the collection and standardization of pharmaceutical supply chain data  
36 in order to determine the data indicators to identify potential supply chain issues, such as  
37 drug shortages.  
38
- 39 13. Our AMA encourages global implementation of guidelines related to pharmaceutical  
40 product supply chains, quality systems, and management of product lifecycles, as well as  
41 expansion of global reporting requirements for indicators of drug shortages.  
42
- 43 14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing  
44 technologies such as continuous pharmaceutical manufacturing.  
45
- 46 15. Our AMA supports the concept of creating a rating system to provide information about  
47 the quality management maturity, resiliency and redundancy, and shortage mitigation  
48 plans, of pharmaceutical manufacturing facilities to increase visibility and transparency  
49 and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and

- 1 purchasers to contractually require manufacturers to disclose their quality rating, when  
2 available, on product labeling.  
3
- 4 16. Our AMA encourages electronic health records (EHR) vendors to make changes to their  
5 systems to ease the burden of making drug product changes.  
6
- 7 17. Our AMA urges the FDA to evaluate and provide current information regarding the quality  
8 of outsourcer compounding facilities.  
9
- 10 18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine  
11 and consider drug shortages as a national security initiative and include vital drug  
12 production sites in the critical infrastructure plan.  
13
- 14 19. Our AMA urges the Drug Enforcement Administration and other federal agencies to  
15 regularly communicate and consult with the FDA regarding regulatory actions which may  
16 impact the manufacturing, sourcing, and distribution of drugs and their ingredients.  
17 (Modify Current HOD Policy)  
18
- 19 2. That Policy H-440.847, "Pandemic Preparedness," which addresses the adequacy of the  
20 Strategic National Stockpile, be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Less than \$1,000



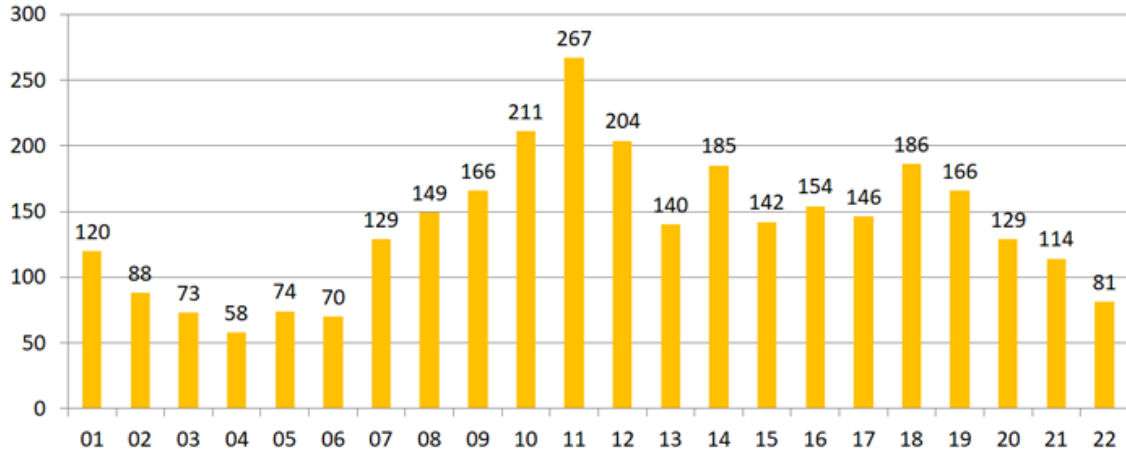
**Box 1. Resources available to assist in mitigation of drug shortages.**

1. [ASHP Resource Center](#)
2. ASHP [list](#) of current shortages
3. [FDA Drug Shortages Page](#) (includes current shortages list, extended use dates, mobile app, and additional information)

## APPENDIX 1

ASHP/University of Utah Drug Information Service Drug Shortage Data

**Figure 1. National Drug Shortages: New Shortages by Year: January 2001 to June 30, 2022**

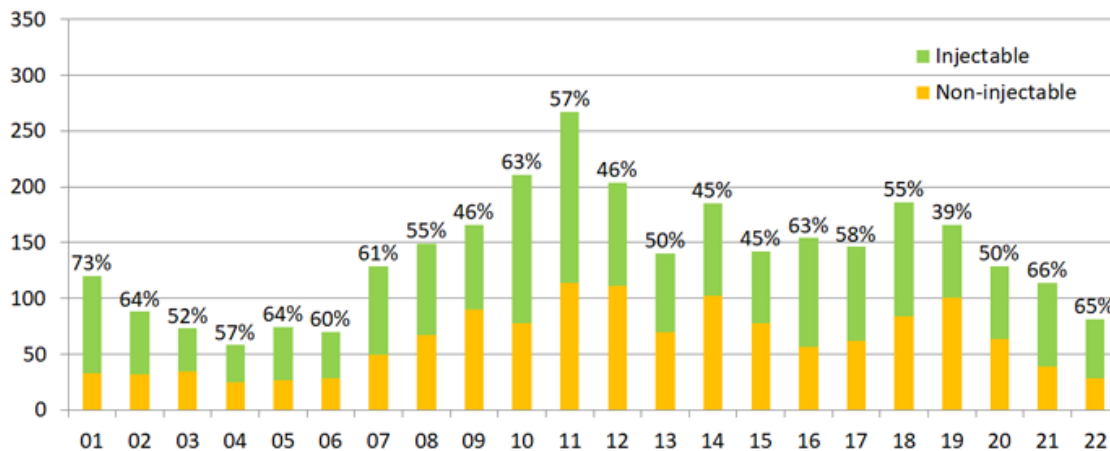


Note: Each column represents the number of new shortages identified during that year.

University of Utah Drug Information Service

Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

**Figure 2. National Drug Shortages: New Shortages by Year - Percent Injectable: January 2001 to June 30, 2022, % Injectable**

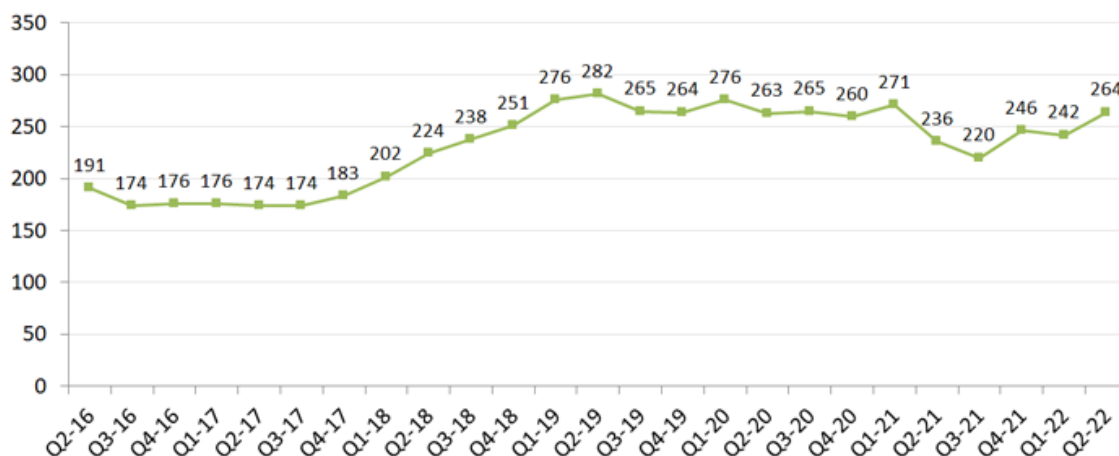


Note: Each column represents the number of new shortages identified during that year.

University of Utah Drug Information Service

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**Figure 3. National Drug Shortages: Active Shortages by Quarter: 5 Year Trend**

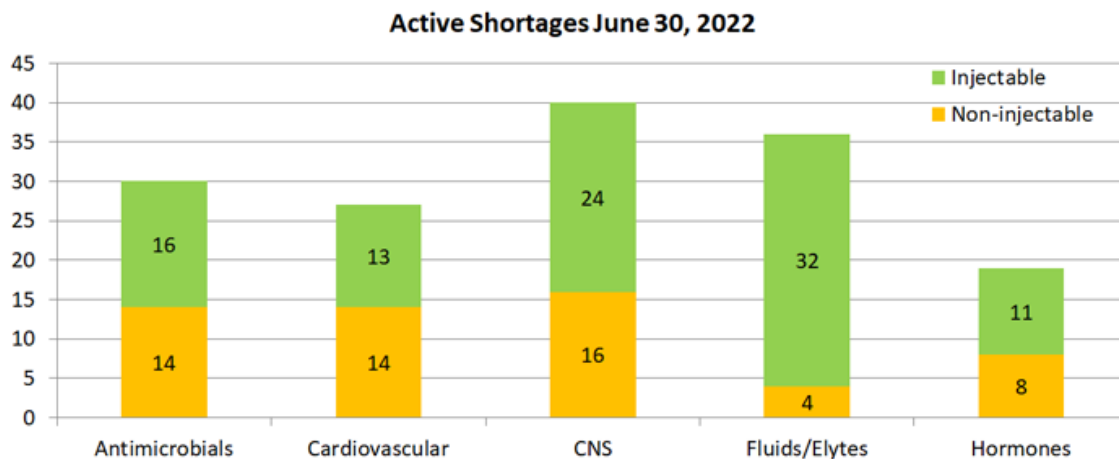


Note: Each point represents the number of active shortages at the end of each quarter.

University of Utah Drug Information Service

Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

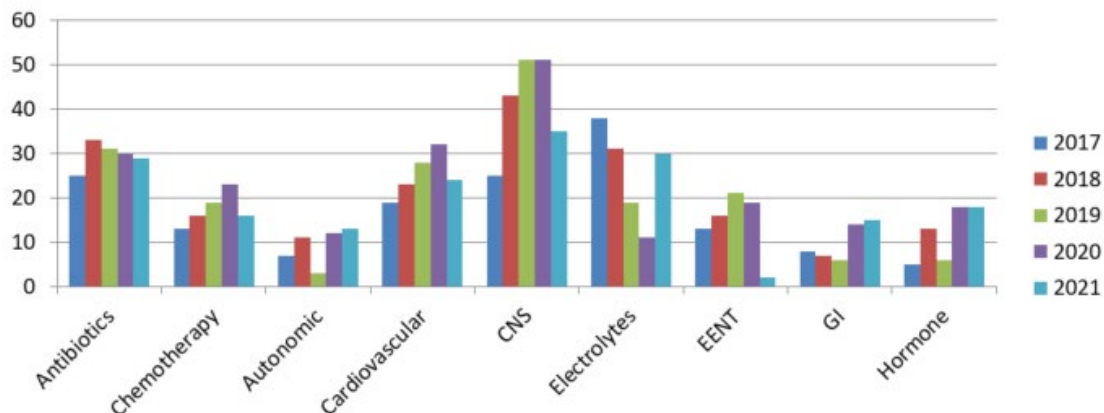
**Figure 4. National Drug Shortages: Active Shortages Top 5 Drug Classes**



University of Utah Drug Information Service

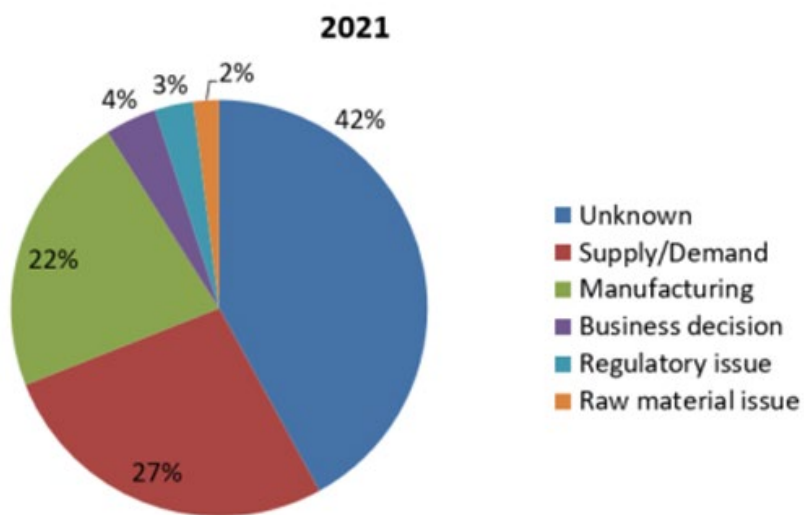
Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

**Figure 5. National Drug Shortages: Common Drug Classes in Short Supply: 5 Year Trend**



University of Utah Drug Information Service  
 Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

**Figure 6. National Drug Shortages: Reasons for Shortages as Reported by Manufacturers During UUDIS Investigation — 2021**



University of Utah Drug Information Service  
 Contact: Erin.Fox@hsc.utah.edu, @foxerinr for more information.

## APPENDIX 2

**Breakdown of CDER's and CBER's Shortage Numbers, CY 2021**

	<b>CDER</b>	<b>CBER</b>
New Shortages	38	3
Prevented Shortages	303	14
Ongoing Shortages	79	4
Notifications	744	33
No. of Manufacturers Notifying	98	23
<b>ACTIONS TAKEN TO MITIGATE SHORTAGES</b>		
Regulatory Flexibility and Discretion	97	0
Expedited Reviews	260	14*
Expedited Inspections	29	0

\* This number includes expedited reviews for eight biologics license application (BLA)/BLA supplements and six lot-release submissions for CBER-regulated products.

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REPORT 02 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-22)  
Climate Change and Human Health  
(Reference Committee K)

EXECUTIVE SUMMARY

**Objective.** The Council on Science and Public Health initiated this report due to the significant public health threat that climate change represents and the impact on the health of patients, with marginalized populations expected to be disproportionately impacted. The Council's last update on climate change was CSAPH Report 3-I-08, "Global Climate Change and Human Health."

**Methods.** Sentinel reports on climate, global climate change, and human health were reviewed including the Intergovernmental Panel on Climate Change (IPCC) assessment reports, *Lancet* Countdown on Health and Climate Change reports, reports from the World Health Organization (WHO), the Environmental Protection Agency (EPA), and the National Oceanic and Atmospheric Administration (NOAA). English language articles were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from January 2012 to June 2022 using the search terms: "climate change and health," "climate crisis and health," "decarbonization and health," and "climate change and equity." Additional articles were also identified by manual review of the reference lists of pertinent publications. Websites managed by federal agencies, applicable professional organizations, and foundations were reviewed for relevant information

**Results.** It is unequivocal that human influence has warmed the atmosphere, ocean and land. The scale of recent changes across the climate system are unprecedented over many centuries. Human-induced climate change is affecting weather and climate extremes in every region across the globe. The extent and magnitude of climate change impacts are larger than previously estimated and they are causing severe and widespread disruption in nature and in society; reducing our ability to grow nutritious food or provide enough clean drinking water, thus affecting people's health and well-being and damaging livelihoods. Limiting global warming to 1.5 degrees Celsius would require "rapid and far-reaching" transitions in land, energy, industry, buildings, transport, and cities.

**Conclusion.** Impacts from climate change on extreme weather, air quality, and the transmission of disease increasingly threaten the health and well-being of people in the U.S., and it is widely recognized that many of the impacts of warming will disproportionately impact the most vulnerable. The health effects of climate change include increased allergies, asthma, respiratory and cardiovascular disease; injuries and premature deaths related to extreme weather events; heat-related deaths due to continued warming; changes in the prevalence and geographical distribution of food- and water-borne illnesses and other infectious diseases, and threats to mental health.

To meet the Paris Agreement goals and prevent catastrophic levels of global warming, global GHG emissions must decline by half within a decade. Emissions are declining too slowly or heading in the wrong direction in the highest emitting sectors. This delay in progress is contributing to millions of deaths each year. The U.S. health care sector is responsible for an estimated 8.5 percent of national carbon emissions. These emissions stem from the operations of health care facilities (scope 1), from both purchased sources of energy, heating, and cooling (scope 2) and from the supply chain of health care goods and services (scope 3). The U.S. health sector accounts for 25 percent of global health sector emissions—the highest proportion attributable to any individual country's health sector. Physician's pledge to do no harm, it's time for the health sector to do the same by addressing the climate crisis and protecting public health



# REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-I-22

Subject: Climate Change and Human Health

Presented by: Noel Deep, MD, Chair

Referred to: Reference Committee K

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1 The Council on Science and Public Health initiated this report due to the significant public health  
2 threat that climate change represents and the impact on the health of patients, with marginalized  
3 populations expected to be disproportionately impacted. The Council's last update on climate  
4 change was CSAPH Report 3-I-08, "Global Climate Change and Human Health."  
5

6 The Council's 2008 report recognized that ongoing adverse global climate change is widely  
7 accepted by the majority of scientists, climatologists, and meteorologists, and human activity is  
8 influencing the rate and extent of this process. The report noted that the extent of climate change  
9 will depend on many factors, most notably, changes in global greenhouse gas (GHG) emissions.  
10 Anthropogenic contributions to global climate change exist, and the International Panel on Climate  
11 Change (IPCC), as well as many other reports, make a compelling case for linkage between these  
12 events. The report concluded the potential exists for devastating events with serious health  
13 implications, including extreme heat and cold events, flooding and droughts, increases in vectors  
14 carrying infectious diseases, and greater air pollution. Furthermore, the report noted the health  
15 effects from these events should be of concern to the medical community and require action. The  
16 report called on the health care community to advocate for public health policies that recognize and  
17 mitigate climate risk and strengthen health services, as well as improve communication and  
18 coordination at regional and international levels.  
19

20 While the American Medical Association (AMA) House of Delegates (HOD) has adopted  
21 numerous policies on climate changes since 2008, the Council initiated this report with  
22 acknowledgement that an update on this topic is long overdue. There is growing recognition of the  
23 impacts of climate change on health, with record-breaking heat waves, wildfires, droughts, and  
24 devastating floods impacting our patients and our communities and a limited window to act. We  
25 acknowledge that additional reports on the topics of climate mitigation and adaptation will be  
26 necessary but have decided to focus this report on the health effects of climate change and  
27 decarbonization. We also want to recognize that the AMA Board of Trustees (BOT) is working on  
28 a strategic plan on climate change, which will be presented to the HOD at the 2023 Annual  
29 Meeting. The BOT will also consider Resolution 605-A-22, which called for the AMA to establish  
30 a climate crisis campaign, determine high-yield advocacy and leadership opportunities, and  
31 centralize our AMA's efforts towards environmental justice and an equitable transition to a net-  
32 zero carbon neutral society. We hope that this report informs the strategy being developed by the  
33 BOT.  
34

## 35 EXISTING AMA POLICY

36  
37 In June 2022, the AMA declared climate change a public health crisis that threatens the health and  
38 well-being of all individuals and called on the AMA to protect patients by advocating for policies

that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens. The policy also called on the AMA to develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting. (D-135.966, “Declaring Climate Change a Public Health Crisis”)

AMA policy supports scientific findings that the Earth is undergoing adverse climate change which will create conditions that affect public health and will have a disproportionate impact on vulnerable populations, including children, the elderly, and the poor (H-135.938, “Global Climate Change and Human Health”). Accordingly, our AMA supports increased climate change education so physicians may understand the health risks that climate change poses and counsel patients on how to protect themselves from those health risks (H-135.919, “Climate Change Education Across the Medical Education Continuum”). It is the policy of the AMA to encourage physicians to implement programs in their practices that promote environmental sustainability and communicate these practices to their patients and their community (H-135.923, “AMA Advocacy for Environmental Sustainability and Climate”). Additionally, the AMA will urge physicians to become spokespersons for environmental stewardship (H-135.969, “Environmental Health Programs”).

With respect to air pollution and GHG reduction, the AMA urges the enactment of comprehensive legislation to address adverse health effects that are the product of air pollution (H-135.984, “Federal Clean Air Legislation”). The AMA encourages the US EPA to use its authority to regulate GHG emissions and limit carbon dioxide emissions. The AMA believes the coordinated efforts of the government along with industry and the public is the best way to minimize air pollution (H-135.999, “Federal Programs”).

## METHODS

Sentinel reports on climate, global climate change, and human health were reviewed including the Intergovernmental Panel on Climate Change (IPCC) assessment reports, *Lancet* Countdown on Health and Climate Change reports, reports from the World Health Organization (WHO), the Environmental Protection Agency (EPA), and the National Oceanic and Atmospheric Administration (NOAA).

English language articles were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from January 2012 to June 2022 using the search terms: “climate change and health,” “climate crisis and health,” “decarbonization and health,” and “climate change and equity.” Additional articles were also identified by manual review of the reference lists of pertinent publications. Websites managed by federal agencies, applicable professional organizations, and foundations were reviewed for relevant information.

## DEFINITIONS

Adaptation is “taking action to prepare for and adjust to both the current and projected impacts of climate change.”<sup>1</sup>

Climate change is “a long-term change in the average weather patterns that have come to define Earth’s local, regional and global climates.”<sup>2</sup>

Decarbonization means “switching from the use of fossil fuels such as coal, natural gas or oil to carbon-free and renewable energy sources.”

Global warming is “the long-term heating of Earth’s surface observed since the pre-industrial period (between 1850 and 1900) due to human activities, primarily fossil fuel burning, which increases heat-trapping greenhouse gas levels in Earth’s atmosphere. This term is not interchangeable with the term “climate change.”<sup>3</sup>

Greenhouse gases (GHGs) are gases that trap heat in the atmosphere.<sup>4</sup> GHGs emitted in the US include carbon dioxide (79 percent), methane (11 percent), nitrous oxide (7 percent), and fluorinated gases (3 percent).<sup>5</sup>

## THE INTERGOVERNMENTAL PANEL ON CLIMATE CHANGE (IPCC)

The IPCC is the United Nations body for assessing the science related to climate change. Limiting global warming to no more than 2 degrees Celsius above pre-industrial levels was the *de facto* target for global policymakers at the UN’s 2010 climate conference in Cancun, Mexico. In 2015, scientists warned that the 2 degrees Celsius limit was not adequate for avoiding some of the more severe impacts of climate change and reducing the limit to 1.5 degrees Celsius would be preferable.<sup>6</sup>

### *The Paris Agreement*

The Paris Agreement is a legally binding international treaty on climate change. It was adopted by 196 Parties at the UN Climate Change Conference of the Parties (COP) 21, on December 12, 2015, and entered into force on November 4, 2016.<sup>7</sup> Its goal is to limit global warming to well below 2, preferably to 1.5 degrees Celsius, compared to pre-industrial levels. To achieve this goal, countries aim to reach global peaking of greenhouse gas emissions as soon as possible to achieve a climate neutral world by mid-century. The Paris Agreement is important because for the first time, a binding agreement brings all nations into a common cause to undertake ambitious efforts to combat climate change and adapt to its effects.

### *Special Report on Global Warming of 1.5°C*

In 2018, the IPCC issued a special report on the impacts of global warming of 1.5 degrees Celsius above pre-industrial levels and related GHG emission pathways contained in the Paris Agreement.<sup>8</sup> The report concluded the global climate has changed relative to the pre-industrial period, and there is evidence that these changes have had impacts on organisms and ecosystems, as well as on human systems and well-being.<sup>9</sup> Human activities are estimated to have caused approximately 1.0 degree Celsius of global warming above pre-industrial levels, with a likely range of 0.8 to 1.2 degrees Celsius.<sup>10</sup> Risks to natural and human systems are expected to be lower at 1.5 degrees Celsius than at 2 degrees Celsius of global warming. This is true for heat-related morbidity and mortality and for ozone-related mortality if emissions needed for ozone formation remain high. Global warming is likely to reach 1.5 degree Celsius between 2030 and 2052 if it continues to increase at the current rate.<sup>11</sup> The report finds that limiting global warming to 1.5 degrees Celsius would require “rapid and far-reaching” transitions in land, energy, industry, buildings, transport, and cities.<sup>12</sup> Global net human-caused emissions of carbon dioxide would need to fall by about 45 percent from 2010 levels by 2030, reaching ‘net zero’ around 2050. The report also recognized that many of the impacts of warming will fall disproportionately on the poor and vulnerable.

## *The Sixth Assessment Cycle*

To date the IPCC has released three reports during this cycle. The Synthesis Report for this cycle is scheduled to be released in late 2022 or early 2023. Below are the high-level findings from the Sixth Assessment reports.

The Physical Science Basis<sup>13</sup> (2021). It is unequivocal that human influence has warmed the atmosphere, ocean and land. The scale of recent changes across the climate system as a whole are unprecedented over many centuries to many thousands of years. Human-induced climate change is already affecting many weather and climate extremes in every region across the globe. Evidence of observed changes in extremes such as heatwaves, heavy precipitation, droughts, and tropical cyclones, and their attribution to human influence, has strengthened. Global warming of 1.5 and 2 degrees Celsius will be exceeded during the 21st century unless deep reductions in GHG emissions occur in the coming decades.

Mitigation of Climate Change<sup>14</sup> (2022). Total net anthropogenic GHG emissions have continued to rise during the period 2010–2019, and average annual GHG emissions during 2010–2019 were higher than in any previous decade, but the rate of growth between 2010 and 2019 was lower than that between 2000 and 2009. Net anthropogenic GHG emissions have increased since 2010 across all major sectors globally. An increasing share of emissions can be attributed to urban areas. The unit costs of several low-emission technologies (solar energy, wind energy, and lithium-ion batteries) have decreased, but innovation has lagged in developing countries due to weaker enabling conditions.

Global GHG emissions are projected to peak between 2020 and 2025 in global modelled pathways that limit warming to 1.5 degrees Celsius with no or limited overshoot and in those that limit warming to 2 degrees Celsius. Global net zero CO<sub>2</sub> emissions are reached in the early 2050s in modelled pathways that limit warming to 1.5°C (>50%) with no or limited overshoot, and around the early 2070s in modelled pathways that limit warming to 2°C (>67%). Reaching and sustaining global net zero GHG emissions results in a gradual decline in warming. Reducing GHG emissions across the full energy sector requires major transitions, including a substantial reduction in overall fossil fuel use, the deployment of low-emission energy sources, switching to alternative energy carriers, and energy efficiency and conservation. The deployment of carbon dioxide removal (CDR) to counterbalance hard-to-abate residual emissions is unavoidable if net zero CO<sub>2</sub> or GHG emissions are to be achieved.

Impacts, Adaptation, and Vulnerability<sup>15</sup> (2022). Climate change is affecting nature, people's lives and infrastructure and its dangerous and pervasive impacts are increasingly evident in every region of the world. These impacts are hindering efforts to meet basic human needs and they threaten sustainable development. This report found that the extent and magnitude of climate change impacts are larger than estimated in previous assessments. They are causing severe and widespread disruption in nature and in society; reducing our ability to grow nutritious food or provide enough clean drinking water, thus affecting people's health and well-being and damaging livelihoods.

Many species are reaching limits in their ability to adapt to climate change, and those that cannot adjust or move fast enough are at risk of extinction. We see a lengthening wildfire season and increases in the area burned. Roughly half of the world's population experiences severe water shortages at some point during the year, in part due to climate change and extreme events such as flooding and droughts. Drought conditions have become more frequent in many regions, negatively affecting agriculture and energy production from hydroelectric power plants. Globally, climate change is increasingly causing injuries, illness, malnutrition, threats to physical and mental health

1 and well-being, and even deaths. Climate change impacts are expected to intensify with additional  
2 warming.

3  
4 Climate change risks and impacts can be reduced, within limits, if humans and nature adapt to the  
5 changing conditions. The scale and scope of actions to reduce climate risks have increased  
6 worldwide. However, there are large gaps between ongoing efforts and adaptation needed to cope  
7 with current levels of warming. Poverty and inequality present significant adaptation limits,  
8 resulting in unavoidable impacts for vulnerable groups, including women, young people, the  
9 elderly, ethnic and religious minorities, indigenous people, and refugees.

## 10 11 HEALTH EFFECTS OF CLIMATE CHANGE

12  
13 Impacts from climate change on extreme weather, air quality, and the transmission of disease  
14 increasingly threaten the health and well-being of people in the U.S., particularly populations that  
15 at increased risk.<sup>16</sup> The health effects of climate change include increased allergies, asthma,  
16 respiratory and cardiovascular disease; injuries and premature deaths related to extreme weather  
17 events; heat-related deaths due to continued warming; changes in the prevalence and geographical  
18 distribution of food- and water-borne illnesses and other infectious diseases, and threats to mental  
19 health.<sup>1</sup> (See Figure 1.) While not discussed in detail in this report, it is important to recognize that  
20 climate change can cause or exacerbate resource scarcity, which may result in conflict or migration  
21 of populations.<sup>17</sup> Individuals most at risk are typically the least able to relocate.<sup>18</sup> The health effects  
22 of climate change are outlined in the Council's 2008 report, but as the IPCC reports indicate, the  
23 frequency and intensity of extreme weather events will likely increase.

24  
25 Allergies and Respiratory Health. The combustion of fossil fuels is a major source of air pollution  
26 and cause of climate change. Fossil fuels release airborne fine particulate matter and ground-level  
27 ozone. Poor air quality contributes to a range of non-communicable diseases, including  
28 cardiovascular and respiratory disease.<sup>19</sup> It is estimated that more than 8 million people died in  
29 2018 from fossil fuel pollution, significantly higher than previous estimates—meaning that air  
30 pollution from burning fossil fuels was responsible for about 1 in 5 deaths worldwide.<sup>20</sup>  
31 Furthermore, hotter temperatures and lack of rainfall increase the risk of drought and wildfires,  
32 both of which create particle pollution.<sup>21</sup> As temperatures rise, plants produce more pollen,  
33 increasing ragweed and other allergens. Warmer temperatures allow allergens to thrive in new  
34 regions and for allergy seasons to last longer.<sup>22,23</sup>

35  
36 Cardiovascular Disease. Air pollution can exacerbate cardiovascular disease and contribute to the  
37 development of the disease. The evidence is particularly strong for outdoor particle pollution  
38 exposure. Exposure to PM <2.5 µm in diameter (PM<sub>2.5</sub>) over a few hours to weeks can trigger  
39 cardiovascular disease-related mortality and nonfatal events; longer-term exposure (increases the  
40 risk for cardiovascular mortality to an even greater extent and reduces life expectancy within more  
41 highly exposed segments of the population by several months to a few years; reductions in PM  
42 levels are associated with decreases in cardiovascular mortality within a time frame as short as a  
43 few years.<sup>24</sup> Short -and long-term exposure to increased concentrations of PM<sub>2.5</sub> has been shown to  
44 increase hospitalizations for serious cardiovascular events such as coronary syndrome, arrhythmia,  
45 heart failure, stroke, and sudden cardiac death, particularly in people with established heart  
46 disease.<sup>25</sup> Numerous studies have shown that exposure to higher concentrations of PM<sub>2.5</sub> and some  
47 gaseous air pollutants (nitrogen oxides, sulfur dioxide, and ozone) can also result in arterial  
48 hypertension and increased blood pressure.<sup>26</sup> Extreme heat also impacts heart health. A recent  
49 study showed 600-700 additional deaths from cardiovascular disease annually over a decade-long  
50 period in the U.S.<sup>27</sup> The spike in deaths during heat waves was most pronounced in men and non-  
51 Hispanic Black adults.<sup>28</sup>

Agriculture and Food Security. The agriculture sector is responsible for 11 percent of U.S. GHG emissions, which come from livestock, agricultural soils, and rice production.<sup>29</sup> GHG emissions from agriculture have increased by 6 percent since 1990, largely driven by a 62 percent growth in combined CH<sub>4</sub> and N<sub>2</sub>O emissions from livestock manure management systems.<sup>30</sup> Research indicates that shifts towards sustainable diets could lead to co-benefits, such as minimizing GHG emissions and land use, reducing the environmental footprint, aiding in climate change mitigation, and improving population health.<sup>31</sup> This is possible by reducing reliance on red meat consumption and prioritizing plant-based foods and other healthier alternatives, which can reduce chronic disease risk. Climate change is also expected to threaten food production, food prices, and distribution systems. Crop yields are predicted to decline due to changes in rainfall, severe weather events, and increasing competition from weeds and pests.<sup>32</sup> Prices are expected to rise in response to declining food production leading to food insecurity and a reliance on foods of poor nutrient quality.

Vector-borne diseases. Climatic hazards have enhanced specific aspects of pathogens, including improved climate suitability for reproduction, acceleration of the life cycle, increasing seasons/length of likely exposure, enhancing pathogen-vector interactions (for example, by shortening incubations) and increasing virulence. Between 2004 and 2018, the number of reported illnesses from mosquito, tick, and flea bites more than doubled, with more than 760,000 cases reported in the United States.<sup>33,36</sup> Nine new germs spread by mosquitoes and ticks were discovered or introduced into the United States during this period.<sup>34</sup> Warming had positive effects on mosquito population development, survival, biting rates and viral replication, increasing the transmission efficiency of West Nile virus.<sup>35</sup> Global mobility, urbanization and climate change is also major driver of the increase in the number of dengue virus infections, which have doubled every decade since 1990.<sup>36,37</sup> Further, the geographic ranges where ticks spread Lyme disease, anaplasmosis, ehrlichiosis, and spotted fever rickettsiosis have expanded, and experts predict that tickborne diseases will continue to increase and perhaps worsen.<sup>38</sup>

Fungi. Rising temperatures have allowed certain disease-causing fungi to spread into new areas that previously were too cold for them to survive. For example, Valley fever, caused by a fungus that lives in the soil in hot and dry areas, has already spread into the Pacific Northwest.<sup>39</sup>

Water-borne diseases. Ocean warming has accelerated the growth of harmful algal blooms and diseases caused by *Pseudo-nitzschia sp.*, blue green cyano-bacteria, and dinoflagellates.<sup>40</sup> Ocean warming and heavy precipitation, which reduces coastal water salinity, is predicted to also provide fertile conditions for *Vibrio vulnificus* and *Vibrio cholerae*, this being a leading explanation for Vibriosis outbreaks in areas where this disease is rare.<sup>41,42</sup> Further, floods and storms are associated with wastewater overflow, leading to the direct and foodborne transmission of noroviruses, hantavirus, hepatitis and *Cryptosporidium*.<sup>43,44,45</sup>

Zoonotic diseases. Patterns of contact between human and wildlife reservoirs have increased as human populations move into previously unoccupied regions. Changing environmental conditions can also alter species range and density, leading to novel interactions between species, and increase the risk of zoonotic emergence.<sup>46</sup> Further, habitat disruptions caused by warming, drought, heatwaves, wildfires, storms, floods and land cover change were also associated with bringing pathogens closer to people. Spillovers from viruses (Nipah virus and Ebola), for instance, were associated with wildlife (bats, rodents, and primates) moving over larger areas foraging for limited food resources caused by drought or finding new habitats following wildfires.<sup>47</sup>

Mental Health. The connections between climate change and mental health have been mostly discussed in relation to emergency preparedness and disaster response, particularly in the context of extreme weather events. The mental health effects of disasters may include trauma and shock, post-traumatic stress disorder (PTSD), feelings of abandonment, and anxiety and depression that can lead to suicidal ideation and risky behavior.<sup>48</sup> Rising temperatures can lead to mood and anxiety disorders, schizophrenia and vascular dementia, and can increase emergency department usage and suicide rates.<sup>49</sup> Concern about climate change coupled with worry about the future can lead to fear, anger, feelings of powerlessness, exhaustion, stress and sadness, which is being referred to as “eco-anxiety” or “climate anxiety.” Climate anxiety and dissatisfaction with government responses are widespread in children and young people and can impact their daily functioning.<sup>50</sup> Distress about climate change in young people is associated with perceiving that they have no future, that humanity is doomed, and that governments are failing to respond adequately, and with feelings of betrayal and abandonment by governments and adults.<sup>51</sup>

## DECARBONIZATION

In 2021, President Biden announced the U.S. target was to achieve a 50-52 percent reduction from 2005 levels in economy-wide net GHG pollution by 2030.<sup>52</sup> Since 1990, gross U.S. GHG emissions have decreased by 7 percent.<sup>53</sup> In 2020, U.S. GHG emissions decreased 11 percent compared to 2019 levels primarily from CO<sub>2</sub> emissions from fossil fuel combustion largely due to the COVID-19 pandemic and reductions in travel and economic activity.<sup>54</sup> However, it is estimated that in 2021 U.S. GHG emissions increased by 6 percent above 2020 levels, returning to pre-pandemic levels.<sup>55</sup>

In efforts to reach the U.S. commitments under the Paris Agreement, the administration signed Executive Order (EO) 14057, “Catalyzing Clean Energy Industries and Jobs Through Federal Sustainability”, a multi-faceted approach to addressing climate change.<sup>56</sup> EO 14057’s stated goals include:

- 100 percent carbon emission free electricity by 2030,
- 100 percent of government acquired vehicles to be zero emission vehicles by 2035,
- a net-zero emission federal building portfolio by 2032,
- a 65 percent reduction in overall greenhouse gas emissions by 2030

Other goals without explicit time frames include net-zero emissions of federal procurements, climate resilient infrastructure and a climate focused federal workforce.

### *The Lancet Countdown on Health and Climate Change*

Published annually, the *Lancet* Countdown is an international, multidisciplinary collaboration, dedicated to monitoring the health profile of climate change, and independently assessing the delivery of commitments made by governments under the Paris Agreement. In 2021, the report indicated that the current global decarbonization commitments are “insufficient to meet Paris Agreement ambitions and would lead to a roughly 2.4 degrees Celsius average global temperature increase by the end of the century.”<sup>57</sup> To meet the Paris Agreement goals and prevent catastrophic levels of global warming, global GHG emissions must reduce by half within a decade. Emissions are declining too slowly or heading in the wrong direction in the highest emitting sectors. This delay in progress is contributing to millions of deaths each year. At the current pace of reduction, it would take more than 150 years for the energy system to fully decarbonize, and the unequal response between countries is resulting in an uneven realization of the health benefits of a low-carbon transition.<sup>58</sup> The use of public funds to subsidize fossil fuels is partly responsible for the

slow decarbonization rate, with 65 out of 84 countries reviewed still providing an overall subsidy to fossil fuels in 2018.<sup>59</sup> Despite years of scientific reporting on the impacts of climate change, efforts to build resilience have been slow and unequal, with countries with low levels of human development index being the least prepared to respond to the changing health profile of climate change and funding remaining a consistent challenge. Even with overwhelming evidence on the health impacts of climate change, countries are not delivering an adaptation response proportionate to the rising risks their populations face.<sup>60</sup>

### *Role of the Health Sector*

The U.S. health care sector is responsible for an estimated 8.5 percent of national carbon emissions. These emissions stem from the operations of health care facilities (scope 1), from both purchased sources of energy, heating, and cooling (scope 2) and from the supply chain of health care goods and services (scope 3). The U.S. health sector accounts for 25 percent of global health sector emissions—the highest proportion attributable to any individual country’s health sector.<sup>61</sup> In 2021, as part of the United Nations Climate Change Conference (COP26), 60 countries, including the United States, committed to creating climate-resilient, low-carbon, sustainable health systems, with 20 countries committing to net-zero health care system emissions by 2050. However, while more than 90 percent of Standard & Poor’s 500 Companies annually publish sustainability reports, as do many private and nongovernmental entities, the same cannot be said of U.S. health care organizations, despite their commitment to improving health.<sup>62</sup>

### *HHS Health Sector Climate Pledge*

In 2022, the US Department of Health & Human Services announced a pledge initiative, calling upon the private health care sector to publicly commit to reducing and reversing their carbon footprint.<sup>63</sup> The voluntary pledge calls upon signees to reduce emissions by 50 percent by 2030, become net-zero emitters by 2050, complete an inventory of supply chain emissions and to develop climate resilience plans for their facilities and communities. The pledge has been signed by more than 60 major hospital groups, pharmaceutical companies, insurers, and medical associations.<sup>64</sup>

### *National Academy of Medicine: Action Collaborative on Decarbonizing the U.S. Health Sector*

NAM has launched an Action Collaborative on Decarbonizing the U.S. Health Sector. This public-private partnership includes leadership from the federal government, the biomedical and pharmaceutical industries, hospital systems, private payers, and health professions, including the AMA, with the aim to develop and implement a shared action plan for decarbonizing the health sector and strengthening its sustainability and resiliency.<sup>65</sup>

The collaborative is focusing its decarbonization efforts in four areas: (1) working with industry to reduce scope 3 emissions, as well as facilitate coordination with the federal government to accelerate and better enable low-carbon innovations; (2) accelerating climate-sensitive health care delivery and practice, including reducing scope 1 and scope 2 emissions and identifying opportunities for linking performance on sustainability metrics to value-based payment and reimbursement; (3) expanding health professionals’ curricula and programming on climate change; and (4) developing sustainability metrics and indicators for industry and health systems, along with shared plans for public reporting.<sup>66</sup>

### *Resources on Health System Decarbonization*



Health Care Without Harm has released a Road Map that provides a plan to get health care toward zero emissions. By implementing this set of seven high-impact actions, health care can put itself firmly on the road to zero emissions, while helping provide leadership for the rest of the world to travel in the same direction.<sup>67</sup> The Road Map identifies seven high-impact actions as key to health care decarbonization:

1. Power health care with 100 percent clean, renewable electricity.
2. Invest in zero emissions buildings and infrastructure.
3. Transition to zero emissions, sustainable travel, and transport.
4. Provide healthy, sustainably grown food and support climate resilient agriculture.
5. Incentivize and produce low-carbon pharmaceuticals.
6. Implement circular health care and sustainable health care waste management.
7. Establish greater health system effectiveness.

The UK's National Health Service (NHS) is the world's first health care system to commit to achieve net-zero carbon emissions. Its Greener NHS plan contains critical lessons for the U.S. health system.<sup>68</sup> The NHS has taken action in the following areas:

- Developing a framework to evaluate the carbon reduction associated with new models of care under consideration.
- Working with suppliers to ensure they meet or exceed the NHS commitment on net-zero emissions before the end of the decade, with new procurement from April 2022 onward required to consider net zero as part of the purchasing process.
- Shifting to using zero-emission vehicles, including production of the world's first zero-emission ambulance.
- Ensuring that digital transformation of health care aligns with the goal of becoming a net-zero health service, investing in innovations to support that goal, and setting up a scanning mechanism to identify future pipeline innovations.
- Supporting the construction of 40 new net-zero hospitals as part of the government's health infrastructure plan, which includes a new net-zero carbon hospital standard.
- Completing a \$60 million LED lighting replacement program that will improve patient comfort and save money.
- Making health care systems more resilient to enable them to withstand or adapt to the demands of future climate events, such as floods and extreme temperatures.
- Appointing a new chief sustainability officer to lead the national program and report regularly to the national board; ensuring that every NHS organization has a board-level net-zero lead and a green plan; and supporting an update to the NHS constitution to include the response to climate change as a core principle.

To support healthcare organizations in advancing toward their decarbonization commitments, the Agency for Healthcare Research and Quality (AHRQ) contracted with the Institute for Healthcare Improvement to develop a primer that offers guidance on high-priority measures and strategies for health care organizations to reduce their carbon footprint.<sup>69</sup> The recommendations are intended to inform organizations beginning their journey in measuring and reducing GHG emissions. The primer describes six domains contributing to GHG emissions in health care: building energy, transportation, anesthetic gas, pharmaceuticals and chemicals, medical devices and supplies, and food. To meaningfully track and reduce GHG emissions, the primer recommends health care organizations should use the Greenhouse Gas Protocol (GHGP) framework, a globally recognized standard for quantifying and reporting on emissions.

1 *U.S. Securities and Exchange Commission (SEC) and Decarbonization*

2  
3 The SEC is expected to finalize a rule requiring publicly traded companies to disclose climate-  
4 related risks.<sup>70</sup> The proposed rules also would require a registrant to disclose information about its  
5 direct GHG emissions (Scope 1) and indirect emissions from purchased electricity or other forms  
6 of energy (Scope 2). In addition, a registrant would be required to disclose GHG emissions from  
7 upstream and downstream activities in its value chain (Scope 3), if material or if the registrant has  
8 set a GHG emissions target or goal that includes Scope 3 emissions. These proposals for GHG  
9 emissions disclosures would provide investors with decision-useful information to assess a  
10 registrant's exposure to, and management of, climate-related risks, and in particular transition risks.  
11

12 EPA AUTHORITY

13  
14 The Clean Air Act is the law that defines the EPA's authority and responsibility to regulate air  
15 pollutants. In 2015, the Obama Administration's Clean Power Plan (CPP) established guidelines  
16 for to cut power-plant emissions and instructed the states to submit their plans by 2018 and then  
17 gave them until 2030 to meet their goals. The CPP relied on section 7411 of the Clean Air Act to  
18 enforce guidelines on power plants. In 2019, the Trump Administration issued its Affordable Clean  
19 Energy (ACE) Rule which eliminated the guidelines set by the Clean Power Plan. However, the  
20 ACE rule was vacated by the U.S. Court of Appeals. As a result, petitioners challenged the EPA's  
21 authority to broadly regulate GHG emissions. In a recent Supreme Court decision, *West Virginia v.*  
22 *EPA*, the Court held Congress did not grant the EPA, under the Clean Air Act, the authority to  
23 devise emissions caps based on the generation shifting approach the agency took in the Clean  
24 Power Plan (CPP). This decision limited the EPA's ability to reduce pollution from power plants.  
25

26 FEDERAL LEGISLATION

27  
28 In August 2022, Congress passed H.R. 5376, also known as the Inflation Reduction Act of 2022  
29 (IRA). The IRA authorized spending of \$369 billion over the next ten years, with much targeted  
30 towards environmental policies. According to the Department of Energy, these policies are  
31 anticipated to cut domestic greenhouse gas emissions by up to 40 percent by 2030.<sup>71</sup> Several of the  
32 programs contained in the IRA are targeted at reducing or reimbursing the upfront investments  
33 required to convert to more environmentally friendly technology. For example, the IRA contains  
34 tax credits or reimbursements for electric vehicle purchases, households that install rooftop solar  
35 panels or heat pumps, and a new Advanced Industrial Facilities Deployment Program to provide  
36 financial assistance for facilities looking to modernize. Other key elements are investments in the  
37 domestic manufacturing workforce to promote green technology production within the United  
38 States.  
39

40 In addition to monetary investments, the IRA also contains important policy changes, particularly  
41 around the powers conferred to the EPA. While the IRA does not abrogate the holdings of *West*  
42 *Virginia v. EPA*, it does provide direct funding to the EPA for seven programs to reduce GHG, and  
43 it explicitly defines GHG as carbon dioxide, hydrofluorocarbons, methane, nitrous oxide,  
44 perfluorocarbons, and sulfur hexafluoride.<sup>72</sup> These changes are expected to strengthen the agency's  
45 ability to mount a legal defense against challenges similar to those levied in *West Virginia v. EPA*.  
46

47 The bill also includes tax credits for carbon capture and sequestration, which could extend the life  
48 of coal plants and make it harder to reach critical targets for clean power. The bill requires the  
49 federal government to offer parts of the Gulf of Mexico and Alaska's Cook Inlet for oil and gas  
50 development. It also requires additional oil and gas leasing for new wind and solar projects to be  
51 approved. As a part of the compromise, negotiators are expected to put forth a separate bill on oil

and gas “permitting reform” that could weaken environmental protections under the National Environmental Policy Act.

## STATE AND LOCAL ACTIONS

At the state level, many of the most impactful state policies are enacted by coalitions of multiple states. For example, California has been allowed to institute stricter tailpipe emission standards since obtaining a Clean Air Act waiver in 1970, and other states are allowed to adopt California’s standards. As of 2019, 17 states and the District of Columbia, representing approximately 40 percent of light duty vehicle sales in the United States, utilize California’s low-emission vehicle emission regulations.<sup>73</sup> As such, this informal coalition of states places significant market pressure on car manufacturers to simply have *all* new vehicles meet California emission standards rather than dealing with the logistical complexity of having two markets with two different sets of regulations in the United States.<sup>74</sup>

Similarly, when the United States initially withdrew from the Paris Agreement, 24 states and 2 territories representing approximately 50 percent of the United States population formed the United States Climate Alliance pledging to meet the US’s Paris Agreement goals under the Clean Power Plan. Other important state coalitions include the Regional Greenhouse Gas Initiative, the Western Climate Initiative, Inc., and the Midwestern Greenhouse Gas Reduction Accord which serve as major “cap-and-trade” markets for their respective regions.

Other notable state-level actions in recent years include California’s Plastic Pollution Prevention and Packaging Producer Responsibility Act (requiring all packaging in the state to be recyclable or compostable by 2032), Illinois’ Climate and Equitable Jobs Act (requiring 100% renewable energy by 2050), and Wisconsin’s Office of Sustainability and Clean Energy (100% carbon-free electricity by 2050).

As of writing, 35 of the 50 largest cities in the United States have published local climate action plans.<sup>75</sup> Similar to states, local governments and cities often tackle climate change through coalitions such as Climate Mayors, a collection of 470 mayors representing approximately 74 million Americans committed to building political will for climate change policy. Many municipal climate plans echo those seen at the federal and state levels aiming to reduce greenhouse gas emissions, but they also provide insight into the unique issues facing different geographies. For example, the city of Miami has invested \$400 million into the Miami Forever bond to fund projects addressing sea-level rise and flood prevention,<sup>76</sup> and the city of Ann Arbor implemented the 10,000 Trees Initiative to give away free trees and rebuild the city’s canopy.<sup>77</sup>

## AMA ACTIONS

### *Medical Society Consortium on Climate and Health (MSCCH)*

The AMA is a member of the MSCCH. The Consortium works to facilitate the medical community’s awareness-raising efforts, by bringing together associations representing over 600,000 clinical practitioners to carry three simple messages:

- Climate change is harming Americans today and these harms will increase unless we act;
- The way to slow or stop these harms is to decrease the use of fossil fuels and increase energy efficiency and use of clean energy sources; and
- These changes in energy choices will improve the quality of our air and water and bring immediate health benefits.

In 2019, the AMA signed on to the “Climate, Health, and Equity: A Policy Action Agenda,” which recognizes climate change is a public health emergency and outlines ten policy recommendations to provide a roadmap to develop coordinated strategies for simultaneously tackling climate change, health, and equity.<sup>3</sup> The agenda calls out 10 specific policy priorities, including the following:

1. Meeting and strengthening greenhouse gas emission reduction commitments and supporting the Paris Agreement.
2. Transitioning rapidly away from the use of coal, oil and natural gas to clean, safe, and renewable energy and energy efficiency.
3. Emphasizing active transportation in the transition to zero-carbon transportation systems.
4. Promoting healthy, sustainable and resilient farms and food systems, forests, and natural lands.
5. Ensuring that all U.S. residents have access to safe and affordable drinking water and a sustainable water supply.
6. Investing in policies that support a just transition for workers and communities adversely impacted by climate change and the transition to a low-carbon economy.
7. Engaging the health sector voice in the call for climate action.
8. Incorporating climate solutions into all health care and public health system.
9. Building resilient communities in the face of climate change.
10. Investing in climate in a way that benefits health, and health in a way that doesn’t harm the climate.

In January of 2020, the AMA joined the MSCCH in calling on President Trump to stop our withdrawal from the Paris Climate Agreement. The letter recognizes that climate change is a public health emergency. Rejoining the Paris Climate Agreement is not just about preventing the worst of the devastating health harms climate change will bring. It is also about seizing this public health crisis and turning it into a major public health opportunity.

#### *NAM Action Collaborative on Decarbonizing the Health Sector*

The AMA is also a member of the National Academy of Medicine Action Collaborative on Decarbonizing the Health Sector as a member of the Steering Committee and co-lead of the Health Care Delivery Workgroup, which is working toward the following four goals:

- Goal 1: Make the multi-faceted case for health systems and hospitals to minimize their carbon footprints and operate more sustainably
- Goal 2: Identify a set of policy and regulatory barriers preventing progress on decarbonization and resilience from accelerating, and identify solutions
- Goal 3: Identify a core set of sustainability metrics for hospitals and clinical practice
- Goal 4: Develop decarbonization playbooks and best practices for hospitals and health care delivery institutions, leveraging existing frameworks and success stories

#### *AMA Litigation Center*

The AMA has long advocated for upholding the Clean Power Plan through amicus briefs and most recently filed such a brief with the American Thoracic Society and dozens of leading medical organizations and public health leaders in *West Virginia v. EPA*. The AMA brief stated the importance of the EPA’s authority to regulate carbon dioxide emissions from power plants in order to mitigate the health effects of climate pollutants and help address climate change as a threat to public health.

## CONCLUSION

It is now unequivocal that human influence has warmed the atmosphere, ocean and land. The scale of recent changes across the climate system are unprecedented over many centuries to thousands of years. Human-induced climate change is affecting weather and climate extremes in every region across the globe. The extent and magnitude of climate change impacts are larger than previously estimated and they are causing severe and widespread disruption in nature and in society; reducing our ability to grow nutritious food or provide enough clean drinking water, thus affecting people's health and well-being and damaging livelihoods. Limiting global warming to 1.5 degrees Celsius would require “rapid and far-reaching” transitions in land, energy, industry, buildings, transport, and cities.<sup>78</sup>

Impacts from climate change on extreme weather, air quality, and the transmission of disease increasingly threaten the health and well-being of people in the U.S., and it is widely recognized that many of the impacts of warming will disproportionately impact the most vulnerable. The health effects of climate change include increased allergies, asthma, respiratory and cardiovascular disease; injuries and premature deaths related to extreme weather events; heat-related deaths due to continued warming; changes in the prevalence and geographical distribution of food- and water-borne illnesses and other infectious diseases, and threats to mental health.

To meet the Paris Agreement goals and prevent catastrophic levels of global warming, global GHG emissions must be reduced by half within a decade. Emissions are declining too slowly or heading in the wrong direction in the highest emitting sectors. This delay in progress is contributing to millions of deaths each year. The U.S. health care sector is responsible for an estimated 8.5 percent of national carbon emissions. These emissions stem from the operations of health care facilities (scope 1), from both purchased sources of energy, heating, and cooling (scope 2) and from the supply chain of health care goods and services (scope 3). The U.S. health sector accounts for 25 percent of global health sector emissions, the highest proportion attributable to any individual country's health sector. Physicians pledge to do no harm; it is time for the health sector to do the same by addressing the climate crisis and protecting public health.

## RECOMMENDATIONS

The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed.

1. That Policy D-135.966, “Declaring Climate Change a Public Health Crisis” be amended by addition to read as follows:

1. Our AMA declares climate change a public health crisis that threatens the health and well-being of all individuals. 2. Our AMA will protect patients by advocating for policies that: (a) limit global warming to no more than 1.5 degrees Celsius, (b) reduce US greenhouse gas emissions aimed at a 50 percent reduction in emissions by 2030 and carbon neutrality by 2050, and (c) support rapid implementation and incentivization of clean energy solutions and significant investments in climate resilience through a climate justice lens. 3. Our AMA consider signing on to the Department of Health and Human Services Health Care Pledge or making a similar commitment to lower its own greenhouse gas emissions. 4. Our AMA encourages the health sector to lead by example in committing to carbon neutrality by 2050. 5. Our AMA will develop a strategic plan for how we will enact our climate change policies including advocacy priorities and strategies to decarbonize

physician practices and the health sector with report back to the House of Delegates at the 2023 Annual Meeting. (Modify Current HOD Policy)

2. That Policy H-135.938, "Global Climate Change and Human Health" be amended by addition and deletion to read as follows:

Our AMA: 1. Supports ~~the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the~~ scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes ~~have adversely affected the physical and mental health of people. will create conditions that affect public health, with~~ We recognize that minoritized and marginalized populations, children, the elderly, rural communities, and those who are economically disadvantaged will suffer disproportionate impacts harms from of climate change on vulnerable populations, including children, the elderly, and the poor.

2. Supports educating the medical community on the ~~potential~~-adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public on the physical and mental health effects of climate change and on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with ~~local and state~~ health departments to strengthen the public health infrastructure to ensure that the ~~global~~ health effects of climate change can be anticipated and responded to more efficiently, and that adaptation interventions are equitable and prioritize the needs of the populations most at risk, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training. (Modify Current HOD Policy)

3. That Policy D-150.978, "Sustainable Food" be reaffirmed.

Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through tax incentive programs, community-level initiatives and federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems. (Reaffirm HOD Policy)

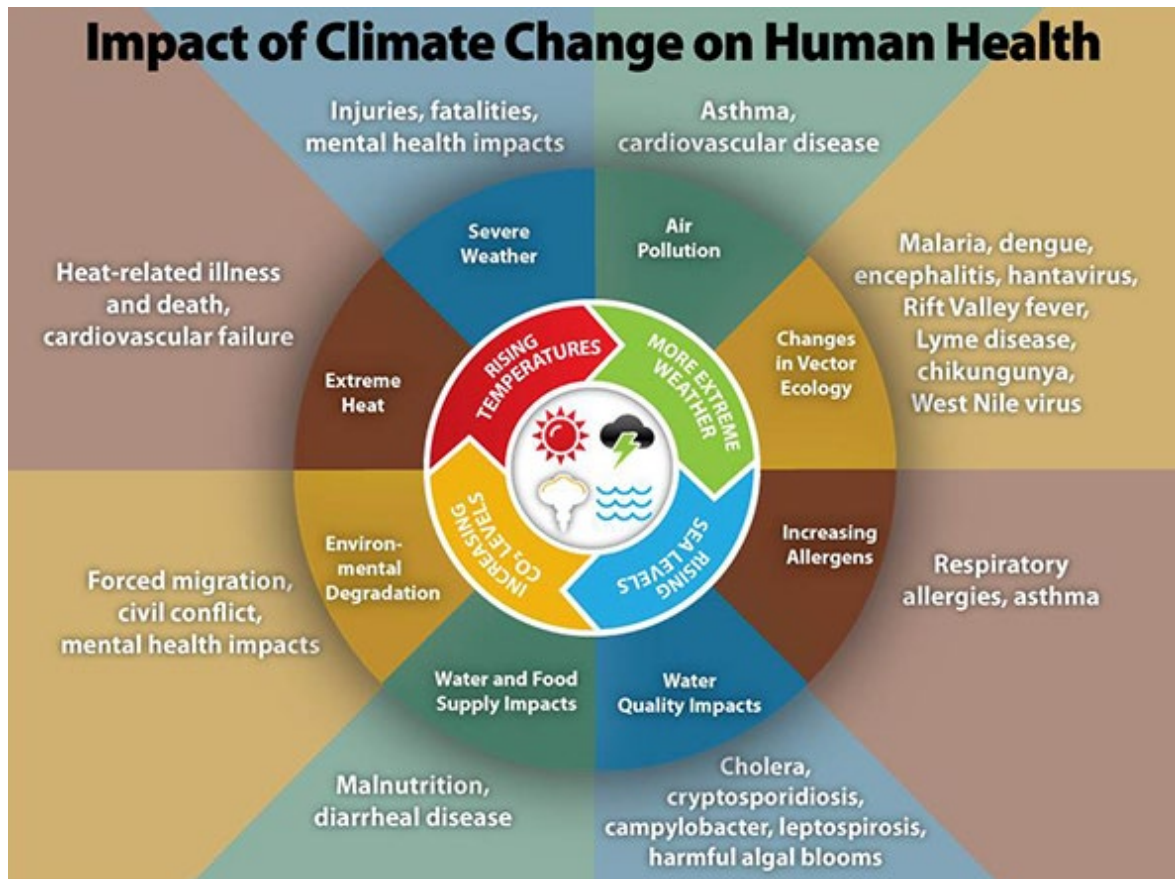
4. That Policy H-135.977, "Global Climate Change - The "Greenhouse Effect"" be rescinded.

~~Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting;~~

- 1 ~~(2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization~~
- 2 ~~policy that will promote more efficient fuel use and energy production;~~
- 3 ~~(3) endorses increased recognition of the importance of nuclear energy's role in the production of~~
- 4 ~~electricity;~~
- 5 ~~(4) encourages research and development programs for improving the utilization efficiency and~~
- 6 ~~reducing the pollution of fossil fuels; and~~
- 7 ~~(5) encourages humanitarian measures to limit the burgeoning increase in world population.~~
- 8 (Rescind HOD Policy)

Fiscal Note: less than \$1,000

FIGURE 1



Source: Centers for Disease Control and Prevention

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## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 902  
(I-22)

Introduced by: Medical Student Section

Subject: Reducing the Burden of Incarceration on Public Health

Referred to: Reference Committee K

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1 Whereas, The United States has the highest incarceration rate in the world<sup>1</sup>; and

2  
3 Whereas, Incarcerated individuals disproportionately have lower incomes and are more likely to  
4 be Black, male, and live in urban settings<sup>2</sup>; and

5  
6 Whereas, In 2018, Black Americans represented 33% of the sentenced prison population,  
7 whites 30%, and Hispanic 23%, whereas these groups made up 12%, 63%, and 16% of the  
8 U.S. adult population, respectively<sup>3</sup>; and

9  
10 Whereas, A 2009 study found that incarcerated people have higher rates of hypertension,  
11 arthritis, cervical cancer, and hepatitis than non-incarcerated individuals<sup>5</sup>; and

12  
13 Whereas, Incarcerated individuals may also experience heightened challenges in transitions of  
14 care relative to the non-incarcerated population, including poor transfer of medical, laboratory  
15 and pharmacy records, poor communication among providers, variable access to care, limited  
16 family involvement, and inability to afford treatment<sup>6,7</sup>; and

17  
18 Whereas, Many states have rules wherein Medicaid beneficiaries who are incarcerated are de-  
19 enrolled and must re-enroll in Medicaid upon release, which can have a significant lag time that  
20 frequently lasts up to several months<sup>8,9</sup>; and

21  
22 Whereas, As of 2019, 43 states had implemented suspension of benefits rather than termination  
23 for certain prisons, and 42 had done this for certain jails, allowing inmates to immediately  
24 reinstate their Medicaid eligibility upon release<sup>10</sup>; and

25  
26 Whereas, Federal rules prohibit Medical matching funds for being used for inmate health  
27 expenses with the exception of costs incurred due to inpatient hospitalization, creating  
28 additional coverage issues for the incarcerated population separate from eligibility<sup>11</sup>; and

29  
30 Whereas, Federal Medicaid rules include a coverage exclusion “related to services for patients  
31 in Institutions for Mental Diseases, which include residential treatment facilities of over sixteen  
32 beds that are primarily engaged in the diagnosis, treatment, or care of persons with mental  
33 diseases”<sup>12</sup>; and

34  
35 Whereas, The Medicaid Reentry Act of 2021 was introduced into the US House of  
36 Representatives and would allow for Medicaid payment for medical services rendered to  
37 incarcerated individuals during the 30-day period before the individual’s release<sup>13</sup>; and

38  
39 Whereas, The Bureau of Justice Assistance awards grants for projects that create strategic,  
40 sustainable plans to facilitate successful reentry, ensure collaboration with the criminal justice

1 system and social services, and collect data to measure performance outcomes related to  
2 recidivism and service provision<sup>14</sup>; and  
3

4 Whereas, Individuals released from prison may legally be barred from pursuing opportunities in  
5 employment, social programs, and voting<sup>15-17</sup>; and  
6

7 Whereas, Pursuant to a report mandated by the Fair Chance to Compete for Jobs Act, the  
8 Bureau of Justice Statistics in the US Department of Justice found that 33% of persons did not  
9 find employment at any point during the 16 quarters after their release from prison from 2010 to  
10 2014<sup>18</sup>; and  
11

12 Whereas, Because the predominant source of insurance in the United States is through  
13 employment, lack of employment opportunities for formerly incarcerated individuals leads to a  
14 concomitant lack of access to health insurance, particularly in states that have not expanded  
15 Medicaid<sup>19</sup>; and  
16

17 Whereas, Homelessness and residential instability has been identified as one of the greatest  
18 challenges confronting ex-offenders and their chance to achieve successful reintegration, with  
19 some studies finding that formerly incarcerated individuals were 10 times more likely to be  
20 homeless than the general public<sup>20,21</sup>; and  
21

22 Whereas, Periods of homelessness have been shown to significantly increase the risk of  
23 recidivism for new convictions, revocations, and readmission to prison, suggesting the presence  
24 of a vicious cycle wherein incarceration increases the risk of homelessness which further  
25 increases the risk of subsequent incarceration<sup>20</sup>; and  
26

27 Whereas, The increased risk of homelessness among the formerly incarcerated population  
28 increases with the number of times an individual has been incarcerated, with people who have  
29 been to prison once experiencing homelessness at a rate 7 times greater than that of the  
30 general public and people who have been incarcerated more than once experiencing  
31 homelessness at a rate 13 times higher than the general public<sup>21</sup>; and  
32

33 Whereas, The AMA has extensive policy on reducing the poor health outcomes associated with  
34 incarceration (H-430.986 Health Care While Incarcerated), on the health impacts of  
35 homelessness (H-160.903 Eradicating Homelessness), on support for standard ongoing  
36 medical, psychiatric, and substance misuse care for inmates upon release from correctional  
37 facilities in order to prevent recidivism (H-430.997 Standards of Care for Inmates of Correctional  
38 Facilities), and on support for the National Commission on Correctional Health Care Standards  
39 and its efforts to improve the quality of health care services for incarcerated persons (D-430.997  
40 Support for Healthcare Services for Incarcerated Persons), but has no policy supporting or  
41 promoting access to stable employment and housing for former inmates; therefore be it  
42

43 RESOLVED, That our American Medical Association support efforts to reduce the negative  
44 health impacts of incarceration, such as: (1) implementation and incentivization of adequate  
45 funding and resources towards indigent defense systems; (2) implementation of practices that  
46 promote access to stable employment and laws that ensure employment non-discrimination for  
47 workers with previous non-felony criminal records; and (3) housing support for formerly  
48 incarcerated people, including programs that facilitate access to immediate housing after  
49 release from carceral settings (New HOD Policy); and be it further

- 1 RESOLVED, That our AMA partner with the American Public Health Association and other  
2 stakeholders to urge Congress, the Department of Justice, and the Department of Health  
3 and Human Services to minimize the negative health effects of incarceration by supporting  
4 programs that facilitate employment and housing opportunities for formerly incarcerated  
5 individuals as well as research into alternatives to incarceration. (Directive to Take Action)

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

Received: 09/20/22

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**RELEVANT AMA POLICY**

**Health Care While Incarcerated H-430.986**

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.



4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
  5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
  6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
  7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
  8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
  9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
  10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community; (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.
  11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
  12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.
- CMS Rep. 02, I-16, Appended: Res. 417, A-19, Appended: Res. 420, A-19, Modified: Res. 216, I-19, Modified: Res. 503, A-21, Reaffirmed: Res. 229, A-21, Modified: Res. 127, A-22

#### **Standards of Care for Inmates of Correctional Facilities H-430.997**

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

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

#### **Disease Prevention and Health Promotion in Correctional Institutions H-430.989**

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, hepatitis, and other infectious diseases. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

CSA Rep. 4, A-03, Modified: CSAPH Rep. 1, A-13, Modified: Alt. Res. 404, I-20

#### **Support for Health Care Services to Incarcerated Persons D-430.997**

Our AMA will:

- (1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
- (2) encourage all correctional systems to support NCCHC accreditation;
- (3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;

- (4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
- (5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
- (6) support an incarcerated person's right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.

Res. 440, A-04, Amended: BOT Action in response to referred for decision Res. 602, A-00, Reaffirmation I-09, Reaffirmation A-11, Reaffirmed: CSAPH Rep. 08, A-16, Reaffirmed: CMS Rep. 02, I-16, Appended: Res. 421, A-19, Appended: Res. 426, A-19

#### **Compassionate Release for Incarcerated Patients H-430.980**

Our AMA supports policies that facilitate compassionate release for incarcerated patients on the basis of serious medical conditions and advanced age; will collaborate with appropriate stakeholders to develop clear, evidence-based eligibility criteria for timely compassionate release; and promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.

BOT Rep. 10, I-20

#### **Dietary Intake of Incarcerated Populations D-430.995**

Our AMA: 1) urges the National Commission on Correctional Health Care, the American Correctional Association, and individual states to mandate adherence to the current Dietary Reference Intakes and Dietary Guidelines for Americans (with adjustments, as needed, for special populations) as a criterion for accreditation and/or standards compliance, until national dietary guidelines specific for adolescent and adult incarcerated populations becomes available; and 2) urges the Food and Nutrition Board of the Institute of Medicine to examine the nutrient status and dietary requirements of incarcerated populations and issue guidelines on menu planning for adolescent and adult incarcerated populations.

CSAPH Rep. 4, A-11, Reaffirmed: Res. 904, I-19

#### **Support for Standardized Diagnosis and Treatment of Hepatitis C Virus in the Population of Incarcerated Persons H-430.985**

Our AMA: (1) supports the implementation of routine screening for Hepatitis C virus (HCV) in prisons; (2) will advocate for the initiation of treatment for HCV when determined to be appropriate by the treating physician in incarcerated patients with the infection who are seeking treatment; and (3) supports negotiation for affordable pricing for therapies to treat and cure HCV among correctional facility health care providers, correctional facility health care payors, and drug companies to maximize access to these disease-altering medications.

Res. 404, A-17

#### **Increased Oversight of Suicide Prevention Training for Correctional Facility Staff H-430.984**

1. Our AMA strongly encourages all state and local adult and juvenile correctional facilities to develop a suicide prevention plan that meets current National Commission on Correctional Health Care standards for accreditation.

2. Our AMA strongly encourages all state and local adult and juvenile correctional facility officers to undergo suicide prevention training annually.

Res. 408, A-17

#### **Medications for Opioid Use Disorder in Correctional Facilities H-430.987**

1. Our AMA endorses: (a) the medical treatment model of employing medications for opioid use disorder (OUD) as the standard of care for persons with OUD who are incarcerated; and (b) medications for persons with OUD who are incarcerated, an endorsement in collaboration with relevant organizations including but not limited to the American Society of Addiction Medicine and the American Academy of Addiction Psychiatry.

2. Our AMA advocates for legislation, standards, policies and funding that require correctional facilities to increase access to evidence-based treatment of OUD, including initiation and continuation of medications for OUD, in conjunction with psychosocial treatment when desired by the person with OUD, in correctional facilities within the United States and that this apply to all individuals who are incarcerated, including individuals who are pregnant, postpartum, or parenting.

3. Our AMA advocates for legislation, standards, policies, and funding that require correctional facilities within the United States to work in ongoing collaboration with addiction treatment physician-led teams, case



managers, social workers, and pharmacies in the communities where patients, including individuals who are pregnant, postpartum, or parenting, are released to offer post-incarceration treatment plans for OUD, including education, medication for addiction treatment and counseling, and medication for preventing overdose deaths, including naloxone (or any other medication that is approved by the United States Food and Drug Administration for the treatment of an opioid overdose), and help ensure post-incarceration medical coverage and accessibility to mental health and substance use disorder treatments, that include medication and behavioral health and social supports for addiction treatment.

4. Our AMA advocates for all correctional facilities to use a validated screening tool to identify opioid withdrawal and take steps to determine potential need for treatment for OUD and opioid withdrawal syndrome for all persons upon entry.

Res. 443, A-05, Reaffirmed: CSAPH Rep. 1, A-15, Appended: Res. 223, I-17, Modified: Res. 503, A-21

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

1. Our AMA, in collaboration with state and national medical specialty societies and other relevant stakeholders, will advocate for the improvement of conditions of incarceration in all correctional and immigrant detention facilities to allow for the implementation of evidence-based COVID-19 infection prevention and control guidance.

2. Our AMA will advocate for adequate access to personal protective equipment and SARS-CoV-2 testing kits, sanitizing and disinfecting equipment for correctional and detention facilities.

3. Our AMA will advocate for humane and safe quarantine protocols for individuals who are incarcerated or detained that test positive for or are exposed to SARS-CoV-2, or other contagious respiratory pathogens.

4. Our AMA supports expanded data reporting, to include testing rates and demographic breakdown for SARS-CoV-2 and other contagious infectious disease cases and deaths in correctional and detention facilities.

5. Our AMA recognizes that detention center and correctional workers, incarcerated persons, and detained immigrants are at high-risk for COVID-19 infection and therefore should be prioritized in receiving access to safe, effective COVID-19 vaccine in the initial phases of distribution, and that this policy will be shared with the Advisory Committee on Immunization Practices for consideration in making their final recommendations on COVID-19 vaccine allocation.

6. Our AMA will advocate: (a) for all employees working in a correctional facility or detention center to be up to date with vaccinations against COVID-19, unless there is a valid medical contraindication; (b) for all employees working in a correctional facility or detention center, not up to date with vaccination for COVID-19 to be COVID rapid tested each time they enter a correctional facility or detention center, as consistent with Centers for Disease Control and Prevention (CDC) or local public health guidelines; (c) for correctional facility or detention center policies that require non-employed, non-residents (e.g. visitors, contractors, etc.) to either show evidence of being up to date for COVID-19 vaccines or show proof of a negative COVID test when they enter a correctional facility or detention center as consistent with CDC or local public health guidelines, at no cost to the visitor; (d) that all people inside a correctional facility or detention center wear an appropriate mask at all times, except while eating or drinking or at a 6 ft. distance from anyone else if local transmission rate is above low risk as determined by the CDC; and (e) that correctional facilities or detention centers be able to request and receive all necessary funding for COVID-19 vaccination and testing, according to CDC or local public health guidelines.

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

# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 904  
(I-22)

Introduced by: International Medical Graduates Section

Subject: Immigration Status Is a Public Health Issue

Referred to: Reference Committee K

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1 Whereas, There are 47 million foreign-born residents in the U.S. in 2022 (14.3% of the  
2 population) being the largest number ever recorded; and  
3

4 Whereas, The Census Bureau projects the foreign-born share of the U.S. population to continue  
5 to increase reaching 69 million by 2060; and  
6

7 Whereas, Immigration status is being increasingly recognized as a social determinant of health  
8 identifying the immigrant population as a vulnerable population that is at increased risk for poor  
9 physical, psychological and social health outcomes, and inadequate healthcare; and  
10

11 Whereas, Poor health outcomes among immigrants are not only dependent on socioeconomic  
12 characteristics, but often determined by factors that are unique for this population – language  
13 barriers, difficulty navigating the healthcare system, stigmatization, marginalization, and  
14 discrimination within the healthcare system, inability to have medical coverage, poor  
15 understanding of specific immigrants' health challenges by health professionals; and  
16

17 Whereas, Healthcare inequities among immigrants include not only personal medical services  
18 but also public health services and programs; for example, immunizations, often due to  
19 institutional, structural, and systemic factors; therefore be it  
20

21 RESOLVED, That our American Medical Association declare that immigration status is a public  
22 health issue that requires a comprehensive public health response and solution (Directive to  
23 Take Action); and be it further  
24

25 RESOLVED, That our AMA recognize interpersonal, institutional, structural, and systemic  
26 factors that negatively affect immigrants' health (New HOD Policy); and be it  
27

28 RESOLVED, That our AMA promote the development and implementation of educational  
29 resources for healthcare professionals to better understand health and healthcare challenges  
30 specific for the immigrant population (Directive to Take Action); and be it further  
31

32 RESOLVED, That our AMA support the development and implementation of public health  
33 policies and programs that aim to improve access to healthcare and minimize systemic health  
34 barriers for immigrant communities. (New HOD Policy)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 09/27/22

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## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 905  
(I-22)

Introduced by: Illinois

Subject: Minimal Age of Juvenile Justice Jurisdiction in the United States

Referred to: Reference Committee K

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1 Whereas, 27 states have no minimum age of juvenile adjudication; and

2  
3 Whereas, Without a minimal age law, children of any age can be arrested; and

4  
5 Whereas, Without minimal age law, children of any age can be charged with a juvenile violation;  
6 and

7  
8 Whereas, Without minimal age law, children of any age can be potentially incarcerated; and

9  
10 Whereas, Without minimal age law, racial injustice and health inequalities take place; and

11  
12 Whereas, Without minimal age law, families and individuals suffer economic burden, social  
13 disgrace and stigmatization impacting future life and employment; and

14  
15 Whereas, Evidence supports decriminalizing young children – providing them with appropriate  
16 support and avoiding handcuffs and cages – as a humane and productive approach with  
17 positive mental and physical health outcomes for the very young of society; and

18  
19 Whereas, The United Nations Standard Minimum Rules for the Administration of Juvenile  
20 Justice (The Beijing Rules) Rules do not set a minimum age, however, they set forth the  
21 considerations when setting a minimum age, such as the emotional, mental and intellectual  
22 maturity of the child; and

23  
24 Whereas, Research by the National Governors Association identifies 15 states that have set the  
25 minimum age at 10 years old for juvenile adjudication; therefore be it

26  
27 RESOLVED, That our American Medical Association create a policy to establish minimal age of  
28 10 years for juvenile justice jurisdiction in the United States (New HOD Policy); and be it further

29  
30 RESOLVED, That our AMA introduce legislation to establish minimal age of 10 for juvenile  
31 justice jurisdiction in the United States. (Directive to Take Action)

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

Received: 09/27/22

**REFERENCES:**

<https://www.nga.org/center/publications/age-boundaries-in-juvenile-justice-systems/>

<https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/beijingrules.pdf>

**RELEVANT AMA POLICY**

**Juvenile Justice System Reform H-60.919**

Our AMA:

1. Supports school discipline policies that permit reasonable discretion and consideration of mitigating circumstances when determining punishments rather than "zero tolerance" policies that mandate out-of-school suspension, expulsion, or the referral of students to the juvenile or criminal justice system.
2. Encourages continued research to identify programs and policies that are effective in reducing disproportionate minority contact across all decision points within the juvenile justice system.
3. Encourages states to increase the upper age of original juvenile court jurisdiction to at least 17 years of age.
4. Supports reforming laws and policies to reduce the number of youth transferred to adult criminal court.
5. Supports the re-authorization of federal programs for juvenile justice and delinquency prevention, which should include incentives for: (a) community-based alternatives for youth who pose little risk to public safety, (b) reentry and aftercare services to prevent recidivism, (c) policies that promote fairness to reduce disparities, and (d) the development and implementation of gender-responsive, trauma-informed programs and policies across juvenile justice systems.
6. Encourages juvenile justice facilities to adopt and implement policies to prohibit discrimination against youth on the basis of their sexual orientation, gender identity, or gender expression in order to advance the safety and well-being of youth and ensure equal access to treatment and services.
7. Encourages states to suspend rather than terminate Medicaid coverage following arrest and detention in order to facilitate faster reactivation and ensure continuity of health care services upon their return to the community.
8. Encourages Congress to enact legislation prohibiting evictions from public housing based solely on an individual's relationship to a wrongdoer, and encourages the Department of Housing and Urban Development and local public housing agencies to implement policies that support the use of discretion in making housing decisions, including consideration of the juvenile's rehabilitation efforts.

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

**Youth Incarceration in Adult Facilities H-60.916**

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

Citation: Alt. Res. 917, I-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 906  
(I-22)

Introduced by: New York

Subject: Requirement for COVID-19 Vaccination in Public Schools Once Fully  
FDA-Authorized

Referred to: Reference Committee K

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1 Whereas, COVID-19 vaccination has demonstrated safety effectiveness in preventing  
2 hospitalization and death for children and adolescents;<sup>1</sup> and  
3

4 Whereas, The risks of cardiac and thromboembolic complications from COVID-19 disease,  
5 including MIS-C, is far higher than the risk of myocarditis from vaccination;<sup>1,3</sup> and  
6

7 Whereas, COVID-19 vaccines reduce the risk of significant morbidity, including “long COVID”  
8 and missed days from school and work;<sup>1</sup> and  
9

10 Whereas, Children can serve as a pool for ongoing community spread of COVID-19 clusters  
11 and outbreaks;<sup>2</sup> and  
12

13 Whereas, Vaccination has been demonstrated to reduce overall community transmission of  
14 COVID-19;<sup>1-3</sup> and  
15

16 Whereas, Risk of exposure to COVID-19 poses significant concern for children with chronic  
17 medical conditions such as asthma, diabetes and developmental disorders;<sup>1,2</sup> therefore be it  
18

19 RESOLVED, That our American Medical Association encourage states to make COVID-19  
20 vaccination a requirement for school attendance for children and college/university students  
21 once the FDA grants full approval for COVID-19 vaccination for all relevant age groups. (New  
22 HOD Policy)

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

Received: 09/27/22

**REFERENCES:**

[https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/children-teens.html?s\\_cid=11368:age%20limit%20for%20covid%20vaccine:sem.ga:p:RG:GM:gen:PTN:FY21](https://www.cdc.gov/coronavirus/2019-ncov/vaccines/recommendations/children-teens.html?s_cid=11368:age%20limit%20for%20covid%20vaccine:sem.ga:p:RG:GM:gen:PTN:FY21)  
<https://www.cdc.gov/coronavirus/2019-ncov/groups/families-children.html>  
<https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html>

## **RELEVANT AMA POLICY**

### **Education and Public Awareness on Vaccine Safety and Efficacy H-440.830**

1. Our AMA (a) encourages the development and dissemination of evidence-based public awareness campaigns aimed at increasing vaccination rates; (b) encourages the development of educational materials that can be distributed to patients and their families clearly articulating the benefits of immunizations and highlighting the exemplary safety record of vaccines; (c) supports the development and evaluation, in collaboration with health care providers, of evidence-based educational resources to assist parents in educating and encouraging other parents who may be reluctant to vaccinate their children; (d) encourages physicians and state and local medical associations to work with public health officials to inform those who object to immunizations about the benefits of vaccinations and the risks to their own health and that of the general public if they refuse to accept them; (e) will promote the safety and efficacy of vaccines while rejecting claims that have no foundation in science; (f) supports state policies allowing minors to override their parent's refusal for vaccinations; and encourages state legislatures to establish comprehensive vaccine and minor consent policies; and (g) will continue its ongoing efforts with other immunization advocacy organizations to assist physicians and other health care professionals in effectively communicating to patients, parents, policy makers, and the media that vaccines do not cause autism and that decreasing immunization rates have resulted in a resurgence of vaccine-preventable diseases and deaths.
2. Our AMA: (a) supports the rigorous scientific process of the Advisory Committee on Immunization Practices as well as its development of recommended immunization schedules for the nation; (b) recognizes the substantial body of scientific evidence that has disproven a link between vaccines and autism; and (c) opposes the creation of a new federal commission on vaccine safety whose task is to study an association between autism and vaccines.

Citation: Res. 9, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 411, A-17; Modified: Res. 011, A-19;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 907  
(I-22)

Introduced by: American Academy of Physical Medicine and Rehabilitation

Subject: A National Strategy for Collaborative Engagement, Study, and Solutions to Reduce the Role of Illegal Firearms in Firearm Related Injury

Referred to: Reference Committee K

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Whereas, The AMA declared gun violence in the United States a national public health crisis (PHC) in 2016; and

Whereas, From January 1, 2022, through September 27, 2022, there were 32,944 gun violence deaths in the United States<sup>1</sup>, including 15,124 homicides, murders, and unintentional deaths; and

Whereas, At least 13% of mass shootings involve the use of illegally purchased weapons<sup>2</sup>; and

Whereas, Over 80% of individuals who engage in K-12 school shootings stole firearms from family members<sup>2</sup>, and

Whereas, From January 1, 2022, through September 27, 2022, there were 29,518 gun violence survivors<sup>1</sup> that were injured; and

Whereas, The economic cost of firearm injury in the United States is estimated to be \$557 billion per year<sup>3</sup>, including immediate costs such as hospital treatment, ambulances, and the police response; subsequent costs such as long-term physical and mental health care, rehabilitation care, institutional care, forgone earnings from disability or death, and criminal justice costs; and quality-of-life costs for pain and suffering over a victim's life span<sup>4</sup>; and

Whereas, The AMA has extensive policy calling for expansion of national research and mitigation strategies from entities such as the Centers for Disease Control and Prevention, the National Institutes of Health, and the United States Surgeon General to address our national firearm injury PHC; and

Whereas, These entities have failed to produce timely research, recommendations, and mitigation strategies to address the national firearm injury PHC; and

Whereas, The US Congress has struggled to develop non-partisan conversations around firearm safety strategies, but has recently taken the first step by passing the *S.2938: Bipartisan Safer Communities Act*<sup>5</sup>; and

Whereas, The majority of community gun violence<sup>6</sup> and firearm related crime in the United States occurs through the use of and access to illegal firearms<sup>7-18</sup>; and

Whereas, The AMA can help reorient the public and the national conversation about the national firearm injury PHC around public health in a solutions-oriented, unbiased, and non-partisan manner; therefore be it

RESOLVED, That our American Medical Association support research looking at the major sources of illegal gun supply, as well as possible methods of decreasing the proliferation of illegal firearms in the United States (New HOD Policy); and be it further



1 RESOLVED, That our AMA work with key stakeholders including, but not limited to, firearm  
2 manufacturers, firearm advocacy groups, law enforcement agencies, public health agencies, firearm  
3 injury victims advocacy groups, healthcare providers, and state and federal government agencies to  
4 study and develop evidence-informed public health recommendations to mitigate the effects of  
5 violence committed with illegal firearms (Directive to Take Action); and be it further  
6 RESOLVED, That our AMA convene national public forums including, but not limited to, online  
7 venues, national radio, and televised/streamed in-person town halls, that bring together key  
8 stakeholders and members of the general public to focus on finding common ground, non-partisan  
9 measures to mitigate the effects of illegal firearms in our firearm injury public health crisis (Directive  
10 to Take Action); and be it further  
11 RESOLVED, That our AMA reaffirm House policies H-145.975, H-145.984, H-145.997, D-145.994,  
12 and D-145.999 calling for increased funding for national firearm violence research. (Reaffirm HOD  
13 Policy)

Fiscal Note: Not yet determined

Received: 09/28/22

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## RELEVANT AMA POLICY

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

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.
  2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
  3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
- Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 3, A-21

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

1. Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths.  
Therefore, the AMA:  
(A) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;  
(B) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;  
(C) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;  
(D) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;  
(E) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;  
(F) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and  
(G) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
  2. Our AMA will advocate for firearm safety features, including but not limited to mechanical or smart technology, to reduce accidental discharge of a firearm or misappropriation of the weapon by a non-registered user; and support legislation and regulation to standardize the use of these firearm safety features on weapons sold for non-military and non-peace officer use within the U.S.; with the aim of establishing manufacturer liability for the absence of safety features on newly manufactured firearms.
- Citation: CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13; Reaffirmed: CSAPH Rep. 04, A-18; Reaffirmation: A-18; Reaffirmation: I-18; Appended: Res. 405, A-19

**Data on Firearm Deaths and Injuries H-145.984**

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

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

**Epidemiology of Firearm Injuries D-145.999**

Our AMA will: (1) strongly urge the Administration and Congress to encourage the Centers for Disease Control and Prevention to conduct an epidemiological analysis of the data of firearm-related injuries and deaths; and (2) urge Congress to provide sufficient resources to enable the CDC to collect and analyze firearm-related injury data and report to Congress and the nation via a broadly disseminated document, so that physicians and other health care providers, law enforcement and society at large may be able to prevent injury, death and the other costs to society resulting from firearms.

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

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

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

Citation: Res. 214, I-16

**Removing Restrictions on Federal Funding for Firearm Violence Research D-145.994**

Our AMA will provide an informational report on recent and current organizational actions taken on our existing AMA policies (e.g. H-145.997) regarding removing the restrictions on federal funding for firearms violence research, with additional recommendations on any ongoing or proposed upcoming actions.

Citation: Res. 201, I-16

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

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

Citation: (Res. 410, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 908  
(I-22)

Introduced by: Senior Physicians Section

Subject: Older Adults and the 988 Suicide and Crisis Lifeline

Referred to: Reference Committee K

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1 Whereas, Suicide is the 12th leading cause of death in the United States (2020), and is a public  
2 health issue for individuals and for the communities they live in;<sup>1</sup> and  
3

4 Whereas, While older adults comprise just 12% of the population, they make up approximately  
5 18% of all suicide deaths;<sup>2</sup> and  
6

7 Whereas, Among people who attempt suicide, one in four seniors will succeed, compared to 1  
8 in 200 youths;<sup>3</sup> and  
9

10 Whereas, The new mental health line, known as the 988 Suicide and Crisis Lifeline, was  
11 launched nationally on July 1, 2022; and  
12

13 Whereas, The Department of Health and Human Services (HHS) through its Substance Abuse  
14 and Mental Health Services Administration, has awarded nearly \$105 million in grant funding,  
15 provided by the American Rescue Plan, to 54 states and territories in advance of the transition  
16 of the National Suicide Prevention Lifeline;<sup>4</sup> and

17 Whereas, With States having varying degrees of operational readiness, the success of 988 now  
18 is important to get activated; and

19 Whereas, The 988 number currently does not designate priority by age group; and  
20

21 Whereas, Seniors who are homebound may lack the social connections they need and call  
22 centers are expected to be appropriately funded and staffed with properly trained operators to  
23 handle suicide risk; therefore be it  
24

25 RESOLVED, That our American Medical Association, with other interested organizations,  
26 develop model legislation for use by states who wish to pursue funding for the 988 Suicide and  
27 Crisis Lifeline (Directive to Take Action); and be it further  
28

29 RESOLVED, That our AMA advocate that the Department of Health and Human Services (HHS)  
30 prioritize education and outreach activities for use of the 988 Suicide and Crisis Lifeline to those  
31 who are at highest risk for suicide completion with a special emphasis on those over age 65.  
32 (Directive to Take Action)

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

Received: 09/29/22

**REFERENCES:**

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**RELEVANT AMA POLICY**

**Awareness Campaign for 988 National Suicide Prevention Lifeline D-345.974**

Our AMA will: (1) utilize their existing communications channels to educate the physician community and the public on the new 9-8-8 National Suicide Prevention Lifeline program; (2) work with the Federation and other stakeholders to advocate for adequate federal and state funding for the 9-8-8 system; and (3) collaborate with the Substance Abuse and Mental Health Services Administration and the 9-8-8 partner community to strengthen suicide prevention and mental health crisis services.

Citation: Res. 423, A-22

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 909  
(I-22)

Introduced by: Senior Physicians Section

Subject: Decreasing Gun Violence and Suicide in Seniors

Referred to: Reference Committee K

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1 Whereas, Our AMA has recognized that gun violence is an urgent public health crisis; and

2  
3 Whereas, While most media attention focuses on mass shootings, the majority (60%) of gun  
4 related deaths are in fact due to suicide;<sup>1</sup> and

5  
6 Whereas, The prototypical gun related suicide happens in older, rural, white males;<sup>2</sup> and

7  
8 Whereas, Suicide is often an impulsive act amenable to intervention; and

9  
10 Whereas, New federal legislation facilitates universal adoption of Extreme Risk Protection  
11 Orders (Red Flag laws);<sup>3</sup> and

12  
13 Whereas, One of the barriers to addressing this crisis is that clinicians are often hesitant to  
14 discuss and counsel about firearm safety;<sup>4</sup> therefore be it

15  
16 RESOLVED, That our American Medical Association and other organizations develop and  
17 disseminate a formal educational program to enable clinicians to effectively and efficiently  
18 address suicides with an emphasis on seniors and firearms (Directive to Take Action); and be it  
19 further

20  
21 RESOLVED, That our AMA develop with other interested organizations a toolkit for clinicians to  
22 use addressing Extreme Risk Protection Orders in their individual states (Directive to Take  
23 Action); and be it further

24  
25 RESOLVED, That our AMA partner with other groups interested in firearm safety to raise public  
26 awareness of magnitude and interventions available regarding senior suicides and firearms.  
27 (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 09/29/22

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## RELEVANT AMA POLICY

### Firearms and High-Risk Individuals H-145.972

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

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

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

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

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

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

Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16; Reaffirmed: BOT Rep. 28, A-18; Reaffirmation: A-18; Modified: CSAPH Rep. 04, A-18; Reaffirmation: I-18; Reaffirmed: CSAPH Rep. 3, A-21

### Ban on Handguns and Automatic Repeating Weapons H-145.985

It is the policy of the AMA to:

(1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to:

(a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers;

(b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21;

(c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel);

(d) the imposition of significant licensing fees for firearms dealers;

(e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and

(f) mandatory destruction of any weapons obtained in local buy-back programs.

(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.

(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.

(4) Oppose concealed carry reciprocity federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.

(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.

Citation: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-14; Appended: Res. 427, A-18; Reaffirmation: A-18; Modified: Res. 244, A-18;

#### **Gun Violence as a Public Health Crisis D-145.995**

Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and

(2) will actively lobby Congress to lift the gun violence research ban.

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

#### **Firearm Availability H-145.996**

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

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

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

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



## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 910  
(I-22)

Introduced by: Resident and Fellow Section

Subject: Gonad Shields: Regulatory and Legislation Advocacy to Oppose Routine Use

Referred to: Reference Committee K

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1 Whereas, Led by the Society of Pediatric Radiology (SPR), the Image Gently Alliance was  
2 formed in late 2006 with the goal of “changing practice by raising awareness of the opportunities  
3 to lower radiation dose in the imaging of children” (1); and  
4

5 Whereas, The SPR recruited other organizations/members of the imaging team into the alliance  
6 in 2007 including the American College of Radiology (ACR), American Association of Physicists  
7 in Medicine (AAPM), and American Society of Radiologic Technologists (ASRT) (1); and  
8

9 Whereas, The practice of shielding reproductive organs and in utero fetuses began in the 1950s  
10 given concerns about the long-term effects of radiation and the potential for passing on genetic  
11 mutations through genetic inheritance (2,3); and  
12

13 Whereas, In response to these concerns, state and federal laws and regulations have been  
14 created requiring the use of gonad shields in medical imaging studies (4,5); and  
15

16 Whereas, Through technological advances, medical physicists estimate the dose from routine  
17 diagnostic imaging to reproductive organs has been reduced by 95% without compromising  
18 diagnostic quality (2,3); and  
19

20 Whereas, Technological advances and optimization have resulted in marginal hereditary risk  
21 reduction from gonad shielding ranging from  $1 \times 10^{-6}$  in women and  $5 \times 10^{-6}$  in men (6); and  
22

23 Whereas, Research on radiation dosing has shown that routine diagnostic imaging does not  
24 produce harmful levels of radiation to patients and fetuses (2,3); and  
25

26 Whereas, Modern mechanisms to optimize imaging parameters such as automatic exposure  
27 control (AEC) are negatively affected by shielding (7); and  
28

29 Whereas, The gonad shield results in decreased activity on the detector, triggering AEC to  
30 increase radiation output, which results in increased exposure and patient dose along with the  
31 degradation of image quality (7); and  
32

33 Whereas, The gonad shield produces artifacts and can obscure relevant anatomy and  
34 diagnostic information (7); and  
35

36 Whereas, Non-diagnostic or obscured images may need to be repeated increasing patient dose  
37 when shields are used (7); and  
38

39 Whereas, The gonad surface shield is ineffective at reducing internal scatter (7); and

Whereas, Studies have shown that gonad shields are incorrectly placed for females in 91% of radiographs and for males in 66% of radiographs, rendering them ineffective (8,9); and

Whereas, On January 12th, 2021, the National Council on Radiation Protection and Measurements (NCRP) issued a statement that the risks of utilizing gonad shields far outweigh the negligible benefits to reproductive organs and therefore they should not be routinely used (10); and

Whereas, Similar statements opposing routine or mandatory use of gonadal shields were released by the ACR and the AAPM in 2019 and by the ASRT in 2021 (11,12); therefore be it

RESOLVED, That our American Medical Association oppose mandatory use of gonad shields in medical imaging considering the risks far outweigh the benefits (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that the U.S. Food and Drug Administration amend the code of federal regulations to oppose the routine use of gonad shields in medical imaging (Directive to Take Action); and be it further

RESOLVED, That our AMA, in conjunction with state medical societies, support model state and national legislation to oppose or repeal mandatory use of gonad shields in medical imaging (New HOD Policy)

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

Received: 09/30/22

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## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 911  
(I-22)

Introduced by: Society for Cardiovascular Angiography & Interventions

Subject: Critical Need for National Emergency Cardiac Care (ECC) System to Ensure Individualized, State-Wide, Care for ST Segment Elevation Myocardial Infarction (STEMI), Cardiogenic Shock (CS) and Out-of-Hospital Cardiac Arrest (OHCA), and to Reduce Disparities in Health Care for Patients with Cardiac Emergencies

Referred to: Reference Committee K

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1 Whereas, Cardiovascular Disease is the number one cause of death for men and women in the  
2 United States<sup>1</sup>, and  
3

4 Whereas, The Acute Coronary Syndromes of unstable angina pectoris (USAP), Non-ST  
5 segment Elevation MI (NSTEMI) and STEMI are major causes of death and disability<sup>1,4,8</sup>, and  
6

7 Whereas, Survival for uncomplicated STEMI patients has dramatically improved over the last 6  
8 decades (> 97% survival rate) with the implementation of systems of Emergency Cardiac Care  
9 (ECC), survival for STEMI with cardiogenic shock (CS) is unacceptably high<sup>2,3,4,8</sup>, and  
10

11 Whereas, STEMI patients with cardiogenic shock (STEMI-CS) have mortality rates near 50%,  
12 except in some U.S. localities where the survival rates may be as high as 70% because of  
13 specialized medical centers that provide care teams and therapeutic modalities, like early use of  
14 Mechanical Circulatory Support (MCS), shock teams and coronary revascularization, through  
15 organized systems of ECC<sup>2,3,8</sup>, and  
16

17 Whereas, Out-of-Hospital Cardiac Arrest (OHCA) is the fifth most common cause of death in the  
18 United States, accounting for more deaths than colon cancer, breast cancer, prostate cancer,  
19 influenza, pneumonia, HIV, firearms and house fires combined<sup>5,6,7</sup>, and  
20

21 Whereas, 90% of OHCA occur in the home or workplace and these patients require intense and  
22 precisely orchestrated ECC on site, during transportation by Emergency Medical  
23 Technicians/Paramedics, and subsequent ECC as inpatients<sup>6</sup>, and  
24

25 Whereas, Survival for patients with OHCA and refractory ventricular fibrillation is markedly  
26 improved, from less than 10% to over 40%, when systems of ECC include uniquely applied  
27 invasive procedures like emergent Extracorporeal Membrane Oxygenation (ECMO/ECPR)<sup>8</sup>, and  
28

29 Whereas, Specialized systems of ECC, designed for coordinating and escalating cardiovascular  
30 care for patients with STEMI, STEMI-CS and OHCA, in some States, have produced significant  
31 improvements in survival for these catastrophic cardiovascular disorders<sup>4,8,14,17</sup>, and  
32

33 Whereas, STEMI and STEMI-CS care is provided in a disparate manner to sociodemographic  
34 groups like the elderly, women, Black and Hispanic patients<sup>9,10</sup> with Black and Hispanic women  
35 having the highest mortality (29% and 46%, respectively), and

Whereas, Hospitals of different sizes, in diverse geographic and socioeconomic locations with varying clinical capabilities, provide different levels of ECC, and pre-hospital care can be quite variable<sup>11,12</sup>, there is a need to systematize ECC in the United States because standardization of systems of ECC<sup>13,14</sup>, results in improved treatment times and survival for patients with STEMI, STEMI-CS and OHCA<sup>4,5,7,8,13,14,15,17</sup>, and

Whereas, The implementation of systems of care for ECC, with strict protocol adherence, diminishes treatment disparities between sociodemographic groups<sup>15,16</sup>, and

Whereas, States that have addressed ECC solutions, unique to their State, some with laws<sup>18</sup> and others with State-wide clinical agreements between health systems and physicians<sup>19</sup>, therefore be it

RESOLVED, That our American Medical Association encourage each state to standardize pre-hospital and inpatient care for cardiac emergencies, with individualized systems of Emergency Cardiac Care (ECC), specific for each state, to improve care and enhance survival for all patients, especially for those citizens who receive sociodemographically disparate care, when they present with cardiac emergencies (STEMI, STEMI-CS and OHCA) (New HOD Policy); and be it therefore,

RESOLVED, That our AMA encourage states to designate hospitals as ECC Centers based on their individual capabilities to provide ECC, much like the designations and systems of care for Stroke and Trauma Centers. (New HOD Policy)

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

Received: 09/30/22

**Abbreviations:**

Acute Coronary Syndrome – ACS

Cardiogenic Shock – CS

Emergency Cardiac Care – ECC

Extracorporeal Membrane Oxygenation – ECMO

Extracorporeal Membrane Oxygenation facilitated Cardio-Pulmonary Resuscitation - ECPR

Mechanical Circulatory Support – MCS

Myocardial Infarction – MI

Out of Hospital Cardiac Arrest – OHCA

ST segment Elevation Myocardial Infarction – STEMI

ST segment Elevation Myocardial Infarction with Cardiogenic Shock – STEMI-CS

Unstable Angina Pectoris – USAP

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## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 912  
(I-22)

Introduced by: Medical Student Section

Subject: Reevaluating the Food and Drug Administration's Citizen Petition Process

Referred to: Reference Committee K

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1 Whereas, Pharmaceutical drug prices in the United States are increasing at an alarming rate  
2 and are more expensive than the rest of the industrialized world<sup>1-3</sup>; and  
3

4 Whereas, Although brand name drugs account for about 15% of prescriptions dispensed by  
5 Medicaid and Medicare Part D, they account for about 75-80% spending on prescription  
6 drugs<sup>1,4</sup>; and  
7

8 Whereas, In many situations, generic and brand name medications have the same clinical  
9 efficacy, risks and benefits because they have the same active ingredients and mechanism of  
10 action<sup>5</sup>; and  
11

12 Whereas, Competition between generic drug companies and brand name manufacturers  
13 typically results in an 85% price reduction, and generic drugs saved the U.S. healthcare system  
14 \$1.67 trillion from 2007 to 2016<sup>5,6</sup>; and  
15

16 Whereas, The Food and Drug Administration's (FDA) citizen petition process is intended as a  
17 method for average individuals, industry or consumer groups to formally request the FDA  
18 commissioner to invoke, amend, or revoke directives or pharmaceutical monographs as a  
19 democratic and transparent mode of regulation<sup>7,8</sup>; and  
20

21 Whereas, Manufacturers of brand name drugs employ strategies including filing petitions to the  
22 FDA that delay and prevent the entry of generic drugs into the market and prevent this loss of  
23 profit<sup>9-11</sup>; and  
24

25 Whereas, An estimated 92% of citizen petitions filed against generic brands are filed by brand-  
26 name manufacturers<sup>12</sup>; and  
27

28 Whereas, One of every five citizen petitions filed by brand-name manufacturers (including but  
29 not limited to pharmaceutical drugs) has had the potential to delay generic entry into the  
30 market<sup>13,14</sup>; and  
31

32 Whereas, An analysis of four frivolous citizen petitions filed by brand-name manufacturers in a  
33 2-year span found a total market delay time of 521 days (against generic drugs) which cost  
34 approximately \$782 million to government-provided insurance programs and \$1.9 billion total<sup>15</sup>;  
35 and  
36

37 Whereas, The Federal Trade Commission (FTC) has filed a formal complaint that these  
38 "repetitive, serial, and meritless filings lacked any supporting clinical data" that have  
39 "succeeded in delaying generic entry at a cost of hundreds of millions of dollars to patients and  
40 other purchasers"<sup>16</sup>; and

Whereas, Despite the overwhelming empirical data on the abuse of the FDA citizen petition process, there is minimal official data on the true cost to society<sup>15</sup>; and

Whereas, The FDA is not obligated to nor does it actively report to Congress which petitions have been filed fraudulently or the nature of generic entry market delay<sup>17</sup>; and

Whereas, Increasing the transparency of the citizen petition process would facilitate more thorough research and analysis of petitions and lower unnecessary resource expenditure by the FDA<sup>17</sup>; therefore be it

RESOLVED, That our American Medical Association support the research of anti-competitive practices on the Food and Drug Administration's (FDA) citizen petitions process (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for further public transparency by the FDA in the content of each petition, the relationship between citizen petitions and decisions to delay generic approval, and the time and resources expended on petition reviews. (Directive to Take Action)

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

Received: 10/05/22

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## RELEVANT AMA POLICY

### Pharmaceutical Costs H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
  2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
  3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
  4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
  5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
  6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
  7. Our AMA supports legislation to shorten the exclusivity period for biologics.
  8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
  9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
  10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
  11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
  12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
  13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
  14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.
- Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21;



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 913  
(I-22)

Introduced by: Medical Student Section

Subject: Supporting and Funding Sobering Centers

Referred to: Reference Committee K

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1 Whereas, Public intoxication related charges were among the top ten reasons for arrest in the  
2 United States (US) in 2019, with over 450,000 arrests<sup>1</sup>; and  
3

4 Whereas, In the US, Black, American Indian, and Alaska Native people are arrested at greater  
5 annual rates per capita for public intoxication charges than those who are White<sup>1</sup>; and  
6

7 Whereas, Several sobering centers are led by Alaska Native tribal organizations and have led to  
8 reduced incarceration rates per capita for public intoxication among Alaska Natives<sup>2</sup>; and  
9

10 Whereas, Specialty and hospital-based treatments for acute alcohol intoxication account for  
11 \$24.6 billion in healthcare costs, with most patients seeking care in emergency departments<sup>3</sup>;  
12 and  
13

14 Whereas, The number of acute alcohol-related emergency department visits increased from  
15 1,801,006 in 2006 to 2,728,313 in 2014, indicating a growing need for substance use disorder  
16 resources and interventions<sup>4</sup>; and  
17

18 Whereas, The US has the highest incarceration rate in the world and incarceration can result in  
19 a series of social sequelae affecting a person's ability to maintain housing, personal health,  
20 employment, and other necessities<sup>5</sup>; and  
21

22 Whereas, A growing number of local jurisdictions within the US and nations around the globe  
23 are shifting towards a health-based response to public intoxication, as opposed to  
24 criminalization<sup>6</sup>; and  
25

26 Whereas, At least 35 sobering centers across 14 US states currently function to safely lead  
27 those acutely intoxicated by various substances to recover under medical observation and to  
28 connect them with substance use disorder recovery programs<sup>7, 8</sup>; and  
29

30 Whereas, Sobering centers are able to treat patients with substance use disorders and are well  
31 positioned to provide services to those disadvantaged by other social barriers, including persons  
32 experiencing homelessness<sup>9</sup>; and  
33

34 Whereas, Houston Recovery Center in Houston, Texas is a nationally recognized sobering  
35 center model, serving the largest metropolitan population among all sobering centers in the  
36 United States<sup>8</sup>; and  
37

38 Whereas, Jail admissions for public intoxication in Harris County, Texas decreased by 95  
39 percent (from 15,357 to 835) from 2012 to 2017 following the opening of the Houston Recovery  
40 Center<sup>10</sup>; and

1 Whereas, A jail admission in Harris County was reported to cost \$286 per day while the  
2 sobering center at full capacity would cost \$127 per admission, allowing Harris County to view  
3 the program as a cost-offset<sup>10</sup>; and  
4

5 Whereas, The primary workforce of the Houston Recovery Center consists of Texas state-  
6 certified peer recovery support specialists who work alongside nurses, licensed chemical  
7 dependency counselors, emergency medical technicians, social workers, and civilians with  
8 institution-specific training who provide comprehensive services<sup>11</sup>; and  
9

10 Whereas, Sobering centers accept clients through multiple referral sources including ambulatory  
11 and vehicular outreach teams, walk-ins, police, emergency medical services, and emergency  
12 departments<sup>11</sup>; and  
13

14 Whereas, Forty-eight percent of the 25,282 clients admitted to the Houston Recovery Center  
15 over 5 years accepted referral to additional services, requested housing assistance, or enrolled  
16 in treatment upon discharge<sup>10</sup>; and  
17

18 Whereas, In 2014 the Houston Recovery Center launched the Partners in Recovery (PIR)  
19 program designed to address substance use among low-income, uninsured clients with complex  
20 needs and more than two admissions to the sobering center<sup>12</sup>; and  
21

22 Whereas, The PIR Houston Recovery Center is able to practice a proactive intervention strategy  
23 by working with individuals with active substance use disorders in criminal justice and street  
24 outreach settings<sup>12</sup>; and  
25

26 Whereas, A modeling study with a sobering center diversion rate of 50 percent resulted in an  
27 estimated annual national savings ranging from \$230 million to \$1.0 billion<sup>13</sup>; and  
28

29 Whereas, The City of Houston reported a \$2.9 million positive fiscal impact in the first 20  
30 months after sobering center operation<sup>14</sup>; and  
31

32 Whereas, Estimated national savings range from \$230 million to \$1.0 billion annually based on  
33 Monte Carlo modeling with a sobering center diversion rate of 50%<sup>15</sup>; and  
34

35 Whereas, Cost analysis of the San Francisco Sobering Center comparing direct costs of  
36 emergency department to per-encounter costs at the Sobering Center found significantly less  
37 cost for care of acute intoxication than in the emergency department, leading to savings of \$243  
38 per patient<sup>16</sup>; and  
39

40 Whereas, A review done by Santa Cruz Recovery Center in 2018 reported a 86% decline in  
41 time spent by law enforcement processing public inebriates, with a 53% decline from 2014 to  
42 2017 in average monthly jail bookings translating into \$83,290 savings in officer costs<sup>17</sup>;  
43 therefore be it  
44

45 RESOLVED, That our American Medical Association recognize the utility, cost effectiveness,  
46 and racial justice impact of sobering centers (New HOD Policy); and be it further  
47

48 RESOLVED, That our AMA support the maintenance and expansion of sobering centers (New  
49 HOD Policy); and be it further  
50

51 RESOLVED, That our AMA support ongoing research of the sobering center public health  
52 model (New HOD Policy); and be it further

- 1 RESOLVED, That our AMA support the use of state and national funding for the development  
2 and maintenance of sobering centers. (New HOD Policy)

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

Received: 10/05/22

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#### RELEVANT AMA POLICY

##### Substance Use and Substance Use Disorders H-95.922

Our AMA:

- (1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;
- (2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to

communicate the fact that substance use disorder is a treatable disease; and  
(3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

Citation: CSAPH Rep. 01, A-18; Reaffirmed: BOT Rep. 14, I-20

#### **Harmful Substance Use H-95.967**

Our AMA encourages every physician to make a commitment to join his/her community in attempting to reduce harmful substance use and that said commitment encourage involvement in at least one of the following roles: (1) donation of time to talk to local civic groups, schools, religious institutions, and other appropriate groups about harmful substance use; (2) join or organize local groups dedicated to the prevention of harmful substance use; (3) talk to youth groups about brain damage and other deleterious effects of harmful substance use; and (4) educate and support legislators, office holders and local leaders about ways to end harmful substance use and providing adequate treatment to patients with substance use disorder.

Citation: Sub. Res. 36, I-90; Modified: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20

#### **Increased Funding for Substance Use Disorder Treatment H-95.973**

Our AMA (1) urges Congress to substantially increase its funding for substance use disorder treatment programs; (2) urges Congress to increase funding for the expansion and creation of new staff training programs; and (3) urges state medical societies to press for greater commitment of funds by state and local government to expand the quantity and improve the quality of the substance use disorder treatment system.

Citation: Res. 116, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: CSAPH Rep. 01, A-20

#### **Involuntary Civic Commitment for Substance Use Disorder H-95.912**

Our AMA opposes civil commitment proceedings for patients with a substance use disorder unless: a) a physician or mental health professional determines that civil commitment is in the patient's best interest consistent with the AMA Code of Medical Ethics; b) judicial oversight is present to ensure that the patient can exercise his or her right to oppose the civil commitment; c) the patient will be treated in a medical or other health care facility that is staffed with medical professionals with training in mental illness and addiction, including medications to help with withdrawal and other symptoms as prescribed by his or her physician; and d) the facility is separate and distinct from a correctional facility.

Citation: BOT Rep. 7, I-20

#### **Addiction and Unhealthy Substance Use H-95.976**

Our AMA is committed to efforts that can help the national problem of addiction and unhealthy substance use from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:

- (1) supports cooperation in activities of organizations in fostering education, research, prevention, and treatment of addiction;
- (2) encourages the development of addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;
- (3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;
- (4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;
- (5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the Substance Abuse and Mental Health Services Administration to continue to support research and demonstration projects around effective prevention and intervention strategies;

(6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco use disorder as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;

(7) affirms the concept that addiction is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and

(8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction.

Citation: BOT Rep. Y, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmation A-09; Modified: CSAPH Rep. 01, A-19

#### **Federal Drug Policy in the United States H-95.981**

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

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

#### **Community-Based Treatment Centers H-160.963**

Our AMA supports the use of community-based treatment centers for substance use disorders, mental health disorders and developmental disabilities.

Citation: BOT Rep. F, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Modified: CSAPH Rep. 1, A-21

#### **Involuntary Civic Commitment for Substance Use Disorder D-95.963**

Our AMA will continue its work to advance policy and programmatic efforts to address gaps in voluntary substance use treatment services.

Citation: BOT Rep. 7, I-20

#### **AMA Support for Justice Reinvestment Initiatives H-95.931**

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

Citation: Res. 205, A-16

#### **Substance Use Disorders as a Public Health Hazard H-95.975**

Our AMA: (1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach;

(2) declares substance use disorders are a public health priority;

(3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction;

(4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and

(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances.

Citation: Res. 7, I-89; Appended: Sub. Res. 401, Reaffirmed: Sunset Rep., I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 01, A-19

**Enhanced Funding for and Access to Outpatient Addiction Rehabilitation D-95.962**

Our AMA will advocate for: (1) the expansion of federal grants in support of treatment for a substance use disorder to states that are conditioned on that state's adoption of law and/or regulation that prohibit drug courts, recovery homes, sober houses, correctional settings, and other similar programs from denying entry or ongoing care if a patient is receiving medication for an opioid use disorder or other chronic medical condition; and (2) sustained funding to states in support of evidence-based treatment for patients with a substance use disorder and/or co-occurring mental disorder, such as that put forward by the American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry and other professional medical organizations.

Citation: BOT Rep.14, I-20

**Increasing Detection of Mental Illness and Encouraging Education D-345.994**

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

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

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

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 915  
(I-22)

Introduced by: Washington

Subject: Pulse Oximetry in Patients with Pigmented Skin

Referred to: Reference Committee K

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1 Whereas, Awareness of concerns on the accuracy of pulse oximetry in pigmented skin has  
2 been noted since the 1970s and the Hewlett Packard Model 47021A Oximeter was designed in  
3 that era specifically with the ability to calibrate for various degrees of skin pigmentation<sup>4</sup>; and  
4

5 Whereas, The Journal of the American Medical Association (JAMA) has reported an increased  
6 incidence of hidden hypoxemia (SaO<sub>2</sub> <88% despite SpO<sub>2</sub> ≥88%) in racial and ethnic minority  
7 groups – specifically Black, Hispanic, and Asian groups – with an associated increase in major  
8 organ dysfunction at 24 hours in otherwise matched groups and increased in-hospital mortality;  
9 and  
10

11 Whereas, The British Medical Journal has reported that in general care inpatient settings across  
12 the Veterans Health Administration where paired readings of arterial blood gas and pulse  
13 oximetry were obtained, black patients had higher odds than white patients of having occult  
14 hypoxemia noted on arterial blood gas but not detected by pulse oximetry; and  
15

16 Whereas, JAMA Internal Medicine has reported that greater occult hypoxemia in Asian, Black,  
17 and non-Black Hispanic patients with COVID-19, which was associated with significantly  
18 delayed or unrecognized eligibility for COVID-19 therapies among Black and Hispanic patients;  
19 and  
20

21 Whereas, The Critical Care Societies Collaborative has urged the FDA to direct pulse oximeter  
22 manufacturers to conduct the tests needed to ensure that their devices provide accurate and  
23 reliable readings for patients with diverse degrees of skin pigmentation; and  
24

25 Whereas, The FDA has acknowledged that skin pigmentation can affect the accuracy of pulse  
26 oximetry readings and is planning to convene a public meeting of the Medical Devices Advisory  
27 Committee later this year to discuss available evidence about the accuracy of pulse oximeters,  
28 recommendations for patients and health care providers, the amount and type of data that  
29 should be provided by manufacturers to assess pulse oximeter accuracy, and to guide other  
30 regulatory actions as needed; therefore be it  
31

32 RESOLVED, That our American Medical Association make recommendations to the US Food  
33 and Drug Administration that will ensure pulse oximeters provide accurate and reliable readings  
34 for patients with diverse degrees of skin pigmentation. (Directive to Take Action)

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

Received: 10/10/22

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 916  
(I-22)

Introduced by: Medical Student Section

Subject: Non-Cervical HPV Associated Cancer Prevention

Referred to: Reference Committee K

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1 Whereas, While Human Papillomavirus (HPV) infection with high risk strains is a well-known risk  
2 factor for cervical cancer and widespread efforts have been made to educate healthcare  
3 providers and the public about screening and vaccination for cervical cancer prevention, HPV  
4 infection has also been associated with the development of other cancers such as vulvar,  
5 vaginal, head and neck, penile, and anal cancer, among others<sup>1-5</sup>; and  
6

7 Whereas, Of the approximately 34,800 new cases of HPV-related cancer diagnoses in the U.S.  
8 annually, less than one third are due to cervical cancer and 40% are found in males<sup>6</sup>; and  
9

10 Whereas, HPV associated head and neck cancer predominates in males in a ratio of 8:1 and  
11 has increased in prevalence by 225% since the 1980s, and the annual number of cases are  
12 expected to surpass the annual number of cervical cancers per year by 2020<sup>7</sup>; and  
13

14 Whereas, HPV vaccination has been recommended by the U.S. Food and Drug Administration  
15 (FDA) for females ages 9 to 26 for cervical, vulvar, and vaginal cancer prevention since 2006,  
16 all individuals for the prevention of anal cancer since 2010, individuals up to age 45 that may be  
17 at higher risk of infection since 2018, and for head and neck cancer prevention since 2020<sup>10,11</sup>;  
18 and  
19

20 Whereas, Despite HPV vaccination being recommended for all individuals, vaccination rates are  
21 still suboptimal, and significantly lower for males (27.4% - 56%) compared to females (45.7% -  
22 65%), with approximately 37% of individuals receiving all three doses<sup>12-15</sup>; and  
23

24 Whereas, It has been hypothesized that vaccination rates are suboptimal in part due to a  
25 “feminization of HPV” that evolved from a focus on cervical cancer screening and the  
26 conception of women bearing the burden of HPV related illness, which suggests that  
27 vaccination rates may increase if stakeholders actively work to normalize HPV vaccination as an  
28 important gender-neutral component of routine healthcare<sup>16</sup>; and  
29

30 Whereas, A 2019 meta-analysis showed that healthcare professionals’ knowledge and  
31 counseling tendencies regarding HPV infection and vaccination remain low and are crucial to  
32 vaccine uptake; notably many providers are unaware that HPV is associated with non-cervical  
33 cancers and that the HPV vaccine can prevent non-cervical cancers<sup>17-20</sup>; and  
34

35 Whereas, In a study of pediatric residents and fellows, 68.3% rated their prior education as  
36 “none” or “fair” regarding HPV related head and neck cancer and over half reported “never”  
37 discussing it with their patients, in contrast to 70.9% who rated their education on cervical  
38 cancer as “good” or “excellent”, and 95% indicated a need for increased HPV education<sup>21</sup>; and

1 Whereas Studies have shown adults have a general lack of knowledge about HPV vaccinations  
2 and less than a third are aware of the association with non-cervical cancers, which has been  
3 associated with lower vaccination rates for themselves and their children<sup>22,23</sup>; and  
4

5 Whereas, While current AMA policies (H-440.872 and H-370.995) address increasing physician  
6 and public education about HPV and cervical cancer, these current policies fail to explicitly  
7 address other HPV related cancers beyond cervical cancer, thereby potentially perpetuating  
8 prevalent misconceptions regarding the scope of HPV related cancers; and  
9

10 Whereas, The Advisory Committee on Immunization Practices support removing barriers to  
11 vaccination access including offering immunizations in schools increasing access and follow up  
12 at appropriate intervals for patients that may have difficulty obtaining their vaccinations<sup>25,26</sup>;  
13 and  
14

15 Whereas, While School-based HPV vaccination programs utilized in several other countries  
16 have resulted in the highest vaccination rates in the world, ranging from 69 to 90%, and large  
17 decreases in HPV related cancers, school-based HPV vaccination is rare in the U.S.<sup>27,28</sup>; and  
18

19 Whereas, A Texas HPV vaccination education and administration program increased  
20 vaccination rates greater than HPV education alone by providing vaccinations to students and  
21 covering the cost by screening for insurance and covering uninsured students<sup>29</sup>; and  
22

23 Whereas, Vaccine mandates to attend school are routine for communicable diseases including  
24 Hepatitis B for which 48 states mandate vaccination, while only 3 have HPV mandates<sup>30,31</sup>; and  
25

26 Whereas, Physicians often present HPV vaccination as optional or non-urgent because it is not  
27 required for school entry which results in greater vaccination hesitancy among patients<sup>32</sup>; and  
28

29 Whereas, AMA policy H-60.923 sets a precedent for supporting mandatory vaccination and H-  
30 440.970 states that nonmedical exemptions from immunizations endanger the health of the  
31 community at large and supports legislation eliminating such nonmedical exemptions; and  
32

33 Whereas, Rhode Island mandates HPV vaccination for school attendance without explicitly  
34 permitting nonmedical exemptions which led to increased vaccine uptake compared to states  
35 that explicitly permit nonmedical exemptions, and funds this program at the state level by  
36 directly purchasing vaccines from the Centers for Disease Control at low costs to give to  
37 providers for free, thus eliminating financial barriers<sup>16,33-35</sup>; and  
38

39 Whereas, Because screening for signs of non-cervical HPV related cancer is limited,  
40 vaccination is the primary method of cancer prevention, however, there has been evidence  
41 supporting the use of non-cervical cancer screening in high risk populations<sup>36-38</sup>; therefore be it

1 RESOLVED, That our American Medical Association amend policy H-440.872, "HPV Vaccine  
2 and Cervical Cancer Prevention Worldwide," by addition and deletion to read as follows:  
3

4 **HPV Vaccine and ~~Cervical~~ Cancer Prevention Worldwide, H-440.872**

- 5 1. Our AMA (a) urges physicians to educate themselves and their patients about HPV  
6 and associated diseases, HPV vaccination, as well as routine ~~cervical~~-cancer  
7 screening for those at risk; and (b) encourages the development and funding of  
8 programs targeted at HPV vaccine introduction and cervical cancer screening in  
9 countries without organized cervical cancer screening programs.
- 10 2. Our AMA will intensify efforts to improve awareness and understanding about HPV  
11 and associated diseases, in all individuals regardless of sex, such as, but not limited  
12 to, cervical cancer, head and neck cancer, anal cancer, and penile cancer, the  
13 availability and efficacy of HPV vaccinations, and the need for routine cervical cancer  
14 screening in the general public.
- 15 3. Our AMA:
- 16 a. encourages the integration of HPV vaccination and routine cervical cancer screening  
17 into all appropriate health care settings and visits ~~for adolescents and young adults~~,
- 18 b. supports the availability of the HPV vaccine and routine cervical cancer screening to  
19 appropriate patient groups that benefit most from preventive measures, including but  
20 not limited to low-income and pre-sexually active populations,
- 21 c. recommends HPV vaccination for all groups for whom the federal Advisory  
22 Committee on Immunization Practices recommends HPV vaccination.
- 23 4. Our AMA encourage appropriate stakeholders to investigate means to increase HPV  
24 vaccination rates by:
- 25 a. facilitating administration of HPV vaccinations in community-based settings including  
26 school settings, and
- 27 b. supporting state mandates for HPV vaccination for school attendance. (Modify  
28 Current HOD Policy); and be it further  
29

30 RESOLVED, That our AMA support legislation and funding for research aimed towards  
31 discovering screening methodology and early detection methods for other non-cervical HPV  
32 associated cancers. (New HOD Policy)

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

Received: 10/12/22

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## **RELEVANT AMA POLICY**

### **Meningococcal Vaccination for School Children H-60.923**

Our AMA supports efforts to require that school children receive meningococcal vaccine per the Advisory Committee on Immunization Practices guidelines. Res. 414, A-14

### **Childhood Immunizations H-60.969**

1. Our AMA will lobby Congress to provide both the resources and the programs necessary, using the recommendations of the National Vaccine Advisory Committee and in accordance with the provision set forth in the National Vaccine Injury Compensation Act, to ensure that children nationwide are immunized on schedule, thus representing progress in preventive medicine.
2. Our AMA endorses the recommendations on adolescent immunizations developed by the Advisory Committee for Immunization Practices and approved by both the American Academy of Family Physicians and the American Academy of Pediatrics.
3. Our AMA will develop model state legislation to require that students entering middle or junior high school be adequately immunized according to current national standards.
4. Our AMA encourages state medical societies to advocate legislation or regulations in their state that are consistent with the AMA model state legislation.
5. Our AMA will continue to work with managed care groups and state and specialty medical societies to support a dedicated preventive health care visit at 11-12 years of age.
6. Our AMA will work with the American Academy of Family Physicians and the American Academy of Pediatrics to strongly encourage the Centers for Medicare & Medicaid Services to deactivate coding edits that cause a decrease in immunization rates for children, and to make these edit deactivations retroactive to January 1, 2013.

Res. 542, A-92; CSA Rep. 4, I-95; Reaffirmed by BOT Rep. 24, A-97; Reaffirmation A-05; Appended: Res. 121, A-13

### **Human Papillomavirus (HPV) Inclusion in School Education Curricula D-170.995**

Our AMA will:

1. strongly urge existing school health education programs to emphasize the high prevalence of human papillomavirus in all genders, the causal relationship of HPV to cancer and genital lesions, and the importance of routine pap tests in the early detection of cancer;
2. urge that students and parents be educated about HPV and the availability of the HPV vaccine; and
3. support appropriate stakeholders to increase public awareness of HPV vaccine effectiveness for all genders against HPV-related cancers.

Res. 418, A-06; Reaffirmed: CSAPH Rep. 01, A-16; Modified: Res. 404, A-18

### **HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872**

1. Our AMA (a) urges physicians to educate themselves and their patients about HPV and associated diseases, HPV vaccination, as well as routine cervical cancer screening; and (b) encourages the development and funding of programs targeted at HPV vaccine introduction and cervical cancer screening in countries without organized cervical cancer screening programs.
2. Our AMA will intensify efforts to improve awareness and understanding about HPV and associated diseases, the availability and efficacy of HPV vaccinations, and the need for routine cervical cancer screening in the general public.
3. Our AMA: (a) encourages the integration of HPV vaccination and routine cervical cancer screening into all appropriate health care settings and visits for adolescents and young adults, (b) supports the availability of the HPV vaccine and routine cervical cancer screening to appropriate patient groups that benefit most from preventive measures, including but not limited to low-income and pre-sexually active populations, and (c) recommends HPV vaccination for all groups for whom the federal Advisory Committee on Immunization Practices recommends HPV vaccination.

Res. 503, A-07; Appended: Res. 6, A-12; Reaffirmed: CSAPH Rep. 1, A-22; Reaffirmation: A-22

### **Insurance Coverage for HPV Vaccine D-440.955**

Our AMA: (1) supports the use and administration of Human Papillomavirus vaccine as recommended by the Advisory Committee on Immunization Practices;

(2) encourages insurance carriers and other payers to appropriately cover and adequately reimburse the HPV vaccine as a standard policy benefit for medically eligible patients; and

(3) will advocate for the development of vaccine assistance programs to meet HPV vaccination needs of uninsured and underinsured populations.

Res. 818, I-06; Reaffirmed: CMS Rep. 01, A-16.

#### **Nonmedical Exemptions from Immunizations H-440.970**

1. Our AMA believes that nonmedical (religious, philosophic, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large.

Therefore, our AMA (a) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (b) supports legislation eliminating nonmedical exemptions from immunization; (c) encourages state medical associations to seek removal of nonmedical exemptions in statutes requiring mandatory immunizations, including for childcare and school attendance; (d) encourages physicians to grant vaccine exemption requests only when medical contraindications are present; (e) encourages state and local medical associations to work with public health officials to develop contingency plans for controlling outbreaks in medically-exempt populations and to intensify efforts to achieve high immunization rates in communities where nonmedical exemptions are common; and (f) recommends that states have in place: (i) an established mechanism, which includes the involvement of qualified public health physicians, of determining which vaccines will be mandatory for admission to school and other identified public venues (based upon the recommendations of the ACIP); and (ii) policies that permit immunization exemptions for medical reasons only.

2. Our AMA will actively advocate for legislation, regulations, programs, and policies that incentivize states to (a) eliminate non-medical exemptions from mandated immunizations and (b) limit medical vaccine exemption authority to only licensed physicians.

CSA Rep. B, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: Res. 10, A-15; Modified: CSAPH Rep. 1, I-15; Appended: Res. 416, A-19; Modified: Res. 207, I-21

#### **Organ Donor Recruitment H-370.995**

Our AMA supports development of "state of the art" educational materials for the medical community and the public at large, demonstrating at least the following:

- (1) the need for organ donors;
- (2) the success rate for organ transplantation;
- (3) the medico-legal aspects of organ transplantation;
- (4) the integration of organ recruitment, preservation and transplantation;
- (5) cost/reimbursement mechanisms for organ transplantation; and
- (6) the ethical considerations of organ donor recruitment.

Citation: Res. 32, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02; Reaffirmed: CSAPH Rep. 1, A-12; Reaffirmed: CEJA Rep. 4, A-22;

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 917  
(I-22)

Introduced by: Society of American Gastrointestinal and Endoscopic Surgeons (SAGES)

Subject: Care for Children with Obesity

Referred to: Reference Committee K

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1 Whereas, Childhood obesity is a major public health problem, and the United States faces a  
2 childhood obesity epidemic that disproportionately affects minority groups; and  
3

4 Whereas, Obesity is now recognized as a disease of the metabolism whereby the body stores  
5 excess fat and can develop metabolic health problems including resistance to insulin; and  
6

7 Whereas, Obesity in children leads to severe health complications, including but not limited to  
8 type 2 diabetes, hypertension, hepatic steatosis, obstructive sleep apnea, gastroesophageal  
9 reflux disease, various orthopedic disorders, and polycystic ovarian syndrome; and  
10

11 Whereas, Many of these comorbidities can be prevented, alleviated, or resolved by a  
12 combination of behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions  
13 to treat obesity; and  
14

15 Whereas, Mild obesity of class I may be preventable and treatable with lifestyle and medical  
16 interventions and the treatment of higher classes of obesity includes bariatric surgery; and  
17

18 Whereas, Current evidence shows bariatric surgery to be the most effective and the only  
19 durable treatment for severe obesity of class II and III in adults and in children; and  
20

21 Whereas, The American Academy of Pediatrics, in a position statement that is co-endorsed by  
22 several surgical organizations, including the Society of American Gastrointestinal and  
23 Endoscopic Surgeons, states that bariatric surgery should be used in the treatment of children  
24 with obesity meeting specific, objective criteria, including body mass index (BMI) at 140% of the  
25 95<sup>th</sup> percentile of the growth curve or at 120% of the 95<sup>th</sup> percentile of the growth curve in the  
26 presence of a comorbidity such as hypertension; and  
27

28 Whereas, Significant barriers to the treatment of childhood obesity persist, such as insurance  
29 coverage denials and the use of outdated eligibility criteria to access care; and  
30

31 Whereas, these barriers delay treatment of obesity and prevention of further comorbidity  
32 development, which results in worse patient outcomes; and  
33

34 Whereas, The negative consequences of delayed treatment extend to adulthood for patients,  
35 families, communities, and impact our health as a nation; therefore be it

36 **RESOLVED**, That our American Medical Association actively support the education of  
37 physicians on the morbidity of childhood obesity, the existence of effective treatment for this  
38 condition, and the importance of patients obtaining bariatric care as early as possible (Directive  
39 to Take Action); and be it further

1 RESOLVED, That our AMA support the development of multidisciplinary care programs for  
2 children with obesity, inclusive of bariatric surgery care, access to medications, nutrition, and  
3 mental health support (Directive to Take Action); and be it further  
4

5 RESOLVED, That our AMA actively work to remove barriers to bariatric surgery, access to  
6 medications, nutrition, and mental health support for the treatment of obesity in children.  
7 (Directive to Take Action)

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

Received: 10/13/22

#### Citations

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## RELEVANT AMA POLICY

### Addressing Obesity D-440.954

1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the



study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.

2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).

3. Our AMA will: (a) work with state and specialty societies to identify states in which physicians are restricted from providing the current standard of care with regards to obesity treatment; and (b) work with interested state medical societies and other stakeholders to remove out-of-date restrictions at the state and federal level prohibiting healthcare providers from providing the current standard of care to patients affected by obesity.

Citation: BOT Rep. 11, I-06; Reaffirmation A-13; Appended: Sub. Res. 111, A-14; Modified: Sub. Res. 811, I-14; Appended: Res. 201, A-18

### **Obesity as a Major Health Concern H-440.902**

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of patients with obesity; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat patients affected by obesity.

Citation: Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04; Reaffirmation A-10; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Modified: Res. 402, A-17

### **Obesity as a Major Public Health Problem H-150.953**

Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions;

(2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs;

(3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians;

(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight;

(5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity;

(6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain;

(7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and

(8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity.

Citation: CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12; Reaffirmation A-13; Reaffirmed: CSAPH Rep. 3, A-13; Reaffirmation: A-19

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 918  
(I-22)

Introduced by: Medical Student Section

Subject: Opposition to Alcohol Industry Marketing Self-Regulation

Referred to: Reference Committee K

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1 Whereas, The American alcohol industry's political activity in opposition to federal regulation of  
2 its marketing venues is based on claims that its advertising practices are responsible and do not  
3 target youth, though there is a strong body of contradictory evidence to suggest that they  
4 consistently violate their own marketing guidelines with respect to youth-targeting behavior<sup>1,9,10</sup>;  
5 and  
6

7 Whereas, The onset of binge drinking and hazardous drinking behaviors has been shown to  
8 have a stronger association with alcohol marketing exposure than with parental drinking status<sup>2</sup>;  
9 and  
10

11 Whereas, Multiple studies have demonstrated that the alcohol industry's advertising practices  
12 disproportionately targets youth and has contributory effect toward the initiation and progression  
13 of youth drinking behaviors<sup>3-5</sup>; and  
14

15 Whereas, The International Center for Alcohol Policies, an alcohol industry-sponsored  
16 organization whose role is to set standards of practice for alcohol marketing, states in its  
17 "Guiding Principles" that alcohol marketing communications should only be placed in media in  
18 which the audience composition is, at minimum, of 70% legal drinking age<sup>6</sup>; and  
19

20 Whereas, Of the top 100 box office-grossing movies of each year from 1996-2009, alcohol  
21 brand placement increased in prevalence approximately 5% each year and was featured in 41%  
22 of top movies rated G, PG, PG-13 for children/adolescents, in direct violation of self-imposed  
23 industry standards<sup>6,7</sup>; and  
24

25 Whereas, Alcohol brand appearances in youth-rated movies trended upward from 1996 to 2009,  
26 increasing from 80 to 145 per year, an increase of 5.2 appearances per year, indicating  
27 increased alcohol industry expenditure on brand placement in these movies<sup>7</sup>; and  
28

29 Whereas, According to a 2015 report put forward by The Beer Institute, an American trade  
30 association which represents the alcohol industry's interests before Congress, the Institute  
31 alleges that the industry's marketing efforts direct consumer attention toward particular brands  
32 but do not encourage drinking in any segment of the population<sup>8</sup>; and  
33

34 Whereas, A 2016 review of recent studies showed evidence of a dose-dependent relationship  
35 between youth alcohol marketing exposure and subsequent initiation of drinking/progression to  
36 binge drinking behaviors<sup>4</sup>; and  
37

38 Whereas, A 2020 study demonstrated that global alcohol sales totaled over \$1.5 trillion, with the  
39 most spending focused in countries with limited industry marketing regulation and high youth  
40 alcohol marketing exposure levels<sup>11</sup>; and

Whereas, In regions of the world where the alcohol industry has self-regulated marketing codes, youth have consistently higher exposure to alcohol marketing<sup>10</sup>; and

Whereas, The youth population is considered a cohort particularly susceptible to socialization-based advertising techniques frequently employed by the alcohol industry, wherein products are intentionally paired with agents of socialization in order to create favorable associations between the two in consumers' minds, including through product placement near to or usage by popular television characters, social media campaigns, and the sponsorship of sporting teams, events, and celebrities<sup>11-13</sup>; and

Whereas, The Master Settlement Agreement (MSA) was reached in 1999 between 46 state attorneys general and 4 tobacco manufacturers to resolve the largest class action lawsuit in American history; among its provisions, the MSA: forced the tobacco industry to make concessions/admissions of guilt regarding the ways in which their advertising practices disproportionately targeted the youth population, placed restrictions on advertising venues for the tobacco industry, and mandated that the industry pay out 206 billion dollars in reparations<sup>14,15</sup>; and

Whereas, Prior to the MSA, the tobacco industry had self-regulatory standards for advertising practices, identical in nature to the current status of the alcohol industry<sup>14,15</sup>; and

Whereas, Following the MSA, youth cigarette usage has now dropped to the lowest levels seen in decades<sup>16</sup>; and

Whereas, A WHO Global Status Report on international alcohol policy demonstrated that up to 56% of countries worldwide have alcohol marketing regulations to protect youth and other vulnerable populations from the harmful effects of alcohol marketing<sup>17</sup>; and

Whereas, The United Nations Convention on the Rights of the Child declares it the responsibility of sovereign nations to create appropriate guidelines to protect children from information and material injurious to their wellbeing<sup>18</sup>; and

Whereas, A 2017 study demonstrated that there is no effective system currently in place to remove- or enforce punitive measures for production of- advertisements deemed "non-compliant" to the American alcohol industry's self-imposed 'youth-protective' advertising regulations<sup>9,10</sup>; therefore be it

RESOLVED, That our American Medical Association amend policy H-30.940, "Labeling Advertising, and Promotion of Alcoholic Beverages," by addition and deletion to read as follows:

**H-30.940, Labeling, Advertising, and Promotion of Alcoholic Beverages**

(1.) (a) Supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of

1 federal legislation to require nutritional labels on alcoholic beverages in accordance  
2 with the Nutritional Labeling and Education Act.

3 (2.) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by  
4 persons under 21 years of age, which creates an image of drinking alcoholic  
5 beverages and thereby may encourage the illegal underaged use of alcohol; (b)  
6 recommends that health education labels be used on all alcoholic beverage containers  
7 and in all alcoholic beverage advertising (with the messages focusing on the hazards  
8 of alcohol consumption by specific population groups especially at risk, such as  
9 pregnant women, as well as the dangers of irresponsible use to all sectors of the  
10 populace); and (c) recommends that the alcohol beverage industry be encouraged to  
11 accurately label all product containers as to ingredients, preservatives, and ethanol  
12 content (by percent, rather than by proof).

13 (3.) Actively supports and will work for a total statutory prohibition of advertising of all  
14 alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal,  
15 our AMA (a) supports federal and/or state oversight for all forms of alcohol advertising  
16 in lieu of the alcohol industry's current practice of self-regulated advertising and  
17 marketing; ~~(a)~~(b) supports continued research, educational, and promotional activities  
18 dealing with issues of alcohol advertising and health education to provide more  
19 definitive evidence on whether, and in what manner, advertising contributes to alcohol  
20 abuse; ~~(b)~~(c) opposes the use of the radio and television any form of advertising which  
21 links alcoholic products to agents of socialization in order to promote drinking; ~~(e)~~(d)  
22 will work with state and local medical societies to support the elimination of advertising  
23 of alcoholic beverages from all mass transit systems; ~~(d)~~(e) urges college and  
24 university authorities to bar alcoholic beverage companies from sponsoring athletic  
25 events, music concerts, cultural events, and parties on school campuses, and from  
26 advertising their products or their logo in school publications; and ~~(e)~~(f) urges its  
27 constituent state associations to support state legislation to bar the promotion of  
28 alcoholic beverage consumption on school campuses and in advertising in school  
29 publications.

30 (4.) (a) Urges producers and distributors of alcoholic beverages to discontinue all  
31 advertising directed toward youth, including ~~such as~~ promotions on high school and  
32 college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating  
33 television program content that depicts the irresponsible use of alcohol without  
34 showing its adverse consequences (examples of such use include driving after  
35 drinking, drinking while pregnant, or drinking to enhance performance or win social  
36 acceptance); (e) supports continued warnings against the irresponsible use of alcohol  
37 and challenges the liquor, beer, and wine trade groups to include in their advertising  
38 specific warnings against driving after drinking; and (f) commends those automobile  
39 and alcoholic beverage companies that have advertised against driving while under  
40 the influence of alcohol. (Modify Current HOD Policy)

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

Received: 10/11/22

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## RELEVANT AMA POLICY

### AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages H-30.940 Our AMA:

- (1) (a) supports accurate and appropriate labeling disclosing the alcohol content of all beverages, including so-called "nonalcoholic" beer and other substances as well, including over-the-counter and prescription medications, with removal of "nonalcoholic" from the label of any substance containing any alcohol; (b) supports efforts to educate the public and consumers about the alcohol content of so-called "nonalcoholic" beverages and other substances, including medications, especially as related to consumption by minors; (c) urges the Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and other appropriate federal regulatory agencies to continue to reject proposals by the alcoholic beverage industry for authorization to place beneficial health claims for its products on container labels; and (d) urges the development of federal legislation to require nutritional labels on alcoholic beverages in accordance with the Nutritional Labeling and Education Act.
- (2) (a) Expresses its strong disapproval of any consumption of "nonalcoholic beer" by persons under 21 years of age, which creates an image of drinking alcoholic beverages and thereby may encourage the illegal underaged use of alcohol; (b) recommends that health education labels be used on all alcoholic beverage containers and in all alcoholic beverage advertising (with the messages focusing on the hazards of alcohol consumption by specific population groups especially at risk, such as pregnant women, as well as the dangers of irresponsible use to all sectors of the populace); (c) recommends that the alcohol beverage industry be encouraged to accurately label all product containers as to ingredients, preservatives, and ethanol content (by percent, rather than by proof); and (d) advocates that the alcohol beverage industry be required to include pictorial health warnings on alcoholic beverages.
- (3) actively supports and will work for a total statutory prohibition of advertising of all alcoholic beverages except for inside retail or wholesale outlets. Pursuant to that goal, our AMA (a) supports continued research, educational, and promotional activities dealing with issues of alcohol advertising and health education to provide more definitive evidence on whether, and in what manner, advertising contributes to alcohol abuse; (b) opposes the use of the radio and television to promote drinking; (c) will work with state and local medical societies to support the elimination of advertising of alcoholic beverages from all mass transit systems; (d) urges college and university authorities to bar alcoholic beverage companies from sponsoring athletic events, music concerts, cultural events, and parties on school campuses, and from advertising their products or their logo in school publications; and (e) urges its constituent state associations to support state legislation to bar the promotion of alcoholic beverage consumption on

school campuses and in advertising in school publications.

(4) (a) urges producers and distributors of alcoholic beverages to discontinue advertising directed toward youth, such as promotions on high school and college campuses; (b) urges advertisers and broadcasters to cooperate in eliminating television program content that depicts the irresponsible use of alcohol without showing its adverse consequences (examples of such use include driving after drinking, drinking while pregnant, or drinking to enhance performance or win social acceptance); (c) supports continued warnings against the irresponsible use of alcohol and challenges the liquor, beer, and wine trade groups to include in their advertising specific warnings against driving after drinking; and (d) commends those automobile and alcoholic beverage companies that have advertised against driving while under the influence of alcohol.

(5) will advocate for the implementation of pictorial health warnings on alcoholic beverages.

Citation: CSA Rep. 1, A-04; Reaffirmation A-08; Reaffirmed: CSAPH Rep. 01, A-18; Modified: Res. 427, A-22

#### **Prevention of Underage Drinking: A Call to Stop Alcoholic Beverages with Special Appeal to Youths D-60.973**

1. Our AMA will advocate for a ban on the marketing of products such as flavored malt liquor beverages, gelatin-based alcohol products, food-based alcohol products, alcohol mists, and beverages that contain alcohol and caffeine and other additives to produce alcohol energy drinks that have special appeal to youths under the age of 21 years of age.
2. Our AMA supports state and federal regulations that would reclassify flavored malt liquor beverages as a distilled spirit so that it can be taxed at a higher rate and cannot be advertised or sold in certain locations.

Citation: Res. 435, A-07; BOT Action in response to referred for decision Res. 411, A-08; Reaffirmed in lieu of Res. 902, I-09; Modified: CSAPH Rep. 01, A-19

#### **Alcohol and Youth D-170.998**

Our AMA will work with the appropriate medical societies and agencies to draft legislation minimizing alcohol promotions, advertising, and other marketing strategies by the alcohol industry aimed at adolescents.

Citation: Res. 415, I-01; Reaffirmation A-08; Reaffirmed: CSAPH Rep. 01, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 919  
(I-22)

Introduced by: Medical Student Section

Subject: Decreasing Youth Access to E-cigarettes

Referred to: Reference Committee K

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1 Whereas, The Centers for Disease Control and Prevention (CDC) defines an “e-cigarette” (also  
2 known as “e-cig,” “e-hookah,” “mod,” “vape pen,” “vape,” “tank system,” and “electronic nicotine  
3 delivery system”) as a device that produces an aerosol by heating a liquid that usually contains  
4 nicotine, flavorings, and other chemicals, such as diacetyl, volatile organic compounds, and  
5 heavy metals, that help to make the aerosol<sup>1</sup>; and  
6

7 Whereas, Per the CDC, the act of using this device is termed as “vaping,” which allows for  
8 ultrafine particles to be inhaled deeply into the lungs<sup>1</sup>; and  
9

10 Whereas, Youth use of electronic cigarettes is widespread in the US, with 10.5% of middle  
11 school students and 27.5% of high school students reporting in 2019 that they used electronic  
12 cigarettes in the past 30 days<sup>2-5</sup>; and  
13

14 Whereas, From July 2019 through February 2020, electronic cigarette, or vaping, product use-  
15 associated lung injury (EVALI) resulted in the hospitalization of 2,807 people across the United  
16 States and at least 68 deaths, with a majority of affected patients being under 25 years of age<sup>6</sup>;  
17 and  
18

19 Whereas, A single cartridge of the e-cigarettes used by the majority of US youth has a nicotine  
20 content equivalent to roughly 20 combustible cigarettes, and nicotine has been determined to be  
21 a highly addictive substance that can adversely harm the developing adolescent brain<sup>4,7</sup>; and  
22

23 Whereas, The safety and health effects of long-term inhalation of the volatile organic  
24 compounds, heavy metals, and known cancer-causing agents contained in e-cigarettes are  
25 currently unknown<sup>8</sup>; and  
26

27 Whereas, The Food and Drug Administration (FDA)’s restrictions on flavored e-cigarettes  
28 passed in February 2020 narrowly targeted pre-filled cartridge-based vaping devices and do not  
29 apply to disposable or refillable tank-based products based on the FDA’s “interest in balancing  
30 between preventing youth usage and preserving options for adults trying to transition away from  
31 combustible products”<sup>9,10</sup>; and  
32

33 Whereas, Existing AMA-MSS policy 490.025MSS “acknowledges the known harms of electronic  
34 nicotine delivery systems, particularly their ineffectiveness of smoking cessation devices” and  
35 existing AMA policy D-495.992 acknowledges the insufficiency of data on the safety and  
36 effectiveness of e-cigarettes products for tobacco cessation purposes; and  
37

38 Whereas, Recent news reports suggest an immediate increase in youth use of flavored  
39 disposable e-cigarettes in response the FDA’s restrictions on cartridge-based e-cigarettes<sup>11,12</sup>;  
40 and

1 Whereas, Prior to the recent popularity of cartridge-based devices, refillable tank-based devices  
2 were the most popular e-cigarette type among youth, with 51.8% of youth using tank-based e-  
3 cigarettes as compared to 47.1% using cartridge-based e-cigarettes in 2017<sup>10,13</sup>; and  
4

5 Whereas, Disposable e-cigarettes and tank-based devices contain the same ingredients as  
6 cartridge-based devices and are considered by the CDC to be in the same overarching category  
7 as cartridge-based devices<sup>1</sup>; and  
8

9 Whereas, Despite use of e-liquids with the same nicotine concentration, modifiable tank-based  
10 e-cigarette products are thought to deliver higher levels of nicotine as compared to other e-  
11 cigarette products<sup>14</sup>; and  
12

13 Whereas, High tobacco retailer density increases access to tobacco products and the likelihood  
14 of smoking initiation, particularly among youth because identification is requested less often,  
15 prices decrease due to increased competition, and there are more advertisements that  
16 incentivize purchase in high-density tobacco retail areas<sup>15-18</sup>; and  
17

18 Whereas, Experimental smoking among high school-aged minors increases when tobacco  
19 retailers are closer to schools and densely populate those locations<sup>19,20</sup>; and  
20

21 Whereas, Higher tobacco retailer densities proximal to schools and homes are  
22 disproportionately prevalent in low-income communities and communities of color, posing a  
23 significant public health injustice, and policies banning tobacco product sales near schools have  
24 been projected to reduce or eliminate existing disparities in tobacco retailer density by income  
25 level and by proportion of African American residents<sup>17,21,22</sup>; and  
26

27 Whereas, Proximity-based point of sale laws that restrict sale of tobacco or opening of new  
28 tobacco retailers within a certain distance of schools, playgrounds, parks, libraries, and existing  
29 retailers have been successfully implemented in California, Illinois, Louisiana, and Rhode  
30 Island<sup>23-28</sup>; and  
31

32 Whereas, E-cigarette marketing in the US contains features that are particularly more appealing  
33 to youth, and youth exposed to e-cigarette advertisements are significantly more likely to initiate  
34 vaping<sup>29,30</sup>; and  
35

36 Whereas, E-cigarette package warning labels that communicate the health risks of e-cigarettes  
37 can reduce students' intention to use e-cigarettes and increase perceived risks of e-cigarette  
38 use<sup>31</sup>; and  
39

40 Whereas, Adolescents who vape e-cigarettes in nontraditional flavors are more likely to continue  
41 vaping and take more puffs per vaping occasion, compared with those who exclusively vaped  
42 tobacco-flavored, mint- or menthol-flavored, or flavorless e-cigarettes<sup>32</sup>; therefore be it  
43

44 RESOLVED, That our American Medical Association support the inclusion of disposable and  
45 tank-based e-cigarettes in the language and implementation of any restrictions that are applied  
46 by the Food and Drug Administration or other bodies to cartridge-based e-cigarettes (New HOD  
47 Policy); and be it further



1 RESOLVED, That AMA policy H-495.986, "Tobacco Product Sales and Distribution," be  
2 amended by addition to read as follows:

3  
4 **Tobacco Product Sales and Distribution, H-495.986**

5 Our AMA:

6 (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and  
7 will actively work with the Food and Drug Administration and other relevant stakeholders  
8 to counteract the marketing and use of addictive e-cigarette and vaping devices, including  
9 but not limited to bans and strict restrictions on marketing to minors under the age of 21;

10 (2) encourages the passage of laws, ordinances and regulations that would set the  
11 minimum age for purchasing tobacco products, including electronic nicotine delivery  
12 systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws  
13 prohibiting the sale of tobacco products to minors;

14 (3) supports the development of model legislation regarding enforcement of laws  
15 restricting children's access to tobacco, including but not limited to attention to the  
16 following issues: (a) provision for licensure to sell tobacco and for the revocation thereof;  
17 (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to  
18 deter violation of laws restricting children's access to and possession of tobacco; (c)  
19 requirements for merchants to post notices warning minors against attempting to  
20 purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to  
21 facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f)  
22 requiring tobacco purchasers and vendors to be of legal smoking age;

23 (4) requests that states adequately fund the enforcement of the laws related to tobacco  
24 sales to minors;

25 (5) opposes the use of vending machines to distribute tobacco products and supports  
26 ordinances and legislation to ban the use of vending machines for distribution of tobacco  
27 products;

28 (6) seeks a ban on the production, distribution, and sale of candy products that depict or  
29 resemble tobacco products;

30 (7) opposes the distribution of free tobacco products by any means and supports the  
31 enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco  
32 products by mail;

33 (8) (a) publicly commends (and so urges local medical societies) pharmacies and  
34 pharmacy owners who have chosen not to sell tobacco products, and asks its members  
35 to encourage patients to seek out and patronize pharmacies that do not sell tobacco  
36 products; (b) encourages other pharmacists and pharmacy owners individually and  
37 through their professional associations to remove such products from their stores; (c)  
38 urges the American Pharmacists Association, the National Association of Retail  
39 Druggists, and other pharmaceutical associations to adopt a position calling for their  
40 members to remove tobacco products from their stores; and (d) encourages state medical  
41 associations to develop lists of pharmacies that have voluntarily banned the sale of  
42 tobacco for distribution to their members; and

43 (9) opposes the sale of tobacco at any facility where health services are provided; and

44 (10) supports that the sale of tobacco products be restricted to tobacco specialty stores.

45 (11) supports measures that prevent retailers from opening new tobacco specialty stores  
46 in proximity to elementary schools, middle schools, and high schools; and

47 (12) support measures that decrease the overall density of tobacco specialty stores,  
48 including but not limited to, preventing retailers from opening new tobacco specialty  
49 stores in proximity to existing tobacco specialty stores. (Modify Current HOD Policy)

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

Received: 10/11/22

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## **RELEVANT AMA POLICY**

### **Tobacco Prevention and Youth H-490.914**

Our AMA:

- (1) (a) urges the medical community, related groups, educational institutions, and government agencies to demonstrate more effectively the health hazards inherent in the use of tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco); (b) encourages state and local medical societies to actively advise municipalities and school districts against use of health education material sponsored or distributed by the tobacco industry; and (c) publicly rejects the tobacco industry as a credible source of health education material;
- (2) opposes the use of tobacco products of any kind in day care centers or other establishments where pre-school children attend for educational or child care purposes;
- (3) advises public and private schools about the very early smoking habits observed in children and encourages appropriate school authorities to prohibit the use of all tobacco products in elementary through senior high school by anyone during the school day and during other school-related activities;
- (4) (a) supports the concept that a comprehensive health education program stressing health maintenance be part of the required curriculum through 12th grade to: (i) help pre-teens, adolescents, and young adults avoid the use of tobacco products, including smokeless tobacco; and (ii) emphasize the benefits of remaining free of the use of tobacco products; (b) will work with other public and private parties to actively identify and promote tobacco prevention programs for minors and encourages the development, evaluation, and incorporation of appropriate intervention programs, including smoking cessation programs, that are tailored to the needs of children; and (c) recommends that student councils and student leaders be encouraged to join in an anti-smoking campaign.
- (5) urges state medical societies to promote the use of appropriate educational films and educational programs that reduce tobacco use by young people;
- (6) (a) favors providing financial support to promising behavioral research into why people, especially youth, begin smoking, why they continue, and why and how they quit; (b) encourages research into further reducing the risks of cigarette smoking; and (c) continues to support research and education programs, funded through general revenues and private sources, that are concerned with health problems associated with tobacco and alcohol use;
- (7) opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products, as youth are particularly susceptible;
- (8) supports working with appropriate organizations to develop a list of physicians and others recommended as speakers for local radio and television to discuss the harmful effects of tobacco usage and to advocate a tobacco-free society; and
- (9) commends the following entities for their exemplary efforts to inform the Congress, state legislatures, education officials and the public of the health hazards of tobacco use: American Cancer Society, American Lung Association, American Heart Association, Action on Smoking and Health, Inc., Groups Against Smoker's Pollution, National Congress of Parents and Teachers, National Cancer Institute, and National Clearinghouse on Smoking (HEW).

Citation: (CSA Rep. 3, A-04; Modified: Res. 402, A-13

### **FDA Regulation of Tobacco Products H-495.988**

1. Our AMA: (A) acknowledges that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health, and that there is no such thing as a safe cigarette; (B) recognizes that currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless and increases youth risk of using combustible tobacco cigarettes; (C) encourages long-term studies of vaping (the use of electronic nicotine delivery systems) and recognizes that complete cessation of the use of tobacco and nicotine-related products is the goal; (D) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (E) reaffirms its position that the Food and Drug Administration (FDA) does, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (F) strongly supports the substance of the August 1996 FDA regulations

intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (G) urges Congress to pass legislation to phase in the production of reduced nicotine content tobacco products and to authorize the FDA have broad-based powers to regulate tobacco products; (H) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; and (I) strongly opposes legislation which would undermine the FDA's authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA's authority to regulate tobacco products.

2. Our AMA: (A) supports the US Food and Drug Administration (FDA) as it takes an important first step in establishing basic regulations of all tobacco products; (B) strongly opposes any FDA rule that exempts any tobacco or nicotine-containing product, including all cigars, from FDA regulation; and (C) will join with physician and public health organizations in submitting comments on FDA proposed rule to regulate all tobacco products.

3. Our AMA: (A) will continue to monitor the FDA's progress towards establishing a low nicotine product standard for tobacco products and will submit comments on the proposed rule that are in line with the current scientific evidence and (B) recognizes that rigorous and comprehensive post-market surveillance and product testing to monitor for unintended tobacco use patterns will be critical to the success of a nicotine reduction policy.

Citation: CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Appended: Res. 234, A-12; Reaffirmation A-13; Modified: Res. 402, A-13; Modified: Speakers Rep., A-14; Appended: Res. 420, A-14; Reaffirmation A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed in lieu of: Res. 412, A-19; Modified: CSAPH Rep. 03, A-19;

#### **Opposition to Addition of Flavors to Tobacco Products H-495.971**

Our AMA: (1) supports state and local legislation to prohibit the sale or distribution of all flavored tobacco products, including menthol, mint and wintergreen flavors; (2) urges local and state medical societies and federation members to support state and local legislation to prohibit the sale or distribution of all flavored tobacco products; and (3) encourages the FDA to prohibit the use of all flavoring agents in tobacco products, which includes electronic nicotine delivery systems as well as combustible cigarettes, cigars and smokeless tobacco.

Citation: CSAPH Rep. 01, A-18; Modified: Res. 916, I-18; Modified: Res. 918, I-19

#### **Electronic Cigarettes, Vaping, and Health H-495.972**

1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly.

2. Our AMA: (a) encourages further clinical and epidemiological research on e-cigarettes; (b) supports education of the public on the health effects, including toxins and carcinogens of electronic nicotine delivery systems (ENDS) including e-cigarettes; and (c) recognizes that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction.

3. Our AMA supports legislation and associated initiatives and will work in coordination with the Surgeon General to prevent e-cigarettes from reaching youth and young adults through various means, including, but not limited to, CDC research, education and a campaign for preventing and reducing use by youth, young adults and others of e-cigarettes, and combustible and emerging tobacco products.

Citation: CSAPH Rep. 2, I-14; Modified in lieu of Res. 412, A-15; Modified in lieu of Res. 419, A-15; Reaffirmed: Res. 421, A-15; Modified: CSAPH Rep. 05, A-18; Reaffirmed: CSAPH Rep. 03, A-19; Appended: Res. 428, A-19

#### **FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973**

Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 21; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth; and (3) urges federal officials, including but not limited to the U.S. Food and Drug Administration to: (a) prohibit the sale of any e-cigarette cartridges and e-liquid refills that do not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling); and (b) require that an accurate nicotine content of e-cigarettes, e-cigarette cartridges, and e-liquid refills be prominently displayed on the product alongside a warning of the addictive quality of nicotine.

Citation: Res. 206, I-13; Modified in lieu of Res. 511, A-14; Modified in lieu of Res. 518, A-14; Modified in lieu of Res. 519, A-14; Modified in lieu of Res. 521, A-14; Modified: CSAPH Rep. 2, I-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 412, A-15; Reaffirmed in lieu of Res. 419, A-15; Reaffirmed: Res. 421, A-15; Reaffirmation A-16; Appended: Res. 429, A-18; Modified: CSAPH Rep. 05, A-18; Reaffirmation: I-19

#### **Tobacco Advertising and Media H-495.984**

Our AMA:

- (1) in keeping with its long-standing objective of protecting the health of the public, strongly supports a statutory ban on all advertising and promotion of tobacco products;
- (2) as an interim step toward a complete ban on tobacco advertising, supports the restriction of tobacco advertising to a "generic" style, which allows only black-and-white advertisements in a standard typeface without cartoons, logos, illustrations, photographs, graphics or other colors;
- (3) (a) recognizes and condemns the targeting of advertisements for cigarettes and other tobacco products toward children, minorities, and women as representing a serious health hazard; (b) calls for the curtailment of such marketing tactics; and (c) advocates comprehensive legislation to prevent tobacco companies or other companies promoting look-alike products designed to appeal to children from targeting the youth of America with their strategic marketing programs;
- (4) supports the concept of free advertising space for anti-tobacco public service advertisements and the use of counter-advertising approved by the health community on government-owned property where tobacco ads are posted;
- (5) (a) supports petitioning appropriate government agencies to exercise their regulatory authority to prohibit advertising that falsely promotes the alleged benefits and pleasures of smoking as well worth the risks to health and life; and (b) supports restrictions on the format and content of tobacco advertising substantially comparable to those that apply by law to prescription drug advertising;
- (6) publicly commends those publications that have refused to accept cigarette advertisements and supports publishing annually, via JAMA and other appropriate publications, a list of those magazines that have voluntarily chosen to decline tobacco ads, and circulation of a list of those publications to every AMA member;
- (7) urges physicians to mark the covers of magazines in the waiting area that contain tobacco advertising with a disclaimer saying that the physician does not support the use of any tobacco products and encourages physicians to substitute magazines without tobacco ads for those with tobacco ads in their office reception areas;
- (8) urges state, county, and specialty societies to discontinue selling or providing mailing lists of their members to magazine subscription companies that offer magazines containing tobacco advertising;
- (9) encourages state and county medical societies to recognize and express appreciation to any broadcasting company in their area that voluntarily declines to accept tobacco advertising of any kind;

- (10) urges the 100 most widely circulating newspapers and the 100 most widely circulating magazines in the country that have not already done so to refuse to accept tobacco product advertisements, and continues to support efforts by physicians and the public, including the use of written correspondence, to persuade those media that accept tobacco product advertising to refuse such advertising;
- (11) (a) supports efforts to ensure that sports promoters stop accepting tobacco companies as sponsors; (b) opposes the practice of using athletes to endorse tobacco products and encourages voluntary cessation of this practice; and (c) opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products;
- (12) will communicate to the organizations that represent professional and amateur sports figures that the use of all tobacco products while performing or coaching in a public athletic event is unacceptable. Tobacco use by role models sabotages the work of physicians, educators, and public health experts who have striven to control the epidemic of tobacco-related disease;
- (13) (a) encourages the entertainment industry, including movies, videos, and professional sporting events, to stop portraying the use of tobacco products as glamorous and sophisticated and to continue to de-emphasize the role of smoking on television and in the movies; (b) will aggressively lobby appropriate entertainment, sports, and fashion industry executives, the media and related trade associations to cease the use of tobacco products, trademarks and logos in their activities, productions, advertisements, and media accessible to minors; and (c) advocates comprehensive legislation to prevent tobacco companies from targeting the youth of America with their strategic marketing programs; and
- (14) encourages the motion picture industry to apply an "R" rating to all new films depicting cigarette smoking and other tobacco use.
- Citation: (CSA Rep. 3, A-04; Appended: Res. 427, A-04; Reaffirmation A-05; Reaffirmation A-14

### **Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986**

H-495.986 Tobacco Product Sales and Distribution

Our AMA:

- (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;
- (2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
- (3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;
- (4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;
- (5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;
- (6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;
- (7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;
- (8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and

- (9) opposes the sale of tobacco at any facility where health services are provided; and
- (10) supports that the sale of tobacco products be restricted to tobacco specialty stores.

Citation: CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 817, I-07; Reaffirmation A-08; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Modified in lieu of Res. 421, A-15; Modified in lieu of Res. 424, A-15; Reaffirmation I-16; Appended: Res. 926, I-18; Reaffirmation: I-19

#### **Tobacco Product Labeling H-495.989**

Our AMA: (1) supports requiring more explicit and effective health warnings, such as graphic warning labels, regarding the use of tobacco (and alcohol) products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco, and ingredients of tobacco products sold in the United States); (2) encourages the Food and Drug Administration, as required under Federal law, to revise its rules to require color graphic warning labels on all cigarette packages depicting the negative health consequences of smoking; (3) supports legislation or regulations that require (a) tobacco companies to accurately label their products, including electronic nicotine delivery systems (ENDS), indicating nicotine content in easily understandable and meaningful terms that have plausible biological significance; (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the United States; (c) an increase in the size of warning labels to include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack of cigarettes to carry a legible, boxed warning such as: "Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;" (4) urges the Congress to require that: (a) warning labels on cigarette packs should appear on the front and the back and occupy twenty-five percent of the total surface area on each side and be set out in black-and-white block; (b) in the case of cigarette advertisements, warning labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (c) warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets; and (5) supports requiring warning labels on all ENDS products, starting with the warning that nicotine is addictive.

Citation: CSA Rep. 3, A-04; Modified: Res. 402, A-13; Modified: Res. 925, I-16; Modified: Res. 428, A-19

#### **Legal Action to Compel FDA to Regulate E-Cigarettes D-495.992**

1. Our AMA will consider joining other medical organizations in an amicus brief supporting the American Academy of Pediatrics legal action to compel the U.S. Food and Drug Administration to take timely action to establish effective regulation of e-cigarettes, cigars and other nicotine tobacco products.

2. Our AMA will: (a) urgently advocate for regulatory, legislative, and/or legal action at the federal and/or state levels to ban the sale and distribution of all e-cigarette and vaping products, with the exception of those which may be approved by the FDA for tobacco cessation purposes and made available by prescription only; and (b) will advocate for research funding to sufficiently study the safety and effectiveness of e-cigarette and vaping products for tobacco cessation purposes.

Citation: Res. 432, A-18; Appended: Res. 910, I-19

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 920  
(I-22)

Introduced by: Medical Student Section

Subject: Mitigating Environmental Contributors to Disease and Sustainability of AMA  
National Meetings

Referred to: Reference Committee K

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1 Whereas, Environmental health is defined as the science and practice of preventing the direct  
2 and indirect adverse effects of hazardous agents on health and wellbeing<sup>1,2</sup>; and  
3

4 Whereas, A 2018 report by the World Health Organization (WHO) on the burden of disease  
5 from environmental risks estimated that approximately thirteen million deaths worldwide could  
6 be attributed to preventable environmental factors and 24% of global deaths were due to  
7 modifiable environmental factors<sup>3</sup>; and  
8

9 Whereas, Environmental justice is defined as the principle that all people and communities  
10 regardless of race, color, national origin, or income, are entitled to equal protection by  
11 environmental and public health laws and regulations, while environmental injustice describes  
12 environmental laws, regulations and policies that overly affect a group of people resulting in  
13 greater exposure to environmental hazards<sup>4</sup>; and  
14

15 Whereas, Environmental racism refers to a type of environmental injustice in which the racial  
16 and ethnic contexts of environmental regulations and policies, exposures, support structures,  
17 and health outcomes cause inequitable environmental hazards for some racial groups<sup>5,6</sup>; and  
18

19 Whereas, Low-income and minoritized communities are burdened by environmental injustice in  
20 that they reside in areas with higher environmental exposures, reduced preventive measures,  
21 and limited medical intervention, further exacerbating health outcome disparities<sup>7-11</sup>; and  
22

23 Whereas, The enactment of exclusionary housing policies, including zoning ordinances,  
24 restrictive covenants, blockbusting, steering, and redlining, purposefully created racial  
25 segregation, exposed Black communities to environmental pollutants and targeting for  
26 construction of toxin-releasing facilities, isolated them from essential health resources such as  
27 healthy food options, hospitals, and green spaces, and permitted health inequities to  
28 concentrate in disadvantaged low-income neighborhoods<sup>12-16</sup>; and  
29

30 Whereas, The environmental justice and fair housing collaboration between the Environmental  
31 Protection Agency (EPA) and U.S. Department of Housing and Urban Development (HUD)  
32 remains inadequate due to insufficient action to provide non-discriminatory and affordable  
33 housing units in locations without risk of environmental health exposures<sup>17</sup>; and  
34

35 Whereas, A combination of inequitable land-use policies, lack of environmental regulation and  
36 enforcement, and market forces in petrochemical and heavy metal industries have contributed  
37 to the perpetuation of poverty and worse health outcomes in minoritized populations<sup>18</sup>; and



Whereas, Proximity to and exposure to hazards from the oil and gas, plastics, animal production, chemical manufacturing, endocrine-disrupting chemicals, and metal industries have been strongly linked to at least one of the following: neural tube defects, preterm birth, low-birth weight, diffuse interstitial lung fibrosis, chronic bronchitis, asthma exacerbation, diabetes, hypertension secondary to chronic inflammation, pneumonia, reduced child cognition from heavy metal exposure, neurologic diseases, cancers, hyperlipidemia, and thyroid disease<sup>19-28</sup>; and

Whereas, Closures of industrial sites and reductions in pollution have been linked to improved fertility and reduced preterm births and respiratory hospitalizations<sup>29-31</sup>; and

Whereas, Recent natural disasters such as hurricanes, the over 1,500 oil spills from the Dakota Access Pipeline and the Keystone Pipeline in the last decade alone, the Texas freeze, and states' responses to these natural disasters perpetuate environmental injustice by disproportionately affecting predominantly minoritized and low-income communities<sup>32-37</sup>; and

Whereas, The health of American Indian tribes depends on essential natural resources that have either been depleted and/or contaminated by mining and oil corporations, leading to adverse health outcomes<sup>38-41</sup>; and

Whereas, Government agencies have failed to act on current policy and integrate current environmental science research or expertise into ongoing environmental regulations and public health initiatives, resulting in continued and amplified environmental hazards and failing to protect people, especially in Black and American Indian communities, from known and predictable environmental health dangers<sup>42-49</sup>; and

Whereas, Climate change represents an important tenet of environmental health that can significantly impact public and community health<sup>50</sup>; and

Whereas, The United States healthcare system alone is responsible for 10% of national greenhouse gas emissions and, if it were its own country, it would be the 13th largest producer of greenhouse gas emissions in the world<sup>50,51</sup>; and

Whereas, Extreme weather and climate events have significantly increased healthcare spending in the United States, with \$14 billion in additional spending through 760,000 additional patient encounters and 1,689 premature deaths between 2000 and 2009<sup>52-53</sup>; and

Whereas, The Intergovernmental Panel on Climate Change (IPCC) has determined it is possible to avoid warming past 1.5°C above pre-industrial levels by 2100 if extreme measures are taken to curtail anthropogenic emissions<sup>54</sup>; and

Whereas, If global warming exceeds 1.5°C, the estimated global effects include 92,207 additional heat-related deaths per year by 2030, 350 million more humans exposed to severe heat by 2050, and 31 to 69 million humans exposed to flooding from sea level rise by 2100<sup>54</sup>; and

Whereas, Compared to no action, limiting global warming to less than 1.5°C would result in ~50% lower annual health-related costs and prevention of ~50% of infectious disease cases in the United States by 2100<sup>52,53</sup>; and

1 Whereas, The IPCC has estimated that limiting global warming to 1.5°C would require “global  
2 net human-caused emissions of carbon dioxide to fall by about 45 percent from 2010 levels by  
3 2030, and reach net zero by approximately 2050”<sup>54</sup>; and  
4

5 Whereas, IPCC defines net zero emissions as a state where anthropogenic emissions of  
6 greenhouse gasses (GHG) are balanced by anthropogenic removals of GHG over a specific  
7 time period<sup>52</sup>; and  
8

9 Whereas, Setting emissions targets is an essential part of carbon abatement, and many non-  
10 profit organizations, large corporations, and countries have committed to carbon neutrality for  
11 their business operations by a date certain in order to improve their business efficiencies and to  
12 foster the development of carbon neutral practices<sup>55-57</sup>; and  
13

14 Whereas, Multiple organizations in the healthcare industry have committed to becoming carbon  
15 neutral on or before 2030, including Harvard Medical School and its affiliated hospitals, all  
16 University of California campus and medical centers, the Cleveland Clinic, and Kaiser-  
17 Permanente<sup>58-61</sup>; and  
18

19 Whereas, Other professional organizations, including the Association of Energy Services  
20 Professionals, and International Federation of Medical Students’ Associations have committed  
21 to making their conferences carbon neutral<sup>62,63</sup>; and  
22

23 Whereas, Our AMA has set discrete benchmark dates for achieving goals in other settings,  
24 including child blood lead levels (H-60.924), accreditation of health care service providers in jails  
25 (D-430.997), and disaggregation of demographic data (H-350.954); and  
26

27 Whereas, Our AMA recognizes that racism, in all its forms, is an urgent public health threat, and  
28 has pledged to work to combat the adverse health effects of racism (H-65.952); and  
29

30 Whereas, Our AMA has substantial policy recognizing the impacts of climate change,  
31 committing to sustainable business operations, emphasizing the importance of physician  
32 leadership regarding climate change, encouraging the study of environmental causes of  
33 disease, and encouraging other stakeholders in healthcare to practice environmental  
34 responsibility, but has no explicit emissions goal and no way to account for progress towards  
35 environmental sustainability (H-135.938, H-135.923, G-630.100, D-135.997, H-135.973);  
36 therefore be it

1 RESOLVED, That our American Medical Association amend Policy D-135.997, "Research into  
2 the Environmental Contributors to Disease," by addition and deletion to read as follows:

3  
4 **Research into the Environmental Contributors to Disease and Advocating for**  
5 **Environmental Justice D-135.997**

6 Our AMA will (1) advocate for greater public and private funding for research into  
7 the environmental causes of disease, and urge the National Academy of Sciences  
8 to undertake an authoritative analysis of environmental causes of disease; (2) ask  
9 the steering committee of the Medicine and Public Health Initiative Coalition to  
10 consider environmental contributors to disease and environmental racism as a  
11 priority public health issues; (3) encourage federal, state, and local agencies to  
12 address and remediate environmental injustice, environmental racism, and all other  
13 environmental conditions that are adversely impacting health, especially in  
14 marginalized communities; and (4) lobby Congress to support ongoing initiatives  
15 that include reproductive health outcomes and development particularly in minority  
16 populations in Environmental Protection Agency Environmental Justice policies  
17 (Modify Current HOD Policy); and be it further

18  
19 RESOLVED, That our AMA commit to reaching net zero emissions for its business operations  
20 by 2030, and remain net zero or net negative, as defined by a carbon neutral certifying  
21 organization (Directive to Take Action); and be it further

22  
23 RESOLVED, That our AMA create educational programs for and encourage the United States  
24 healthcare system, including but not limited to hospitals, clinics, ambulatory care centers, and  
25 healthcare professionals, to decrease emissions to half of 2010 levels by 2030 and become net  
26 zero by 2050, and remain net zero or negative, as defined by a carbon neutral certifying  
27 organization (Directive to Take Action); and be it further

28  
29 RESOLVED, That our AMA report the progress on implementing this resolution at each Annual  
30 Meeting hereafter. (Directive to Take Action)

Fiscal Note: Estimated cost of \$125K to implement resolution.

Received: 10/11/22

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## RELEVANT AMA POLICY

### Global Climate Change and Human Health H-135.938

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health

infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

7. Encourages physicians to assess for environmental determinants of health in patient history-taking and encourages the incorporation of assessment for environmental determinants of health in patient history-taking into physician training.

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

### **Global Climate Change - The "Greenhouse Effect" H-135.977**

Our AMA: (1) endorses the need for additional research on atmospheric monitoring and climate simulation models as a means of reducing some of the present uncertainties in climate forecasting;

(2) urges Congress to adopt a comprehensive, integrated natural resource and energy utilization policy that will promote more efficient fuel use and energy production;

(3) endorses increased recognition of the importance of nuclear energy's role in the production of electricity;

(4) encourages research and development programs for improving the utilization efficiency and reducing the pollution of fossil fuels; and

(5) encourages humanitarian measures to limit the burgeoning increase in world population.

Citation: (CSA Rep. E, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 408, A-14)

### **AMA Advocacy for Environmental Sustainability and Climate H-135.923**

Our AMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change; (2) will incorporate principles of environmental sustainability within its business operations; and (3) supports physicians in adopting programs for environmental sustainability in their practices and help physicians to share these concepts with their patients and with their communities.

Citation: Res. 924, I-16; Reaffirmation: I-19

### **Stewardship of the Environment H-135.973**

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation; (12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues; (15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

### **AMA to Protect Human Health from the Effects of Climate Change by Ending its Investments in Fossil Fuel Companies H-135.921**

1. Our AMA will: (a) choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption; and (b) support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers.

2. Our AMA: (a) declares that climate change is an urgent public health emergency, and calls upon all governments, organizations, and individuals to work to avert catastrophe; (b) urges all health and life insurance companies, including those that provide insurance for medical, dental, and long-term care, to work in a timely, incremental, and fiscally responsible manner to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels; and (c) will send letters to the nineteen largest health or life insurance companies in the United States to inform them of AMA policies concerned with climate change and with fossil fuel divestments, and urging these companies to divest.

Citation: BOT Rep. 34, A-18; Appended: Res. 607, A-22

### **Support of Clean Air and Reduction in Power Plant Emissions H-135.949**

1. Our AMA supports (a) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (b) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation's power generating plants, efforts to improve the efficiency of power plants and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels.

2. Our AMA will: (a) support the Environmental Protection Agency's proposal, under the Clean Air Act, to regulate air quality for heavy metals and other air toxins emitted from smokestacks. The risk of dispersion through air and soil should be considered, particularly for people living downwind of smokestacks; and (b) urge the EPA to finalize updated mercury, cadmium, and air toxic regulations for monitoring air quality emitted from power plants and other industrial sources, ensuring that recommendations to protect the public's health are enforceable.

Citation: Res. 429, A-03; Reaffirmation I-07; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Modified: Res. 506, A-15; Modified: Res. 908, I-17; Appended: Res. 401, A-22

### **EPA and Green House Gas Regulation H-135.934**

1. Our AMA supports the Environmental Protection Agency's authority to promulgate rules to regulate and control green house gas emissions in the United States.

2. Our AMA: (a) strongly supports evidence-based environmental statutes and regulations intended to regulate air and water pollution and to reduce greenhouse gas emissions; and (b) will advocate that environmental health regulations should only be modified or rescinded with scientific justification.

Citation: Res. 925, I-10; Reaffirmed in lieu of Res. 526, A-12; Reaffirmed: Res. 421, A-14; Appended: Res. 523, A-17

### **Conservation, Recycling and Other "Green" Initiatives G-630.100**

AMA policy on conservation and recycling include the following: (1) Our AMA directs its offices to implement conservation-minded practices whenever feasible and to continue to participate in "green" initiatives. (2) It is the policy of our AMA to use recycled paper whenever reasonable for its in-house printed matter and publications, including JAMA, and materials used by the House of Delegates, and that AMA printed material using recycled paper should be labeled as such. (3) During meetings of the American Medical Association House of Delegates, our AMA Sections, and all other AMA meetings, recycling bins, where and when feasible, for white (and where possible colored) paper will be made prominently available to participants. Citation: CCB/CLRPD Rep. 3, A-12; Modified: Speakers Rep., A-15; Reaffirmed: CCB/CLRPD Rep. 1, A-22

**Disaggregation of Demographic Data Within Ethnic Groups H-350.954**

1. Our AMA supports the disaggregation of demographic data regarding: (a) Asian-Americans and Pacific Islanders in order to reveal the within-group disparities that exist in health outcomes and representation in medicine; and (b) ethnic groups in order to reveal the within-group disparities that exist in health outcomes and representation in medicine.

2. Our AMA: (a) will advocate for restoration of webpages on the Asian American and Pacific Islander (AAPI) initiative (similar to those from prior administrations) that specifically address disaggregation of health outcomes related to AAPI data; (b) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in health outcomes; (c) supports the disaggregation of data regarding AAPIs in order to reveal the AAPI ethnic subgroup disparities that exist in representation in medicine, including but not limited to leadership positions in academic medicine; and (d) will report back at the 2020 Annual Meeting on the issue of disaggregation of data regarding AAPIs (and other ethnic subgroups) with regards to the ethnic subgroup disparities that exist in health outcomes and representation in medicine, including leadership positions in academic medicine.

Citation: Res. 001, I-17; Appended: Res. 403, A-19

**Reducing Lead Poisoning H-60.924**

1. Our AMA: (a) supports regulations and policies designed to protect young children from exposure to lead; (b) urges the Centers for Disease Control and Prevention to give priority to examining the current weight of scientific evidence regarding the range of adverse health effects associated with blood lead concentrations below the current "level of concern" in order to provide appropriate guidance for physicians and public health policy, and encourage the identification of exposure pathways for children who have low blood lead concentrations, as well as effective and innovative strategies to reduce overall childhood lead exposure; (c) encourages physicians and public health departments to screen children based on current recommendations and guidelines and to report all children with elevated blood levels to the appropriate health department in their state or community in order to fully assess the burden of lead exposure in children. In some cases this will be done by the physician, and in other communities by the laboratories; (d) promotes community awareness of the hazard of lead-based paints; and (e) urges paint removal product manufacturers to print precautions about the removal of lead paint to be included with their products where and when sold.

2. Our AMA will call on the United States government to establish national goals to: (a) ensure that no child has a blood lead level  $>5$  g/dL ( $>50$  ppb) by 2021, and (b) eliminate lead exposures to pregnant women and children, so that by 2030, no child would have a blood lead level  $>1$  g/dL (10 ppb).

3. Our AMA will call on the United States government in all its agencies to pursue the following strategies to achieve these goals: (a) adopt health-based standards and action levels for lead that rely on the most up-to-date scientific knowledge to prevent and reduce human exposure to lead, and assure prompt implementation of the strongest available measures to protect pregnant women and children from lead toxicity and neurodevelopmental impairment; (b) identify and remediate current and potential new sources of lead exposure (in dust, air, soil, water and consumer products) to protect children before they are exposed; (c) continue targeted screening of children to identify those who already have elevated blood lead levels for case management, as well as educational and other services; (d) eliminate new sources of lead introduced or released into the environment, which may entail banning or phasing out all remaining uses of lead in products (aviation gas, cosmetics, wheel weights, industrial paints, batteries, lubricants, and other sources), and the export of products containing lead, and setting more protective limits on emissions from battery recyclers and other sources of lead emissions; (e) provide a dedicated funding stream to enhance the resources available to identify and eliminate sources of lead exposure, and provide educational, social and clinical services to mitigate the harms of lead toxicity, particularly to protect and improve the lives of children in communities that are disproportionately exposed to lead; and (f) establish an independent expert advisory committee to develop a long-term national strategy, including recommendations for funding and implementation, to achieve the national goal of eliminating lead toxicity in pregnant women and children, defined as blood lead levels above 1 g/dL (10 ppb).

4. Our AMA supports requiring an environmental assessment of dwellings, residential buildings, or child care facilities following the notification that a child occupant or frequent inhabitant has a confirmed elevated blood lead level, to determine the potential source of lead poisoning, including testing the water supply.

Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 926, I-16; Appended: Res. 412, A-17



#### **Pollution Control and Environmental Health H-135.996**

Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in pollution control and improvement of environmental health.

Citation: Sub. Res. 40, A-70; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00;  
Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

#### **Research into the Environmental Contributors to Disease D-135.997**

Our AMA will (1) advocate for greater public and private funding for research into the environmental causes of disease, and urge the National Academy of Sciences to undertake an authoritative analysis of environmental causes of disease; (2) ask the steering committee of the Medicine and Public Health Initiative Coalition to consider environmental contributors to disease as a priority public health issue; and (3) lobby Congress to support ongoing initiatives that include reproductive health outcomes and development particularly in minority populations in Environmental Protection Agency Environmental Justice policies.

Citation: Res. 402, A-03; Appended: Res. 927, I-11; Reaffirmed in lieu of: Res. 505, A-19

#### **Environmental Health Programs H-135.969**

Our AMA (1) urges the physicians of the United States to respond to the challenge for a clean environment individually and through professional groups by becoming the spokespersons for environmental stewardship; and (2) encourages state and county medical societies to establish active environmental health committees.

Citation: Res. 124, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

#### **Federal Programs H-135.999**

The AMA believes that the problem of air pollution is best minimized through the cooperative and coordinated efforts of government, industry and the public. Current progress in the control of air pollution can be attributed primarily to such cooperative undertakings. The Association further believes that the federal government should play a significant role in these continuing efforts. This may be done by federal grants for (1) the development of research activity and (2) the encouragement of local programs for the prevention and control of air pollutants.

Citation: BOT Rep. M, A-63; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98;  
Reaffirmation I-06; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17

#### **Racism as a Public Health Threat H-65.952**

1. Our AMA acknowledges that, although the primary drivers of racial health inequity are systemic and structural racism, racism and unconscious bias within medical research and health care delivery have caused and continue to cause harm to marginalized communities and society as a whole.
2. Our AMA recognizes racism, in its systemic, cultural, interpersonal, and other forms, as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care.
3. Our AMA encourages the development, implementation, and evaluation of undergraduate, graduate, and continuing medical education programs and curricula that engender greater understanding of: (a) the causes, influences, and effects of systemic, cultural, institutional, and interpersonal racism; and (b) how to prevent and ameliorate the health effects of racism.
4. Our AMA: (a) supports the development of policy to combat racism and its effects; and (b) encourages governmental agencies and nongovernmental organizations to increase funding for research into the epidemiology of risks and damages related to racism and how to prevent or repair them.
5. Our AMA will work to prevent and combat the influences of racism and bias in innovative health technologies.

Citation: Res. 5, I-20; Reaffirmed: Res. 013, A-22; Modified: Speakers Rep., A-22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 921  
(I-22)

Introduced by: American Academy of Pediatrics

Subject: Firearm Injury and Death Research and Prevention

Referred to: Reference Committee K

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1 Whereas, The 1996 Dickey Amendment led to a near 25 year prohibition on federal funding for  
2 research into gun violence and prevention; and  
3

4 Whereas, Congressional funding for research into firearm injury prevention has remained flat at  
5 \$25 million annually despite federal budget requests for increased dollars; and  
6

7 Whereas, This lack of funding and research has impeded our ability to apply evidence-based  
8 approaches to decrease firearm injuries and deaths in US children and youth; and  
9

10 Whereas, The National Highway Transportation and Safety Administration has detailed  
11 databases on motor vehicle crash deaths and injuries, which have been vitally important in  
12 implementing interventions and ultimately decreasing motor vehicle-related death; and  
13

14 Whereas, As of 2020 funding has been appropriated in all 50 states to provide data for the  
15 National Violent Death Reporting System (NVDRS); and  
16

17 Whereas, While the NVDRS is an important first step, a real-time surveillance system for  
18 injuries, including those involving firearms, is necessary to truly understand the changing  
19 dynamic of firearm injuries and death; and  
20

21 Whereas, The use of state firearm registration files, including hand guns, rifles, and semi-  
22 automatic weapons for research is prohibited by the 2003 Tiahrt amendment; therefore be it  
23

24 RESOLVED, That our American Medical Association and all interested medical societies  
25 advocate for a comprehensive national-level data system for firearm injuries and deaths  
26 including real-time surveillance and continued improvements to the quality and comparability of  
27 currently collected data (Directive to Take Action); and be it further  
28

29 RESOLVED, That our AMA advocate for repeal of the 2003 Tiahrt amendment which prohibits  
30 the release of firearm tracing data for research (Directive to Take Action); and be it further  
31

32 RESOLVED, That our AMA advocate for additional federal budgetary funding for expanded  
33 firearm injury and death prevention research at all appropriate federal agencies in order to  
34 better understand the risk and protective factors for firearm injuries and to develop evidence-  
35 based interventions at the individual, house-hold, community, state, and federal levels to  
36 decrease firearm injuries and deaths. (Directive to Take Action)

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

Received: 10/13/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 922  
(I-22)

Introduced by: American Academy of Pediatrics

Subject: Firearm Safety and Technology

Referred to: Reference Committee K

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1 Whereas, Firearms have the highest fatality rate(>90%) compared with other methods of  
2 suicide; and  
3

4 Whereas, Technology advancements currently allow safety locks on cell phones ensuring only  
5 authorized users can access personal cellphone data; and  
6

7 Whereas, Firearms are the leading cause of death in children and youth ages 0-24 years,  
8 surpassing deaths from motor vehicle crashes, since 2017; therefore be it  
9

10 RESOLVED, That our American Medical Association solicit technology company interest in and  
11 advocate for the design of affordable personalized “smart” gun and safety technology which  
12 allow only authorized users to pull the trigger on the firearm. (Directive to Take Action)

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

Received: 10/13/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 923  
(I-22)

Introduced by: American Academy of Pediatrics

Subject: Physician Education and Intervention to Improve Patient Firearm Safety

Referred to: Reference Committee K

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1 Whereas, The majority of deaths from firearms (85%) in younger children ages 0-12 years occur  
2 in the home; and

3  
4 Whereas, Older children (13-18 years) are equally likely to be killed at home (39%) or on the  
5 sidewalk/street; and

6  
7 Whereas, Providing barriers to access to firearms in the home is a crucial mechanism to  
8 decrease the risks of unintentional firearm shooting as well as suicide and homicide; and

9  
10 Whereas, Safer storage of guns in homes includes storing the firearm unloaded, storing the  
11 firearm locked, storing the ammunition separately from the firearm, and storing the ammunition  
12 locked; and

13  
14 Whereas, Studies have demonstrated that parents underestimate their child's response to  
15 encountering an unsecured gun; and

16  
17 Whereas, Studies have also demonstrated that patients and families will accept safe storage  
18 devices for guns when provided by their physician; and

19  
20 Whereas, In the context of suicide prevention, "lethal means counseling" means 1) assessing  
21 whether a person at risk for suicide has access to a firearm or other lethal means, and 2)  
22 working with them and their family and support system to limit their access to said lethal means  
23 until they are no longer at elevated risk; and

24  
25 Whereas, Permanent or even temporary removal of a firearm from a home with a person at risk  
26 of lethal intent can prevent the injury or death from occurring; and

27  
28 Whereas, In many instances firearms can be temporarily transferred to other people, stored at  
29 gun clubs or shooting ranges, or stored with the local police in many localities; therefore be it

30  
31 RESOLVED, That our American Medical Association and all interested medical societies  
32 educate physicians about firearm epidemiology, anticipatory guidance, and lethal means  
33 screening for and exploring potential restrictions to access to high-lethality means of suicide  
34 such as firearms. Health care clinicians, including trainees, should be provided training on the  
35 importance of anticipatory guidance and lethal means counseling to decrease firearm injuries  
36 and deaths and be provided training introducing evidence-based techniques, skills and  
37 strategies for having these discussions with patients and families (Directive to Take Action); and  
38 be it further

1 RESOLVED, That our AMA and all interested medical societies educate physicians about lethal  
2 means counseling in health care settings and intervention options to remove lethal means,  
3 either permanently or temporarily from the home (Directive to Take Action); and be it further  
4

5 RESOLVED, That our AMA and all interested medical societies advocate for policies that  
6 support the provision of funding for physicians to provide affordable rapid-access safe storage  
7 devices to patients with firearms in the home (Directive to Take Action); and be it further  
8

9 RESOLVED, That our AMA and all interested medical societies educate the public about: (1)  
10 best practices for firearm storage safety; (2) misconceptions families have regarding child  
11 response to encountering a gun in the home; and (3) the need to ask other families with whom  
12 the child interacts regarding the presence and storage of guns in other homes the child may  
13 enter. (Directive to Take Action)

Fiscal Note: Moderate - between \$5,000 - \$10,000

Received: 10/13/22

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 924  
(I-22)

Introduced by: Association for Clinical Oncology

Subject: Domestic Production of Personal Protective Equipment

Referred to: Reference Committee K

Whereas, The Biden Administration on January 21, 2021, issued an Executive Order on a Sustainable Public Health Supply Chain, directing the development of a strategy to design, build, and sustain a long-term capability in the United States to manufacture supplies for future pandemics and biological threats<sup>1</sup>; and

Whereas, This strategy shall include an approach to develop a multi-year implementation plan for domestic production of pandemic supplies; and

Whereas, The Biden Administration on February 24, 2021, issued an Executive Order<sup>2</sup> on America's Supply Chains, ordering an examination of several critical supply chains and the issuance within 100 days of a report<sup>3</sup> with recommendations to the White House; and

Whereas, The Centers for Medicare and Medicaid Services in July, 2022, proposed policy<sup>4</sup> to enable and encourage hospitals to purchase and utilize domestically-produced N95 respirators via a payment adjustment to compensate hospitals for the additional resource costs of acquiring domestically-made NIOSH-approved surgical N95 respirators for cost reporting periods beginning on or after January 1, 2023; and

Whereas, The Association for Clinical Oncology has previously recommended<sup>5</sup> that the Executive Branch identify raw materials, components, parts or accessories of critical devices that should have domestic manufacturing capacity to improve the resilience of the U.S. device supply chain and incentivize their production without limiting access to foreign sources of devices; therefore be it

RESOLVED, That our American Medical Association support state and federal incentives to locate the manufacturing of goods used in healthcare and healthcare facilities in the United States (New HOD Policy); and be it further

<sup>1</sup> White House. Executive Order on a Sustainable Public Health Supply Chain. 2021 Jan 21. <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/21/executive-order-a-sustainable-public-health-supply-chain/>

<sup>2</sup> White House. Executive Order on America's Supply Chains. 2021 Feb 24. <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/02/24/executive-order-on-americas-supply-chains/>

<sup>3</sup> White House. Building Resilient Supply Chains, Revitalizing American Manufacturing, and Fostering Broad-Based Growth. 2021 June. <https://www.whitehouse.gov/wp-content/uploads/2021/06/100-day-supply-chain-review-report.pdf>

<sup>4</sup> Federal Register. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs; Organ Acquisition; Rural Emergency Hospitals: Payment Policies, Conditions of Participation, Provider Enrollment, Physician Self-Referral; New Service Category for Hospital Outpatient Department Prior Authorization Process; Overall Hospital Quality Star Rating. 2022 July 26. <https://www.federalregister.gov/documents/2022/07/26/2022-15372/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment>

<sup>5</sup> American Medical Association, American Society of Anesthesiologists, American Society of Health-System Pharmacists, Association for Clinical Oncology, and the United States Pharmacopeia. Improving the Quality and Resilience of the United States Healthcare Supply Chain. <https://www.ashp.org/-/media/assets/news-and-media/docs/Healthcare-Supply-Chain-Recommendations>

1 RESOLVED, That our AMA support the efforts of the Administration and CMS to encourage the  
2 purchase of domestically produced personal protective equipment (New HOD Policy); and be it  
3 further

4  
5 RESOLVED, That our AMA reaffirm policy H-440.847, "Pandemic Preparedness." (Reaffirm  
6 HOD Policy)

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

Received: 10/13/22

## RELEVANT AMA POLICY

### Pandemic Preparedness H-440.847

In order to prepare for a pandemic, our AMA:

- (1) urges the Department of Health and Human Services Emergency Care Coordination Center, in collaboration with the leadership of the Centers for Disease Control and Prevention (CDC), state and local health departments, and the national organizations representing them, to urgently assess the shortfall in funding, staffing, supplies, vaccine, drug, and data management capacity to prepare for and respond to a pandemic or other serious public health emergency;
- (2) urges Congress and the Administration to work to ensure adequate funding and other resources: (a) for the CDC, the National Institutes of Health (NIH), the Strategic National Stockpile and other appropriate federal agencies, to support the maintenance of and the implementation of an expanded capacity to produce the necessary vaccines, anti- microbial drugs, medical supplies, and personal protective equipment, and to continue development of the nation's capacity to rapidly manufacture the necessary supplies needed to protect, treat, test and vaccinate the entire population and care for large numbers of seriously ill people, without overreliance on unreliable international sources of production; and (b) to bolster the infrastructure and capacity of state and local health departments to effectively prepare for and respond to a pandemic or other serious public health emergency;
- (3) encourages states to maintain medical and personal protective equipment stockpiles sufficient for effective preparedness and to respond to a pandemic or other major public health emergency;
- (4) urges the federal government to meet treaty and trust obligations by adequately sourcing medical and personal protective equipment directly to tribal communities and the Indian Health Service for effective preparedness and to respond to a pandemic or other major public emergency;
- (5) urges the CDC to develop and disseminate electronic instructional resources on procedures to follow in an epidemic, pandemic, or other serious public health emergency, which are tailored to the needs of health care personnel in direct patient care settings;
- (6) supports the position that: (a) relevant national and state agencies (such as the CDC, NIH, and the state departments of health) continue to plan and test distribution activities in advance of a public health emergency, to assure that physicians, nurses, other health care personnel, and first responders having direct patient contact, receive any appropriate vaccination or medical countermeasure in a timely and efficient manner, in order to reassure them that they will have first priority in the event of such a pandemic; and (b) such agencies should publicize now, in advance of any such pandemic, what the plan will be to provide immunization to health care provider;
- (7) will monitor progress in developing a contingency plan that addresses future vaccine production or distribution problems and in developing a plan to respond to a pandemic in the United States.

Citation: CSAPH Rep. 5, I-12; Reaffirmation A-15; Modified: Res. 415, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 926  
(I-22)

Introduced by: Michigan

Subject: Limit the Pornography Viewing by Minors Over the Internet

Referred to: Reference Committee K

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1 Whereas, The pornography industry has developed at a fast-pace secondary to Internet  
2 accessibility; and  
3

4 Whereas, Explicit material is readily available on the internet; and  
5

6 Whereas, The number of pornography consumers is steadily increasing, mostly represented by  
7 men and young adults below the age of 34; and  
8

9 Whereas, 70 percent of adult U.S. citizens aged 18-30 admit to watching online pornography at  
10 least once per month; and  
11

12 Whereas, 60 percent of college students admit to viewing pornography once per week; and  
13

14 Whereas, 59-96 percent of adolescents in countries such as Taiwan and Sweden view  
15 pornography; and  
16

17 Whereas, While pornography has a long history, new technology offers unlimited sexual  
18 diversity via free-of-charge online websites; and  
19

20 Whereas, Long term use of pornography correlates with erectile dysfunction, decreased libido,  
21 and lower sexual and relationship satisfaction, and has a negative effect on the quality of social  
22 relationships; and  
23

24 Whereas, While the incidence of pornographic use is mostly in the male population, the  
25 incidence of women using pornography is increasing; and  
26

27 Whereas, Frequent use of pornography leads to increased incidence of buying sex; therefore be  
28 it



1 RESOLVED, That our American Medical Association amend existing policy H-60.934,  
2 "Internet Pornography Protecting Children and Youth Who Use the Internet and Social Media,"  
3 by addition to read as follows:

4  
5 Our AMA:

- 6 (1) Recognizes the positive role of the Internet in providing health information to  
7 children and youth.  
8 (2) Recognizes the negative role of the Internet in connecting children and youth to  
9 predators and exposing them to pornography.  
10 (3) Supports federal legislation that restricts Internet access to pornographic materials  
11 in designated public institutions where children and youth may use the Internet.  
12 (4) Encourages physicians to continue efforts to raise parent/guardian awareness  
13 about the importance of educating their children about safe Internet and social media  
14 use.  
15 (5) Supports school-based media literacy programs that teach effective thinking,  
16 learning, and safety skills related to Internet and social media use.  
17 6) Actively support legislation that would strengthen child-centric content protection by  
18 internet service providers and/or search engines in order to limit the access of  
19 pornography to minors on the internet and mobile applications. (Modify Existing  
20 Policy)

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

Received: 10/13/22

#### RELEVANT AMA POLICY

##### **Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media H-60.934**

Our AMA:

- (1) Recognizes the positive role of the Internet in providing health information to children and youth.  
(2) Recognizes the negative role of the Internet in connecting children and youth to predators and exposing them to pornography.  
(3) Supports federal legislation that restricts Internet access to pornographic materials in designated public institutions where children and youth may use the Internet.  
(4) Encourages physicians to continue efforts to raise parent/guardian awareness about the importance of educating their children about safe Internet and social media use.  
(5) Supports school-based media literacy programs that teach effective thinking, learning, and safety skills related to Internet and social media use.

Citation: BOT Rep. 10, I-06; Modified: CSAPH Rep. 01, A-16

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 927  
(I-22)

Introduced by: Michigan

Subject: Off-Label Policy

Referred to: Reference Committee K

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1 Whereas, "One size does not fit all" and physicians are uniquely positioned to discuss and  
2 evaluate the risks and benefits of specific medications and dosage for each individual; and  
3

4 Whereas, Physicians have the best interests of the individual at the forefront, education to  
5 evaluate studies, and the ability to move more quickly than official channels especially when  
6 profits are a determinant of such approval; and  
7

8 Whereas, New data is continuously emerging that may affect new treatments, dosage,  
9 conditions, and situations; and  
10

11 Whereas, AMA policy, Patient Access to Treatments Prescribed by Their Physicians H-120.988,  
12 affirms the autonomous clinical decision-making authority of a physician and the ability of that a  
13 physician to lawfully use an FDA approved drug product or medical device for an off-label  
14 indication when such use is based upon sound scientific evidence or sound medical opinion;  
15 supports the need for physicians to have access to accurate and unbiased information about  
16 off-label uses of drugs and devices; supports the dissemination of generally available, unedited,  
17 independently derived, peer reviewed, scientifically sound, and truthful information about off-  
18 label uses by manufacturers to physicians; recognizes the obligations of physicians to interpret  
19 and put into context information received from any source, including pharmaceutical  
20 manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use);  
21 supports the addition to FDA-approved labeling those uses of drugs for which safety and  
22 efficacy have been demonstrated; and, supports the continued authorization, implementation,  
23 and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research  
24 Equity Act; therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-120.988, "Patient Access  
2 to Treatments Prescribed by Their Physicians," by addition to read as follows:

3  
4 1. Our AMA confirms its strong support for the autonomous clinical decision-making  
5 authority of a physician and that a physician may lawfully use an FDA approved drug  
6 product or medical device for an off-label indication when such use is based upon sound  
7 scientific evidence or sound medical opinion; and affirms the position that, when the  
8 prescription of a drug or use of a device represents safe and effective therapy, third  
9 party payers, including Medicare, should consider the intervention as clinically  
10 appropriate medical care, irrespective of labeling, should fulfill their obligation to their  
11 beneficiaries by covering such therapy, and be required to cover appropriate 'off-label'  
12 uses of drugs on their formulary.

13 2. Our AMA strongly supports the important need for physicians to have access to  
14 accurate and unbiased information about off-label uses of drugs and devices, while  
15 ensuring that manufacturer-sponsored promotions remain under FDA regulation.

16 3. Our AMA supports the dissemination of generally available information about off-label  
17 uses by manufacturers to physicians. Such information should be independently derived,  
18 peer reviewed, scientifically sound, and truthful and not misleading. The information  
19 should be provided in its entirety, not be edited or altered by the manufacturer, and be  
20 clearly distinguished and not appended to manufacturer-sponsored materials. Such  
21 information may comprise journal articles, books, book chapters, or clinical practice  
22 guidelines. Books or book chapters should not focus on any particular drug.

23 Dissemination of information by manufacturers to physicians about off-label uses should  
24 be accompanied by the approved product labeling and disclosures regarding the lack of  
25 FDA approval for such uses, and disclosure of the source of any financial support or  
26 author financial conflicts.

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

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

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

34 7. Our AMA supports physician autonomy with regard to deciding appropriate dosing.  
35 (Modify Current Policy)

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

Received: 10/13/22

**RELEVANT AMA POLICY****Patient Access to Treatments Prescribed by Their Physicians H-120.988**

1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary.
  2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation.
  3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts.
  4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use).
  5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated.
  6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.
- Citation: Res. 30, A-88; Reaffirmed: BOT Rep. 53, A-94; Reaffirmed and Modified by CSA Rep. 3, A-97; Reaffirmed and Modified by Res. 528, A-99; Reaffirmed: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 6, A-03; Modified: Res. 517, A-04; Reaffirmation I-07; Reaffirmed: Res. 819, I-07; Reaffirmation A-09; Reaffirmation I-10; Modified: BOT Rep. 5, I-14; Reaffirmed: Res. 505, A-15; Reaffirmed: CMS Rep. 6, I-20; Reaffirmed: Res. 509, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 928  
(I-22)

Introduced by: Medical Student Section

Subject: Expanding Transplant Evaluation Criteria to Include Patients that May Not Satisfy Center-Specific Alcohol Sobriety Requirements

Referred to: Reference Committee K

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1 Whereas, In 2017, liver cirrhosis was the 11th leading cause of death in the United States (over  
2 44,000 deaths), and among all cirrhosis deaths, 50% were alcohol associated<sup>1</sup>; and  
3

4 Whereas, From 2010 to 2016, alcohol-associated liver disease was the primary cause of nearly  
5 1 in 3 liver transplants in the United States, replacing hepatitis C virus infection as the leading  
6 cause of liver transplantation due to chronic liver disease<sup>2-3</sup>; and  
7

8 Whereas, Liver transplants in patients presenting with life-threatening severe alcoholic hepatitis  
9 due to alcohol-associated liver dysfunction without 6-month sobriety have major improvements  
10 in mortality (1 year survival of 94% compared with a 6-month predicted survival of less than  
11 20%) with low post-transplant alcohol relapse rates<sup>4</sup>; and  
12

13 Whereas, Patients suffering from either severe acute alcoholic hepatitis or acute-on-chronic liver  
14 failure and not responding to medical therapy have high 3-month mortality rates ranging from  
15 60%-70%, even reaching as high as 90% within the first year<sup>6</sup>; and  
16

17 Whereas, The justification for the 6-month rule in 1997 at the conference of the American  
18 Association for the Study of Liver Diseases and American Society of Transplantation cited three  
19 studies that were confounded by small sample sizes and methodological flaws<sup>7</sup>; and  
20

21 Whereas, Subsequent studies have failed to show the 6-month rule affects patient survival after  
22 liver transplant and instead can be lethal<sup>8</sup>; and  
23

24 Whereas, Studies have shown that alcohol relapse rates among liver transplant recipients are  
25 identical whether or not there is a 6-month wait before transplant if there is careful selection of  
26 patients with factors such as a strong social support, awareness of the role of alcohol in their  
27 condition, free of severe comorbid psychiatric or comorbid disease<sup>9</sup>; and  
28

29 Whereas, Transplant centers such as Johns Hopkins University<sup>10</sup> regularly transplant livers into  
30 patients with alcohol-related liver disease whose sobriety does not reach the six-month  
31 threshold<sup>10</sup> and transplant centers such as the University of California, Los Angeles<sup>11</sup>, University  
32 of Chicago<sup>12</sup>, and others consider listing patients without 6-month sobriety after careful  
33 selection<sup>13</sup>; and  
34

35 Whereas, Reluctance to perform liver transplantation in patients with alcohol use disorder is  
36 based on the fact that alcoholism is frequently considered to be self-inflicted and due to fears of  
37 harmful post-transplant alcoholism recurrence<sup>14</sup>; and

1 Whereas, Alcohol use disorder is a recognized disease and not a mental failure, diagnosed  
2 based on the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, and is due to  
3 complex interactions between environmental factors, genetics, psychiatric conditions<sup>15</sup>; and  
4

5 Whereas, The utilization of abstinence periods unfairly discriminates against a patient  
6 population with a specific medical condition<sup>16</sup>; and  
7

8 Whereas, Despite the widespread adoption of a 6-month rule requiring abstinence prior to liver  
9 transplant, this has never been a formal recommendation from the International Liver  
10 Transplantation Society<sup>17</sup>, the Organ Transplant Procurement Network or European consensus  
11 groups<sup>9</sup> likely due the fact that it is an indefensible position from a legal standpoint<sup>18</sup>; and  
12

13 Whereas, Failure to create national policy on abstinence periods may exacerbate existing  
14 inequities and disparities in access to liver transplantation<sup>2</sup>; and  
15

16 Whereas, The American Academy of Addiction Psychiatry has a policy (Re: Organ  
17 Transplantation) in support of the evaluation of a patient's candidacy for organ transplantation  
18 based on clinical grounds alone, without an arbitrary length of time for a sobriety period, and  
19 substance use and the possibility of future substance use being just one clinical factor in  
20 evaluation<sup>19</sup>; and  
21

22 Whereas, The American Medical Association-Medical Student Section (AMA-MSS) has a policy  
23 (370.014MSS) in support of removing cannabis as a contraindication for potential organ  
24 transplant; and  
25

26 Whereas, The AMA-MSS has a policy transmittal (440.101MSS) in support of opposing sobriety  
27 requirements for hepatitis C treatment; and  
28

29 Whereas, The AMA has a policy (H- 370.973) in support of the removal of transplant center  
30 policy excluding patients maintained on methadone from liver transplant waiting lists and  
31 encouraging transplant centers to assess patients maintained on methadone on a case-by-case  
32 basis; and  
33

34 Whereas, The AMA has a policy (H-370.982) in support of ethical considerations in the  
35 allocation of organs among patients, stating allocation decisions should respect the individuality  
36 of patients and the particulars of individual cases as much as possible; therefore be it  
37

38 RESOLVED, That our American Medical Association encourage transplant centers to expand  
39 potential recipient evaluation criteria to include patients that may not satisfy center-specific  
40 alcohol sobriety requirements on a case-by-case basis, using medically appropriate criteria  
41 supportable by peer-reviewed and published research. (New HOD Policy)

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

Received: 10/12/22

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## RELEVANT AMA POLICY

### Methadone Maintenance and Transplantation H-370.973

Our AMA: (1) urges transplant centers across the nation to abrogate any policies that automatically exclude patients maintained on methadone from liver transplant recipient waiting lists; and (2) encourages transplant centers to assess patients maintained on methadone on a case-by-case basis using medically appropriate criteria supportable by peer-reviewed and published research.

Citation: Res. 405, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 01, A-20

### Medical, Surgical, and Psychiatric Service Integration and Reimbursement H-345.983

Our AMA advocates for: (1) health care policies that insure access to and reimbursement for integrated and concurrent medical, surgical, and psychiatric care regardless of the clinical setting; and (2) standards that encourage medically appropriate treatment of medical and surgical disorders in psychiatric patients and of psychiatric disorders in medical and surgical patients.

Citation: Res. 135, A-99; Reaffirmation A-00; Reaffirmed: CMS Rep. 6, A-10; Reaffirmed: CMS Rep. 6, A-15; Reaffirmation: I-18

**Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients H-370.982**

Our AMA has adopted the following guidelines as policy: (1) Decisions regarding the allocation of scarce medical resources among patients should consider only ethically appropriate criteria relating to medical need. (a) These criteria include likelihood of benefit, urgency of need, change in quality of life, duration of benefit, and, in some cases, the amount of resources required for successful treatment. In general, only very substantial differences among patients are ethically relevant; the greater the disparities, the more justified the use of these criteria becomes. In making quality of life judgments, patients should first be prioritized so that death or extremely poor outcomes are avoided; then, patients should be prioritized according to change in quality of life, but only when there are very substantial differences among patients. (b) Research should be pursued to increase knowledge of outcomes and thereby improve the accuracy of these criteria. (c) Non-medical criteria, such as ability to pay, social worth, perceived obstacles to treatment, patient contribution to illness, or past use of resources should not be considered.

(2) Allocation decisions should respect the individuality of patients and the particulars of individual cases as much as possible. (a) All candidates for treatment must be fully considered according to ethically appropriate criteria relating to medical need, as defined in Guideline 1. (b) When very substantial differences do not exist among potential recipients of treatment on the basis of these criteria, a "first-come-first-served" approach or some other equal opportunity mechanism should be employed to make final allocation decisions. (c) Though there are several ethically acceptable strategies for implementing these criteria, no single strategy is ethically mandated. Acceptable approaches include a three-tiered system, a minimal threshold approach, and a weighted formula.

(3) Decision making mechanisms should be objective, flexible, and consistent to ensure that all patients are treated equally. The nature of the physician-patient relationship entails that physicians of patients competing for a scarce resource must remain advocates for their patients, and therefore should not make the actual allocation decisions.

(4) Patients must be informed by their physicians of allocation criteria and procedures, as well as their chances of receiving access to scarce resources. This information should be in addition to all the customary information regarding the risks, benefits, and alternatives to any medical procedure. Patients denied access to resources have the right to be informed of the reasoning behind the decision.

(5) The allocation procedures of institutions controlling scarce resources should be disclosed to the public as well as subject to regular peer review from the medical profession.

(6) Physicians should continue to look for innovative ways to increase the availability of and access to scarce medical resources so that, as much as possible, beneficial treatments can be provided to all who need them.

(7) Physicians should accept their responsibility to promote awareness of the importance of an increase in the organ donor pool using all available means.

Citation: CEJA Rep. K, A-93; Reaffirmed: CSA Rep. 12, I-99; Reaffirmed: CSA Rep. 6, A-00; Appended: Res. 512, A-02; Reaffirmed: CEJA Rep. 3, A-12; Reaffirmed: CEJA Rep. 4, A-22



## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 929  
(I-22)

Introduced by: Medical Student Section

Subject: Opposing the Marketing of Pharmaceuticals to Parties Responsible for  
Captive Populations

Referred to: Reference Committee K

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1 Whereas, The United States has over 2 million individuals in its prisons or jails at any given  
2 time<sup>1</sup>; and  
3

4 Whereas, An estimated 41% of incarcerated individuals have a chronic medical condition such  
5 as hypertension, diabetes, or asthma, equating to almost 820,000 incarcerated individuals with  
6 a chronic medical condition<sup>2</sup>; and  
7

8 Whereas, Mental illness specifically is increasingly prevalent in the incarceration system, with  
9 20% of individuals in jails and 15% of individuals in prisons estimated to have serious mental  
10 illness<sup>3</sup>; and  
11

12 Whereas, There are significant racial disparities in incarceration rates, with Black people having  
13 a per capita imprisonment rate nearly six times that of Whites and nearly double that of Hispanic  
14 individuals<sup>4</sup>; and  
15

16 Whereas, Incarceration generally constrains individuals and restricts their ability to make truly  
17 voluntary and unforced decisions, establishing incarcerated individuals as a vulnerable  
18 population for which special protections are warranted<sup>5</sup>; and  
19

20 Whereas, Incarcerated individuals have specific sets of protections with respect to human  
21 subjects research under 45 CFR 46 Subpart C, indicating the same acknowledgement by the  
22 U.S. government<sup>6</sup>; and  
23

24 Whereas, The loss of autonomy is even more pronounced for detainees of Immigration and  
25 Customs Enforcement (ICE); since non-citizens are not entitled to a lawyer, detainees have very  
26 few avenues to ensure complaints they submit are adequately reviewed, and therefore this  
27 population is even more captive than even a "standard" prison population composed of  
28 citizens<sup>7,8</sup>; and  
29

30 Whereas, Despite the constitutional guarantee of healthcare access to incarcerated individuals,  
31 the autonomy of incarcerated individuals with respect to their own healthcare is restricted for a  
32 variety of reasons, including financial interests of management, the safety of other incarcerated  
33 individuals, and discrimination by their providers, all of which can lead to long-term  
34 consequences that follow former inmates years after release<sup>9,10</sup>; and  
35

36 Whereas, While persons being detained by ICE are entitled to receive medical care and  
37 treatment as needed, drug procurement and formulary management differs based on the type of  
38 facility an individual is detained at<sup>11,12</sup>; and

1 Whereas, ICE manages three types of facilities: service processing centers (SPCs) that are run  
2 entirely by ICE, contract detention facilities (CDFs) where third parties contract with ICE to  
3 provide detention services, and local, state, and federal jails that ICE may reimburse to house  
4 inmates<sup>12</sup>; and

5  
6 Whereas, The ICE Health Service Corps (IHSC) is the division of ICE responsible for providing  
7 medical care to SPCs and for financial reimbursement for medical care, including  
8 pharmaceuticals, provided by CDFs and ICE-contracted jails<sup>13</sup>; and

9  
10 Whereas, IHSC operates a formulary consisting of approved medications that applies to  
11 pharmaceuticals prescribed and dispensed at non-IHSC staffed facilities<sup>14</sup>; and

12  
13 Whereas, Non-formulary prescriptions require prior authorization by IHSC<sup>15</sup>; and

14  
15 Whereas, The pharmacy benefits provided by IHSC, including the formulary used to determine  
16 which medications are pre-approved for inmates, appear to be managed by the pharmacy  
17 benefit manager ScriptCare, but there is no public information about how the formulary is set or  
18 what factors are used to set the formulary, raising a concerning set of questions about whether  
19 decisions made on the basis of financial incentives for ScriptCare or IHSC are impacting the  
20 quality of healthcare available to ICE detainees<sup>15</sup>; and

21  
22 Whereas, There are no universally applies standards for the procurement or availability of  
23 medications in jails and prisons<sup>16,17</sup>; and

24  
25 Whereas, The Federal Bureau of Prisons maintains its own formulary, but this formulary is not  
26 used by state prisons and jails<sup>16,17</sup>; and

27  
28 Whereas, The Office of Justice Program only requires that for jail health services a formulary be  
29 created, contributing to the lack of formulary standardization across the country<sup>16,17</sup>; and

30  
31 Whereas, The National Commission on Correctional Health Care (NCCH) stipulates that  
32 departments of correction must have a method for approving off-formulary medications, but  
33 these are only recommendations and may not consistently be applied<sup>18</sup>; and

34  
35 Whereas, This notable lack of standardization has created an opaque situation where the exact  
36 criteria used to set formularies for prisons and jails across the nation is unclear and different  
37 from institution to institution, leading the American Society of Health-System Pharmacists  
38 (ASHP) recently releasing updated guidance that formulary decisions should include  
39 representative medical staff from the facility including practicing physicians and other providers,  
40 as well as other facility leaders, and patient or family stakeholders<sup>19</sup>; and

41  
42 Whereas, Because state prison systems have to dedicate 15-23% of their health benefit  
43 expenditures to pharmaceuticals, the primary driver of formulary creation tends to be cost  
44 reduction<sup>20</sup>; and

45  
46 Whereas, There are multiple methods that jails and prisons use to procure medications,  
47 including direct purchase by Department of Corrections (DOC) physicians, bulk purchases via  
48 contracts with private groups, purchase through state universities/academic medical centers  
49 when these institutions provide care to inmates, or centralized ordering and distribution as seen  
50 in Massachusetts<sup>20</sup>; and

Whereas, Though the Federal Bureau of Prisons has released guidance for securing the lowest-cost medications ethically, these guidelines are not followed universally<sup>21</sup>; and

Whereas, Pharmaceutical companies may exert influence over these decision makers and even offer free samples or rebates to incentivize their products being preferred on formulary<sup>22</sup>; and

Whereas, While some may advocate for accepting these reduced-cost drugs as a cost-saving measure, it can be a source of bias and compromises medical necessity being a driver of formulary creation, particularly for inmates who have no choice or agency in where they access their healthcare<sup>23</sup>; and

Whereas, While existing American Medical Association policy expresses strong support for the ethical provision of medical care to incarcerated individuals (see: D-430.997, Item 9.7.2 of the AMA Code of Medical Ethics), opposes direct-to-consumer (H-105.988) and EHR-facilitated direct-to-provider (D-478.961) prescription drug advertising, and endorses principles for sound formulary design (H-125.985), but has no policy explicitly recognizing the unique protections that must be afforded to vulnerable, captive populations like incarcerated individuals with respect to formulary design and medication procurement; therefore be it

RESOLVED, That our American Medical Association oppose the practice of pharmaceutical marketing towards those who make decisions for captive populations, including, but not limited to, doctors working in a correctional capacity, judges, wardens, sheriffs, correctional officers, Immigration and Customs Enforcement, and other detention administrators (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for the inclusion of physicians in the selection of medications available to vulnerable populations such as incarcerated individuals (Directive to Take Action); and be it further

RESOLVED, That our AMA support and work with state medical societies to support measures to increase transparency in medication procurement, including but not limited to: (1) requiring those responsible for medical procurement to report gifts from pharmaceutical companies over a minimum amount; and (2) centralizing formulary choices in a physician-led office, agency, or commission following the principles of a sound formulary. (New HOD Policy)

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

Received: 10/12/22

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## RELEVANT AMA POLICY

### Support for Health Care Services to Incarcerated Persons D-430.997

Our AMA will:

- (1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;
- (2) encourage all correctional systems to support NCCHC accreditation;
- (3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;
- (4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;
- (5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and
- (6) support an incarcerated person's right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.

Citation: Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep. 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19

### Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988

1. To support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices.
2. That until such a ban is in place, our AMA opposes product-claim DTCA that does not satisfy the following guidelines:

- (a) The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device, and the disease, disorder, or condition for which the drug or device is used.
  - (b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should convey a clear, accurate and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug's or device's approval for marketing.
  - (c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products.
  - (d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as "Your physician may recommend other appropriate treatments," is recommended.
  - (e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.
  - (f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.
  - (g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.
  - (h) In general, product-claim DTCA should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTCA, a disclaimer should be prominently displayed.
  - (i) The use of actual health care professionals, either practicing or retired, in DTCA to endorse a specific drug or implantable medical device product is discouraged but if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.
  - (j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.
  - (k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies and guidelines.
3. That the FDA review and pre-approve all DTCA for prescription drugs or implantable medical device products before pharmaceutical and medical device manufacturers (sponsors) run the ads, both to ensure compliance with federal regulations and consistency with FDA-approved labeling for the drug or implantable medical device product.
4. That the Congress provide sufficient funding to the FDA, either through direct appropriations or through prescription drug or implantable medical device user fees, to ensure effective regulation of DTCA.
5. That DTCA for newly approved prescription drug or implantable medical device products not be run until sufficient post-marketing experience has been obtained to determine product risks in the general population and until physicians have been appropriately educated about the drug or implantable medical device. The time interval for this moratorium on DTCA for newly approved drugs or implantable medical devices should be determined by the FDA, in negotiations with the drug or medical device product's sponsor, at the time of drug or implantable medical device approval. The length of the moratorium may vary from drug to drug and device to device depending on various factors, such as: the innovative nature of the drug or implantable medical device; the severity of the disease that the drug or implantable medical device is intended to treat; the availability of alternative therapies; and the intensity and timeliness of the education about the drug or implantable medical device for physicians who are most likely to prescribe it.
6. That our AMA opposes any manufacturer (drug or device sponsor) incentive programs for physician prescribing and pharmacist dispensing that are run concurrently with DTCA.
7. That our AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical and medical device industries to conduct or fund research on the effect of DTCA, focusing on its impact on the patient-physician relationship as well as overall health outcomes and cost benefit analyses; research results should be available to the public.

8. That our AMA supports the concept that when companies engage in DTCA, they assume an increased responsibility for the informational content and an increased duty to warn consumers, and they may lose an element of protection normally accorded under the learned intermediary doctrine.
  9. That our AMA encourages physicians to be familiar with the above AMA guidelines for product-claim DTCA and with the Council on Ethical and Judicial Affairs Ethical Opinion E-9.6.7 and to adhere to the ethical guidance provided in that Opinion.
  10. That the Congress should request the Agency for Healthcare Research and Quality or other appropriate entity to perform periodic evidence-based reviews of DTCA in the United States to determine the impact of DTCA on health outcomes and the public health. If DTCA is found to have a negative impact on health outcomes and is detrimental to the public health, the Congress should consider enacting legislation to increase DTCA regulation or, if necessary, to prohibit DTCA in some or all media. In such legislation, every effort should be made to not violate protections on commercial speech, as provided by the First Amendment to the U.S. Constitution.
  11. That our AMA supports eliminating the costs for DTCA of prescription drugs as a deductible business expense for tax purposes.
  12. That our AMA continues to monitor DTCA, including new research findings, and work with the FDA and the pharmaceutical and medical device industries to make policy changes regarding DTCA, as necessary.
  13. That our AMA supports "help-seeking" or "disease awareness" advertisements (i.e., advertisements that discuss a disease, disorder, or condition and advise consumers to see their physicians, but do not mention a drug or implantable medical device or other medical product and are not regulated by the FDA).
  14. Our AMA will advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer's suggested retail price of those drugs.
- Citation: BOT Rep. 38 and Sub. Res. 513, A-99; Reaffirmed: CMS Rep. 9, Amended: Res. 509, and Reaffirmation I-99; Appended & Reaffirmed: Sub. Res. 503, A-01; Reaffirmed: Res. 522, A-02; Reaffirmed: Res. 914, I-02; Reaffirmed: Sub. Res. 504, A-03; Reaffirmation A-04; Reaffirmation A-05; Modified: BOT Rep. 9, A-06; Reaffirmed in lieu of Res. 514, A-07; BOT Action in response to referred for decision: Res. 927, I-15; Modified: BOT Rep. 09, I-16; Appended: Res. 236, A-17; Reaffirmed in lieu of: Res. 223, A-17; Reaffirmed in lieu of: Res. 112, A-19

#### **Pharmaceutical Advertising in Electronic Health Record Systems D-478.961**

Our AMA: (1) opposes direct-to-prescriber pharmaceutical and promotional content in electronic health records (EHR); (2) opposes direct-to-prescriber pharmaceutical and promotional content in medical reference and e-prescribing software, unless such content complies with all provisions in Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices (H-105.988); (3) encourages study of the effects of direct-to-prescriber advertising at the point of care, including advertising in EHRs, on physician prescribing, patient safety, data privacy, health care costs, and EHR access for physician practices; (4) opposes the preferential placement of brand name medications in e-prescription search results or listings; and (5) encourages e-prescribing and EHR companies to ensure that the generic medication name will appear first in e-prescription search results and listings.

Citation: Res. 207, I-19; Modified: BOT Rep. 14, A-21;

#### **Expanded Use of the AMA's Principles of a Sound Drug Formulary H-125.985**

Our AMA urges managed care organizations, pharmacy benefit managers, and others who design benefit packages and/or make pharmacy benefit decisions, to utilize the Principles of a Sound Drug Formulary System (as described in BOT Rep. 28, I-00) as they develop their pharmaceutical benefit plan(s) and that the Principles of a Sound Drug Formulary System be readily available on the AMA web site.

Citation: Res. 520, A-01; Amended: Res. 514, A-02; Reaffirmed: CSA Rep. 2, A-04; Reaffirmation I-04; Reaffirmed: Sub. Res. 529, A-05; Reaffirmed in lieu of Res. 535, A-05; Reaffirmed: BOT Action in response to referred for decision Res. 503, A-05; Reaffirmation A-06; Reaffirmed: CSAPH Rep. 01, A-

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 930  
(I-22)

Introduced by: Medical Student Section

Subject: Addressing Longitudinal Health Care Needs of Children in Foster Care

Referred to: Reference Committee K

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1 Whereas, The most recent estimation showed 424,000 children in foster care in the U.S. in  
2 2019, which has stayed consistent since 2009<sup>1,2</sup>; and  
3

4 Whereas, American Indian/Alaska Native (AI/AN) children were disproportionately  
5 overrepresented in the foster care system by double their share of the U.S. population in 2020,  
6 are twice as likely as their White counterparts to be removed from their family, and more likely to  
7 have special health care needs<sup>3, 4, 5</sup>; and  
8

9 Whereas, Upon entering foster care, 30% to 80% of children have at least one physical health  
10 problem, 33% have a chronic health condition, 40% have significant dental issues, and up to  
11 80% have a significant mental health need<sup>6,7</sup>; and  
12

13 Whereas, During foster care, 50% of children have healthcare needs which remain chronic or  
14 unmet and 30% of children with potential mental health needs went 12 months without  
15 intervention<sup>8,9</sup>; and  
16

17 Whereas, While in foster care, 50% of children are subject to at least one change of placement,  
18 and 20% move at least three times in one year<sup>10</sup>; and  
19

20 Whereas, Poor communication between caregivers, Child welfare services, and medical  
21 personnel results in 50% of children having discrepancies in identifying data that prevents their  
22 electronic medical record from being matched with their child welfare files, and more than 40%  
23 of those children lack a basic social history in their health record such as why they entered  
24 foster care<sup>6,11,12</sup>; and  
25

26 Whereas, Incomplete medical histories and frequent changes in physical custody lead to  
27 decreased continuity of care, causing the health needs of children in foster care to often go  
28 undiagnosed and untreated<sup>1,6,8,13,14,15,16</sup>; and  
29

30 Whereas, A “pediatric medical home” is a primary care model which provides a single home for  
31 medical records, maintains provider continuity throughout the childhood of a patient, and  
32 coordinates specialty care<sup>17,18,19</sup>; and  
33

34 Whereas, In 2016, only 40% to 50% of all children in the U.S. were reported to have access to a  
35 medical home<sup>18</sup>; and  
36

37 Whereas, Pediatric medical homes are associated with increased primary care utilization and  
38 improved health outcomes, making them ideal for children in foster care<sup>19, 20, 21, 22</sup>; and

1 Whereas, Computerized intersystem health information exchange platforms are associated with  
2 increased immunization and health record completeness, reduced care disparities, and  
3 increased overall quality of care<sup>23</sup>; and  
4

5 Whereas, Interagency information exchange results in more than a threefold increase in the  
6 likelihood of receiving needed behavioral health services for a child managed by child welfare  
7 agencies<sup>24</sup>; and  
8

9 Whereas, Several states have implemented computerized health systems to improve  
10 information exchange between child welfare agencies and health care services including The  
11 Texas Health Passport, Ohio IDENTITY, Pennsylvania UPMC for You, and California Foster  
12 Health Link<sup>25</sup>; and  
13

14 Whereas, Health case management services and designation of accountability for the health  
15 services of a child in foster care are associated with positive health outcomes and more than a  
16 threefold increase in likelihood of a child receiving needed health services<sup>24,26</sup>; and  
17

18 Whereas, Some states have implemented medical case management programs to longitudinally  
19 follow children in foster care including California and North Carolina<sup>8,27,28</sup>; and  
20

21 Whereas, The variability in infrastructure to address health needs of children in foster care  
22 between and within states suggests a need for standardization of care quality through state-  
23 level supervision<sup>6,25,27,28</sup>; and  
24

25 Whereas, The Indian Child Welfare Act (ICWA), enacted in 1978 to address the disparities in  
26 Native child foster placement, provides placements for AI/AN children that are conducive to  
27 longitudinal health care by requiring minimal Federal standards for their removal and placement  
28 of such children in long-lasting, culturally appropriate homes<sup>5,29</sup>; and  
29

30 Whereas, The American Academy of Pediatrics (AAP) recognizes that the ICWA protects AI/AN  
31 children and adolescents from disproportionate rates of child removal and negative health  
32 outcomes, and supports increased engagement with the Indian Health Service which provides  
33 medical care to AI/AN children<sup>5</sup>; and  
34

35 Whereas, The AAP recommends the use of pediatric medical homes, increased information  
36 exchange between child welfare and medical providers, and the appointment of a pediatrician to  
37 supervise state-level medical case management of children in foster care<sup>6</sup>; and  
38

39 Whereas, Our American Medical Association MSS policies support the health coverage of all  
40 children in foster care and the entire transferability of electronic health records data between  
41 independent healthcare systems (Enabling Contiguous, National Electronic Health Record  
42 Network 315.003MSS, Addressing Healthcare Accessibility for Current and Aged-Out Youth in  
43 the Foster Care System 60.037MSS); and  
44

45 Whereas, Existing AMA policy encourages the use of medical homes, supports the use of  
46 health information technology in conjunction with medical homes, and advocates for  
47 comprehensive and evidence-based care that addresses the specific health care needs of  
48 children in foster care (The Patient-Centered Medical Home H-160.918, Principles of the  
49 Patient-Centered Medical Home H-160.919, Addressing Healthcare Needs of Children in Foster  
50 Care H-60.910); and



Whereas, No existing AMA policy addresses longitudinal continuity of care needs of children in foster care which remain unaddressed in spite of legal access to medical care for foster children<sup>30,31</sup>; therefore be it

RESOLVED, That our American Medical Association support the construction of computerized health information systems to enhance information exchange between both tribal and non-tribal child welfare agencies and healthcare professionals (New HOD Policy); and be it further

RESOLVED, That our AMA promote existing pediatric medical homes which provide continuity of care to children in foster care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the designation of medical providers, teams, and/or committees to longitudinally follow children in foster care (Directive to Take Action); and be it further

RESOLVED, That our AMA support the appointment of a pediatrician in each state with experience in child welfare to the position of state medical director of foster care health case management in accordance with AAP guidelines to ensure standards of care are met (New HOD Policy); and be it further

RESOLVED, That the AMA support the longitudinal stability and care of American Indian and Alaska Native children in foster care by promoting the Indian Child Welfare Act. (New HOD Policy)

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

Received: 10/12/22

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29. Indian Child Welfare Act, 25 U.S.C. § 1902 (1978).
30. Fostering Connections to Success and Increasing Adoptions Act of 2008, 42 U.S.C. § 1305 (2008).
31. Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010)

## RELEVANT AMA POLICY

### The Patient-Centered Medical Home H-160.918

Our AMA:

1. will urge the Centers for Medicare and Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;
2. will urge CMS to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources;
3. will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings – such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C) – and not be subject to a budget neutrality offset in the Medicare physician payment schedule;
4. will advocate that all payers support and assist PCMH transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care recognizing that payer support is crucial to the long-term sustainability of delivery reform; and
5. encourages health agencies, health systems, and other stakeholders to support and assist patient-centered medical home transformation and maintenance efforts at levels that provide a stable platform for optimized patient-centered care.

Citation: CMS Rep. 8, A-09; Modified: CMS Rep. 03, I-18;

### Principles of the Patient-Centered Medical Home H-160.919

1. Our AMA adopts the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association "Joint Principles of the

Patient-Centered Medical Home" as follows:

*Principles*

*Personal Physician* - Each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

*Physician Directed Medical Practice* - The personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

*Whole Person Orientation* - The personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

*Care is coordinated and/or integrated* across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

*Quality and safety* are hallmarks of the medical home:

Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.

Evidence-based medicine and clinical decision-support tools guide decision making.

Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

Patients and families participate in quality improvement activities at the practice level.

*Enhanced access* to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

*Payment* appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.

It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

It should support adoption and use of health information technology for quality improvement.

It should support provision of enhanced communication access such as secure e-mail and telephone consultation.

It should recognize the value of physician work associated with remote monitoring of clinical data using technology.

It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).

It should recognize case mix differences in the patient population being treated within the practice.

It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.

It should allow for additional payments for achieving measurable and continuous quality improvements.

2. Our AMA supports the patient-centered medical home (as defined in Policy H-160.919) as a way to provide care to patients without restricting access to specialty care.

3. It is the policy of our AMA that medical home participation criteria allow any physician practice to qualify as a medical home, provided it can fulfill the principles of a patient-centered medical home.

4. Our AMA will work with The Joint Commission (TJC) to examine the structures of TJC-accredited medical homes and determine whether differences exist in patient satisfaction, quality, value, and patient safety, as reflected by morbidity and mortality outcomes, between physician-led (MD/DO) and non-physician-led medical homes.

5. Our AMA supports the physician-led patient-centered medical home and advocate for the public reporting/notification of the professional status (education, training, experience) of the primary care clinician who leads the primary care medical home.

Citation: Res. 804, I-08; CMS Rep. 8, A-09; Reaffirmed: CME Rep. 15, A-10; Reaffirmed: Res. 723, A-11; Appended: Res. 723, A-11; Reaffirmed: BOT Rep. 9, I-11; Reaffirmed in lieu of Res. 706, A-12; Reaffirmed: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 03, I-18

**Addressing Healthcare Needs of Children in Foster Care H-60.910**

Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.

Citation: Res. 907, I-17;

**Medicaid Coverage for American Indian and Alaska Native Children D-350.992**

Our AMA will advocate for immediate changes in Medicaid regulations to allow American Indian/Alaska Native (AI/AN) children who are eligible for Medicaid in their home state to be automatically eligible for Medicaid in the state in which the Bureau of Indian Affairs boarding school is located.

Citation: BOT Action in response to referred for decision Res. 102, A-06; Reaffirmed: Res. 221, A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 931  
(I-22)

Introduced by: Medical Student Section

Subject: Amending H-160.903 Eradicating Homelessness to Include Support for Street Medicine Programs

Referred to: Reference Committee K

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Whereas, "Street medicine" is the practice of providing medical care to unsheltered people experiencing homelessness in locations like encampments, parks, and under bridges<sup>1</sup>; and

Whereas, Street medicine is an evidence-based health provision model that effectively bridges the unique barriers and gaps in care seen in populations experiencing unsheltered homelessness by bringing medicine to the streets and connecting individuals to the existing resources they need and have difficulty accessing<sup>2,3</sup>; and

Whereas, Approximately one third of the estimated 580,466 persons experiencing homelessness in 2020 were unsheltered according to reports from the United States Department of Housing and Development and the Urban Institute<sup>4</sup>; and

Whereas, The National Healthcare for the Homeless Council reports up to 46,500 persons experiencing homelessness die each year in the United States, and this number is climbing<sup>5</sup>; and

Whereas, Life expectancy for people living on the streets is estimated to be twelve years shorter than the national average, and chronic diseases and disabilities are abundant and exacerbated by life on the street<sup>5,6</sup>; and

Whereas, The COVID-19 pandemic resulted in an increased rate of persons experiencing homelessness, increased criminalization of homelessness, and increased death rates amongst people experiencing homelessness<sup>5,7,8</sup>; and

Whereas, 1.4 million unsheltered people access emergency shelter or transitional housing each year, placing them in congregative settings which pose tremendous risk for the spread of communicable diseases like COVID-19, with the New York City Department of Emergency Services reporting that COVID-19 mortality rates are 49 percent higher for sheltered homeless individuals<sup>9</sup>; and

Whereas, Lack of access to health care services, limited autopsies, and the absence of housing status on death certificates and hospital records leads to a severe undercount of COVID-related cases and deaths among unsheltered individuals<sup>10,11</sup>; and

Whereas, Rent prices have risen dramatically in recent years, placing undue burden upon lower income households<sup>12</sup>; and

1 Whereas, Communities criminalize homelessness and make it illegal for people to sit, sleep, or  
2 eat in public places, thus creating arrest records that further prevent unsheltered people from  
3 obtaining jobs or housing<sup>13</sup>; and  
4

5 Whereas, A report from the American Hospital Association showed that those experiencing  
6 homelessness are five times more likely to be admitted as inpatients into a hospital and  
7 experience longer hospital stays after admission, and further showed that investing in the care  
8 of these patients will reduce this cost burden<sup>14</sup>; and  
9

10 Whereas, Unsheltered individuals have health care costs on average five times higher than the  
11 national average, largely due to their overreliance on Emergency Rooms; the majority do not  
12 have health insurance or a primary care doctor, and up to 80% of these Emergency Room visits  
13 are for ailments that could have been addressed preventatively<sup>2,15-18</sup>; and  
14

15 Whereas, Individuals experiencing homelessness who were treated by a Street Medicine team  
16 were more likely to subsequently engage with a primary care provider as compared to  
17 individuals experiencing homelessness who were not seen by a Street Medicine team, and  
18 therefore did not receive referral to crucial healthcare services<sup>19,20</sup>; and  
19

20 Whereas, Street Medicine has been shown to decrease hospital admissions, hospital length-of-  
21 stay, emergency department visits, and saved one health system 3.7 million dollars in  
22 Emergency Department visits<sup>21,22</sup>; and  
23

24 Whereas, Institutions such as the Street Medicine Institute, a non-profit organization that aims to  
25 cultivate and improve Street Medicine programs both nationally and globally, have successfully  
26 maintained 85 programs along with their student coalition, which contains 30 student-run  
27 programs across 17 states<sup>23</sup>; and  
28

29 Whereas, There are multiple ways to implement a street medicine program based on the  
30 geographical regions of people experiencing homelessness or through follow up discharge visits  
31 after hospitalization<sup>24</sup>; and  
32

33 Whereas, Street medicine program creation involves education, funding, partnering with local  
34 agencies, establishing supplies, implementing protocols, and the formation of a medical team<sup>25</sup>;  
35 and  
36

37 Whereas, There may be challenges to starting a Street medicine program such as maintaining  
38 connection in a population with a migratory culture, building interpersonal relationships, and  
39 establishing institutional partnerships that can be overcome through joint efforts such as  
40 partnerships between institutions knowledgeable in this area as well as recruiting professionals  
41 that are experienced with this population<sup>26</sup>; and  
42

43 Whereas, There is growing legislative awareness around the impact of such programs, with the  
44 California State legislature having recently passed AB 369, which will now require Medi-Cal,  
45 California's Medicaid program, to reimburse street medicine<sup>19</sup>; and  
46

47 Whereas, There are several existing AMA policies (H-160.903, H-160.978, H-160.894, H-  
48 20.903, H-345.975, H-440.938) that advocate for and support measures that improve access to  
49 adequate health care for people experiencing homelessness through methods such as waiving  
50 co-pays, or providing care through free clinics; and

Whereas, H-160.903 specifically asks that the AMA “recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address [homelessness] on a long-term basis”, and as such has set precedence for feasibly supporting such measures; therefore be it

RESOLVED, That our American Medical Association encourage medical schools to implement Street Medicine programs and/or promote student-led Street Medicine programs (New HOD Policy); and be it further

RESOLVED, That our AMA recognizes and supports the use of Street Medicine programs by amending policy H-160.903 Eradicating Homelessness by addition and deletion to read as follows:

**Eradicating Homelessness, H-160.903**

Our AMA:

- (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
- (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
- (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
- (4) supports the use of street medicine programs, which travel to individuals who are unhoused or unsheltered and provide healthcare and social services, as well as funds, including Medicaid and other public insurance reimbursement, for their maintenance;
- ~~(45)~~ recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
- ~~(56)~~ encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
- ~~(67)~~ will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians’ role therein, in addressing these needs;
- ~~(78)~~ encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
- ~~(89)~~ encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
- ~~(910)~~ (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available; and
- ~~(1011)~~ recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods; ~~and~~

(4412) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals; and  
(13) supports federal and state efforts to enact just cause eviction statutes and examine and restructure punitive eviction practices; instate inflation-based rent control; guarantee tenants' right to counsel in housing disputes and improve affordability of legal fees; and create national, state, and/or local rental registries. (Modify Current HOD Policy)

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

Received: 10/12/22

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## RELEVANT AMA POLICY

### Eradicating Homelessness H-160.903

Our AMA:

- (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services;
- (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless;
- (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis;
- (4) recognizes the need for an effective, evidence-based national plan to eradicate homelessness;
- (5) encourages the National Health Care for the Homeless Council to study the funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons;
- (6) will partner with relevant stakeholders to educate physicians about the unique healthcare and social needs of homeless patients and the importance of holistic, cost-effective, evidence-based discharge planning, and physicians' role therein, in addressing these needs;
- (7) encourages the development of holistic, cost-effective, evidence-based discharge plans for homeless patients who present to the emergency department but are not admitted to the hospital;
- (8) encourages the collaborative efforts of communities, physicians, hospitals, health systems, insurers, social service organizations, government, and other stakeholders to develop comprehensive homelessness policies and plans that address the healthcare and social needs of homeless patients;
- (9) (a) supports laws protecting the civil and human rights of individuals experiencing homelessness, and (b) opposes laws and policies that criminalize individuals experiencing homelessness for carrying out life-sustaining activities conducted in public spaces that would otherwise be considered non-criminal activity (i.e., eating, sitting, or sleeping) when there is no alternative private space available;
- (10) recognizes that stable, affordable housing is essential to the health of individuals, families, and communities, and supports policies that preserve and expand affordable housing across all neighborhoods; and
- (11) (a) supports training to understand the needs of housing insecure individuals for those who encounter this vulnerable population through their professional duties; (b) supports the establishment of multidisciplinary mobile homeless outreach teams trained in issues specific to housing insecure individuals; and (c) will make available existing educational resources from federal agencies and other stakeholders related to the needs of housing-insecure individuals.

Citation: Res. 401, A-15; Appended: Res. 416, A-18; Modified: BOT Rep. 11, A-18; Appended: BOT Rep. 16, A-19; Appended: BOT Rep. 28, A-19; Appended: Res. 414, A-22;

### Housing Insecure Individuals with Mental Illness H-160.978

- (1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws

that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population. Citation: BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16; Reaffirmed: BOT Rep. 16, A-19; Reaffirmed: Res. 414, A-22

### **Maintaining Mental Health Services by States H-345.975**

Our AMA:

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

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

### **11.1.4 Financial Barriers to Health Care Access**

Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means.

In view of this obligation,

(a) Individual physicians should:

(i) take steps to promote access to care for individual patients, such as providing pro bono care in their office or through freestanding facilities or government programs that provide health care for the poor, or, when permissible, waiving insurance copayments in individual cases of hardship. Physicians in the poorest communities should be able to turn for assistance to colleagues in more prosperous communities.

(ii) help patients obtain needed care through public or charitable programs when patients cannot do so themselves.

(b) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.

(c) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services.

(d) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure sufficient access to appropriate health care for all people.

### **AMA Principles of Medical Ethics: I,II,VI,VII,IX**

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

Citation: Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 933  
(I-22)

Introduced by: Medical Student Section

Subject: Reducing Disparities in HIV Incidence through Pre-Exposure Prophylaxis (PrEP) for HIV

Referred to: Reference Committee K

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Whereas, Sexual identity is fluid and can be defined on a spectrum, ranging from exclusively homosexual behavior to exclusively heterosexual behavior<sup>1</sup>; and

Whereas, According to the U.S. National Survey of Family Growth, 17.4% of women and 6.2% of men aged 18-44 report any same-sex sexual behavior at any time in their life, despite only 6.8% of women and 3.9% of men aged 18-44 report being homosexual, gay, lesbian, or bisexual<sup>2</sup>; and

Whereas, Patients' reported sexual behavior and orientation is not always consistent with actual sexual behavior as patients may not be willing to report their sexual histories accurately<sup>2</sup>; and

Whereas, In 2017, 30% of new HIV diagnoses in the United States were not attributed to the men who have sex with men (MSM) demographic<sup>3</sup>; and

Whereas, From 2010-2016, African American heterosexual women accounted for the second highest incidence of HIV infection after MSM<sup>4</sup>; and

Whereas, Black men who have sex with men and women (MSMW) have been hypothesized to be the "bridge" through which HIV has been transmitted to black heterosexual men and women<sup>5-6</sup>; and

Whereas, Several studies have shown that African American MSMW may challenge targeted HIV prevention approaches that focus explicitly on sexual orientation since this population may not identify as gay or bisexual and is therefore unlikely to participate in programs that prioritize gay community affiliation as foundations for HIV prevention<sup>5-6</sup>; and

Whereas, In 2017, the African American population and Hispanic population collectively accounted for 69% of HIV diagnoses, despite comprising only 31% of the U.S. population<sup>3</sup>; and

Whereas, A report from the CDC concluded that increasing HIV prevention services among heterosexuals at increased risk is important, especially among racial and ethnic groups disproportionately affected by HIV infection, such as blacks and Hispanics/Latinos<sup>7</sup>; and

Whereas, In 2019, the United States Preventive Services Task Force (USPSTF) recommended with an "A" rating that clinicians offer HIV pre-exposure prophylaxis (PrEP) to persons who are at high risk of HIV acquisition as an evidence-based primary prevention because PrEP reduces the risk of sexual transmission of HIV by about 99% when taken daily<sup>8-9</sup>; and

1 Whereas, While there are over 77,000 PrEP users in the United States, over 1.1 million  
2 additional individuals would benefit from being on it<sup>10-13</sup>; and

3  
4 Whereas, Sixty-nine percent of the individuals that could benefit from PrEP are Black or  
5 Hispanic, yet these individuals comprise only 4% of the individuals who are prescribed it<sup>11-12</sup>;  
6 and

7  
8 Whereas, PrEP uptake does not reflect the general distribution of the HIV epidemic in the  
9 United States, as people of color and women bear a high HIV burden, but have a  
10 disproportionately limited uptake<sup>14</sup>; and

11  
12 Whereas, Only 28% of primary care physicians are comfortable with prescribing PrEP, with the  
13 most frequently cited barrier to prescribing it being lack of knowledge<sup>15-16</sup>; and

14  
15 Whereas, A 2018 study showed that medical students were unable to identify individuals at  
16 highest risk of HIV acquisition and recommend PrEP accordingly<sup>17</sup>; and

17  
18 Whereas, Educational interventions targeted at primary care physicians that focus on HIV  
19 epidemiology, an introduction to PrEP and appropriate candidates, an overview of how to  
20 prescribe PrEP, as well as recommendations on sexual-history taking have all been shown to  
21 increase rates of PrEP prescribing when clinically indicated<sup>16</sup>; and

22  
23 Whereas, Regardless of the patient's current stated sexual behavior, routine primary care office  
24 visits are comprised of a comprehensive discussion of sexual health, sexual activity, sexuality,  
25 contraception, and prevention of sexually transmitted infections/diseases (STIs), beginning as  
26 early as age 11<sup>18-19</sup>; and

27  
28 Whereas, It is considered a best practice in primary care settings to educate patients about all  
29 the available options for preventing STIs, especially in sexually active adolescents and in adults  
30 at increased risk for STIs<sup>18-19</sup>; and

31  
32 Whereas, PrEP is considered to be an option for the prevention of HIV infection in seronegative  
33 individuals at high risk of HIV acquisition, yet it is not routinely discussed with patients<sup>8,15</sup>; and

34  
35 Whereas, A study found that the strongest factor influencing PrEP uptake among majority non-  
36 white heterosexual individuals at high risk of HIV, a group with disproportionately low PrEP  
37 uptake, was suggestion to initiate PrEP by a healthcare provider<sup>14</sup>; and

38  
39 Whereas, AMA policies H-180.944 "Plan for Continued Progress Toward Health Equity" and H-  
40 350.974 "Racial and Ethnic Disparities in Health Care" has named the elimination of racial and  
41 ethnic disparities in health care "an issue of highest priority" as they are a "barrier to effective  
42 medical diagnosis and treatment"; and

43  
44 Whereas, H-350.974 calls on the importance of "evidence-based guidelines to promote the  
45 consistency and equity of care for all persons" and "supports research to identify the most  
46 effective strategies for educating physicians on how to eliminate disparities in health outcomes  
47 in all at-risk populations"; and

48  
49 Whereas, No existing AMA policy explicitly acknowledges the disparities that exist in HIV  
50 prevention and treatment nor proposes a specific intervention to reduce such disparities;  
51 therefore be it

RESOLVED, That our American Medical Association amend Policy H-20.895 “Pre-Exposure Prophylaxis (PrEP) for HIV” by addition to read as follows:

**Pre-Exposure Prophylaxis (PrEP) for HIV, H-20.895**

1. Our AMA will educate physicians, physicians-in-training, and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.
5. Our AMA encourages the discussion of and education about PrEP during routine sexual health counseling, regardless of a patient’s current reported sexual behaviors. (Modify Current HOD Policy)

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

Received: 10/13/22

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## RELEVANT AMA POLICY

### Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.
  2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.
  3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.
  4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.
- Citation: CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16; Modified: Res. 903, I-17; Modified: Res. 904, I-17; Res. 16, A-18; Reaffirmed: CSAPH Rep. 01, I-18

### Eliminating Health Disparities - Promoting Awareness and Education of Sexual Orientation and Gender Identity Health Issues in Medical Education H-295.878

- Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues related to sexual orientation and gender identity; and (3) encourages medical education accreditation bodies to both continue to encourage and periodically reassess education on health issues related to sexual orientation and gender identity in the basic science, clinical care, and cultural competency curricula in undergraduate and graduate medical education.
- Citation: Res. 323, A-05; Modified in lieu of Res. 906, I-10; Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16; Modified: Res. 16, A-18; Modified: Res. 302, I-19

**Improving the Health of Black and Minority Populations H-350.972**

Our AMA supports:

- (1) A greater emphasis on minority access to health care and increased health promotion and disease prevention activities designed to reduce the occurrence of illnesses that are highly prevalent among disadvantaged minorities.
- (2) Authorization for the Office of Minority Health to coordinate federal efforts to better understand and reduce the incidence of illness among U.S. minority Americans as recommended in the 1985 Report to the Secretary's Task Force on Black and Minority Health.
- (3) Advising our AMA representatives to the LCME to request data collection on medical school curricula concerning the health needs of minorities.
- (4) The promotion of health education through schools and community organizations aimed at teaching skills of health care system access, health promotion, disease prevention, and early diagnosis.

Citation: CLRPD Rep. 3, I-98; Reaffirmation A-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CEJA Rep. 1, A-21

**Plan for Continued Progress Toward Health Equity H-180.944**

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

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

**Racial and Ethnic Disparities in Health Care H-350.974**

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

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

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

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

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

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

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

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

**Pre-Exposure Prophylaxis (PrEP) for HIV H-20.895**

1. Our AMA will educate physicians and the public about the effective use of pre-exposure prophylaxis for HIV and the US PrEP Clinical Practice Guidelines.
2. Our AMA supports the coverage of PrEP in all clinically appropriate circumstances.
3. Our AMA supports the removal of insurance barriers for PrEP such as prior authorization, mandatory consultation with an infectious disease specialist and other barriers that are not clinically relevant.
4. Our AMA advocates that individuals not be denied any insurance on the basis of PrEP use.

Citation: Res. 106, A-16; Modified: Res. 916, I-16; Appended: Res. 101, A-17

**Support of a National HIV/AIDS Strategy H-20.896**

1. Our AMA supports the creation of a National HIV/AIDS strategy, and will work with relevant stakeholders to update and implement the National HIV/AIDS strategy.
2. Our AMA supports and will strongly advocate for the funding of plans to end the HIV epidemic that focus on: (a) diagnosing individuals with HIV infection as early as possible; (b) treating HIV infection to achieve sustained viral suppression; (c) preventing at-risk individuals from acquiring HIV infection, including through the use of pre-exposure prophylaxis; and (d) rapidly detecting and responding to emerging clusters of HIV infection to prevent transmission.

Citation: Sub Res. 425, A-09; Modified: CSAPH Rep. 01, A-19; Appended: Res. 413, A-19

**HIV/AIDS Education and Training H-20.904****(1) Public Information and Awareness Campaigns**

Our AMA:

- a) Supports development and implementation of HIV/AIDS health education programs in the United States by encouraging federal and state governments through policy statements and recommendations to take a stronger leadership role in ensuring interagency cooperation, private sector involvement, and the dispensing of funds based on real and measurable needs. This includes development and implementation of language- and culture-specific education programs and materials to inform minorities of risk behaviors associated with HIV infection.
- b) Our AMA urges the communications industry, government officials, and the health care communities together to design and direct efforts for more effective and better targeted public awareness and information programs about HIV disease prevention through various public media, especially for those persons at increased risk of HIV infection;
- c) Encourages education of patients and the public about the limited risks of iatrogenic HIV transmission. Such education should include information about the route of transmission, the effectiveness of universal precautions, and the efforts of organized medicine to ensure that patient risk remains immeasurably small. This program should include public and health care worker education as appropriate and methods to manage patient concern about HIV transmission in medical settings. Statements on HIV disease, including efficacy of experimental therapies, should be based only on current scientific and medical studies;
- d) Encourages and will assist physicians in providing accurate and current information on the prevention and treatment of HIV infection for their patients and communities;
- e) Encourages religious organizations and social service organizations to implement HIV/AIDS education programs for those they serve.

**(2) HIV/AIDS Education in Schools**

Our AMA:

- a) Endorses the education of elementary, secondary, and college students regarding basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies;
- b) Supports efforts to obtain adequate funding from local, state, and national sources for the development and implementation of HIV educational programs as part of comprehensive health education in the schools.

**(3) Education and Training Initiatives for Practicing Physicians and Other Health Care Workers**

Our AMA supports continued efforts to work with other medical organizations, public health officials, universities, and others to foster the development and/or enhancement of programs to provide comprehensive information and training for primary care physicians, other front-line health workers (specifically including those in addiction treatment and community health centers and correctional facilities), and auxiliaries focusing on basic knowledge of HIV infection, modes of transmission, and recommended risk reduction strategies. Citation: CSA Rep. 4, A-03; Appended: Res. 516, A-06; Modified: CSAPH 01, A-16; Reaffirmed: Res. 916, I-16;



## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 935  
(I-22)

Introduced by: Medical Student Section

Subject: Government Manufacturing of Generic Drugs to Address Market Failures

Referred to: Reference Committee K

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1 Whereas, Among United States adults, 24% indicate that it is difficult to afford the cost of their  
2 prescription medication(s) and 29% state that they have been unable to take their medications  
3 as prescribed within the past year (either not filling a prescription, substituting an over-the-  
4 counter drug, cutting pills in half, skipping doses, or some combination thereof) due to inability  
5 to afford them<sup>1</sup>; and  
6

7 Whereas, In 2019, 1.49 million Medicare Part D enrollees exceeded the out-of-pocket  
8 catastrophic coverage threshold of \$6,550, such that they had to pay out of pocket for 5% of  
9 total drug costs with no hard cap on total spending by enrollees, resulting in \$1.8 billion in out-  
10 of-pocket spending by these enrollees for drug costs over the threshold<sup>2</sup>; and  
11

12 Whereas, Spending on prescription pharmaceuticals constitutes 10% of national health  
13 spending, 18% of large employer health benefit expenses, 19% of out-of-pocket spending for  
14 Medicare beneficiaries, and 17% of out-of-pocket spending for employees<sup>3</sup>; and  
15

16 Whereas, One analysis of the economic impact of medication non-adherence among fourteen  
17 disease groups estimated the all-causes cost of non-adherence at between \$5,271 and \$52,341  
18 per patient<sup>4</sup>; and  
19

20 Whereas, A 2017 study published in *Cancer* determined that 23.8% of adolescent and young  
21 adult cancer survivors (aged 15 to 39 years) experience cost-related medication non-  
22 adherence, with Black survivors, uninsured survivors, and survivors with multiple comorbidities  
23 suffering the highest rates of medication non-adherence<sup>5</sup>; and  
24

25 Whereas, Research on patients with hypertension demonstrated that patients with cost-related  
26 non-adherence are less likely to have self-reported normal blood pressure (59.5% versus 69.8%  
27 for patients without nonadherence)<sup>6</sup>; and  
28

29 Whereas, An analysis by the Kaiser Family Foundation found that 50% of drugs covered by  
30 Medicare Part D had list price increases that were greater than the rate of inflation between July  
31 2018 and 2019, with 14% of Part D-covered drugs having list price increases of 10% or more  
32 over that year-long timeframe<sup>7</sup>; and  
33

34 Whereas, Approximately 60% of total Medicare Part D spending (\$87 billion) results from the  
35 purchase of the 250 top-selling drugs covered by Part D that have one manufacturer and no  
36 generic or biosimilar competition<sup>8</sup>; and  
37

38 Whereas, The number of generic suppliers per market decreased over time from 2004 to 2016,  
39 due to both increased exit from markets and decreased market entry<sup>9</sup>; and

1 Whereas, The median number of drug manufacturers per market in 2016 was two, with 40% of  
2 pharmaceutical markets supplied by a sole manufacturer as of 2016<sup>9</sup>; and  
3

4 Whereas, There is evidence that the price of generic drugs is undergoing a statistically  
5 significant increase over time, and the price increases are associated with decreasing numbers  
6 of manufacturers for each generic drug, as well as alternative measures of increased supplier  
7 concentration<sup>9</sup>; and  
8

9 Whereas, According to a 2016 United States Government Accountability Office report, between  
10 2010 and 2015, 315 of the 1,441 generic pharmaceuticals that were available for the duration of  
11 the study period (22%) underwent at least one “extraordinary” price increase in Medicare Part  
12 D, defined as a price increase of 100% or more<sup>10</sup>; and  
13

14 Whereas, Generic drug shortages in the United States quadrupled between 2005 and 2011,  
15 increasing from 61 drugs to 250 drugs<sup>11</sup>; and  
16

17 Whereas, The entry of additional generic manufacturers to a pharmaceutical market frequently  
18 results in rapidly decreasing prices, as generic drugs entering the market between 2002 and  
19 2014 lowered drug prices by 51% in the first year<sup>11</sup>; and  
20

21 Whereas, An antitrust investigation into generic manufacturers in 2018 uncovered evidence of a  
22 generic “cartel” implicating at least 16 companies, in which anti-competitive price-fixing  
23 agreements involving 300 pharmaceuticals resulted in price increases of up to 2,000  
24 percent<sup>12,13</sup>; and  
25

26 Whereas, A *National Bureau of Economic Research* paper noted that “for products targeting  
27 exceptionally small patient populations, the fixed costs of entry and the likelihood of intense  
28 post-entry price competition mean that a new entrant is unlikely to earn profits”- in other words,  
29 a generic manufacturer is highly unlikely to ever enter the market for some drugs targeted at  
30 small patient populations<sup>14</sup>; and  
31

32 Whereas, In 2018, a group of major hospital systems, including the Mayo Clinic and HCA  
33 Healthcare, and philanthropies launched a non-profit generic drug manufacturer to produce  
34 generic drugs experiencing shortages or dramatic price increases<sup>15,16</sup>; and  
35

36 Whereas, A recent *New England Journal of Medicine* perspective proposed the creation of a  
37 non-profit generic pharmaceutical manufacturer to mitigate generic market failures and sell  
38 generic drugs directly to hospitals and other institutional partners, with predetermined contracts  
39 to ensure low prices and a minimum volume, which would protect the non-profit manufacturer  
40 from being forced out of the market because of price changes<sup>17</sup>; and  
41

42 Whereas, There is federal legislation most recently re-introduced in January 2020 that seeks to  
43 establish an Office of Drug Manufacturing within the Department of Health and Human Services  
44 to facilitate public manufacturing of generic drugs<sup>18-20</sup>; and  
45

46 Whereas, In recent testimony before the House of Representatives Subcommittee on  
47 Regulatory Reform, Commercial and Antitrust Law, economist Craig Garthwaite characterized  
48 the proposal to establish a government generic manufacturer for small market drugs as “a  
49 potentially viable policy option” to mitigate the market failure resulting from the dearth of  
50 competition in markets for generic drugs with insufficient market size to support more than one  
51 manufacturer, which creates a natural monopoly<sup>21</sup>; and

Whereas, A federal non-profit government manufacturer would be able to focus production of generic version of prescription drugs on circumstances in which market failures occur, as in scenarios where there are no generic manufacturers within a market or there are two or fewer manufacturers and a significant price increase or a drug shortage<sup>18,22,23</sup>; therefore be it

RESOLVED, That our American Medical Association support the formation of a non-profit government manufacturer of pharmaceuticals to produce small-market generic drugs. (New HOD Policy)

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

Received: 10/13/22

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## RELEVANT AMA POLICY

### Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980

1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
    - a. The arbitration process should be overseen by objective, independent entities;
    - b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
    - c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
    - d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
    - e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
    - f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
    - g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
    - h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
    - i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
  2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
    - a. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
    - b. The use of any international drug price index or average should preserve patient access to necessary medications;
    - c. The use of any international drug price index or average should limit burdens on physician practices; and
    - d. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.
  3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.
- Citation: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Modified: CMS Rep. 4, A-22

### Prescription Drug Prices and Medicare D-330.954

1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

Citation: Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 113, I-21; Reaffirmed: CMS Rep. 4, A-22

#### **Pharmaceutical Costs H-110.987**

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
  2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
  3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
  4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
  5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
  6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
  7. Our AMA supports legislation to shorten the exclusivity period for biologics.
  8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
  9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
  10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
  11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
  12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
  13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.
  14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.
- Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21;

#### **Pay for Delay Arrangements by Pharmaceutical Companies H-110.989**

Our AMA supports: (1) the Federal Trade Commission in its efforts to stop "pay for delay" arrangements by pharmaceutical companies and (2) federal legislation that makes tactics delaying conversion of medications to generic status, also known as "pay for delay," illegal in the United States.

Citation: Res. 520, A-08; Appended: Res. 222, I-12; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 817, I-16

#### **Price of Medicine H-110.991**

Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health

plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies' contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient's co-pay is higher than the drug's cash price; (4) will disseminate model state legislation to promote drug price and cost transparency and to prohibit "clawbacks"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard.

Citation: CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Reaffirmation: A-19; Appended: Res. 126, A-19

### **Incorporating Value into Pharmaceutical Pricing H-110.986**

1. Our AMA supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.

2. Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research.

3. Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.

Citation: CMS Rep. 05, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS-CSAPH Rep. 01, A-17; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: CSAPH Rep. 2, I-19; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 6, I-20

### **Cost of Prescription Drugs H-110.997**

Our AMA:

(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;

(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;

(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;

(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;

(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;

(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA

A-rated generic); and

(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

Citation: BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep.3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

#### **Opposition to Medicare Part B to Part D Changes H-110.982**

Our AMA will advocate against Medicare changes which would recategorize Medicare Part B drugs into Part D.

Citation: Res. 217, I-18

#### **Insulin Affordability H-110.984**

Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to investigate insulin pricing and market competition and take enforcement actions as appropriate; (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies; and (3) support state and national efforts to limit the ultimate expenses incurred by insured patients for prescribed insulin.

Citation: CMS Rep. 07, A-18; Modified: Res. 118, A-22

#### **Reducing Prescription Drug Prices D-110.993**

Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.

Citation: (CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation A-14; Reaffirmed in lieu of Res. 229, I-14)

#### **Co-Pay Accumulators D-110.986**

Our AMA will develop model state legislation regarding Co-Pay Accumulators for all pharmaceuticals, biologics, medical devices, and medical equipment, and support federal and state legislation or regulation that would ban co-pay accumulator policies, including in federally regulated ERISA plans.

Citation: Res. 205, I-19; Appended: Res. 212, I-20

#### **Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers H-100.950**

1. Our AMA will advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek Food and Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system.

2. Our AMA supports requiring pharmaceutical companies to allow for reasonable access to and purchase of appropriate quantities of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays.

3. Our AMA will advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs.

Citation: Res. 809, I-16

#### **Prescription Drug Price and Cost Transparency D-110.988**

1. Our AMA will continue implementation of its TruthinRx grassroots campaign to expand drug pricing transparency among pharmaceutical manufacturers, pharmacy benefit managers and health plans, and to communicate the impact of each of these segments on drug prices and access to affordable treatment.

2. Our AMA will report back to the House of Delegates at the 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign. Citation: Alt. Res. 806, I-17

### **Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988**

1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.
2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.
3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.
4. Our AMA supports measures that increase price transparency for generic prescription drugs.

Citation: Sub. Res. 106, A-15; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

### **Cost Sharing Arrangements for Prescription Drugs H-110.990**

Our AMA:

1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes;
3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and patient-specific out-of-pocket costs of individual prescription drugs, taking into account insurance status or payer type, prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition; and
4. supports public and private prescription drug plans in offering patient-friendly tools and technology that allow patients to directly and securely access their individualized prescription benefit and prescription drug cost information.

Citation: CMS Rep. 1, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed in lieu of Res. 105, A-13; Reaffirmed in lieu of: Res. 205, A-17; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: CMS Rep. 07, A-18; Appended: CMS Rep. 2, I-21

### **Study of Actions to Control Pharmaceutical Costs H-110.992**

Our AMA will monitor the relationships between pharmaceutical benefits managers and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs.

Citation: Sub. Res. 114, A-01; Reaffirmed: Res. 533, A-03; Reaffirmed: CMS Rep. 4, A-13; Reaffirmed in lieu of Res. 229, I-14; Reaffirmed: CMS 2, I-15; Reaffirmed: CMS Rep. 07, A-18; Reaffirmed: CMS Rep. 08, A-19

### **Cost of New Prescription Drugs H-110.998**

Our AMA urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs.

Citation: (Res. 112, I-89; Reaffirmed: Res. 520, A-99; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed in lieu of Res. 229, I-14)

### **Public Reporting of PBM Rebates H-110.981**

Our AMA will advocate for: (1) Pharmacy Benefit Managers (PBMs) and state regulatory bodies to make rebate and discount reports and disclosures available to the public; and (2) the inclusion of required public reporting of rebates and discounts by PBMs in federal and state PBM legislation.

Citation: Res. 813, I-19



## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 936  
(I-22)

Introduced by: Medical Student Section

Subject: Promoting the Use of Multi-Use Devices and Sustainable Practices in the Operating Room

Referred to: Reference Committee K

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1 Whereas, The United States leads the world in solid waste production with 262 million tons per  
2 year, with the healthcare industry as its second highest waste-producing industry, accounting for  
3 9% of U.S. energy use and 8% of U.S. greenhouse gas emissions<sup>1-7</sup>; and  
4

5 Whereas, Approximately 70% of the total waste generated by the healthcare sector is produced  
6 by operating rooms and labor and delivery suites, and surgical and medical instrument  
7 manufacturing is the leading cause for ozone depletion<sup>8,9</sup>; and  
8

9 Whereas, According to the Centers for Medicare and Medicaid Services, the cost of healthcare  
10 continues to increase each year, estimated at \$3.8 trillion in 2019 and projected to increase at  
11 an average rate of 5.5% per year until 2027<sup>1,5</sup>; and  
12

13 Whereas, Expenditures for outpatient surgical care consisted of 36% of all outpatient costs, and  
14 inpatient surgical admissions made up 49% of all inpatient healthcare spending in 2017<sup>10</sup>; and  
15

16 Whereas, It has been shown that decreasing the use of disposable drapes, attire, and other  
17 plastic materials in the operating room resulted in savings of thousands of dollars per year with  
18 no change in the infection rate<sup>11-16</sup>; and  
19

20 Whereas, Converting to reusable products in the operating room can reduce up to 65% of  
21 operating room waste, diverting up to 25 tons of medical waste, saving up to \$150,000 per  
22 hospital per year, and reducing water, carbon footprint, and volatile organics<sup>17-19</sup>; and  
23

24 Whereas, A “reusable” device is one that the manufacturer has demonstrated to the FDA can  
25 safely withstand harsh sterilization processes, compared to “reprocessing” single-use devices,  
26 which is the act of sterilizing and reusing devices that the manufacturer has not marketed for  
27 reuse, and therefore did not have to meet FDA’s stringent criteria for adequate safe sterilization  
28 to be sold<sup>20</sup>; and  
29

30 Whereas, Single-use devices are not intended to be reused by the original manufacturer, and  
31 exposure to heat and chemicals during the sanitation process could weaken the product<sup>21,22</sup>;  
32 and  
33

34 Whereas, Overall, the safety standards for multi-use devices are much higher and stricter than  
35 those for single-use devices, and some single-use devices are labeled single-use because there  
36 is not sufficient evidence to categorize them as reusable<sup>21,22</sup>; and  
37

38 Whereas, The U.S. Government Accountability Office released a report in 2008 noting that  
39 “neither existing FDA data nor studies performed by others are sufficient to draw definitive

1 conclusions about the safety of reprocessed single use devices compared to similar original  
2 devices,"<sup>20</sup>; and

3  
4 Whereas, The Joint Commission International published a report in 2017 to raise awareness of  
5 the risks associated with reprocessing certain single use devices and the need for stricter  
6 regulatory requirements for third-party re-processors and hospitals that use reprocessed  
7 devices<sup>23</sup>; and

8  
9 Whereas, Even with the increased FDA and Joint Commission oversight, the trends by hospitals  
10 and surgical centers to decrease costs by reprocessing devices and utilizing sustainable  
11 practices are counteracted by increased efforts by original manufacturers, who do not reprocess  
12 their own single-use devices, to sell more single-use devices and discourage reprocessing  
13 practices<sup>24,25</sup>; and

14  
15 Whereas, Current policy on the reprocessing of single-use devices (H-480.959) does not  
16 adequately promote sustainable practices by the original device manufacturers as they continue  
17 to increase production of single-use devices and are not held liable once their device labeled  
18 "single-use" is reprocessed or reused; therefore be it

19  
20 RESOLVED, That our American Medical Association advocate for research into and  
21 development of intended multi-use operating room equipment and attire over devices,  
22 equipment and attire labeled for "single-use" with verified similar safety and efficacy profiles.  
23 (Directive to Take Action)

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

Received: 10/13/22

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## RELEVANT AMA POLICY

### Reprocessing of Single-Use Medical Devices H-480.959

1. Our AMA: (a) supports the Food and Drug Administration (FDA) guidance titled "Enforcement Priorities for Single-Use Devices Reprocessed by Third Parties and Hospitals" that was issued on August 2, 2000;(b) supports the development of device-specific standards for the reuse and reprocessing of single-use medical devices involving all appropriate medical and professional organizations and the medical device industry;(c) encourages increased research by the appropriate organizations and federal agencies into the safety and efficacy of reprocessed single-use medical devices; and(d) supports the proper reporting of all medical device failures to the FDA so that surveillance of adverse events can be improved.

2.Our AMA strongly opposes any rules or regulations regarding the repair or refurbishment of medical tools, equipment, and instruments that are not based on objective scientific data.

Citation: CSA Rep. 3, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 217, I-17

### Expansion of Hazardous Waste Landfills Over Aquifers H-135.943

Our AMA:

- (1) recognizes that the expansion of hazardous waste landfills or the construction of new hazardous waste landfills over principal aquifers represents a potential health risk for the public water supply and is inconsistent with sound principles of public health policy, and therefore should be opposed;
- (2) will advocate for the continued monitoring of groundwater sources, including principal aquifers, that may be contaminated by hazardous waste landfill or other landfill leachate; and
- (3) supports efforts to improve hazardous waste treatment, recycling, and disposal methods in order to reduce the public health burden.

Citation: CSAPH Rep. 4, A-07; Reaffirmed: CSAPH Rep. 01, A-17

### Green Initiatives and the Health Care Community H-135.939

Our AMA supports: (1) responsible waste management and clean energy production policies that minimize health risks, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; (5) the establishment, expansion, and continued maintenance of affordable, accessible, barrier-free, reliable, and clean-energy public transportation; and (6) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities.

Citation: CSAPH Rep. 1, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 402, A-10; Reaffirmed in lieu of: Res. 504, A-16; Modified: Res. 516, A-18; Modified: Res. 923, I-19

### **Health Care Expenditures D-155.996**

1. Our AMA will work to improve our health care system by: (a) researching and collating existing studies on how health care dollars are currently spent; (b) identifying the amount of public and private health care spending that is transferred to insurance administration compared to industry and corporate standards, including money spent on defensive medicine; and (c) disseminating these findings to the American public, US Congress, and appropriate agencies.
2. Our AMA will continue its efforts to identify ways to reduce waste in the health care sector so that the trend of increasing health care costs over the years could be reversed.

Citation: Res. 103, A-05; Appended: Res. 121, A-10; Reaffirmed: CMS Rep. 01, A-20

### **Expense of Biohazardous Waste Removal H-135.953**

(1)The AMA encourages the Environmental Protection Agency (EPA): (a) to explore the feasibility of establishing a national definition of biohazardous waste, emphasizing the origins and relative importance of wastes that can plausibly transmit infection compared with wastes that cannot, and (b) to monitor the sources of medical waste in environmental settings and develop guidelines applicable to all waste generators, including home health care sites, to reduce these sources of environmental pollution. (2)The AMA will work with appropriate governmental agencies and medical societies to educate physicians about the management of biohazardous waste and advocate that these groups work collectively to attain cost savings in biohazardous waste management.(3) The AMA urges practicing physicians to develop a biohazardous waste management program that fulfills their county, state, and municipal regulations, and that considers the different health risks to employees and the general public.

Citation: CSA Rep. 4, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

### **Toxicity of Computers and Electronics Waste H-135.948**

Our AMA (1) encourages its members and US health institutions to adopt purchasing or leasing contracts only with electronics manufacturers and distributors who are committed to safely handling the products at the end of life, meaning that they reuse and recycle to the greatest extent possible, do not export hazardous electronic waste to developing countries and safely dispose of the waste that can not be reused or recycled; (2) encourages its members and US health institutions to provide purchasing/leasing preferences to electronics manufacturers that minimize the use of toxic and hazardous constituents, use recycled content and design products that can be easily recycled in order to minimize the adverse public health impacts from electronic waste; and (3) supports policies that hold electronics manufacturers and distributors responsible for taking back their products at the end of life, with the objective of redesigning their products for longevity and reduction of harmful materials.

Citation: (Res. 423, A-03; Reaffirmed: CSAPH Rep. 1, A-13)

### **Stewardship of the Environment H-135.973**

The AMA: (1) encourages physicians to be spokespersons for environmental stewardship, including the discussion of these issues when appropriate with patients; (2) encourages the medical community to cooperate in reducing or recycling waste; (3) encourages physicians and the rest of the medical community to dispose of its medical waste in a safe and properly prescribed manner; (4) supports enhancing the role of physicians and other scientists in environmental education; (5) endorses legislation such as the National Environmental Education Act to increase public understanding of environmental degradation and its prevention; (6) encourages research efforts at ascertaining the physiological and psychological effects of abrupt as well as chronic environmental changes; (7) encourages international exchange of information relating to environmental degradation and the adverse human health effects resulting from environmental degradation; (8) encourages and helps support physicians who participate actively in international planning and development conventions associated with improving the environment; (9) encourages educational programs for worldwide family planning and control of population growth; (10) encourages research and development programs for safer, more effective, and less expensive means of preventing unwanted pregnancy; (11) encourages programs to prevent or reduce the human and environmental health impact from global climate change and environmental degradation.(12) encourages economic development programs for all nations that will be sustainable and yet nondestructive to the environment; (13) encourages physicians and environmental scientists in the United States to continue to incorporate concerns for human health into current environmental research and public policy initiatives; (14) encourages physician educators in medical schools, residency programs, and continuing medical education sessions to devote more attention to environmental health issues;

(15) will strengthen its liaison with appropriate environmental health agencies, including the National Institute of Environmental Health Sciences (NIEHS); (16) encourages expanded funding for environmental research by the federal government; and (17) encourages family planning through national and international support.

Citation: CSA Rep. G, I-89; Amended: CLRPD Rep. D, I-92; Amended: CSA Rep. 8, A-03; Reaffirmed in lieu of Res. 417, A-04; Reaffirmed in lieu of Res. 402, A-10; Reaffirmation I-16

#### **Policy to Reduce Waste from Pharmaceutical Sample Packaging H-115.979**

Our AMA: (1) supports reducing waste from pharmaceutical sample packaging by making sample containers as small as possible and by using biodegradable and recycled materials whenever possible; and (2) supports the modification of any federal rules or regulations that may be in conflict with this policy.

Citation: Res. 508, I-91; Modified: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 1, A-21

#### **Recycling of Nursing Home Drugs H-280.959**

Our AMA supports the return and reuse of medications to the dispensing pharmacy to reduce waste associated with unused medications in long-term care facilities (LTCFs) and to offer substantial savings to the health care system, provided the following conditions are satisfied: (1) The returned medications are not controlled substances. (2) The medications are dispensed in tamper-evident packaging and returned with packaging intact (e.g., unit dose, unused injectable vials and ampules). (3) In the professional judgment of the pharmacist, the medications meet all federal and state standards for product integrity. (4) Policies and procedures are followed for the appropriate storage and handling of medications at the LTCF and for the transfer, receipt, and security of medications returned to the dispensing pharmacy. (5) A system is in place to track re-stocking and reuse to allow medications to be recalled if required. (6) A mechanism (reasonable for both the payer and the dispensing LTC pharmacy) is in place for billing only the number of doses used or crediting the number of doses returned, regardless of payer source.

Citation: CSA Rep. 2, I-97; Reaffirmed: BOT Rep. 33, A-07; Modified and Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 01, A-19;

#### **Health Care Expenditures D-155.996**

1. Our AMA will work to improve our health care system by: (a) researching and collating existing studies on how health care dollars are currently spent; (b) identifying the amount of public and private health care spending that is transferred to insurance administration compared to industry and corporate standards, including money spent on defensive medicine; and (c) disseminating these findings to the American public, US Congress, and appropriate agencies.

2. Our AMA will continue its efforts to identify ways to reduce waste in the health care sector so that the trend of increasing health care costs over the years could be reversed.

Citation: Res. 103, A-05; Appended: Res. 121, A-10; Reaffirmed: CMS Rep. 01, A-20

#### **Medications Return Program H-135.925**

1. Our AMA supports access to safe, convenient, and environmentally sound medication return for unwanted prescription medications

2. Our AMA supports such a medication disposal program be fully funded by the pharmaceutical industry, including costs for collection, transport and disposal of these materials as hazardous waste.

3. Our AMA supports changes in federal law or regulation that would allow a program for medication recycling and disposal to occur.

Citation: Res. 214, A-16; Reaffirmed in lieu of: Res. 928, I-16

#### **Hospital Dress Codes for the Reduction of Health Care-Associated Infection Transmission of Disease H-440.856**

Our AMA encourages: (1) research in textile transmission of health care-associated infections (HAI); (2) testing and validation of research results before advocating for adoption of dress code policies that may not achieve reduction of HAIs; (3) all clinicians to assume "antimicrobial stewardship," i.e., adherence to evidence-based solutions and best practices to reduce of HAIs and HAI infection rates; and (4) all clinicians when seeing patients to wear attire that is clean, unsoiled, and appropriate to the setting of care.

Citation: BOT Rep. 3, A-10; Reaffirmation A-15